**ASSISTED OUTPATIENT TREATMENT EVALUATION**

**FINAL REPORT**

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# **Introduction**

On July 15th, 2014, the Los Angeles County Board of Supervisors voted unanimously to implement Assisted Outpatient Treatment (AOT), also known as Laura’s Law. Briefly, AOT is a unique program where individuals who are not currently engaged in treatment receive intensive outreach and engagement from a dedicated team of Los Angeles County Department of Mental Health (LACDMH) staff in order to connect them to mental health services. The program targets individuals who have a history of multiple hospitalizations and arrests or who are experiencing grave disability, or present a danger to self or others, and who could benefit from treatment. The implementation of the AOT program was launched on May 15th, 2015. Los Angeles County was the 3rd major California County to deploy AOT.

DMH contracted with a team of interdisciplinary researchers from the University of California, Los Angeles to conduct a quality improvement assessment of the AOT program from September 2016 – June 2020. This report summarizes the observations and findings of that evaluation. There have been four broad components. First, we conducted qualitative interviews to orient the UCLA team to the perspectives of key stakeholders (by phone and in-person) and to introduce the UCLA evaluation; we also conducted interviews with provider staff, family members of AOT clients and some clients. In total, we conducted more than 60 interviews. Second, we made ethnographic observations of the LACDMH EOTD (Engagement Outreach and Triage Division) team’s outreach activities to referred individuals, of interactions between provider staff and AOT clients, and of ongoing program and oversight meetings Los Angeles County Department of Mental Health (LACDMH) and other stakeholders. In total, we carried out more than 1500 hours of ethnographic field observations. We also carried out randomized medical record reviews at seven provider sites. Third, we evaluated and analyzed administrative data that was provided by EOTD, Countywide Resource Management (CRM), Integrated System (IS)/Integrated Behavioral Health Information System (IBHIS) and Outcomes Measurement Application (OMA). Fourth, we analyzed survey data collected from the EOTD team, Full Service Partnership (FSP) and Enriched Residential Services (ERS) providers, and from family members and participants in the program. In this report, we will outline the methods, status of each component of the evaluation, as well as observations and data of the program as of December 30th, 2019.

## Evaluation Overview

As noted below, the LACDMH AOT program has been characterized by dedicated efforts on the part of the EOTD team and of many clinical provider staff and 225 individuals enrolled in the program (of a total of 2055 referrals) have successfully completed treatment and been referred to the next level of care. Nevertheless, our evaluation has shown that AOT has been only a partial success in LA County for the following reasons:

1) The program’s focus, like that of all AOT programs, is on *getting the client into treatment,* through an innovative mechanism (outreach and engagement) and a statutory mechanism (court orders), with the corollary assumption that once in treatment, the client is on the road to stabilization and a positive outcome.

2) AOT is only one small (and not very well-resourced) component injected into a larger existing system with many inadequate resources and weak coordination points (not unlike many other urban mental health systems in the US).

Getting the client into treatment is not sufficient to ensure successful engagement and long-term positive outcomes, without the support of additional resources and improved systemic coordination.

We have noted these specific inadequacies in the program:

1) The outreach and engagement process is often successful, but the EOTD teams are seriously understaffed and unable to maintain client relationships once the client is enrolled in treatment.

2) There is no overall coordination of referrals, so any family member or agency with a problem individual is going to refer that person to AOT, regardless of the person's actual needs, diagnosis, current service status, previous history; thus, the EOTD team wastes a lot of time evaluating and redirecting referrals.

3) Often AOT has been used as a substitute for crisis management of the severely ill. As a result, outreach has in several cases led to criminalization of mental illness rather than effective engagement. Those referred to AOT are often the subjects of forced holds and criminal justice interactions, while their frequent victimization on the street is ignored.

4) The existing clinical resources for outpatient treatment of the severely mentally ill are inadequate, so when enrolled, AOT clients are referred to a very diverse group of clinical providers. Some of these are excellent; others are understaffed, inexperienced and often unable to engage difficult clients on a long-term basis. Even the best providers are hampered by high rates of staff turnover.

5) Providers are also often unable to meet essential needs of AOT clients, due to inadequate and poorly coordinated county resources. First, many clients need substance abuse treatment coordinated with mental health care. Second, they need stable housing; housing slots that will accept the clients and limited and the different providers are often forced to compete for them.

6) Not all providers are able to offer early medical appointments and timely follow-ups; consequently, not all clients are able to have medications and dosages adjusted as needed.

7) As a result of these factors, AOT clients are often discharged before treatment is completed. Many are then re-referred; many clients are repeatedly re-engaged and re-enrolled, completely losing continuity of care.

8) Poor system coordination and inadequate hospital bed space often results in inadequate response to AOT clients in crisis. Clients are repeatedly hospitalized and released after only short stays without notification of AOT or the clinical provider. Or clients are jailed and again released without adequate coordination. Hospital and jail days for AOT clients may be reduced but without positive impact on the client.

9) The court order, which is meant to enforce AOT client compliance through the "black robe effect," will only succeed in a system with adequate resources and sufficient providers with adequate experience.

## Current Suggestions for Quality Improvement

Our current suggestions for quality improvement of the existing AOT program are as follows:

 1) *Inadequate outreach and engagement staffing.* We suggest that *additional staffing* be allocated to the EOTD outreach teams to allow them to handle referrals more effectively and provide more extended continuity of care as clients are assigned to clinical providers.

2) *Uncertain availability of timely medication appointments.* We also suggest that *additional psychiatric services* be allocated to the AOT program to ensure timely medication reviews and adjustments.

3) *Poor physical health of many AOT clients at enrollment.* We suggest that providers be encouraged *to pay attention to physical health problems* that newly enrolled clients may have; at present, MCAS scores for physical health seem to be higher than would be expected.

4) *Incarceration of potential AOT clients.* We suggest a review and possible reemphasis of *the mechanisms for getting potential clients released from incarceration and into MIST or AOT programs*; when these are not in operation, many severely mentally ill individuals are left to subsist in severely suboptimal conditions in county jails. Also, individuals may be held in jail waiting for an IMD bed in a locked facility, since bed space throughout the county continues to be inadequate.

5) *Regular provider reporting and analysis of the data is essential* if program effectiveness is to be maintained and provider reporting should be a contractual obligation. Moreover, as data collection is a time burden for providers and reduces the time for clinical services, data should be regularly analyzed and reported to justify this effort. Currently, there is no single database of all administrative data maintained at LACDMH, insufficient data analysis personnel assigned to the program, many IT barriers to information sharing among DMH departments, and no regular procedures for rigorous data vetting. We strongly encourage the allocation of sufficient data analysis personnel and the development of independent oversight or stronger internal oversight for all DMH services. Additionally, we encourage small one-time investments in improved efficiency, such as installing Adobe Acrobat Pro software on DMH computers so that administrative staff can export MCAS, MRT, and survey data from PDF forms directly into a spreadsheet rather than spending many hours doing error-prone manual data entry.

6) *Ongoing training for provider staff.* We would strongly suggest the development of *a targeted training program* for all provider staff; providers are too often “figuring things out as I go along,” due to high rates of provider staff turnover, combined with the fact that many provider staff were not specifically trained to work with the very demanding AOT clients or are unfamiliar with the rating instruments for AOT.

7) *Failure of private hospitals to coordinate* with DMH EOTD or provider staff, releasing clients without notification, medications, or coordination to ensure their transport to their housing site or treatment facility and compromising client follow-up and effective treatment. We strongly suggest that MHC, DMH and NAMI collaborate with DHS to create new enforceable guidelines for all hospitals in the county.

## Recommendations for Quality Improvement Submitted to Los Angeles County Board of Supervisors

On April 29, 2019, ten recommendations developed from our evaluation process and reviewed and amended by the Mental Health Commission’s AOT Oversight Committee were presented to the LA County Board of Supervisors. These are listed below, with comments on the current status provided in red:

*Recommendations to DMH Emergency Outreach & Triage Division:*

1) Problem: Provider staff unfamiliarity with AOT treatment guidelines and procedures. DMH has provided training sessions, but ongoing training is requisite, due to high staff turnover and prevalence of inexperienced staff at many of the contract agencies. Recommended: An online manual of AOT guidelines and procedures, to be updated by DMH EOTD (Engagement Outreach and Triage Division) as needed. The manual has been developed and disseminated as a printed document. Improved ongoing training is still needed, as noted under current QA suggestion #6 above.

2) Problem: Families with unrealistic expectations of AOT program. Some family members of AOT clients expect that the program will immediately conserve, administer medication or hospitalize their family member for an extended period involuntarily. Recommended: EOTD creation of a “What AOT does/What AOT doesn’t do” flyer for posting on DMH websites and for distribution to all families of referred clients. This document has been created and disseminated.

*Recommendations to DMH for improvements to provider contracts and related actions:*

3) Problem: Gaps in Monthly Reporting Tool (MRT) and Multnomah Community Abilities Scale (MCAS) data reporting from providers. These reporting tools are used to track Los Angeles County Mental Health Commission “Advocacy, Accountability and Oversight in Action” 7 client progress and improvement. Gaps in data reporting are a continuing problem that, if not corrected, will make it impossible for DMH to evaluate the effectiveness of the program. Recommended: Inclusion of monthly MRT and MCAS submissions as data items in the provider contracts. Provider reporting improved significantly in 2020. We encourage making this task a priority under current QA suggestion #5 above.

4) Problem: Missed medication appointments and overlong wait times for first psychiatric appointment. Early medication appointments with psychiatrists and regular follow-up appointments are essential for the treatment success of AOT clients. In several cases, clients have had to wait for or have missed medication appointments due to unavailability of psychiatrists or transportation difficulties, severely compromising treatment. Recommended: Inclusion of specifications for medication appointments in the provider contract, with time limits for first appointments; Hiring of at least one full-time field psychiatrist; use of Uber Pool and Lyft Line to transport clients. Timely medication appointments continue to be a problem and are addressed under current QA suggestion #2 above.

5) Problem: Provider non-compliance with staffing and field time requirements. Recommended: Definition of staffing and field time requirements which providers can reasonably meet and inclusion of these requirements in the provider contract. Provider compliance still appears to be an issue.

6) Problem: High rates of substance abuse among AOT clients and inability of some providers to provide good dual diagnosis services. Recommended: Inclusion of substance abuse and dual diagnosis guidelines in the contract for all providers; consideration of supplementary contracts with drug treatment providers; inclusion of available resources in the provider manual. There has been some improvement as the Mental Health Court has provided a SAPC CENS navigator to work with providers to assist with substance abuse treatment.

*Recommendations to Mental Health Court:*

7) Problem: Time burden on providers in attending Mental Health Court with petitioned clients. Court attendance by clients and regular provider reporting is essential to ensure individualized assessment and guidance by the court for each client; however, each half-day court visit takes time from therapeutic and case management services. Recommended: Standardization and simplification of court reports, with clear guidelines as to when provider reporting is necessary; exploration of a video conferencing option for providers. Court reports have been standardized and simplified.

*Recommendations for Countywide action:*

8) Problem: Improvement of jail linkage and increase in jail referrals. Many individuals arrested for misdemeanors are potentially eligible for AOT. Some potential AOT clients may be referred from jail mental health to the Office of Diversion and Re-Entry; but a number have been released without referrals or coordination with DMH EOTD. Recommended: Identification of Liaison in Sheriff’s Department to work with EOTD as well as with ODR. Jailing of potential AOT clients continues to be a problem and is addressed under current QA suggestion #4 above.

9) Problem: Lack of adequate flexible housing options. Recommended: Continued exploration of creative housing options beyond board and care homes and collaboration with other County housing initiatives; a possible example would be more use of SROs with supportive services. Adequate housing remains a problem, although we are aware there are several major County initiatives in progress to improve the situation.

10) Problem: Hospitals that admit and discharge AOT clients without adequate follow-up or notification of DMH EOTD and provider staff. AOT clients may be hospitalized on 5150 holds or for medical reasons at any hospital in the County. Private hospitals in particular often fail to coordinate with DMH EOTD or provider staff, releasing clients without notification, medications, or coordination to ensure their transport to their housing site or treatment facility. This lack of coordination compromises client follow-up and effective treatment. DMH liaisons are in place at County hospitals, so lack of coordination is less likely to occur. Recommendation: MHC, DMH and NAMI collaboration with DHS to create new enforceable guidelines for all hospitals in the county. Coordination with private hospitals remains a problem and is addressed under current QA suggestion #7 above.

## Specific Quality Domains to be Addressed in this Report

In our initial proposal to LAC DMH, we presented a plan for addressing these domains:

1) Quality improvement, including penetration of target population (demographics), client engagement, court interactions with clients and impact thereof, client service utilization, medication adherence, provider completion of expected tasks. These areas are discussed below. Over the course of our evaluation, we have made a number of suggestions for quality improvement of the program, ten of which were approved by the AOT Oversight Committee and presented to the Board of Supervisors. We include these and other recommendations below.

2) Effectiveness, including effectiveness of outreach activities, provider services and court processes, improvement in mental health functioning, reduction in hospitalization, reduction in substance use and abuse, improvement in physical health, increased progress toward employment or education, reduction in criminal justice interactions, reduction in victimization and reduction in violence.

3) Community improvement, including criminal justice involvement and homelessness.

4) Stakeholder satisfaction, including family perceptions of the program. Each of these domains 1-4 is addressed in this report using the data sources outlined below.

5) Cost; due to inadequate data, we are not able to present a cost evaluation of the AOT program.

## Data Sources Overview

### *Administrative Data*

Administrative data sources include the following: **programmatic data on all AOT-referred clients**, including EOTD’s administrative data on all AOT referrals, EOTD data on all eligible clients referred to FSP providers, and CRM’s administrative data on all eligible clients referred to ERS providers; **utilization data on all referred clients,** extracted from ***IS/IBHIS*** by Clinical Informatics, showing community outreach services, outpatient, inpatient, and emergency mental health services utilization for all AOT-referred clients with IS/IBHIS numbers (timeframe: 12 months prior to referral, and follow-up data as many as 3 years post-referral depending on when the client was referred), as well as diagnoses and demographic data; and **client outcomes data for enrolled clients**, including data from the ***Monthly Reporting Tools and Multnomah Community Ability Scales***, completed monthly by providers and delivered to UCLA by EOTD and CRM, and ***OMA data***, including baseline, 3-month, and key event tracking data, provided by the MHSA Implementation and Outcomes Division via Clinical Informatics.

To ensure that all data sent to UCLA for analysis are de-identified but linkable across sources, EOTD assigned a study identifier to each AOT-referred client in the EOTD database. At the end of each fiscal quarter, EOTD generated a spreadsheet that included all clients referred (from start of program through end of the fiscal quarter in question) and linked the study identifier to PHI identifiers (name, date of birth, demographic data, IS/IBHIS number, etc.), and securely distributed this spreadsheet to DMH staff in CRM and Clinical Informatics responsible for de-identifying different data sources. Because clients may have more than one IS/IBHIS number, Clinical Informatics performed a dataflux matching procedure to identify all IS/IBHIS numbers for each client in the sample for use in extracting IS/IBHIS data, and Clinical Informatics sent this expanded list to MHSA Outcomes for use in extracting OMA data. Data fields to be extracted were listed previously in Quarterly Report 2.

Final programmatic datasets were provided by EOTD on **March 3, 2020** and by CRM on **April 27, 2020.** As noted in various quarterly reports, following each delivery to UCLA, EOTD and CRM datasets went through an extensive data reconciliation process, predominantly to account for overlap and inconsistencies in data on FSP-referred clients due to the mid-program (November 1, 2017) transition of the FSP component of the program from CRM and EOTD, but also to identify, inquire about, and correct other data errors to ensure accuracy. EOTD and CRM datasets were combined to ensure that all treatment assignments are associated with AOT referral dates and client variables, and reshaped into formats that allowed them to be merged with other data sources in order to perform analyses. The data management burden involved in preparing these data sources for analysis raises concerns about the challenges DMH may face in conducting its own analyses for future reports to the state or for other purposes. The MRT and MCAS entries also require constant monitoring as study ids may be entered incorrectly and make it appear that data is missing, data is sometimes not entered or there are significant delays in entry, and providers may have long lag times before they complete reports. Our team did supplemental data entry and provided feedback across the course of the project on the completion of the MCAS and MRT and continuous vetting needs to occur in the future. DMH has not had their staff perform the linkage of these data with administrative data for AOT before, which are required to evaluate the completeness of data and for key analyses, and this requires significant effort to remove duplicate reports and to clean these data of errors.

