

## MEMORANDUM

January 3, 2003

TO: Governing Board  
California Mental Health Directors Association

FROM: David Meyer, Chair  
L.P.S. Workgroup

SUBJECT: **INTERIM REPORT**

At the 2002 Governing Board Annual Retreat, a workgroup was established to assess the problems and opportunities related to involuntary treatment under the Lanterman Petris Short (LPS) Act. Workgroup members are Alan Edwards, M.D., Orange County; Dick Harig, Ph.D., Tehama County; Mark Refowitz, San Diego County; Dave Meyer, Los Angeles County; Mike Ferguson, M.D., Ventura County; Harvey Tureck, Berkeley City; Rod Shaner, M.D., Los Angeles County; Jerry Wengerd, Fresno County; Fred Heacock, Yolo County; and Esther Castillo, Yolo County. Also participating and contributing have been Patricia Ryan, CMHDA; Sandra Goodwin, Ph.D., CIMH and Jack Tanenbaum, CMHDA. Ron Bettencourt and Mel Voyles from the State Department of Mental Health have participated and made significant contributions. This is an interim report that focuses on AB1421.

After a contentious, some say divisive, three-year legislative parturition, AB1421 (Thompson) was enacted as Welfare and Institutions Code (WIC) sections 5345 through 5349.5 to be effective January 1, 2003. Plainly, this is pilot legislation as the bill's provisions sunset on January 1, 2008 and its operative provisions are denominated the Assisted Outpatient Demonstration Project Act of 2002.

Entitled "Laura's Law" in remembrance of a murder victim in Nevada County, AB1421 establishes a new form of court-ordered care denominated "Assisted Outpatient Treatment" (AOT). Partly due to serial amendment during the legislative process, the statutory provisions are complex and poorly organized. The language contains minute detail related to some aspects of care delivery and legal process, but is silent or vague as to others. This, along with the fact that implementation is a local option and without state funding, has given rise to concern in many quarters. This working paper is intended to support discussions within CMHDA and provide information to Directors in whose counties AB1421 implementation is being considered.

### **Principles of Assisted Outpatient Treatment (AOT)**

The operative premise of AOT is that court process and a court order provide a coercive element to the PACT model that, in turn, increases the prospects for long-term recovery.

The widespread implementation of drug courts provides abundant evidence of the effectiveness of the coercive element of court process to engage individuals in care and behavior modification for substance abuse problems. This success has led court systems to implement specialized programs related to human services issues such as domestic violence. Recently, there has been an expansion of the mental health court model pioneered in Broward County, Florida. The evidence related to these programs is less clear than for the drug courts. It should be noted, as well, that all of these court programs are components of the criminal justice system. AOT, and like programs in other states, are “civil” court proceedings that do not involve crimes or the threat of punishment.

The legislative findings supporting AB 1421 rely, in part, on a study by Rand Corporation that was commissioned by the legislature. A summary of the study’s findings is available online at <http://www.rand.org/publications/RB/RB4537>. Essentially, the Rand study provides little comfort for either proponents or opponents of the legislation. The summary concludes, “The Rand team’s research could not provide an answer to the question of whether an involuntary outpatient treatment system in California is worth the additional costs.” Many other states have enacted similar laws, often referenced as involuntary outpatient commitment. A summary compilation of these laws is available online from the Bazelon Center for Mental Health Law at <http://bazelon.org.gravitatehosting.com/LinkClick.aspx?fileticket=CBmFgyA4i-w%3d&tabid=324>. Proponents cite favorable outcomes studies of such laws in New York and North Carolina. The NAMI Treatment Advocacy Center has references to these studies online at <http://www.treatmentadvocacycenter.org/>. Opponents criticize these studies, joined by the Bazelon Center and information is attached.

One of the strongest arguments for an AOT implementation is that it is a demonstration project; the purpose of which is to test the efficacy of this form of involuntary care. The statute does have requirements that extensive data, including outcomes data, be taken and submitted to the State Department of Mental Health (SDMH) that, in turn, reports to the legislature. Opponents argue that the high costs and complex requirements of the AOT statute do not justify dedicating limited resources on a yet to be proven theory. These arguments continue and they can be expected to continue with vigor wherever AOT implementation is being considered. The analysis below does not reflect either argument. It focuses on the provisions of the AOT law and the issues facing counties that are considering local implementation.