Final IS/IBHIS were provided by Clinical Informatics on **January 23, 2020**, and final OMA data were provided on **January 29, 2020**. These final dates were chosen to allow UCLA to complete analyses for the FY 2018-19 report to the state, as well as to perform analyses for this final report to DMH. Because a several-month data lag can occur in entering claims in to IS/IBHIS, the January 2020 data delivery ensured that the data were relatively complete in accounting for utilization through June 30, 2019 (end of the FY for the state report) and through May 17, 2019 (end of the period that captures at least one year of follow-up on all individuals referred to AOT during the first three years of the program). IS/IBHIS data were used extensively in reporting utilization outcomes for eligible AOT-referred individuals and, like programmatic data, were available on all AOT-referred individuals. OMA data are only available on clients who enrolled in services and, further, suffer from low completion rates by providers; as such, they were examined as needed to augment other data sources.

### *Provider and Client Surveys*

Two surveys were created by UCLA to supplement the administrative data already completed by DMH: a client self-report survey, which treatment providers were asked to administer to enrolled individuals every three months following enrollment; and a provider-rated treatment goals progress survey, which providers were asked to complete for each of their enrolled clients every six months following enrollment or if the client was discharged prior to the next survey due data. Completed surveys were submitted to EOT (FSP providers) or CRM (ERS providers) to be de-identified and passed along to UCLA for analysis. This report analyzes client and provider surveys completed through **December 31, 2020**. Because very few ERS surveys were delivered to UCLA, this report only includes information from surveys completed by or for FSP-enrolled clients. FSP client and provider survey data were merged with programmatic data in order to link survey dates to enrollment dates and to evaluate survey completion rates, overall and by provider. Summaries of survey results note the non-representativeness of the surveys data due to the survey completion rate and, in the case of client surveys, the potential lack of surveys from clients who are reluctant to engage.

DMH continues to deliver completed surveys to UCLA for data extraction; UCLA will provide DMH with a complete survey dataset for all client surveys completed through June 30, 2020 so that DMH can use this dataset in completing the FY 2019-2020 report to the state, which DMH will be completing on its own next year. UCLA will not process surveys completed beyond June 30, 2020 but will provide DMH with guidance on how to extract data from survey forms using Adobe Acrobat Professional software rather than entering data manually.

# Quality Improvement

Data was drawn from several sources for our evaluation. EOTD team performance and the work of the more experienced providers continue to be excellent. The Mental Health Court staff have contributed a great deal and we have observed positive outcomes for a significant subset of clients. The problems of inadequate resources, provider inexperience and inadequate continuity of care persist, contributing to client attrition and poor outcomes for many clients.

## Barriers to Implementation: Ethnographic Observations

Our ethnographic observations and interviews have identified multiple barriers to effective implementation of the AOT program. First, program implementation is limited by inadequate resources. As noted under recommendations, the EOTD outreach teams need more staff to cover multiple referrals within the sprawling County area. The program needs more clinical providers in specific areas – Service Area 1 and Service Area 3 have only one provider each –and all areas need more experienced providers. Furthermore, the providers need access to additional psychiatrists assigned to the program to ensure that client medications are timely and appropriate, that clients do not decompensate or become over-medicated. Long waits for appointments complicate the effectiveness of treatment. Most providers try to schedule early visits for the client with a prescribing psychiatrist, but can wait up to four weeks. Some agencies fail to ensure regular follow-up visits or timely follow-up when dosage changes are needed; again, with long wait times, clients lose focus and fail to appear. Where prescribers are able to go into the field to give medication, this option appears to be very effective; otherwise, psychiatrists spend 15-20 minutes with each client, but leave medication management up to the therapists.

A second persistent problem is provider inexperience and inability to deal effectively with the severely ill AOT clients. Rates of staff turnover are very high (7 of our initial group of 24 interviewees, or just under 30%, left the agency within 2 years), Many AOT staff are recent graduates of social work or family therapy training programs; not infrequently, they are working at the agency to accumulate the practice hours necessary for licensure. Often quite inexperienced staffers are assigned to difficult AOT clients. Also, prior to AOT, the emphasis at many provider sites had been on voluntary treatment, and not all providers have been able to shift their clinical approaches to deal effectively with court-mandated clients. Finally, programs differ greatly in the resources they have available, particularly adequate client-centered housing options; drug counselors or SA treatment; and psychiatrists on-site for medication appointments. These deficiencies could be addressed by stricter contract requirements and additional resources.

Third, uneven continuity of care is a byproduct of provider inexperience, but also of the program design; those referred to AOT build relationships with the EOTD team, only to be handed on to a contract provider, where staff shortages may mean contact with multiple individuals; the initial assignment may be followed by reassignment to multiple contract providers, if the first engagement is unsuccessful. Wary and fearful to begin with, clients may find AOT “a little bit overwhelming,” “six different faces talking to them;” they are reluctant to meet providers regularly or take prescribed medications. Fourth, many private hospitals, and even LAC-USC, have failed to cooperate adequately with the program and there have been no measures instituted by the County to improve cooperation. Clients in crisis may be transported to any nearby hospital; the admitting institution will stabilize the client, but is often reluctant to give appropriate meds or to keep him/her even for the usual 72 hours. Hospital discharge planners often fail to inform the AOT provider when a client is released or to coordinate medication, or other treatment. In some instances, documented in medical record reviews, a client was hospitalized at two different facilities within one week with apparently no communication or follow-up between the hospitals or with the AOT team. Finally, all hospitals face bed shortages and are reluctant to pursue conservatorships even when this is the best option for the client. (EOTD has persisted in seeking conservatorships and 177 individuals referred to AOT have been conserved at some point.)

Fifth, effective client engagement is often derailed by criminal justice involvement. As the result of some outreach encounters with aggressive and potentially violent clients, County Deputies have begun accompanying EOTD workers on field calls. AOT referrals often experience frequent 5150 holds and even arrests, which only increases their wariness and reluctance to engage. When clients on the other hand are wandering into dangerous situations, are attacked or raped, law enforcement personnel may be reluctant to intervene, fearing reprimands and unfavorable publicity. For many clients with substance abuse problems or persistent criminal justice interactions, there are no effective protocols for engagement and no good outcomes. (see the case of Emmanuel at the end of this section). Sixth, many AOT clients are in urgent need of housing, but housing options for individuals with severe mental illness and/or substance abuse disorders are limited in the County. Clients placed in housing are often dissatisfied because they must share a room with someone they do not know, and who, like them, lacks social skills and suffers from paranoia or confusion. Issues with roommates and housemates are one of the most frequent causes of clients leaving housing, or suffering eviction after a dispute.

Finally, two logistical problems have from the beginning prevented effective AOT implementation for some clients. The first is that the statutory enrollment period, six months, is simply not long enough for effective engagement; as its inadequacy was recognized by EOTD, providers and the Mental Health Court, enrollments have been extended for two years and longer, benefitting many recent clients. The second is that private insurers have consistently refused to cover AOT treatment programs; so that providers are only reimbursed for clients with MediCal. This problem remains unaddressed.

### *Case Study: Emmanuel (pseudonym); Ethnographer: Charlotte Neary-Bremer*

Emmanuel’s grandmother has been trying to get him help for years; he has a diagnosis of “psychosis unspecified” mostly brought on by using methamphetamine. Social workers told his grandmother that the best option to get Emmanuel treatment would be to take out a restraining order against him, so that he would be arrested, jailed and subsequently diverted to treatment services. Emmanuel has spent the past two months in jail for violating the restraining order and is being released today. I meet him at the jail exit with Ellen (pseudonym), a social worker with the Department of Mental Health. Emmanuel is glad to see Ellen and excited to be out. We get in to the car to drive Emmanuel to a drug rehab facility. He is exuberant and fun to be around, talking about his plans for the future. It feels like being in the car with friends rather than transporting a man from jail to a mandatory rehab facility.

Then Ellen’s tone changes: “Now, Emmanuel, I’m serious, you have to do well in this placement. No matter how much I want you to do well, I can’t want it for you. Everyone is here to support you and get you the services you need but you have to stick at the placement. If you don’t stick with the placement, we’ll call your attorney and tell him to make sure you get two years in jail next time. If you walk out, all of the police everywhere all over the city will be looking for you.” Emmanuel seems to believe Ellen and is horrified at the thought of two more years in jail. I notice that Emmanuel is wheezing; in jail he used an inhaler for asthma and medications for seizures. He was released from the jail without any medications. His breathing deteriorates rapidly so we divert to the emergency department. He has a really severe asthma attack and I am scared to think what would have happened if he had been released to the streets with no medications. He improves in the Emergency Department and is discharged just in time to make it to the rehab center.

“You’re too late,” says the rehab intake social worker as we walk in to the waiting area, and Ellen protests that it’s 5 minutes before the 4pm deadline. The intake staff continue to try to avoid admitting Emmanuel, "He's got mental illness, not a drug problem." Ellen notes that meth is listed before psychosis in his record. Then they claim they only have a top bunk is available and with his history of seizures, they can’t take him (Emmanuel points out that he was sleeping on the top bunk in jail for the past two months). Eventually they reluctantly agree to accept him.

The next week I find out that Emmanuel only lasted one night at the rehab center and left without any of his medications. The staff said that Emmanuel became too “demanding”, that he had medical needs they could not accommodate and that he would be a risk to himself and others if he became psychotic. Emmanuel goes back on meth, violates his restraining order, is sent back to jail, and the cycle starts all over again. Some months later, I receive a text message from Ellen: “Just wanted to tell you that Emmanuel died from an apparent overdose last night.” I calculated that Emmanuel spent over two thirds of the last year of his life in jail.

## Program Referrals and Demographics

Data for this report will be for individuals referred to AOT within the first four years of its operation (May 18, 2015 – May 17, 2019) and inclusive of information on their progress through the program as of December 31st, 2019. The decision to restrict our analyses to these data is a reflection of the need to have sufficient lengths of involvement in the program to properly flow through the program and to potentially receive services for at least 6 months.

### *Referrals to AOT Program*

As of May 17th, 2019, there were 2307 referrals processed for 2055 individuals referred to the AOT program. Some individuals were referred to the program multiple times (up to 6 times) but the count of 2055 individuals does not include any duplicate referrals.

Of the 2307 referrals, 1187 referrals met criteria (51.45%) and 1120 did not meet criteria (48.55%). These rates differ from those recorded by EOTD as we have re-coded individuals who initially met criteria but were later determined to not meet criteria after additional information was gathered (applicable to 211 cases across 205 individuals).

***Criteria for Referral.*** The criteria for AOT include: (1) age 18 or older, (2) mental illness, (3) probable inability to survive in the community without assistance, (4) history of noncompliance with treatment, (5) history of at least two hospitalizations OR forensic mental health services in the last 36 months OR one or more acts, attempts, or threats of harm to self or others, (6) at risk of clinical deterioration or currently deteriorating, (7) continued refusal of treatment, (8) AOT is least restrictive placement, and (9) likelihood of benefit from treatment.

Since the Spring of 2016: the number of hospitalizations, the number of arrests, the number of acts of violence to themselves, and the number of acts of violence towards others have been tracked**.** Data was provided for 1490 individuals across 1638 referrals about the number of hospitalizations prior to AOT referral. Of the 1490 individuals who had data, 1362 had at least one instance of hospitalization (91%)

Data was provided on 1295 individuals across 1424 referrals. Of the 1295 individuals with data on the number of their arrests, 847 had at least one arrest (65%) for at least one referral.

Regarding risk for harm to self, there was data on 1027 individuals across 1123 cases. There were no instances of violence to self for 576 individuals in at least one case and at least one instance of self-harm for 451 individuals (44% of those with data).

In terms of violence to others, there was data for 1135 individuals across 1242 cases. Of the 1135 with data, 389 had not instances of harm and 746 individuals had least one instance of harm to others (65% of the individuals with data).

These data suggest that there are very high rates of hospitalization, arrest, harm to self, and harm to others among those referred to AOT, though it is possible that these are biased estimates due to the high rates of missing data.This suggests that AOT referrals are for persons who have higher than usual risk rates for adverse outcomes and are particularly critical to engage in services.

**Reasons Criteria Not Met.** The most common reason that participants did not meet criteria is because they were noted as “receiving services” (41%; n = 456). This does not necessarily mean that they are receiving mental health services. According to EOTD staff, people are classified as “receiving services” if they fall into four general categories: 1) if the client is linked to a mental health provider at the time of the referral and they are not deemed as not participating in services; 2) the client is hospitalized for medical or psychiatric reasons and their future care will be developed by the hospital when they are ready for discharge; 3) the client is on a T-CON and is waiting a conservatorship hearing (rarely); or 4) the client is linked to a different mental health outreach team that is actively working to get them into services. However, it is important to note that EOTD also recorded some individuals as meeting criteria and “receiving services” (n = 18). In these cases, this could be due to 1) the referring party had referred them to non-AOT services as well and so multiple teams made contact; 2) the client is hospitalized long-term for medical purposes and therefore will handle their discharge services; 3) a client is connected to another set of services but they are missing required or desired services; 4) during a period where the client could not be found, they received some services; or 5) the client needs residential services and will participate in services through that provider (even though they aren’t specially contracted to deliver AOT services). The second most common reason that a person was determined to not meet criteria was if they were referred to other services (19%; n = 213). There was insufficient information in the administrative dataset to determine why other services were determined to be more appropriate systematically.

Other reasons for not meeting criteria included being unable to be located by 8% (n = 86), not meeting criteria for insufficient hospitalizations/incarcerations by 8% (n = 85), being incarcerated already by 6% (n = 63), issues with the referral or referring party for 9% (n=97), conservatorship for 3% (n = 35), having left the County for 3% (n = 37), the remaining cases were for a smattering of reasons, such as being under the age of 18 (n =1), not deteriorating (n =7), being unlikely to benefit from AOT (n = 2), being on parole (n =2), marked for future revisit (n =3), needs review by MEU (n = 6), or not having a qualifying mental health diagnosis (n = 14), In ten cases, no reason was noted.

In the future, we recommend more detailed notes on why criteria were not met in order to better facilitate program planning for those excluded from the AOT program, including the allowance of multiple reasons for why a person did not meet criteria.

**Met criteria but not assigned a provider.**  There were 400 individuals (across 415 cases) who met criteria but did not get assigned to a provider for at least one referral. For 50% of cases, the most common reason was that they could not be located (n = 205). Other reasons included 18% that were incarcerated/enrolled in MIST/FIST (n = 75) during the outreach and engagement period, 16% ended up being conserved instead (n = 65), 10% were determined to not be deteriorating after all (n = 43), 3% were referred to other services (n = 12), 2% were noted as disenrolled from AOT for reasons that are unclear (n = 10), and 1 person each was determined to be receiving other services, future revisit, petition denied, and terminally ill. Lastly, there were 6 people who died during the outreach and engagement phase (4 of whom were homeless, 1 living with family/other adults, and 1 living in an apartment independently). The most severe mental health diagnosis among those not assigned a provider included: 60% schizophrenia (n = 248), 15% schizoaffective (n = 61), 10% psychotic disorder (n = 40), 6% bipolar (n=24), 2% mood disorder (n = 8), and .5% (n=2) had a substance use disorder. Notably, for 39% of this group, they also had a co-occurring substance use issue.

### *Demographics of all AOT Referrals*

There have been 1103 individuals who ever met criteria for AOT out of the 2055 referred (over 2307 referrals) according to EOTD/CRM’s databases.In this report, we will present descriptives of all cases referred to the program, those for the first time a person was referred, and those who met criteria vs those who did not.

***Age.*** The ages of those referred to AOT services are evaluated as a continuous variable (ages 16-80). The mean age of participants who were referred to AOT services is 37.74 (SD = 12.78).Three individuals who were referred were under the age of 18 and all were determined to not meet criteria. The mean age at the first referral is 37.55 (SD = 12.85).The average age of those who met criteria for AOT (at their first referral) were significantly younger on average (M = 36.85, SD = 12.35) than those who did not (M = 38.32, SD = 13.41).

***Gender*.** The majority of referrals were for males (n = 1328/64.6% individuals across 1493 referrals), 34.6% were females (n = 711 individuals across 797 cases), .54% male to female transgender (n = 11 individuals across 12 cases) and .10% were female to male transgender (n = 2 individuals/cases). There were 3 cases where no information is provided about the gender of the client. A gender breakdown of those who met criteria vs not met criteria is provided below. There were no differences in the rates of those who met criteria vs those who did not in Fisher’s exact comparisons when comparing male vs female (p = .34) or male vs female vs transgender (p = .20).

***Race / Ethnicity***. The largest group referred to AOT are Whites (33%, n = 763), followed by 30% Hispanics/LatinXs (n = 696), 25% Blacks/African Americans (n = 566), 9% Asian / Pacific Islanders (n = 206), .5% American Indians (n = 11), 2% those from ‘other’ races/ethnicities (n =47) and 1% that were unknown (n =18).These figures are under-representative of LatinX/Hispanics and over-representative of African Americans relative to their proportions of the population of LA County.

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| **Table A1. Race/Ethnicity for First Referral, All Referrals, and Whether Criteria were Met, N (%).** |
|  | **Black** | **Hispanic/ LatinX** | **White** | **Asian** | **Other** |
| **First Referral** | 500 (24%) | 622 (30%) | 681 (33%) | 182 (9%) | 69 (3%) |
| **All Referrals** | 566 (25%) | 696 (30%) | 763 (33%) | 206 (9%) | 76 (3%) |
|  **Did Not Meet Criteria** | 275 (26%) | 326 (28%) | 374 (33%) | 96 (7%) | 49 (4%) |
|  **Met Criteria** | 291 (24%) | 370 (31%) | 389 (31%) | 110 (10%) | 27 (2%) |

***Housing Status.*** The largest group of housing status at the time of referral is homeless (41%). Individuals who are referred from jail are less likely to meet criteria than to meet criteria. Those who were living with family were more likely to meet criteria than not (χ2 (4,2272) = 21.71, p <.001).

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| **Table A2. Housing Status for First Referral, All Referrals, and Whether Criteria were Met, N (%).** |
|  | **Homeless** | **Family/Adult** | **Apartment** | **MH Facility** | **Jail** | **Missing** |
| **First Referral** | 842 (41%) | 512 (25%) | 354 (17%) | 203 (10%) | 115 (6%) | 28 (1%) |
| **All Referrals** | 952 (42%) | 569 (25%) | 393 (17%) | 225 (10%) | 137 (6%) | 31 (1%) |
|  **Did Not Meet Criteria** | 460 (41%) | 245 (22%) | 184 (16%) | 125 (11%) | 85 (8%) | 21 (2%) |
|  **Met Criteria** | 492 (41%) | 324 (27%) | 209 (18%) | 100 (8%) | 52 (4%) | 10 (1%) |

***Mental Health Diagnosis.*** Using data drawn from IS/IBHIS, we explored the mental health diagnoses of those referred to AOT. Data was provided for 1893 individuals across 2136 referrals. Across all referrals, the most common of the most severe diagnosis reported for a person was schizophrenia (70%; n = 1494) and to a smaller degree there were other diagnoses of schizoaffective disorder (12%, n = 253), psychotic disorder NOS (8%; n = 162), bipolar disorder (7%, n = 159), mood disorder NOS (3%, n = 56), other mental health diagnoses (.3%; n = 7) and substance use (.2%, n = 5). Among those who met criteria, the most common of the most severe primary diagnosis reported for a person was schizophrenia (73%; n = 834) and to a smaller degree there were other diagnoses of schizoaffective disorder (12%, n = 142), psychotic disorder NOS (6%; n = 69), bipolar disorder (7%, n = 80), mood disorder NOS (1%, n = 14), and substance use (.2%, n = 2). Among those who did not meet criteria, the most common of the most severe primary diagnosis reported for a person was schizophrenia (66%; n = 660) and to a smaller degree there were other diagnoses of schizoaffective disorder (11%, n = 111), psychotic disorder NOS (9%; n = 93), bipolar disorder (8%, n = 79), mood disorder NOS (4%, n = 42), other mental health diagnoses (.7%; n= 7) and substance use (.3%, n = 3).

### *Enriched Residential Services (ERS) Referrals (CRM Administrative Data)*

County Wide Resource Management recorded 201 individuals who were processed across 342 attempted enrollments to Enriched Residential Service facilities (ERS) as of May 17, 2019. There are a few important terms to define. A *rescinded* referral means that a person’s referral was cancelled before enrollment in services. A *pending* referral means that a person has been sent to CRM for services but they have not enrolled in services with a provider yet. An *enrolled* referral means that a person has ever in the length of the program enrolled in services with a provider. A *discharged* referral means that after enrollment a person discontinued services before they completed required services. An *active* referral means that a person is currently in services.

Within the CRM dataset, we collected the following dates: a) the date that a person is referred to CRM for services, b) the date of enrollment, c) the date a referral is rescinded (used when someone does not ever enroll), d) the date that a person is discharged (used when someone enrolls but does not complete treatment to graduation), and e) the date of their graduation. There were 8 enrollments in 2015 (May 2015-December 2015), 21 enrollments in 2016, 37 enrollments in 2017, 32 enrollments in 2018, and 18 in 2019 (as of May 17th).Table A3 below summarizes the number of cases processed, not the number of people, for their flow through the ERS program. People may be represented in multiple columns. The average length of time spent in an ERS before a discharge was 66.68 days (SD = 70.16; range: 0-385 days)and the average length of treatment until a graduation was 252.69 days (SD = 99.75, range: 76-499).

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| **Table A3. Cases Ever Referred to ERS (n=342)** |
| **Never / Not Yet Enrolled (n=225)** |  **Ever Enrolled (n=117)** |
| **Referral Rescinded** | **Pending** | **Discharged** | **Graduated** | **Active** |
| 225 | 0 | 69 | 42 | 6 |
| ***Note:* Referral rescinded + Enrolled + Pending =342 cases.** |

The majority of those who were discharged (of 63 individuals who were discharged across 69 cases) was due to their inability to be located (55%, n = 38). Other reasons included transfer to an FSP provider (n = 7, 10%), relocation (n = 7, 10%), being arrested (9%, n = 6), being hospitalized (7% n = 5), being conserved (6%, n = 4), no longer meeting criteria (1%, n = 1), and needing an unspecified higher level of care (1%, n = 1).

In terms of rescinded referrals, of the 242 cases, a reason was noted for 223 cases. The primary reason for a referral to be rescinded was because it was canceled and no additional information was provided by CRM. However, it is notable that in the main EOTD dataset, 15 of those whose referral was cancelled, were also noted to be conserved. This suggests that conservatorship among those whose referral was rescinded is not being well recorded across the two systems. An additional 16 cases were identified in both columns as being conserved for a possible total of 19% of cases of rescinded referrals ending in conservatorship. The second largest category of reasons for a referral to be rescinded was because a lower level of care (FSP) was chosen (though interestingly 7 of those cases were also noted as conserved elsewhere, which belies the idea that a lower level of care was more appropriate). A smaller number of cases had other reasons noted, including no longer meeting criteria (n = 19), unable to locate (n = 6), and arrested/incarcerated (n = 5). The lack of usable information about the reasons for referrals being cancelled is problematic for evaluation of the reasons why individuals do not enroll in ERS.

***Outcomes by Individual.*** According to the CRM data in terms of the people instead of the number of cases processed, there were 201 assigned to ERS and 107 individuals enrolledever (53% of those referred).There were 63 individuals discharged at least once**,** 42 individuals who graduated and 6 individuals were identified as actively enrolled in services.

***ERS Providers.*** Normandie East was assigned 65 individuals (72 referrals), Percy Village was assigned 60 individuals (64 referrals), SSG was assigned 111 individuals (121 referrals), and Telecare had 79 individuals (85 referrals). The number of rescinded, enrollments, active, graduations, and discharges in Table A4 below represents the number of cases processed rather than the individuals.

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| ***Table A4. All Referrals to ERS (n=342)*** |
|  |  | ***Never Enrolled (n=225)*** | ***Ever Enrolled (n=117)*** |
| ***Provider Name*** | ***Total Referrals*** | ***Pending*** | ***Rescinded*** | ***Active*** | ***Graduation*** | ***Discharge*** |
| ***Normandie East*** | 72 | 0 (0%) | 49 (22%)  | 0 (0%) | 12 (29%) | 11 (16%) |
| ***Percy Village*** | 64 | 0 (0%) | 40 (18%) | 3 (50%) | 4 (10%) | 17 (25%) |
| ***SSG*** | 121  | 0 (0%) | 69 (31%) | 3 (50%) | 21 (50%) | 28 (41%) |
| ***Telecare*** | 85  | 0 (0%) | 67 (30%) | 0 (0%) | 5 (12%) | 13 (19%) |
| ***Note:*** Total Referrals = Pending + Rescinded + Enrolled. Enrolled = Active + Graduation + Discharge. The percentage next to each number is out of the total number of referrals of each category per provider. |

One way of evaluating the success of the program is to examine the length of time that participants remained in services. Participants had the shortest stays before discharge at Percy Village (Mean = 47.23, SD = 64.10), followed closely by SSG (Mean = 50.42, SD = 37.24). Stays were about 1 month longer at Normandie East (Mean = 73.36, SD = 69.35) and about 3 months longer at Telecare (Mean = 121.46, SD = 104.12). Similarly, participants had the shortest stays at SSG (Mean = 209.10) and Percy Village (Mean = 214.25, SD = 27.80) and longer stays at Telecare (Mean = 295.80, SD = 140.63) and Normandie East (Mean = 323.83, SD = 112.28). It is unclear why the lengths of stay were different across the agencies but these patterns were similar for both those who were discharged or graduated. Additional methods of evaluating the programs will be explored in later sections of the report.

**Post-AOT for graduates.** Of the42 graduates of ERS, there was a post-AOT provider noted for all of them (100%), 8 of which were ERS providers, 1 to FCCS, 2 to unspecified levels of care and the remainder to FSP (74%).

### *Full Service Partnership Referrals (CRM Administrative Data)*

CRM/EOTD has recorded 813 referrals to FSP programs (including 3 referrals to non-AOT providers that will not be included in the rest of this report) across662 unique individuals as of May 17th, 2019. This report will only evaluate the 810 cases (across 662 individuals) that were assigned to contracted AOT providers. There were 26 enrollments in 2015 (May 2015-December 2015), 131 in 2016, 155 in 2017, 191 in 2018, 74 in 2019, and 3 in 2020 (for those referred by May 17th, 2019).Table 7below represents the number of referrals processed rather than individual outcomes.The average length of time in FSPs before discharge was 216.59 days (SD = 159.02; range = 0-882). The average length before graduation is 344.91 days (SD = 195.75; range: 92-1031).

Over time, referrals have been curvilinear and the peak referral year was in 2017 and the peak enrollment year was 2018.

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| ***Table A5. Total FSP Referrals (n=810)*** |
| ***Never/Not Yet Enrolled (n=230)*** | ***Ever Enrolled (n=580)*** |
| ***Rescinded*** | ***Pending*** | ***Actively in Treatment*** | ***Discharged*** | ***Graduated*** |
| 230 | 0 | 141 | 249 | 190 |
| *Note:* Rescinded + Pending + Enrolled = 927 cases. |

Of the 249 cases of discharge, the most common reason for discharge included being unable to locate them. In order to examine the overlap in reasons for FSP and ERS discharge, both are presented below. The most common reasons for discharge across both programs is being unable to locate participants (34%) and their being arrested (17%).

Reasons for rescinded referrals are insufficiently tracked in the EOTD dataset. A reason is only noted in 145 of 230 cases in a single variable (more reasons might exist in other columns of data but a consistent source is lacking within the dataset). Of those who did not enroll in FSP, the most common reason was that they could not be located (22% of those with data, n = 32), following by ‘other’ (21%, n = 31). In 13% of cases a different level of care was needed (n =19), 10% were incarcerated (n = 14), 8% had internal agency issues (n = 14), 5% had a clinical barrier (n = 8), 5% had insurance issues (n = 7), 4% of clients relocated (n = 7), 3% no longer met AOT criteria (n = 5), and remainder were 1-2 person instances of awaiting petition, canceled referral, client rejection, EOB requested change in provider, out of County, out of service area, safety issue, the need to continue outreach and engagement and language barrier. We suggest that more meaningful categories and the option to track multiple reasons for rescinded referrals would be more useful for understanding why individuals do not enroll.

***FSP Providers.*** Eighteen FSP providers have had potential AOT clients referred. Table A6 below presents the outcomes across the total referrals (not individuals); therefore, some individuals are represented more than once across outcomes. We will only present those who were assigned a provider.For this report, we will present percentages of each outcome across providers (which is different than how we have presented these data in prior reports). These data suggest that rescinding of referrals is quite common across providers. Providers may need more support during the warm hand-off or that other issues may be hampering their efforts to engage and retain clients, such as the severity of the participants’ clinical, legal, or functional issues that prohibit engagement or difficulty in locating some participants. As there are no pending cases, this column will not appear in the table below as it has in prior reports. Ocean Park FSP ceased participating in AOT within the first year and we will not evaluate their performance.

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| ***Table A6. Outcomes of FSP Referral by Provider*** |
|  |  | ***Never Enrolled (n=230)*** |  | ***Ever Enrolled n=580)*** |
| ***Provider*** | ***Total******(n=810)*** | ***Rescinded******(n=230)*** |  | ***Active******(n=141)*** | ***Discharged******(n=249)*** | ***Graduated******(n=190)*** |
| Behavioral Health Services  | 68 | 18 (8%) |  | 12 (9%) | 25 (10%) | 13 (7%) |
| Exodus Recovery | 60 | 17 (7%) |  | 10 (7%) | 20 (8%) | 13 (7%) |
| Hathaway Sycamore | 60 | 4 (2%) |  | 16 (11%) | 21 (8%) | 19 (10%) |
| Hillview Mental Health | 39 | 14 (6%) |  | 3 (2%) | 11 (4%) | 11 (6%) |
| IMCES | 43 | 15 (7%) |  | 6 (4%) | 13 (5%) | 9 (5%) |
| Masada Homes | 43 | 7 (3%) |  | 11 (8%) | 17 (7%) | 8 (4%) |
| Ocean Park | 4 | 2 (1%) |  | 0 (0%) | 1 (.4%) | 1 (.5%) |
| PACS | 65 | 25 (11%) |  | 15 (11%) | 13 (5%) | 12 (6%) |
| Percy Village | 8 | 4 (2%) |  | 0 (0%) | 1 (.4%) | 3 (2%) |
| SFVCMHC | 46 | 11 (5%) |  | 5 (4%) | 17 (7%) | 13 (7%) |
| SSG Silver | 9 | 3 (1%) |  | 3 (2%) | 0 (0%) | 3 (2%) |
| SSG | 66 | 14 (6%) |  | 10 (7%) | 15 (6%) | 27 (14%) |
| SHIELDS | 38 | 15 (7%) |  | 5 (4%) | 8 (3%) | 10 (5%) |
| Starview | 27 | 8 (3%) |  | 8 (6%) | 7 (3%) | 4 (2%) |
| Step Up on 2nd | 47 | 18 (7%) |  | 6 (4%) | 14 (6%) | 9 (5%) |
| Tarzana Treatment Centers | 60 | 16 (7%) |  | 12 (9%) | 24 (10%) | 8 (5%) |
| Telecare | 51 | 13 (6%) |  | 10 (7%) | 17 (7%) | 11 (6%) |
| Tessie Cleveland | 76 | 26 (11%) |  | 9 (6%) | 25 (10%) | 16 (8%) |
| *Note:* **Total Referrals** = Pending + Rescinded + Enrolled. **Enrolled** = Active + Graduation + Discharge. The percentage below each number is out of the total number of the column. |

In looking at the length of treatment among FSP providers, there was considerable variability. The shortest stay before discharge was 0 days (Masada Homes, Hillview), though some providers also had lengths of stay as short as 2 days (PACS, Tarzana). In instances where the length of treatment is 0 days, the reasons for discharge included 1 being relocated and the other 2 as unable to locate, which suggests that these should not truly be considered enrollments. The shortest time until graduation was 92 days at Step Up on 2nd and the longest was 1031 days at IMCES (2.82 years).