### **Eligibility for AOT Services**

AOT applies only to adults. There are both clinical and behavioral eligibility criteria that must predate the AOT legal process. The person subjected to AOT must come within

the Bronzan-McCoquodale definitions of serious mental disorder and target population; something not shared by other LPS provisions. There must be a “clinical determination” that the person cannot survive safely in the community unsupervised and that his or her condition is “substantially deteriorating.” A lack of treatment compliance must exist as demonstrated by either 1) at least two hospitalizations or treatment episodes in a correctional facility within the last 36 months, or 2) one or more acts, attempts or threats of serious and violent behavior to self or others within the last 48 months. AOT must be the least restrictive approach to ensuring recovery and stability and it must be likely that the person will benefit by it. Finally, AOT-like services must be offered to and refused by the person prior to initiating the AOT process. These detailed criteria are each necessary components to the establishing AOT because each must be separately listed in a petition to initiate an AOT proceeding and each must be proved in court.

### **AOT Program Requirements**

WIC section 5348 lists the AOT program components—very specifically. Essentially, it provides for the PACT model of care, and in many ways it parallels the provisions of AB34/2034. However, it is quite prescriptive about service provision that must include “Community-based, mobile, multidisciplinary, highly trained mental health teams that use high staff-to-client ratios of no more than 10 clients per team member...” The treatment team must include a personal services coordinator (PSC) who has varied responsibilities for care assessment and provision. Interestingly, the statute requires the PSC to “...consult with the designated conservator, if one has been appointed...” suggesting that AOT was intended to coexist with conservatorships.

Counties that implement AOT must undertake a wide-ranging “service planning and delivery process.” This includes a requirement to consult a broad range of stakeholder constituencies and law enforcement groups. The resulting service plan must address a comprehensive list of wrap-around mental health, social, physical health and housing services. It must have specific strategies for a lengthy list of potential AOT service recipients and stakeholders such as families. The plan must have provision for individuals “...who have been suffering from an untreated severe mental illness for less than one year, and who do not require the full range of services, but who are at risk of becoming homeless unless a comprehensive individual and family support services plan is implemented...” (WIC section 5348(a)(2)(K)). While this requirement appears to be intended to prevent the described population from requiring AOT, it may require some counties to establish new non-AOT services.

Implementation of AOT must include a comprehensive training and education program for purposes of improving the delivery of services to AOT recipients and those who are at risk of becoming such recipients. A broad range of stakeholders, including the State Department of Mental Health (SDMH), must be consulted in the development of the training. Once developed, this training must be provided to AOT mental health treatment providers along with law enforcement officials and LPS hearing officers. The statute does not address the frequency with which the training must be provided.

## Costs and Funding Issues

No state funding was appropriated to support AOT implementation or AOT service provision. As implementation is a local option, SB 90 reimbursement is not available. Further, the legislation creates a funding anomaly because it provides that "...no voluntary mental health program serving adults and no children's mental health program, may be reduced as a result of the implementation." Consequently, AOT programs can be financed only by additional local General Fund appropriations or funding shifts from "involuntary" mental health programs. Presumably, the latter means services provided either during LPS short-term holds or under conservatorships. Such a shift would necessarily reduce resources from those who currently qualify for existing involuntary LPS services. Additional appropriations from the County General Fund would, obviously, have no impact on existing voluntary or involuntary programs.

WIC section 5348 (b) provides that "Any county that provides assisted outpatient services pursuant to this article shall offer the same services on a voluntary basis." Obviously, the intent of this language is to assure that those seeking services are not disadvantaged compared to those receiving involuntarily AOT services. Implementing counties that also offer AB 34/2034 or other intensive service programs may take the position that services substantially similar to AOT already are being provided. Again, however, it should be noted that WIC section 5348(a) is quite specific and directive about the content and provision of AOT. In addition, SDMH has expressed skepticism about using capacity in existing intensive care programs for service to AOT recipients, arguing that this may constitute a shift of funds from voluntary care.