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| **Table A7. Lengths of Treatment by FSP Providers.** |
|  | **Length in Treatment – Discharge**  | **Length in Treatment – Graduation** |
| **Provider** | **Mean (SD)** | **Range** | **Mean (SD)** | **Range** |
| Behavioral Health Services  | 166.84 (100.47) | 12-413 | 351.38 (216.99) | 105-804 |
| Exodus Recovery | 212.70 (120.28) | 56-497 | 328.77 (168.40) | 173-680 |
| Hathaway Sycamore | 277.71 (154.34) | 71-647 | 407.05 (232.13) | 111-840 |
| Hillview Mental Health | 169.64(132.96) | 0-342 | 286.82 (130.62) | 175-629 |
| IMCES | 258.62 (174.74) | 92-599 | 434.44 (268.19) | 145-1031 |
| Masada Homes | 211.12 (166.46) | 0-527 | 338.75 (197.02) | 160-659 |
| Ocean Park\*  | 77 |  | 170 |  |
| PACS | 267.62 (191.06) | 2-641 | 314.25 (100.63) | 173-448 |
| Percy Village | 35 |  | 461.33 (335.79) | 261-849 |
| SFVCMHC | 225.29 (112.20) | 102-448 | 283.15 (120.43) | 162-547 |
| SSG Silver | 0 |  | 459.00 (339.85) | 103-780 |
| SSG | 253.80 (197.36) | 40-720 | 318.59 (163.75) | 151-725 |
| SHIELDS | 153.88 (151.91) | 25-461 | 376.50 (195.94) | 181-812 |
| Starview | 223.00 (144.75) | 113-533 | 376.00 (167.21) | 213-563 |
| Step Up on 2nd | 234.64 (214.54) | 60-753 | 210.78 (94.66) | 92-374 |
| Tarzana Treatment Centers | 232.33 (196.62) | 2-882 | 398.75 (303.34) | 125-965 |
| Telecare | 252.00 (204.77) | 41-631 | 312.64 (182.95) | 168-672 |
| Tessie Cleveland | 152.36 (93.27) | 35-365 | 4000.06 (230.15) | 174-874 |

**Note:** In columns where no SD and range were provided, this was due to there being only one case, which negates the calculation of these numbers. \*Ocean Park ceased participation within the first year and had very few clients.

**Post-AOT for Graduates.** Of the 190 graduations for 186 individuals, a reason was recorded for 129 cases, though in 15 of those cases (12%) they were noted as having no linkage, which means that 60% of those who graduated were linked to a post-AOT treatment program. It is also notable that in two cases, their post-FSP provider was an ERS, which is a higher level of care and thus does not logically make sense.

## Provider Effectiveness with Clients and Data Completion Rates

### *Ethnographic Observations*

Our observations have documented that nearly all provider staff are dedicated to trying to engage the AOT clients and to provide them with the best services possible. They find the work “frustrating but rewarding.” Therapists plan to schedule two or more visits a week with clients initially, more often if the client needs and is receptive to more intense service, and maintain ongoing contact; case managers meet with clients as well, at least twice a month. Contact levels vary significantly among providers however, through medical record review, we found that three providers managed to maintain a mean level of at least six contacts a month, whereas others seemed to make 3-4. Virtually everyone we interviewed agreed that six months is insufficient for AOT treatment; they spend two to three months “just doing rapport.” Most providers also try to schedule early visits for the client with a prescribing psychiatrist, although this is variable, as discussed above. Many providers stated that they did not push medication where clients were resistant. If clients are willing to go to medication appointments, providers may or may not assist with transportation.

Provider strategies for engagement include: simple persistence, showing up when expected, checking in by phone often, always answering the client’s call; the use of incentives, including food, haircuts and shopping trips; building alliances with the client versus the court and/or the family doing little things to help, so that the client can see the provider is on his/her side; client education and re-orientation to reality. Providers try to talk to the client “like a human being,” avoiding blame, ridicule or minimization, and giving positive reinforcement for any small positive step. “Hearing them out” is a major part of rapport building, as “they don’t have anyone in their lives to talk to.” They seek to get him/her to “speak for herself” in expressing what s/he needs and wants; then they try to find ways to meet those goals, and to show the client how engaging in treatment and taking medication will help them get what they want. “You have to help yourself if we are going to be able to help you.” (For examples see Case Studies of Ms. A and Mr. B below.) During most of the initial enrollment period, and for some AOT clients throughout enrollment, providers appear to invest most of their time in engagement and case management; clients only receive therapy at later stages in the program.

Once a level of rapport is established, therapists rely on numerous techniques, “whatever it takes,” to engage difficult clients, most often including motivational interviewing, supportive feedback, reflective listening, and cognitive redirection. They may also use DMH and the potential for a court-order or just reminding the client that their behavior “has to be reported” as leverage, again trying to show in doing so that they are aligned with the client. These techniques work well in a number of cases, but when they do not work, particularly if clients will not take prescribed meds, client visits tend to degenerate into repetitive, non-productive encounters, “the hamster wheel effect”, or worse, repeated missed appointments or encounters where the provider tries to communicate through a screen door or window. Inexperienced staff often have no tools available to deal with violence perpetration or with victimization. Staff do share experiences and techniques at weekly staff meetings, though sufficient time may not be available to do this. Staff speak of “figuring things out as I go along” and comment that “the clients are not a match for the level of care.”

**Case Studies: Ms. A and Mr. B**

Ms. A had a 10-year-old child; family members were supportive, but she rejected their assistance. She wanted to get a job and be independent. She was stable on medications but often refused to take them during her first three months in AOT. She questioned the visits of the therapist and case manager – “Why are you always here?” and often created neighborhood disturbances, removing her clothing and running into traffic. She was hospitalized repeatedly, “back-to-back-to-back,” during this period. DCFS became involved and took custody of her child. The FSP team stood by her, went to children’s court with her and gradually gained her trust. They helped her see that to get her child back and to get the job she wanted, she would have to work on goals such as completing tasks and reducing verbal aggression; and that staying on medications would help with that. After three months, she began taking her medications and became compliant. After six months, she graduated from AOT and was transferred to FSP Adult Services.

Mr. B was living outside his mother’s home; she was moving away and did not plan to let him know where to follow her. He was very isolated and wary of other people. The FSP team visited him and bought him food, but he refused to make eye contact, covered his ears when spoken to, and ate the food sitting at a distance from them. However, when he was approached by an individual in the neighborhood who had intimidated or bullied him in the past, “asking about something the client borrowed and did not return,” the case manager spoke up and said if there was any problem, he would handle it for Mr. B. This incident helped to gain the client’s trust. The FSP team was able to get him housed in a board and care home; there he stayed in his bed, and refused to take medication or see the psychiatrist, because he said he was allergic to the medication. (An allergy was documented in an earlier clinical record.) The FSP therapist was able to get the psychiatrist to visit him in the board and care at his bedside, talk to him, and prescribe some medication the client was able to take.

### *Multnomah Community Ability Scale and Monthly Reporting Tool: Rates of Completion and Available Data*

The MCAS and MRT data is collected on a monthly basis in order to track key outcomes for the state’s reporting requirements. However, this process has been extremely challenging for providers to complete and for DMH to enter these data in a timely manner. In an effort to enter all the MCAS individual items (rather than just the subscales and total score), we had teams who have been entering the items into CRM’s dataset and adding them to the datasets provided previously by CRM and those entered by EOTD. However, it is notable that CRM has been able to enter all the individual items since they assumed oversight of ERS facilities only and that rates of completion among ERS providers is consistently better as well. At our request, EOTD followed up with providers about their 2017-2019 reports to verify whether data was missing due to data entry or failure to submit. We had significant lag times in our supplemental entry of the MCAS items due to challenges with onboarding student workers and EOTD was able to assist in this task for the 2018-2019 datasets more significantly over time as well. We would like to thank EOTD and CRM staff for their help in ensuring the collection and entry of these data in time for our report.

In the table below we outline the number of reports received by year for FSP and ERS. In order to evaluate what the expected completion rates of reports should be for each agency, we calculated the number of months that participants should have reports for based on whether they were enrolled for any length of time in particular calendar month. We did not include the requirement for those who were referred by May 19th, 2019 but had a new enrollment in 2020 (which excluded 3 active participants in FPS and 1 in ERS) as we only evaluated report completion through December 2019.

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| **Table R1. Report submission by year and provider type.** |
|  | **2015** | **2016** | **2017** | **2018** | **2019** | **Total Collected** | **Total Projected** |
| **FSP** | 66 | 668 | 1251 | 1596 | 1792 | 5373 | 6407 |
| **ERS** | 14 | 64 | 140 | 198 | 181 | 597 | 627 |

If all the data were collected perfectly, there were have been 2335 reports collected on those in FSP who graduated, 2025 on those who were discharged, and 2047 for those actively in treatment as of December 2019 for an expected total of 6407 reports, which is an 84% completion rate. This is considerably higher than what we have found in prior reports, and reflects the efforts to improve the collection and data entry by UCLA and DMH staff. For ERS, there would have been 393 reports for those who graduated, 217 for those who were discharged, and 17 for those actively in treatment, for a total of 627 reports, which is a 95% completion rate.

**Report Completion by Provider.** Providers completed monthly reporting tools and MCAS ratings that are submitted electronically to DMH. There were significant delays for the receipt or entry of these data over the course of the evaluation that limited the UCLA team’s ability to evaluate the completion rates by providers as a whole or individually earlier in our evaluation. Several FSP providers had a completion rate of over 100% (Exodus, Percy Village, SFVCMHC, SHIELDS), which could indicate differences in understanding of when a client is enrolled or discharged/graduated from the program. IMCES had the lowest completion rate (33%). We met with IMCES across the course of the evaluation and changes in personnel were part of the issue for their completion of these ratings. The only period of time that this provider completed the expected reporting at acceptable levels was in the Fall of 2018 – Spring 2019 and for two months in the Fall of 2019. Other providers with low rates of transmission included SSG Silver and Ocean Park. As noted earlier in the report, Ocean Park stopped participating in the AOT program within the first year and therefore their lower reporting rates are expected. The low rates by SSG Silver merit further examination by DMH. It is possible that due to their lower rates of AOT participants, the reporting requirements of AOT may not have been as salient to their staff. Hillview, BHS, and Masada Homes were also below 80% for their report submissions and this also merits further review.

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| **Table R2. Report submission by FSP provider.** |
| **Provider** | **Total Completed** | **Total Projected for Completion** | **% Completed** |
| Behavioral Health Services  | 391 | 519 | 75% |
| Exodus Recovery | 495 | 486 | 102% |
| Hathaway Sycamore | 675 | 691 | 98% |
| Hillview Mental Health | 135 | 203 | 71% |
| IMCES | 114 | 350 | **33%** |
| Masada Homes | 277 | 378 | 76% |
| Ocean Park  | 5 | 9 | 56% |
| PACS | 362 | 449 | 81% |
| Percy Village | 52 | 50 | 104% |
| SFVCMHC | 357 | 344 | 104% |
| SSG Silver | 53 | 97 | **55%** |
| SSG | 515 | 573 | 90% |
| SHIELDS | 247 | 245 | 101% |
| Starview | 203 | 241 | 84% |
| Step Up on 2nd | 234 | 283 | 83% |
| Tarzana Treatment Centers | 445 | 550 | 81% |
| Telecare | 401 | 452 | 89% |
| Tessie Cleveland | 412 | 487 | 85% |

Among ERS providers, the lowest rate of completion was 92% and the highest rate of completion was 101%.

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| **Table R3. Report submission by ERS provider.** |
| ***Provider Name*** | **Total Completed** | **Total Projected for Completion** | **% Completed** |
| Normandie East | 174 | 176 | 99% |
| Percy Village | 84 | 83 | 101% |
| SSG | 229 | 249 | 92% |
| Telecare | 110 | 119 | 92% |

After merging the administrative and MCAS/MRT datasets for FSP participants, there was no data provided on 40 individuals (though notable 2 are for Ocean Park and 3 are for non-AOT providers). It is important to note that there were 193 FSP reports that were not associated with any participants, so it is possible that these data are not missing but mislabeled. Similarly, for ERS participants there were 13 individuals whom no data was provided and 51 reports for participants that had not enrolled in ERS. It was not possible to correct this issue in time for the report but EOTDCRM should make an effort to link or remove these reports from their system.

While 2020 MCAS data are not part of this evaluation, we do make note that some providers had not turned in any MCAS as of the date that we received data and we suggest that additional follow-up efforts be paid to these reporting delays, which could reflect delays by providers or in data entry.

## Court Processes

### *Ethnographic Observations*

AOT clients, providers, and families alike meet and participate actively in the AOT process in Mental Health Court. Although the setting is public, all individuals who attend court do get an opportunity to speak to the judge and interact with court staff. Clients are usually reluctant to participate in AOT services and sometimes hostile at their initial court appearance. The Mental Health Court judges and Public Defenders have shown great investment in the program and taken active steps to improve effectiveness. The judge has worked to streamline provider reporting. When she is empathetic as an overseer of treatment and an ally to the client, clients do build trust with her. However, clients’ negative perceptions and often their humiliation are exacerbated when they have to defend themselves in an open and public court hearing. Discussion of personal and medical matters by treatment providers in the court setting may also challenge the therapeutic alliance providers with their clients.

The Public Defender and her staff have worked with clients and EOTD staff to ensure the best outcomes, often persuading clients to sign settlement agreements. In 2018, the Court transitioned all AOT cases to one courtroom (from three), increasing the speed of cases moving through the system, reducing client confusion and centralizing the court staff to one location. In 2019, the Public Defender employed a CENS (Client Engagement and Navigation Services) navigator to work with providers and get AOT clients with substance abuse issues into co-occurring disorder programs; the court and EOTD requested and obtained a change in DMH policy to allow for referrals outside of contract providers. These innovations should significantly improve program effectiveness. The Mental Health Court is also scheduled to move from the Downtown Courthouse on Hill Street to the new Hollywood Boulevard Courthouse, but it is unclear when this will happen; the move would have significant benefits in client privacy and convenience.

### *Court Orders and Enrollments*

The first court order that was obtained was in March 2016. Since then, there have been 138 individuals who were assigned to treatment by either a settlement agreement or sustained petition at some point (before or during enrollment/non-enrollment). Among those who met criteria and who were assigned to a provider, there were 771 individuals (across 1155 cases) processed where a court-order could have been applied. These cases include people who may have been processed multiple times and had a court order applied in some of their cases but not in others. Across all their assignments, 627 individuals never had a court order. Of these, 487 had at least one enrollment in services (63% of the 771 overall), and 140 never enrolled (18% of the 771 overall). An additional 144 individuals had a court order for at least one of their treatment assignments; of these, 107 were court-ordered for every assignment, and 37 had some assignments without a court order and some with a court order in effect. Of the 144 individuals with a court order, 114 people had at least one enrollment, 105 of whom were only enrolled while under court order and 9 of whom had both voluntary and involuntary enrollments. The other 30 individuals with court orders (23 of whom were always under court order, and 7 of whom had assignments both under court order and without a court order) never enrolled.

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| **Table V1. Enrollment status of individuals assigned to treatment, by court order, across all treatment assignments for each individual. N (%).** |
| **Court-Order Status** | **Enrollment Status** | **Number and Percent(n = 771)** |
| Voluntary Only | Enrolled | 487 (63%) |
| Not Enrolled | 140 (18%) |
| Involuntary Only | Enrolled  | 84 (11%) |
| Not Enrolled | 23 (3%) |
| Mixed | Enrolled with a court order; Did not enroll when not court-ordered | 21 (3%) |
| Enrolled with a court order; Enrolled voluntarily | 9 (1%) |
| Did not enroll with a court order; Did not enroll when not court-ordered | 7 (1%) |

These data suggest that a significant proportion of individuals can enroll in services voluntarily but that the court mechanism is useful for a small proportion of individuals in order for them to enroll or stay enrolled in services. We will explore whether there are characteristics that are associated with the use of the court throughout the report.

## Outreach to AOT-Eligible Individuals

### *Community Outreach Services*

Because outreach and engagement services provided by the two AOT outreach teams are for the most part not billable, they are not captured in the IS/IBHIS billing data. So that we can examine the frequency of these services as well as the billable treatment services clients receive, Clinical Informatics has begun providing us with data on community outreach services (COS). The section below presents analyses previously presented in Quarterly Report 9 (February 15, 2019).

Table O1 shows the mean number of COS services clients received in the 6 months prior to referral to AOT and the 6 months following referral to AOT, among those individuals referred to the AOT program for the first time prior to July 1, 2018 (to allow 6 months of follow-up data). Subsequent referrals were excluded to ensure that the period prior to AOT referral was truly pre-AOT; i.e., to avoid situations where the pre-referral period for a second referral would reflect outreach services provided following the initial referral. The two left-hand columns show pre-post comparisons for clients who met AOT criteria and therefore were intended to receive outreach services; the two right-hand columns show pre-post comparisons for clients who did not meet AOT criteria. In a small number of cases, clients who were ultimately found not to meet criteria receive some outreach before that determination is made; this outreach may be reflected in the average numbers in the right-hand columns, which sometimes show a small increase from the pre-referral period to the post-referral period.

COS services received are broken down by type of provider. Because this is a first look at the COS data, this is an opportunity to see to what extent AOT-received clients receive COS services not only from the AOT outreach and engagement teams, but from other providers as well. The only other notable provider of COS services from the standpoint of AOT referral was Residential and Bridging Services (7213A RESIDENTIAL AND BRIDGING SVCS): clients who were AOT-eligible saw an increase in the average number of COS services received from this provider, with an average of 1.25 in-person and 0.80 phone services per client in the 6 months following referral to AOT, compared with 0.31 in-person and 0.14 phone services per client in the 6 months prior to AOT referral.

We are primarily interested in the number of COS services provided by the two AOT outreach and engagement teams (“7926A ASSISTED OUTPATIENT TREATMENT LA” and “7928A ASSISTED OUTPATIENT TREATMENT LA”), and this is where we see the bulk of post-AOT referral services. Looking at both AOT-eligible (those who met criteria) and AOT-ineligible clients, we can see that receipt of COS services from the AOT teams was very uncommon in the 6 months prior to AOT referral. To the extent that some clients did receive these services prior to referral, this could reflect the small number of cases in which outreach efforts began before the formal referral was received and logged. As we explore these data further, we will look at the timing of these pre-referral AOT COS services.

In the 6 months following AOT referral, the data show a substantial average number of AOT outreach services per AOT-eligible client. These eligible clients received an average of 5.28 in-person services with the client, 2.08 phone services with the client, 0.49 in-person services with a family member, and 0.46 phone services with a family member.

Means can be an imperfect way of looking at data like these, since the number of services is averaged across clients who received no services as well as those outliers who received dozens of services. The histograms in Figure O1 show the distribution of services in the follow-up period among AOT-eligible clients. Services provided to the client are on the left, and services provided to a family member are on the right.

Nearly 25% of eligible clients received no in-person COS services from the AOT outreach teams in the 6 months post-referral; it is likely that many of these individuals could not be located. The median number of these services (50th percentile) was 4, with an interquartile range (25th percentile to 75th percentile) of 1 to 7; the overall range was 1 to 43. Similarly, nearly 60% of eligible clients received no post-referral phone COS services from the AOT outreach teams; therefore, median number of phone services was 0, with an interquartile range of 0 to 2 and an overall range of 1 to 56.

Over 80% of eligible clients had no in-person COS services provided to a family member. Among those who did receive in-person family services, the number of services received ranged from 1 to 32. Finally, more than 80% of eligible clients had no phone COS services provided to a family member. Among those whose family did receive phone COS services, the number of services ranged from 1 to 15.

Adding together the number of COS services received from the AOT teams in the post-referral period (client in-person + client phone + family in-person + family phone), Figure O2 gives us an overall picture of the volume of COS services delivered by the AOT teams to AOT-eligible post-referral clients. Only around 18% of clients received no COS services of any type (client or family; in-person or phone) from the AOT teams. The median number of services was 6, with an interquartile range of 2 to 12. Among those who did receive COS services of any kind, the number of services ranged from 0 to 75.

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| **Table O1. Number of COS services received in the 6 months pre-referral and 6 months post-referral to AOT, Mean (SD).** |
|  | **Met AOT Criteria (n=1,105)** | **Did Not Meet AOT Criteria (n=747)** |
|  | **Pre-Referral** | **Post-Referral** | **Pre-Referral** | **Post-Referral** |
| **AOT Outreach** |
| Client, In Person | **0.01 (0.16)** | **5.28 (5.95)** | 0.01 (0.15) | 0.24 (1.11) |
| Client, By Phone | **0.01 (0.08)** | **2.08 (4.73)** | 0.00 (0.00) | 0.18 (0.90) |
| Family, In Person | **0.00 (0.07)** | **0.49 (1.75)** | 0.00 (0.00) | 0.09 (0.39) |
| Family, By Phone | **0.01 (0.16)** | **0.46 (1.60)** | 0.00 (0.04) | 0.07 (0.46) |
| **Residential and Bridging Services** |
| Client, In Person | 0.31 (1.31) | 1.25 (2.20) | 0.24 (0.97) | 0.54 (2.24) |
| Client, By Phone | 0.14 (0.80) | 0.80 (1.52) | 0.07 (0.46) | 0.25 (1.06) |
| Family, In Person | 0.00 (0.00) | 0.00 (0.00) | 0.00 (0.00) | 0.00 (0.04) |
| Family, By Phone | 0.00 (0.00) | 0.00 (0.00) | 0.00 (0.00) | 0.00 (0.00) |
| **Court Linkage** |
| Client, In Person | 0.11 (0.62) | 0.19 (1.11) | 0.16 (1.00) | 0.21 (1.45) |
| Client, By Phone | 0.02 (0.23) | 0.05 (0.40) | 0.04 (0.56) | 0.04 (0.34) |
| Family, In Person | 0.00 (0.00) | 0.00 (0.00) | 0.00 (0.00) | 0.00 (0.00) |
| Family, By Phone | 0.00 (0.00) | 0.00 (0.00) | 0.00 (0.00) | 0.00 (0.00) |
| **Crisis Resolution** |
| Client, In Person | 0.01 (0.16) | 0.00 (0.04) | 0.00 (0.08) | 0.15 (0.25) |
| Client, By Phone | 0.02 (0.30) | 0.00 (0.05) | 0.01 (0.16) | 0.00 (0.07) |
| Family, In Person | 0.00 (0.00) | 0.00 (0.00) | 0.00 (0.00) | 0.00 (0.04) |
| Family, By Phone | 0.00 (0.00) | 0.00 (0.03) | 0.00 (0.00) | 0.00 (0.00) |
| **Crisis Homeless** |
| Client, In Person | 0.04 (0.23) | 0.04 (0.25) | 0.02 (0.16) | 0.01 (0.12) |
| Client, By Phone | 0.02 (0.21) | 0.02 (0.19) | 0.03 (0.19) | 0.01 (0.14) |
| Family, In Person | 0.02 (0.14) | 0.02 (0.14) | 0.02 (0.16) | 0.01 (0.10) |
| Family, By Phone | 0.01 (0.12) | 0.02 (0.15) | 0.01 (0.10) | 0.01 (0.11) |
| **FSP or FCCS** |
| Client, In Person | 0.06 (0.64) | 0.01 (0.16) | 0.04 (0.38) | 0.06 (0.65) |
| Client, By Phone | 0.14 (0.24) | 0.01 (0.10) | 0.01 (0.15) | 0.02 (0.27) |
| Family, In Person | 0.00 (0.00) | 0.00 (0.00) | 0.00 (0.05) | 0.00 (0.00) |
| Family, By Phone | 0.00 (0.00) | 0.00 (0.12) | 0.00 (0.00) | 0.00 (0.00) |
| **EOTD Homeless Outreach and Mobile Engagement** |
| Client, In Person | 0.06 (0.88) | 0.06 (1.08) | 0.06 (0.82) | 0.08 (0.90) |
| Client, By Phone | 0.00 (0.06) | 0.01 (0.10) | 0.00 (0.00) | 0.00 (0.04) |
| Family, In Person | 0.00 (0.00) | 0.00 (0.00) | 0.00 (0.00) | 0.00 (0.00) |
| Family, By Phone | 0.00 (0.00) | 0.00 (0.00) | 0.00 (0.00) | 0.00 (0.00) |
| **Law Enforcement Teams** |
| Client, In Person | 0.09 (0.39) | 0.22 (1.24) | 0.04 (0.33) | 0.07 (0.44) |
| Client, By Phone | 0.01 (0.16) | 0.04 (0.29) | 0.00 (0.04) | 0.02 (0.19) |
| Family, In Person | 0.01 (0.14) | 0.01 (0.13) | 0.01 (0.09) | 0.01 (0.09) |
| Family, By Phone | 0.01 (0.01) | 0.00 (0.06) | 0.00 (0.04) | 0.00 (0.04) |
| **Service Area Mobile Triage** |
| Client, In Person | 0.14 (1.69) | 0.09 (1.07) | 0.03 (0.31) | 0.11 (0.76) |
| Client, By Phone | 0.05 (0.54) | 0.03 (0.27) | 0.01 (0.19) | 0.02 (0.19) |
| Family, In Person | 0.00 (0.00) | 0.00 (0.00) | 0.00 (0.00) | 0.00 (0.00) |
| Family, By Phone | 0.00 (0.00) | 0.00 (0.00) | 0.00 (0.00) | 0.00 (0.00) |
| **Service Area Navigation Teams** |
| Client, In Person | 0.09 (0.52) | 0.06 (0.34) | 0.05 (0.35) | 0.06 (0.30) |
| Client, By Phone | 0.02 (0.22) | 0.01 (0.09) | 0.01 (0.09) | 0.02 (0.19) |
| Family, In Person | 0.00 (0.06) | 0.00 (0.03) | 0.00 (0.08) | 0.01 (0.08) |
| Family, By Phone | 0.00 (0.03) | 0.00 (0.03) | 0.00 (0.00) | 0.00 (0.04) |
| **DMH Pre-Admit**  |
| Client, In Person | 0.04 (0.27) | 0.06 (0.43) | 0.02 (0.22) | 0.02 (0.16) |
| Client, By Phone | 0.00 (0.05) | 0.01 (0.12) | 0.00 (0.05) | 0.01 (0.09) |
| Family, In Person | 0.00 (0.07) | 0.01 (0.09) | 0.00 (0.04) | 0.00 (0.05) |
| Family, By Phone | 0.00 (0.04) | 0.00 (0.07) | 0.00 (0.00) | 0.00 (0.04) |
| **Other Provider** |
| Client, In Person | 0.09 (0.41) | 0.08 (0.38) | 0.12 (1.08) | 0.10 (0.67) |
| Client, By Phone | 0.02 (0.14) | 0.03 (0.25) | 0.03 (0.28) | 0.06 (0.56) |
| Family, In Person | 0.01 (0.17) | 0.00 (0.07) | 0.01 (0.09) | 0.00 (0.06) |
| Family, By Phone | 0.00 (0.07) | 0.00 (0.03) | 0.00 (0.08) | 0.00 (0.00) |

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| **Figure O1: Distribution of the number of COS services received from the AOT outreach and engagement teams by AOT-eligible individuals in the 6 months following referral to AOT.**  |
| **Client, In-Person** | **Family, In-Person** |
| **Client, By Phone** | **Family, By Phone** |

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| **Figure O2: Distribution of the number of COS services received from the AOT outreach and engagement teams by AOT-eligible individuals in the 6 months following referral to AOT, totaled across type of COS service (client and family; in-person and phone).** |

Finally, Table O2 looks at whether clients who met criteria and either did or did not receive any in-person COS from AOT outreach teams in the 6 months post-referral were able to be reached by the AOT team in some other way, either by phone COS with the client, COS delivered to a family member in-person or by phone, or both. Most of the 843 eligible clients who received in-person COS from AOT outreach teams also received either phone contact (29%), family contact (15%) or both (21%); only 36% received only in-person client COS. While the way these data are presented makes the phone and family COS appear to be additional, in many cases the phone or family outreach may have been what made the in-person client COS possible.

Among the 262 eligible clients who did not receive in-person COS, however, 78% also did not receive any other AOT COS services, either by phone or with a family member. These are the most difficult clients to reach; the AOT teams likely were unable to locate them and did not have a family contact they could reach out to. Of these 262 clients with no in-person client COS, the outreach teams were able to deliver phone COS to 10%, family COS to 9%, and both phone and family COS to 3%. This demonstrates both success in finding various ways of outreaching to clients, and also the reality that phone or family outreach does not always translate into the ability to meet face-to-face with a client. These other forms of COS may nonetheless have had benefits for the clients or their families, as they may have been opportunities to provide psychoeducation or tell clients and families about the benefits of treatments and other resources.

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| **Table O2. Among clients meeting criteria, who either did or did not receive AOT COS delivered in-person to the client in the 6 months post-referral, what other AOT COS services—client phone contact, or contact with a family member (phone or in-person), were delivered? Number (percent).**  |
|  | **Other AOT COS Services Received** |
| **AOT COS: Client In-Person Delivered?** | **Client PhoneOnly** | **Family Only** | **Client Phone and Family** | **No Other AOT COS** | **Total** |
| **Yes** | 241 (29%) | 124 (15%) | 178 (21%) | 300 (36%) | 843 (100%) |
| **No** | 25 (10%) | 24 (9%) | 9 (3%) | 204 (78%) | 262 (100%) |

### *AOT Outreach Team Post-Outreach Survey Overview*

The section below presents analyses previously presented in Quarterly Report 9 (February 15, 2019). These analyses also were presented at an NIMH conference and will be available in an upcoming publication in *Research on Social Work Practice*.

The AOT Outreach and Engagement (O&E) Team has been completing Post-Outreach Surveys since July 2017, via UCLA’s web-based REDCap system. Following an in-person training of O&E staff on 5/24/17, modifications to the survey and system based on their feedback, and submission of REDCap access forms and HIPAA certificates for all O&E staff, finalized survey instructions were distributed to O&E staff via email on 7/13/2017. At that point, O&E staff began completing surveys for clients whose outreach had recently ended as well as going forward for clients whose outreach subsequently ended.

As of January 22, 2019, 486 surveys had been entered in RedCAP on clients whose outreach had ended. Table O3 presents client characteristics for that sample, including demographic characteristics, diagnosis, and referral source**.**

The Post-Outreach Survey asks O&E staff to report on a number of topics to provide a clearer picture of all clients who receive outreach, including those who do not enroll in treatment, as well as to provide a more complete understanding of the outreach and engagement process. We present a subset of the survey results in the following sections.