Implementing counties that currently do not offer AB 34/2034 or other intensive service programs would have to establish and fund AOT program compliant services for both voluntary and involuntary recipients. All implementing counties would also have to establish programs for individuals addressed by WIC section 5348(a)(2)(K).

The aggregate costs of an AOT program are very hard to estimate. None of the research done by the Workgroup and CMHDA provided insight to potential workload variables or potential service demand. Neither the Rand Report, referenced above, nor the legislative history provides useful information on this issue. The Los Angeles County Mental Health Court ventured a "guesstimate" of a statewide yearly workload of 1500 AOT court filings based on the experience in New York with "Kendra's Law." It concedes, however, that this is a "maximum" caseload scenario.

The per-client costs of AB 34/2034 and PACT-like programs in California are known. Responses to the below referenced survey from counties having these programs had a range of costs from \$4,500 to \$22,000 with most responses in the \$15,000 to \$22,000 range.

To the costs of care for an AOT program must be added expenses solely related to the court process and court oversight. Since Judges and court personnel are state employees, their expense is a state charge. However, the costs of lawyers and legal

support staff for both counties and AOT recipients is a local charge. In each county, these costs are relatively high compared to the salary and benefits of mental health care providers. As above, without a definitive way to estimate workload, these aggregate legal costs cannot be accurately estimated.

There are costs related to pre-filing investigation of the AOT petition. While court Conservatorship Investigators might assume this task in counties where Mental Health Directors provide this service, there will be the incremental additional costs for each AOT petition request. In addition, the AOT investigation has clinical components that some Conservatorship Investigators may not be able to address with existing staffs. The licensed mental health treatment provider designated by the county Director must engage the person at least 10 days prior to the petition, must complete an affidavit for the petition, and must testify in court—all of which has a cost. In addition, there are periodic court reporting requirements that will require staff time. There will also be costs arising from the training provided under the county implementation plan.

FFP Medi-Cal or Medi-Medi may be partial revenue offset, assuming that the AOT recipient is eligible and for these benefits. As the population at whom the statute is directed is presumed to be treatment refractory, benefits qualification and establishment is an issue. For recipients who start the AOT process in, or are recently coming from, a custodial or other excluded facility, benefits re-establishment will be an issue. SAMHSA has produced a policy report entitled *Civil Commitment under Medicaid Managed Care* that may be helpful on these issues. This report is attached.

The one county that responded to the Workgroup survey indicating that it is implementing AOT indicated that it would limit access to its program to individuals being released from criminal court incompetency to stand trial commitments. In effect, this limits the AOT entry process with the result that potential costs of the program are controlled. Other counties considering implementation may develop alternative approaches to “front-end” cost controls. It should be noted, however, that the statute does not address these limited approaches potentially subjecting them to challenges.

### **Court and Legal Processes**

There are three components to the AOT legal process: 1) pre-filing engagement of the person and investigation, 2) the court hearings and due process requirements, and 3) supervision of AOT after the court has ordered it. The California Administrative Office of the Courts has produced an outline analysis of the court proceedings, accompanied by flow charts of the process. A copy of that analysis is attached.

The AOT process can be initiated by a varied list of individuals having personal, clinical or criminal justice related relationships with the person for whom it is sought. Any of these individuals may “request” a county mental health department to petition the Superior Court for an AOT order. The county Mental Health Director is required to conduct an investigation of the “appropriateness” of filing a petition for AOT. In turn, the Director files the petition “...only if he or she determines that there is a reasonable

likelihood that all the necessary elements to sustain the petition can be proved in a court of law by clear and convincing evidence.” This is a tricky standard, given that it calls for at least three levels of judgment making. Making the process harder yet, the necessary elements of the petition are spread across different sections of the statute. Since the court may order AOT only after determining the “...person meets the criteria...” of the statute, there will be extensive litigation, and perhaps appellate opinions, before this standard is fully understood.

If the Director decides to file an AOT petition, it must be accompanied by an affidavit of a licensed mental health treatment provider whom the Director has designated. Under California law, a statement subscribed under penalty of perjury by the affiant, something known as a declaration, may serve this purpose in lieu of the traditional sworn oath that accompanies an affidavit (California Code of Civil Procedure sections 2012 and 2015.5.) Such a “sworn” declaration can be subject to a court’s contempt power or a prosecution for perjury, so its accuracy is essential. The statute is specific about the contents of the affidavit. It must contain the fact that the treatment provider has either examined the person for whom AOT is sought within the prior ten days or has attempted unsuccessfully to do so. It must also indicate that the person for whom AOT is sought is believed to meet the statutory criteria and that the affiant is willing and able to testify in court on the issue.