### *Outreach Strategies and Barriers to Treatment*

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| **Table O3. Characteristics of Clients in Post-Outreach** **Survey Sample** |
|  | N | Percent |
| **Race and Ethnicity (n=486)** |  |  |
| White | 150  | 31% |
| Black | 104 | 21% |
| Hispanic | 165 | 34% |
| Asian Indian | 5 | 1% |
| Burmese | 1 | 1% |
| Cambodian | 1 | .2% |
| Chinese | 17 | 4% |
| Filipino | 5 | 1% |
| Guamanian | 1 | .2% |
| Hawaiian | 1 | .2% |
| Japanese | 2 | .4% |
| Korean | 10 | 2% |
| Samoan | 1 | .2% |
| Vietnamese | 1 | .2% |
| Multiple Selected/Other | 17 | 4% |
| **English Speaking (n=486)** |  |  |
| Yes | 477 | 98% |
| No | 6 | 1% |
| Unknown | 3 | .6% |
| **Preferred Language (n=9)** |  |  |
| Armenian | 1 |  |
| Cantonese or Mandarin | 4 |  |
| Korean | 2 |  |
| Spanish | 2 |  |
| **Diagnosis (n=486)** |  |  |
| Schizophrenia | 222 | 46% |
| Schizoaffective | 84 | 17% |
| Psychotic Disorder | 74 | 15% |
| Bipolar | 68 | 14% |
| Mood Disorder | 32 | 7% |
| Other | 4 | 1% |
| Missing | 2 | .4% |
| **Referral Source (n=156)** |  |  |
| Clinician/hospital | 47 | 29% |
| Family member | 46 | 29% |
| PMRT or LET | 39 | 25% |
| Social service agency | 15 | 10% |
| Law enforcement/probation officer | 7 | 4% |
| Roommate | 1 | 1% |
| Other: DMH Homeless Outreach & Mobile Engagement | 1 | 1% |

Figures O3-O6 show the different outreach strategies used by O&E staff with the clients represented by these surveys and how effective they were with that particular client, as well as various issues present for the client and the extent to which they served as barriers to treatment for that particular client. Most of the strategies or barriers were provided as checkboxes so that O&E staff could note whether or not they were used with/present for a particular client and then, if selected, rate them; the list of strategies and barriers included in the survey was initially developed by UCLA researchers but then presented to the O&E teams for refinement prior to finalizing the survey to ensure that it included the most likely items. The survey also included “other” options where O&E staff could enter and rate other strategies or barriers relevant for that particular client; those are either noted as “OTHER: [text]” in the figures or folded into an existing strategy/barrier if highly similar to a pre-specified option.

Outreach strategies were rated as very effective, somewhat effective, not effective, or counterproductive. Figure O3 shows outreach strategies categorized as “services provided to the client during outreach.” Among the most common were: psychoeducation to family; emotional support; purchase of food or coffee; psychoeducation to client; motivational interviewing; informational support (linkage); and assistance with housing. Notable is the wide array of strategies used and the variable effectiveness with different clients; a strategy that was very effective with one client could be counterproductive with another. It is clear that the O&E staff often exhausted the possibilities in order to try to find a way to connect with a particular client.

Figure O4 shows outreach strategies that were categorized as “legal strategies.” These were somewhat less frequently use than the strategies shown in Figure O3. The most common was advising the client that AOT could/would pursue court-ordered AOT, which was used with 30% of clients, with variable effectiveness**;** court-ordered AOT was actually pursued with 10% of clients. Suggesting that AOT might prevent future arrests was used with 22% of clients; either suggesting mental health services as diversion from jail or working with a public defender to try to accomplish diversion was used with 12% of clients; and advising that the client might face a jail or probation violation was used with 4% of clients. A 5150 was pursued with 10% of clients; and O&E staff helped support conservatorship with 4% of clients.

Figure O5 shows outreach strategies that were categorized as “services advertised to clients as benefits of treatment.”Case management services were most frequent, at 53%; followed by psychiatric medication, at around 43%, housing, at 40%, and therapy, at 33%.Assistance with employment or going back to school, assistance with reintegration, and assistance with benefits were all relatively frequently advertised to clients; groups/socialization opportunities and substance use services were less commonly mentioned**.** Of note, though not surprising: mentioning psychiatric medication and substance use services were rated as counterproductive with some clients, whereas the offer of benefits and housing were counterproductive in a small number of cases.

Figure O6 shows potential barriers to treatment, whether they were present for a client, and, if present, the extent to which they were a barrier for that client.38% of clients presented with distrust of mental health providers and 39% resistance to medication; resistance to medication was often a serious or moderate barrier to treatment (83% of those who resisted).23% of clients presented with threatening words or behaviors, which also could pose a serious barrier. Over at third (38%) of clients were noted to have had past psychiatric hospitalizations, and often this history was a barrier to treatment due to traumatic experiences.

Client mental health was frequently an issue, with 60% of clients noted as having lack of insight; 46% with paranoia; around 40% with anger issues;around 40% with substance use; around 34% with lack of motivation; and 14**%** with grave disability.Suicidality was noted in around 7%, and homicidal ideation in around 6%. All of these were more often than not noted as serious or moderate barriers to treatment.The client circumstances most often present were lack of housing (around 36%), legal issues (11%), and lack of financial resources (around 16%). Family mental health issues (5%) and family interference (8%) with treatment were both present at low rates.

Housing placement barriers were present in 36% of cases and typically posed a moderate or serious barrier. Insurance status, which looms large in logistical discussions, were relatively infrequent, but could be serious problems when presence. Among potential barriers to housing a client, medical issues were more frequently present than arson history, lack of medical clearance, or being a sex offender, though the latter three were much more serious barriers when present due to licensing restrictions of board and care facilities.Among potentially problematic insurance status, the most commonly noted was private insurance, at 9%, which was most frequently rated as a minor barrier;only 3% were noted as being uninsured, and fewer than 3% had Medicare issues.

**Figure O3. Outreach Strategies. Services provided to the client during outreach: Frequency and Effectiveness (n=485)**

**Figure O4. Outreach Strategies. Legal strategies: Frequency and Effectiveness (n=485)**

**Figure O5. Outreach Strategies. Services advertised to clients as benefits of treatment: Frequency and Effectiveness (n=485)**

**Figure O6. Presence of potential barriers to treatment, and extent to which it posed a barrier if present**

ATTITUDES/BEHAVIORS BACKGROUND CIRCUMSTANCES HOUSING PLACEMENT BARRIERS

INSURANCE STATUS MENTAL HEALTH TRAUMA

### *Family Involvement*

Tables O4-O6 summarize O&E staff’s assessment of family involvement for each outreached client. The majority of clients had some degree of contact with their families. 36% were known to be living with family members; 20% were known to have contact but were living separately; 16% had limited contact, possibly only by phone; 10% had no contact; and for 17% of clients the O&E staff did not know whether the client had contact with their family.

Out of the 353 clients known to have some degree of contact with their families, O&E staff were able to characterize the quality of client-family interactions for 291 clients. They characterized interactions between client and family as primarily positive for 16% of clients; a mix of positive and negative for 52% of clients; and primarily negative for 16% of clients.

For the 353 clients with known family contact, O&E staff reported that 53% had families who were very involved in the client’s mental health care; 27% had families who were somewhat or inconsistently involved; 6% had families who were not at all involved; and for 14% the degree of family involvement was unknown.

For 42% of the 353 clients with known family contact, O&E staff reported that the family to enhance client’s participation in treatment; for 52%, the family does not seem to affect client’s participation; and for 5% the family seems to negatively affect client’s participation. However, in only a few instances was the explanation for how the family negatively affects the client’s participation in treatment clearly due to the family’s behavior:

* “Mother was not forthcoming with information and was also not cooperative with team about client's symptoms and behavior. Mother appeared overprotective of client and would minimize his behavior.”
* “There appears to be a parent/child conflict. It appears that the relationship is dysfunctional and very enmeshed.”

In other instances, it is unclear whether the issue referenced is reflective of a problematic dynamic between family members, is due to the client’s illness-related lack of trust, or simply reflects the client’s need for privacy or autonomy from family:

* “The client was open to her mother hearing about her treatment but was upset when her brother was around.”
* “At times he agrees with his mother. Other times feels his mother is paying us to follow him ruin his life.”
* “Client's sister is the one that did the referral and if client had known that her sister was the one that did the referral client would have not talked to AOT team members.”
* “Mother keeps nagging at client”
* “Client blames his mother for forcing him to get treatment and client says mother has stolen his belongings. But mother initiates referrals for mental health care.”
* “The client doesn't trust his family. He feels they are all mentally ill.”

In four instances, the outreach workers referenced family members’ fear of the client:

* “Client’s family doesn’t want to be involved with client because of her past violence toward family members.”
* “Per brother, family currently has a restraining order in effect against the client.”
* “Client is violent towards family members.”
* “Per brother, family currently has a restraining order in affect against the client at several locations.”

Finally, in four instances seem primarily to reflect the client’s mental health state:

* “Client is paranoid about parents. He does not believe he has a mental illness and feels as if parents are trying to sabotage his life by having him connected to mental health services.”
* “Depending on the client. At times he agrees with his mother. Other times feels his mother is paying us to follow him ruin his life.”
* “The client doesn't trust his family. He feels they are all mentally ill”
* “Client gets agitated when family gets involved.”

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| **Table O4. Family Involvement.** |
|  | Number | Percent | Percent, excluding “Don’t know” |
| **Does the client have contact with their family?** | **(n=486)** | **(n=486)** | **(n=403)** |
| No contact | 50 | 10% | 12% |
| Limited contact or only by phone | 77 | 16% | 19% |
| Contact but live separately | 99 | 20% | 25% |
| Contact and lives with family member(s) | 177 | 36% | 44% |
| Don’t know | 83 | 17% | n/a |
| **How would you characterize the quality of the client's relationship w/ their family?** | **(n=353)** | **(n=353)** | **(n=291)** |
| Primarily positive interactions | 57 | 16% | 20% |
| A mix of positive and negative interactions | 285 | 52% | 64% |
| Primarily negative interactions | 49 | 14% | 17% |
| Don’t know | 62 | 18% | n/a |
| **How involved is the family in the client's mental health care?** | **(n=353)** | **(n=119)** | **(n=304)** |
| Family not involved in care | 21 | 6% | 7% |
| Family is somewhat or inconsistently involved | 97 | 27% | 32% |
| Family is very involved | 186 | 53% | 61% |
| Don’t know | 49 | 14% | n/a |
| **How does the family appear to affect the client's participation in treatment?** | **(n=351)** | **(n=351)** |  |
| Seems to enhance client’s participation | 149 | 42% |  |
| Does not seem to affect client’s participation | 183 | 52% |  |
| Seems to negatively affect client’s participation (see text for explanations) | 19 | 5% |  |
| **Is the client open to having their family involved in their treatment?** | **(n=353)** | **(n=353)** | **(n=249)** |
| Actively opposed to family involvement | 73 | 21% | 29% |
| Open to family involvement | 146 | 41% | 59% |
| Strongly prefers family involvement | 30 | 9% | 12% |
| Don’t know | 104 | 29% | n/a |
| **Is the family open to being involved in the client's treatment?** | **(n=353)** | **(n=353)** | **(n=289)** |
| Actively opposed to being involved | 16 | 5% | 6% |
| Open to being involved | 138 | 39% | 48% |
| Strongly prefers to be involved | 135 | 38% | 47% |
| Don’t know | 64 | 18% | n/a |

For 249 out of 353 clients, O&E staff were able to evaluate whether the client was open to their family being involved in their treatment; of these, 12% were rated as strongly preferring family involvement; 59% were rated as open to family involvement; and 29% were rated as actively opposing family involvement. For 289 out of 353 clients, O&E staff were able to evaluate whether the family was open to being involved in the client’s treatment; of these, 47% had family that strongly preferred to be involved; 48% had family that were open to being involved; and 6% had family that were actively opposed to being involved.

Table O5 shows the overlap between client and family openness to family involvement, including clients for whom O&E staff were unable to rate client and/or family openness. Green squares indicate good opportunities for family involvement in treatment, where both client and family either strongly prefer or are open to family involvement; orange squares indicate that family involvement is unlikely, but contention between client and family is also unlikely (at least client or family is actively opposed, and the other is at best open to involvement); and red squares indicate likely contentious or disappointing situations, with either client strongly preferring family involvement but family actively opposing being involved, or family strongly preferring to be involved but clients strongly opposing their involvement. Gray squares indicate that O&E staff were unable to rate openness to involvement for client and/or family.

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| **Table O5. Overlap between client and family openness to family involvement in client’s treatment (n=353):** * **Number of clients with each combination of client and family preference;**
* **Percent of clients with a given preference, among families with the preference reflected by each column;**
* **Percent of families with a given preference, among clients with the preference reflected by each row.**
 |
| **Client** **openness to** **having family** **involved** | **Family openness to being involved** |
| **TOTAL** | **Actively** **opposed to****involvement** | **Open to** **Involvement** | **Strongly** **prefers** **involvement** | **Don’t** **know** |
| **TOTAL** | **353****(100% of C)****(100% of F)** | **16****(100% of C)****(5% of F)** | **138****(100% of C)****(39% of F)** | **135****(100% of C)****(38% of F)** | **64****(100% of C)****(18% of F)** |
| **Actively** **opposed to** **involvement** | **73** **(21% of C)****(100% of F)** | 6 (8% of C)(38% of F) | 29 (40% of C)(21% of F) | 32 (44% of C)(24% of F) | 6(8% of C)(9% of F) |
| **Open to** **involvement** | **146** **(41% of C)****(100% of F)** | 1(1% of C)(6% of F) | 76(52% of C)(55% of F) | 57(39% of C)(42% of F) | 12(8% of C)(19% of F) |
| **Strongly** **prefers** **involvement** | **30** **(9% of C)****(100% of F)** | 0(0% of C)(0% of F) | 2(7% of C)(1% of F) | 27(90% of C)(20% of F) | 1(3% of C)(2% of F) |
| **Don’t** **know** | **104** **(29% of C)** **(100% of F)** | 9(9% of C)(56% of F) | 31(30% of C)(22% of F) | 19(18% of C)(14% of F) | 45(43% of C)(70% of F) |

Looking in detail at Table O5, we can see that 135 clients have families that strongly prefer to be involved. Of clients whose families strongly prefer to be involved, 27 (20%) of the clients also strongly prefer for their families to be involved; 57 (42%) are open to having their families involved; 32 (24%) are actively opposed to having their families involved; and for 19 (14%) O&E staff were unable to rate the client’s preference. We also can see that of the 30 clients overall who strongly prefer to have their families involved, 27 (90%) also have families that also strongly prefer to be involved; 2 (7%) have families that are open to being involved; none have families that are actively opposed to being involved; and for 1 (3%) O&E staff were unable to rate the family’s openness to involvement. Overall, active opposition to family involvement was relatively uncommon, but more common among clients (21%) than among family (5%). For 32 clients (44%), O&E staff rated the family as strongly preferring to be involved while the client actively opposed their involvement; these situations are likely to be among the more frustrating for family members and potentially for clients, as well as challenging for treatment providers to navigate.

Table O6 shows the kinds of family support reported by O&E staff for the clients with some degree of family contact. The most common kinds of family support reported were housing (41%), emotional support (41%), money (40%), and transportation (27%). Medication assistance was provided by 14% of families, and 7% served as a representative payee. O&E staff reported that 8% of clients with family contact received no support.

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| **Table O6. What kinds of support is the family currently providing (check all that apply)? (n=353)** |
|  | **Number** | **Percent** |
| None | 38 | 8% |
| Housing | 200 | 41% |
| Money | 194 | 40% |
| Emotional support | 198 | 41% |
| Transportation | 130 | 27% |
| Medication assistance | 70 | 14% |
| Representative payee | 32 | 7% |
| Other (see below)  | 20 | 4% |
| *Information about client* | *3* |  |
| *Allow to live in yard/housing* | *2* |  |
| *Employment* | *1* |  |
| *Food/groceries/meal out* | *6* |  |
| *Caregivers for client’s children* | *2* |  |
| *Conservatorship* | *1* |  |
| *Legal assistance* | *1* |  |
| *Advocate for conservatorship* | *2* |  |
| *Education* | *1* |  |
| *Unknown* | *1* |  |

Table O7 shows O&E staff reports of issues families had with clients. The biggest ongoing issues between clients and families were related to safety. O&E staff reported that 48% of families with client contact had concern for family safety, and 13% had a restraining/protective order against the client. O&E staff reported no ongoing issues with the client for 36% of families.

O&E staff were asked to report their assessment of the family’s expectations of the AOT program; these free-text responses were abstracted into the categories in Table O8, with multiple categories potentially present for an individual family. Most commonly reported were mental health services (76%), followed by higher functioning (37%), general help or benefits from the program (12%), housing (11%), and legal assistance, including jail diversion and other legal help (2%). For 3% of clients, O&E staff wrote that family members wished for the client to be conserved; for 1% they wrote that the family wished for the client to be placed in a locked facility; and for 4% they wrote that the family wanted AOT to make the client comply with medication. Note that in some instances these may be expectations beyond what AOT can accomplish, but the client sample for the Post-Outreach Survey includes clients who ended up being conserved and/or hospitalized as well as those who enrolled in AOT services or were lost to follow-up; the current analysis does not examine the eventual treatment status of the clients, and it’s possible that some of the clients whose family members felt they needed to be conserved did end up conserved.

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| **Table O7. Does the family have any ongoing issues with the client (check all that apply)? (n=353)** |
|  | **Number** | **Percent** |
| None | 127 | 36% |
| Concerns for family safety | 170 | 48% |
| Restraining/protective order against client | 47 | 13% |
| Concerns about theft by client | 32 | 9% |
| Other (see below; only present if spontaneously noted by outreach worker) | 42 | 12% |
| *Concerns for safety of family members' neighbors* | *1* |  |
| *Concerns for client safety* | *12* |  |
| *Need for conservatorship* | *2* |  |
| *Ability to care for self; substance use* | *5* |  |
| *DCFS/custody/visitation issues (client’s children)* | *4* |  |
| *DCFS issues (family’s children; don’t want client there due to open case)* | *1* |  |
| *DCFS issues (not specified; restraining order advised due to case; case closed)* | *1* |  |
| *Client resistance to treatment and medications* | *1* |  |
| *Too exhausted to deal with client* | *1* |  |
| *Client goes looking for kids he claims to have in other cities* | *1* |  |
| *Theft by client or client’s friends/partner* | *2* |  |
| *Treatment refusal* | *1* |  |
| *Maternal health*  | *1* |  |
| *Unknown* | *2* |  |

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| **Table O8. What are the family's expectations of the AOT program? (Abstracted from free text; multiple may be checked; n excludes 20 “don’t know.”) (n=413)** |  |  |
|  | **Number** | **Percent** |
| Mental health services | 312 | 76% |
| General help or benefit from the program | 50 | 12% |
| Housing | 46 | 11% |
| Legal assistance (jail diversion/prevention; other legal assistance) | 9 | 2% |
| Conservatorship | 14 | 3% |
| Mandated treatment | 10 | 2% |
| Locked facility | 5 | 1% |
| Medication compliance | 15 | 4% |
| O&E team be the treatment provider or stay involved with treatment | 2 | .5% |
| Stop O&E | 1 | .24% |
| Don’t force services | 1 | .24% |
| Substance use treatment/sobriety | 14 | 3% |
| Treatment to address violence or threats | 3 | 1% |
| Improved safety for client | 1 | .24% |
| Higher functioning |  153 | 37% |
| Stabilize client/keep client stable | 19 | 5% |
| Help getting back to school/work | 5 | 1% |
| Hope | 2 | .48% |
| Benefits | 1 | .24% |
| Link to community resources | 1 | .24% |
| Pay client expenses | 1 | .24% |

### *Other Outreach Information*

Table O9 shows why Outreach and Engagement was ending for the clients in the sample. Of those who enrolled, 48.9% were in voluntary AOT; 4.4% in court-ordered AOT; and 3.7% in AOT via settlement agreement. Another 6.4% of clients had been conserved; 3.7% were enrolled in MIST or FIST; and 13 (2.7%) were serving a long-term incarceration. Outreach was ending due to an inability to locate 16.4% of clients and 19.9% for other reasons.

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| **Table O9. Why is Outreach and Engagement ending for this client? (n=483)** |
|  | **N** | **Percent** |
| AOT, Voluntary | 207 | 48.9% |
| AOT, Involuntary | 21 | 4.4% |
| AOT, Settlement Agreement | 18 | 3.7% |
| Conservatorship | 31 | 6.4% |
| MIST or FIST | 18 | 3.7% |
| Long-term incarceration | 13 | 2.7% |
| Can’t find client | 79 | 16.4% |
| Other | 96 | 19.9% |

### *Post-Outreach MCAS*

In addition to the material presented, O&E staff also completed the MCAS for each client at the end of outreach in order to provide a post-outreach comparison between clients who do and don’t enroll in AOT. A summary and descriptives of these items is presented in Table O10. Items are scored from 1 to 5 with higher scores indicating less impairment.

**Table O10. MCAS Scores by LACDMH Outreach and Engagement Team of All Those Referred to AOT (n = 480)**

|  |  |  |  |
| --- | --- | --- | --- |
| **MCAS Item** | **Mean** | **Standard Deviation** | **Percent Missing/ Unable to Rate** |
| 1. Physical Health
 | 4.34 | 1.19 | 38% |
| 1. Cognitive Functioning
 | 4.27 | 1.18 | 37% |
| 1. Thought Processes
 | 2.70 | 1.31 | 24% |
| 1. Mood
 | 2.79 | 1.24 | 25% |
| 1. Response to Stress
 | 2.63 | 1.16 | 41% |
| 1. Money Management
 | 1.99 | 1.16 | 59% |
| 1. Independence in Daily Living
 | 2.91 | 1.38 | 39% |
| 1. Acceptance of Disability
 | 2.33 | 1.31 | 33% |
| 1. Social Acceptability
 | 2.62 | 1.12 | 70% |
| 1. Social Interest
 | 2.74 | 1.25 | 70% |
| 1. Social Effectiveness
 | 2.55 | 1.07 | 69% |
| 1. Social Network
 | 1.62 | .81 | 53% |
| 1. Social Activity
 | 2.04 | 1.20 | 61% |
| 1. Medication Adherence
 | 2.16 | 1.28 | 35% |
| *Medications Prescribed?*  | *Yes, 49%; no, 22%* | *29%* |
| 1. Engagement with Treatment
 | 2.04 | 1.20 | 25% |
| 1. Alcohol/Drug Abuse
 | 2.41 | 1.43 | 46% |
| 1. Impulse Control
 | 2.47 | 1.14 | 41% |

Domains related to social functioning and interest were the hardest for outreach staff to rate, as evidenced by the high rates of missing items. The lowest scoring items were social network and money management. The highest scoring items were physical health and cognitive functioning, which is somewhat surprising given the high rates of homelessness and psychotic disorders that are associated with cognitive impairments.

## Service Use by AOT-Eligible Referrals: Outpatient, Crisis, and Hospital Services

### *Outpatient services use by AOT-referred clients who met eligibility criteria*

Tables S1-S4 show the average number of outpatient mental health services received by AOT-eligible individuals in the year prior to their first eligible referral and in each year subsequent to that referral. The top section of each table has the largest sample size (n=982), restricted to individuals whose first eligible referral took place during the first 3 years of the AOT program (May 18, 2015 through May 17, 2018), with one year of follow-up data available.[[1]](#footnote-1) The second section of each table is restricted to individuals whose first eligible referral took place during the first 2 years of the AOT program (May 18, 2015 through May 17, 2017), which allows two years of follow-up, but with a smaller sample size (n=573). Finally, the last section of the table is restricted to individuals whose first eligible referral took place during the first year of the AOT program (May 18, 2015 through May 17, 2016), which allows three years of follow-up, but with an even smaller sample size (n=241).

Within each sample, statistics are presented for the overall sample of eligible clients, as well as broken down by whether or not the individual enrolled in services. Because a small number of individuals did not enroll in services as part of their first eligible referral but did enroll as part of a subsequent eligible referral, which could have happened considerably later, results are presented separately for those who enrolled (1) as part of their first eligible referral, (2) only as part of a subsequent eligible referral, or (3) not at all. Because the number of individuals who enrolled only as part of a subsequent eligible referral is so small, their statistics are not very interpretable; they are presented separately only to avoid complicating the other two groups (those who enrolled as part of the first eligible referral, and those who never enrolled). It is important to note that individuals who never enroll are likely very different from those who enroll, and cannot be used as an equivalent comparison group; due to the observational nature of these analyses, we do not have a control group to show what utilization would have looked like for enrolled individuals if they had not enrolled. Rather, the service use statistics for non-enrolled clients are presented because they are part of the population that AOT sought to treat, and it is important to show what service outcomes were like for eligible individuals who did not end up enrolling. In the text below, we focus on discussing service use by the subset of clients who did enroll.

Of the 982 eligible individuals from the first three years of referrals to the AOT program, 464 enrolled as part of their first eligible referral. As expected, given that they enrolled in services, the percentage of individuals receiving various types of services from an outpatient provider was higher in the post-referral year than the pre-referral year. Clients who enrolled received an average of 11.5 case management services in the post-referral year (SD=14.7), compared with 3.7 in the pre-referral year (SD=7.8) (t=10.7, p<0.0001) (Table S1). They received an average of 31.7 rehabilitation services in the post-referral year (SD=61.1), compared with 6.6 in the pre-referral year (SD=20.9) (t=8.8, p<0.0001) (Table S2); an average of 12.9 therapy services in the post-referral year (SD=15.2), compared with 2.0 in the pre-referral year (SD=5.9) (t=15.0, p<0.0001) (Table S3); and an average of 3.7 medication services in the post-referral year (SD=5.7), compared with 3.4 in the pre-referral year (SD=5.8) (t=3.4, p=-.0009) (Table S4).

Notably, the post-referral year in which services were received includes the outreach period leading up to enrollment, which can be prolonged, and in some cases includes time post-discharge or post-graduation; therefore, these averages do not reflect service intensity while enrolled, which is presented in the yearly state reports. Additionally, these averages include individuals who, though enrolled, received no services in a given category. Case management services were received by 80.0% of enrolled individuals in the post-referral year, compared with 43.5% in the pre-referral year (chi-sq=18.7; p<0.001) (Table S1); rehabilitation services were received by 83.2% of enrolled individuals in the post-referral year, compared with 28.9% in the pre-referral year (chi-sq=10.0; p<0.001) (Table S2); therapy services were received by 70.0% of enrolled individuals in the post-referral year, compared with 21.3% in the pre-referral year (chi-sq=8.3; p=0.004) (Table S3); and medication services were received by 51.7% of enrolled individuals in the post-referral year, compared with 46.6% in the pre-referral year (chi-sq=377.2; p<0.001) (Table S4).

Of the 573 eligible individuals from the first two years of referrals to the AOT program, 271 enrolled as part of their first eligible referral, and of the 241 eligible individuals from the first year of referrals to the AOT program, 113 enrolled as part of their first eligible referral. Among those who enrolled, average service utilization and the percentage of individuals with any utilization were lower in the second and third post-referral years than in the first post-referral year, but they were still higher than in the pre-referral year in most cases, at least through the second year and sometimes in the third.

Other categories of outpatient services are not presented in tables here, but are briefly summarized for the 464 individuals who enrolled as part of their first eligible referral. Diagnostic, testing and screening services were received by 81.9% of enrolled individuals in year 1, compared with 30.8% in the pre-referral year (chi-sq=1.0; p=0.310). For the three categories of services that that did not involve client contact, collateral services were billed for 63.8% of enrolled individuals in year 1, compared with 26.5% in the pre-referral year (chi-sq=20.2; p<0.001); team plan development was billed for 79.3% of enrolled individuals in year 1, compared with 36.2% in the pre-referral year (chi-sq=5.4; p=0.20); and report-writing was billed for 16.6% of enrolled individuals in year 1, compared with 6.9% in the pre-referral year (chi-sq=1.8; p=0.185). Outpatient crisis services are not presented here because they are reported in the next section along with other crisis services from non-outpatient providers. Also not included here are case management, rehabilitation, therapy, or medication services that were received from urgent care centers rather than outpatient providers.

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| **Table S1. Case Management Services by Year****All Eligible Individuals, Based on First Eligible Referral; Pre-Referral Year and Post-Referral Year(s)** |
|  | **Pre-Referral Year** | **1st Year Post** | **2nd Year Post** | **3rd Year Post** |
| **First 3 years of eligible referrals: Referred by May 17, 2018 (at least 1 year of follow-up available)** |
|  **All Individuals, Regardless of Enrollment Status (n=982)** |
|  **Mean (SD)** | **3.0 (7.3)** | **6.4 (12.4)** | **N/A** | **N/A** |
|  **Percent with Any** | **38.7%** | **52.6%** | **N/A** | **N/A** |
|  **Enrolled as part of 1st eligible referral (n=464)** |
|  Mean (SD) | 3.7 (7.8) | 11.5 (14.7) | N/A | N/A |
|  Percent with Any | 43.5% | 80.0% | N/A | N/A |
|  **Enrolled as part of subsequent eligible referral (n=26)** |
|  Mean (SD) | 1.5 (4.2) | 2.2 (6.3) | N/A | N/A |
|  Percent with Any | 26.9% | 34.6% | N/A | N/A |
|  **Never enrolled (n=492)** |
|  Mean (SD) | 2.5 (6.7) | 1.7 (4.7) | N/A | N/A |
|  Percent with Any | 34.8% | 27.8% | N/A | N/A |
| **First 2 years of eligible referrals: Referred by May 17, 2017 (at least 2 years of follow-up available)** |
|  **All Individuals, Regardless of Enrollment Status (n=573)** |
|  **Mean (SD)** | **3.6 (8.4)** | **6.2 (11.3)** | **4.8 (10.3)** | **N/A** |
|  **Percent with Any** | **40.5%** | **53.2%** | **41.9%** | **N/A** |
|  **Enrolled as part of 1st eligible referral (n=271)** |
|  Mean (SD) | 4.5 (9.1) | 11.0 (14.0) | 8.0 (12.9) | N/A |
|  Percent with Any | 46.9% | 81.2% | 59.0% | N/A |
|  **Enrolled as part of subsequent eligible referral (n=16)** |
|  Mean (SD) | 2.3 (5.2) | 2.6 (7.7) | 7.0 (8.2) | N/A |
|  Percent with Any | 37.5% | 37.5% | 81.3% | N/A |
|  **Never enrolled (n=286)** |
|  Mean (SD) | 2.9 (7.9) | 1.9 (5.1) | 1.7 (5.7) | N/A |
|  Percent with Any | 34.6% | 27.6% | 23.4% | N/A |
| **First 1 year of eligible referrals: Referred by May 17, 2016 (at least 3 years of follow-up available)** |
|  **All Individuals, Regardless of Enrollment Status (n=241)** |
|  **Mean (SD)** | **3.5 (8.4)** | **7.0 (12.3)** | **4.4 (8.8)** | **4.7 (11.2)** |
|  **Percent with Any** | **39.4%** | **57.3%** | **43.6%** | **37.8%** |
|  **Enrolled as part of 1st eligible referral (n=113)** |
|  Mean (SD) | 4.0 (6.8) | 12.2 (15.1) | 6.4 (10.5) | 6.0 (11.9) |
|  Percent with Any | 46.0% | 88.5% | 55.8% | 44.2% |
|  **Enrolled as part of subsequent eligible referral (n=7)** |
|  Mean (SD) | 3.1 (7.1) | 1.0 (2.2) | 4.9 (4.8) | 13.7 (13.4) |
|  Percent with Any | 28.6% | 28.6% | 71.4% | 100.0% |
|  **Never enrolled (n=121)** |
|  Mean (SD) | 3.2 (9.7) | 2.5 (6.5) | 2.4 (6.5) | 3.0 (9.9) |
|  Percent with Any | 33.9% | 29.8% | 30.6% | 28.1% |