After the investigation is completed and a determination is made to file the AOT petition, the court process is initiated. It is unclear in the statute which attorney would file the petition and conduct the court proceedings on behalf of the Director; it references only the “counsel designated by the county.” Since AOT appears in that part of the WIC that contains the LPS provisions, however, it is probably that there is the local option of the District Attorney or County Counsel (see WIC section 5114). The petition for AOT is required by the statute to contain “...all the grounds on which the petition is based...” and in any subsequent hearing, evidence is “...limited to the stated facts...” Consequently, the contents of the petition are crucial to the outcome of the AOT process. Interestingly, the AOT petition must be “verified.” This means that the petition itself must be subscribed with a sworn statement of its accuracy by the petitioner—in this case the Director. This is very unusual in California courts, which for most proceedings long ago abandoned the requirement of verified pleadings. Whichever attorney represents the Director in AOT cases, he or she will be extremely careful about the contents of the petition.

Once the AOT petition has been filed, the court must hear it within five business days. Continuances of the hearing are discouraged. A copy of the petition must be served on the person who is subject to the petition, along with the county Office of Patients’ Rights and “... the current health care provider appointed for the person...” There is spare provision in statute concerning evidence at the hearing. The statute requires “examining licensed mental health treatment provider” to testify. Other likely witnesses would include the person who requested AOT, family members, other clinicians and, perhaps, law enforcement officers. If advance notice is given, and “If it is deemed

advisable by the court...the court may examine in or out of court the person who is the subject of treatment.”

The person subject to the petition has statutory due process rights to controvert the petition, including the right to counsel and the court appointment of the Public Defender if he or she has not retained an attorney. Two items in the statutory list of due process rights will create significant legal issues. First, the person has the right to “Be present at the hearing unless he or she waives the right to be present.” However, a different provision permits the court to conduct the hearing in the person’s absence if “...appropriate attempts to elicit the attendance of the person have failed...” This issue may also have constitutional implications. It is sure to be vigorously litigated by Public Defenders. Second, the statute gives the person the right “To be informed of his or her right to judicial review by writ of habeas corpus.” Presumably, this is a form of judicial review other than the AOT hearing which gives rise to the right. Elsewhere in the statute, there is provision for a petition for a Writ of Habeas Corpus on the part of an individual who was not present at the AOT hearing. It is unclear whether these references are to the LPS statutory “writ” procedure under WIC section 5275 or the traditional Writ of Habeas Corpus that is available to individuals being held against their will or subject to coercion by government authority. The procedures pertaining respectively to these proceedings are quite different. One possibility is that these references give rise to an additional form of appellate review. There is no reference in the statute, one way or the other, to trial by jury. As in other areas, appellate court decisions will, ultimately, resolve these various issues.

The entire AOT hearing may be foreclosed if the person subject to the petition enters into a voluntary agreement for AOT services. This may occur only after the petition for AOT is filed, hence involving the person’s appointed or retained attorney. The settlement agreement has the same force and effect as a finding of the court, and like the court order, may not exceed 180 days in duration. Modifications to the agreement may be sought by either party during that time. Non-compliance with the agreement concerning “...violations of the conditions of the agreement...” may be brought to the attention of the court.

An AOT petition will be sustained if the court finds “clear and convincing evidence” of the allegations of the petition. This is a high standard of proof, albeit not as high as the “beyond a reasonable doubt” standard that applies to conservatorships. However, the court must make additional findings before ordering AOT. First, the court must find that “...there is no appropriate and feasible less restrictive alternative...” to AOT. Second, the court must approve a written treatment plan that comports with the AOT statutory treatment requirements and meets extensive age, gender and culturally appropriate rehabilitation model requirements. The treatment plan must consider any provisions of an advance health care directive, if one has been established. Finally, the written treatment plan must evidence the availability of statutorily required AOT services and establish that these services have been offered voluntarily to the person, but refused. Once these findings have been made, the court may order the person to receive AOT

services for a period not to exceed six months. AOT can be extended for an additional 180 days on the application of the director if the “condition of the patient” requires it.

Once AOT is established, the “director of the outpatient treatment program” must file an affidavit with the court at 60-day intervals affirming that the person continues to meet the AOT criteria. On these occasions, the person subject to AOT has a right to a hearing on the issue. Further, during each of these 60-day periods, the person subject to AOT may petition the court for a Writ of Habeas Corpus. Again, it is unclear what litigation procedures apply to this petition. It is clear, however, that the provision of AOT is replete with court process.

As suggested above, a premise of AOT is that the coercive element of the court process and court order will help to engage treatment refractory individuals in care. However, the AOT statute contains remarkably little on the subject. There is no provision for forced treatment such as exists in conservatorships under WIC sections 5357 and 5358. The statute provides that “Involuntary medication shall not be allowed...” absent a separate hearing medication refusal incapacity (Riese) hearing. But, there is no specific authority to force the administration of medication, notwithstanding incapacity to refuse it. The statute provides that “Failure to comply with an order of assisted outpatient treatment may not be grounds for involuntary civil commitment or a finding that the person who is the subject of the petition is in contempt of court.” If a person refuses to cooperate in the assessments of the pre-filing stage of AOT, or if a person subject to AOT refuses to comply with the ordered treatment, he or she may be taken into custody for up to 72 hours for purposes of evaluation. In the case of the individual who refuses to comply with ordered treatment, he or she must be transported to an LPS designated facility for evaluation pursuant to WIC section 5150. For individuals who meet 5150 criteria, this merely restates what LPS involuntary treatment authority already exists. For individuals who meet AOT criteria, but who do not meet 5150 criteria, there will be but a short stay at the hospital. One judicial officer described the net of the court’s coercive power as limited to “harsh language.”

### **Program Oversight**

Counties with AOT programs must report to SDMH detailed data for 14 criteria, which include specified outcomes. The report must also contain an evaluation of the effectiveness of the program in reducing homelessness and law enforcement involvement. In turn, SDMH reports to the legislature.

SDMH has indicated that it will require implementing counties to amend their performance contracts to reflect compliance with AOT requirements. SDMH plans on monitoring county AOT programs to ensure that there is no reduction in voluntary services and that the training requirements are met. There is every indication that SDMH plans on actively overseeing AOT programs.

### **Workgroup Survey**

To support this project, the LPS Workgroup surveyed the county Directors on the subject of AOT during December 2002. A copy of the 10 questions asked is attached. Forty-six (46) responses were returned. Of the respondents, only one indicated a firm plan to implement AB 1421. Sixteen (16) respondents indicated that some level of discussion or assessment was in process. Three (3) respondents indicated that lack of funding would foreclose implementation. The remaining respondents were not actively considering AOT.

## **Conclusion and Next Steps**

This memorandum summarizes the work and findings of the LPS Workgroup to date on the subject of AB 1421. We hesitate to go further in this process without additional direction from the Governing Board and Directors. Few counties are actively pursuing implementation. With budgets surely to be badly bruised in the near term, we do not see a rush to fund AOT programs given the rich staffing, court-related and oversight requirements of the law.

One suggestion heard by the Workgroup was that it develop a specific “cook book” describing the steps to implement and maintain AOT programs. The specificity of this approach certainly would be helpful both to counties considering implementation and those actually implementing. However, the work done by the Workgroup to date suggests that such a project would require a great deal of effort and many person hours expended. This would require the dedication of a large block of CMHDA staff time or a long horizon for Workgroup members to complete the project. Consequently, we await additional direction from the Governing Board.

The LPS Workgroup has also considered and assessed the potential for improvements to the existing LPS structure. Several hours of discussion have produced a lengthy LPS “worst practices” list. In fact, this is a preliminary effort to identify gaps and opportunities for improvement in the role involuntary treatment plays in the system of care. The Workgroup will continue to meet regularly on this project and anticipates generating recommendations to the Governing Board for legislative, regulatory and practice modifications.

DM/dm/lkb

Attachments: 2