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| **Table S2. Rehabilitation Services by Year****All Eligible Individuals, Based on First Eligible Referral; Pre-Referral Year and Post-Referral Year(s)** |
|  | **Pre-Referral Year** | **1st Year Post** | **2nd Year Post** | **3rd Year Post** |
| **First 3 years of eligible referrals: Referred by May 17, 2018 (at least 1 year of follow-up available)** |
|  **All Individuals, Regardless of Enrollment Status (n=982)** |
|  **Mean (SD)** | **5.6 (20.1)** | **17.1 (46.6)** | **N/A** | **N/A** |
|  **Percent with Any** | **24.9%** | **49.9%** | **N/A** | **N/A** |
|  **Enrolled as part of 1st eligible referral (n=464)** |
|  Mean (SD) | 6.6 (20.9) | 31.7 (61.1) | N/A | N/A |
|  Percent with Any | 28.9% | 83.2% | N/A | N/A |
|  **Enrolled as part of subsequent eligible referral (n=26)** |
|  Mean (SD) | 0.5 (1.8) | 5.2 (24.7) | N/A | N/A |
|  Percent with Any | 7.7% | 19.2% | N/A | N/A |
|  **Never enrolled (n=492)** |
|  Mean (SD) | 5.0 (19.7) | 4.0 (20.3) | N/A | N/A |
|  Percent with Any | 22.2% | 20.1% | N/A | N/A |
| **First 2 years of eligible referrals: Referred by May 17, 2017 (at least 2 years of follow-up available)** |
|  **All Individuals, Regardless of Enrollment Status (n=573)** |
|  **Mean (SD)** | **6.3 (21.6)** | **15.8 (41.5)** | **16.0 (40.8)** | **N/A** |
|  **Percent with Any** | **26.0%** | **49.7%** | **41.2%** | **N/A** |
|  **Enrolled as part of 1st eligible referral (n=271)** |
|  Mean (SD) | 7.6 (23.0) | 29.3 (53.6) | 20.9 (39.6) | N/A |
|  Percent with Any | 30.3% | 83.8% | 60.5% | N/A |
|  **Enrolled as part of subsequent eligible referral (n=16)** |
|  Mean (SD) | 0.6 (2.2) | 8.3 (31.4) | 31.6 (42.3) | N/A |
|  Percent with Any | 12.5% | 25.0% | 81.3% | N/A |
|  **Never enrolled (n=286)** |
|  Mean (SD) | 5.3 (20.9) | 3.4 (18.8) | 10.4 (41.2) | N/A |
|  Percent with Any | 22.7% | 18.9% | 22.0% | N/A |
| **First 1 year of eligible referrals: Referred by May 17, 2016 (at least 3 years of follow-up available)** |
|  **All Individuals, Regardless of Enrollment Status (n=241)** |
|  **Mean (SD)** | **7.2 (24.1)** | **17.1 (41.4)** | **18.1 (44.8)** | **16.9 (40.1)** |
|  **Percent with Any** | **29.5%** | **54.4%** | **43.2%** | **38.6%** |
|  **Enrolled as part of 1st eligible referral (n=113)** |
|  Mean (SD) | 8.7 (24.5) | 32.3 (52.6) | 22.7 (38.8) | 14.8 (32.7) |
|  Percent with Any | 33.6% | 91.2% | 61.9% | 52.2% |
|  **Enrolled as part of subsequent eligible referral (n=7)** |
|  Mean (SD) | 0.1 (0.4) | 0.1 (0.4) | 32.3 (63.2) | 11.9 (11.7) |
|  Percent with Any | 14.3% | 14.3% | 71.4% | 85.7% |
|  **Never enrolled (n=121)** |
|  Mean (SD) | 6.3 (24.4) | 4.0 (21.1) | 13.0 (48.6) | 19.2 (63.3) |
|  Percent with Any | 26.4% | 22.3% | 24.0% | 23.1% |

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| **Table S3. Therapy Services by Year****All Eligible Individuals, Based on First Eligible Referral; Pre-Referral Year and Post-Referral Year(s)** |
|  | **Pre-Referral Year** | **1st Year Post** | **2nd Year Post** | **3rd Year Post** |
| **First 3 years of eligible referrals: Referred by May 17, 2018 (at least 1 year of follow-up available)** |
|  **All Individuals, Regardless of Enrollment Status (n=982)** |
|  **Mean (SD)** | **1.7 (5.7)** | **6.7 (12.3)** | **N/A** | **N/A** |
|  **Percent with Any** | **17.5%** | **40.7%** | **N/A** | **N/A** |
|  **Enrolled as part of 1st eligible referral (n=464)** |
|  Mean (SD) | 2.0 (5.9) | 12.9 (15.2) | N/A | N/A |
|  Percent with Any | 21.3% | 70.0% | N/A | N/A |
|  **Enrolled as part of subsequent eligible referral (n=26)** |
|  Mean (SD) | 0.5 (2.0) | 3.7 (7.3) | N/A | N/A |
|  Percent with Any |  11.5% | 38.5% | N/A | N/A |
|  **Never enrolled (n=492)** |
|  Mean (SD) | 1.5 (5.7) | 1.0 (3.7) | N/A | N/A |
|  Percent with Any | 14.2% | 13.2% | N/A | N/A |
| **First 2 years of eligible referrals: Referred by May 17, 2017 (at least 2 years of follow-up available)** |
|  **All Individuals, Regardless of Enrollment Status (n=573)** |
|  **Mean (SD)** | **1.7 (5.8)** | **6.8 (12.3)** | **6.3 (13.5)** | **N/A** |
|  **Percent with Any** | **18.2%** | **40.5%** | **37.8%** | **N/A** |
|  **Enrolled as part of 1st eligible referral (n=271)** |
|  Mean (SD) | 1.9 (5.8) | 13.2 (15.0) | 10.5 (16.7) | N/A |
|  Percent with Any | 21.4% | 70.1% | 53.9% | N/A |
|  **Enrolled as part of subsequent eligible referral (n=16)** |
|  Mean (SD) | 0.8 (2.6) | 3.0 (6.8) | 10.8 (13.6) | N/A |
|  Percent with Any | 12.5% | 31.3% | 62.5% | N/A |
|  **Never enrolled (n=286)**  |
|  Mean (SD) | 1.7 (5.9) | 1.0 (3.7) | 1.9 (7.4) | N/A |
|  Percent with Any | 15.4% | 12.9% | 17.1% | N/A |
| **First 1 year of eligible referrals: Referred by May 17, 2016 (at least 3 years of follow-up available)** |
|  **All Individuals, Regardless of Enrollment Status (n=241)** |
|  **Mean (SD)** | **1.7 (5.6)** | **7.7 (13.1)** | **6.4 (13.6)** | **6.0 (15.4)** |
|  **Percent with Any** | **17.8%** | **41.9%** | **36.1%** | **31.5%** |
|  **Enrolled as part of 1st eligible referral (n=113)** |
|  Mean (SD) | 1.2 (3.6) | 14.4 (15.8) | 10.7 (17.0) | 7.2 (14.8) |
|  Percent with Any | 19.5% | 71.7% | 54.9% | 42.5% |
|  **Enrolled as part of subsequent eligible referral (n=7)** |
|  Mean (SD) | 1.9 (3.8) | 3.6 (9.4) | 4.2 (6.0) | 10.6 (13.2) |
|  Percent with Any | 28.6% | 14.3% | 42.9% | 85.7% |
|  **Never enrolled (n=121)** |
|  Mean (SD) | 2.1 (7.1) | 1.6 (5.2) | 2.5 (8.2) | 4.6 (16.1) |
|  Percent with Any | 15.7% | 15.7% | 18.2% | 18.2% |

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| **Table S4. Medication Services by Year****All Eligible Individuals, Based on First Eligible Referral; Pre-Referral Year and Post-Referral Year(s)** |
|  | **Pre-Referral Year** | **1st Year Post** | **2nd Year Post** | **3rd Year Post** |
| **First 3 years of eligible referrals: Referred by May 17, 2018 (at least 1 year of follow-up available)** |
|  **All Individuals, Regardless of Enrollment Status (n=982)** |
|  **Mean (SD)** | **2.7 (5.2)** | **2.9 (5.2)** | **N/A** | **N/A** |
|  **Percent with Any** |  **38.3%** | **41.6%** | **N/A** | **N/A** |
|  **Enrolled as part of 1st eligible referral (n=464)** |
|  Mean (SD) | 3.4 (5.8) | 3.7 (5.7) | N/A |  N/A |
|  Percent with Any | 46.6% | 51.7% | N/A | N/A |
|  **Enrolled as part of subsequent eligible referral (n=26)** |
|  Mean (SD) | 1.3 (3.0) | 1.5 (3.0) | N/A | N/A |
|  Percent with Any | 30.1% | 34.6% | N/A | N/A |
|  **Never enrolled (n=492)** |
|  Mean (SD) | 2.2 (4.7) | 2.3 (4.8) | N/A | N/A |
|  Percent with Any | 30.9% | 32.5% | N/A | N/A |
| **First 2 years of eligible referrals: Referred by May 17, 2017 (at least 2 years of follow-up available)** |
|  **All Individuals, Regardless of Enrollment Status (n=573)** |
|  **Mean (SD)** | **2.5 (5.0)** | **2.8 (5.1)** | **3.0 (5.8)** | **N/A** |
|  **Percent with Any** | **36.1%** | **39.3%** | **40.0%** | **N/A** |
|  **Enrolled as part of 1st eligible referral (n=271)** |
|  Mean (SD) | 3.1 (5.6) | 3.5 (5.7) | 3.8 (5.8) | N/A |
|  Percent with Any | 44.6% | 49.1% | 49.8% | N/A |
|  **Enrolled as part of subsequent eligible referral (n=16)** |
|  Mean (SD) | 1.1 (2.2) | 1.1 (2.2) | 1.1 (2.2) | N/A |
|  Percent with Any | 31.3% | 31.3% | 31.3% | N/A |
|  **Never enrolled (n=286)** |
|  Mean (SD) | 2.0 (4.5) | 2.1 (4.6) | 2.4 (5.0) | N/A |
|  Percent with Any | 28.3% | 30.4% | 31.1% | N/A |
| **First 1 year of eligible referrals: Referred by May 17, 2016 (at least 3 years of follow-up available)** |
|  **All Individuals, Regardless of Enrollment Status (n=241)** |
|  **Mean (SD)** | **2.5 (4.7)** | **2.9 (4.8)** | **3.2 (5.1)** | **3.2 (5.0)** |
|  **Percent with Any** | **41.5%** | **44.8%** | **46.5%** | **46.9%** |
|  **Enrolled as part of 1st eligible referral (n=113)** |
|  Mean (SD) | 2.9 (4.8) | 3.6 (5.5) | 3.9 (5.6) | 3.7 (5.3) |
|  Percent with Any | 49.6% | 54.9% | 55.8% | 56.6% |
|  **Enrolled as part of subsequent eligible referral (n=7)** |
|  Mean (SD) | 1.9 (3.1) | 1.9 (3.1) | 1.9 (3.1) | 2.0 (3.1) |
|  Percent with Any | 42.9% | 42.9% | 42.9% | 42.9% |
|  **Never enrolled (n=121)** |
|  Mean (SD) | 2.3 (4.6) | 2.3 (4.1) | 2.7 (4.6) | 2.8 (4.8) |
|  Percent with Any | 33.9% | 35.5% | 38.0% | 38.0% |

### *Crisis services use by AOT-referred clients who met eligibility criteria*

Tables S5-S9 show the average number of crisis mental health services—emergency department, joint DMH-law enforcement mobile services, EOTD crisis homeless mobile services, urgent care center crisis services, and outpatient crisis services—received by AOT-eligible individuals in the year prior to their first eligible referral and in each year subsequent to that referral. The tables are structured identically to Tables S1-S4, as described in the section above.

Of the 982 eligible individuals from the first three years of referrals to the AOT program, 464 enrolled as part of their first eligible referral. We might expect that use of crisis services would decline among individuals who enrolled in AOT, compared with the pre-AOT year. However, we also might expect use of crisis services to decline among all AOT-eligible clients, even those who do not enroll in services, due to regression to the mean: clients often are referred to AOT when they are particularly in crisis and have a recent history of crisis and inpatient services, and therefore are likely to naturally see a decline in their acute service use following the exacerbation that led to AOT eligibility. Because we do not have an equivalent comparison group, we cannot evaluate whether crisis service use decreased among AOT-eligible or AOT-enrolled clients more than it would have in the absence of the program; we can only report on whether it is lower post-referral than in the pre-referral year. Though we report the results of significance tests for pre-post comparisons discussed in the text, the statistical significance of a difference does not mean that the difference can be attributed to the AOT program.

Clients who enrolled in services received an average of 1.1 emergency department crisis services in the post-referral year (SD=2.4), compared with 1.4 in the pre-referral year (SD=2.5) (t=-2.1, p=0.04) (Table S5). They received an average of 0.6 joint DMH-law enforcement mobile services in the post-referral year (SD=1.6), compared with 0.7 in the pre-referral year (SD=2.4) (t=-1.4, p=0.16) (Table S6); an average of 0.4 EOTD crisis homeless mobile services in the post-referral year (SD=1.0), compared with 0.8 in the pre-referral year (SD=1.8) (t=-5.1, p<0.0001) (Table S7); an average of 0.9 urgent care center crisis services in the post-referral year (SD=1.7), compared with 1.1 in the pre-referral year (SD=2.0) (t=-1.5, p=-.14) (Table S8); and an average of 1.9 outpatient crisis services in the post-referral year (SD=3.3), compared with 1.0 in the pre-referral year (SD=2.0) (t=5.0, p<0.0001) (Table S9). The increase in outpatient crisis services is expected, given that these are clients who enrolled with an outpatient provider; these results also could have been presented in the previous section as part of the menu of services clients receive from their outpatient providers while enrolled, but are included here due to being crisis services.

As in the previous section, these averages include individuals who, though enrolled, received no services in a given category. Emergency department services were received by 31.5% of enrolled individuals in the post-referral year, compared with 40.9% in the pre-referral year (chi-sq=22.3; p<0.001) (Table S5); joint DMH-law enforcement mobile services were received by 23.9% of enrolled individuals in the post-referral year, compared with 23.7% in the pre-referral year (chi-sq=46.6; p<0.001) (Table S6); EOTD crisis homeless mobile services were received by 17.9% of enrolled individuals in the post-referral year, compared with 25.9% in the pre-referral year (chi-sq=26.8; p<0.001) (Table S7); urgent care center crisis services were received by 37.5% of enrolled individuals in the post-referral year, compared with 39.2% in the pre-referral year (chi-sq=23.6; p<0.001) (Table S8); and outpatient crisis services were received by 52.2% of enrolled individuals in the post-referral year, compared with 45.5% in the pre-referral year (chi-sq=6.8; p=0.009) (Table S9).

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| **Table S5. Emergency Department Crisis Services by Year****All Eligible Individuals, Based on First Eligible Referral; Pre-Referral Year and Post-Referral Year(s)** |
|  | **Pre-Referral Year** | **1st Year Post** | **2nd Year Post** | **3rd Year Post** |
| **First 3 years of eligible referrals: Referred by May 17, 2018 (at least 1 year of follow-up available)** |
|  **All Individuals, Regardless of Enrollment Status (n=982)** |
|  **Mean (SD)** | **1.6 (3.0)** | **1.0 (2.2)** | **N/A** | **N/A** |
|  **Percent with Any** | **43.5%** | **29.7%** | **N/A** | **N/A** |
|  **Enrolled as part of 1st eligible referral (n=464)** |
|  Mean (SD) | 1.4 (2.5) | 1.1 (2.4) | N/A | N/A |
|  Percent with Any | 40.9% | 31.5% | N/A | N/A |
|  **Enrolled as part of subsequent eligible referral (n=26)** |
|  Mean (SD) | 1.3 (2.3) | 0.6 (1.2) | N/A | N/A |
|  Percent with Any | 46.2% | 26.9% | N/A | N/A |
|  **Never enrolled (n=492)** |
|  Mean (SD) | 1.8 (3.4) | 0.9 (2.1) | N/A | N/A |
|  Percent with Any | 45.7% | 28.3% | N/A | N/A |
| **First 2 years of eligible referrals: Referred by May 17, 2017 (at least 2 years of follow-up available)** |
|  **All Individuals, Regardless of Enrollment Status (n=573)** |
|  **Mean (SD)** | **1.6 (2.8)** | **1.3 (2.4)** | **0.3 (1.0)** | **N/A** |
|  **Percent with Any** | **45.2%** | **38.0%** | **10.8%** | **N/A** |
|  **Enrolled as part of 1st eligible referral (n=271)** |
|  Mean (SD) | 1.4 (2.2) | 1.4 (2.7) | 0.2 (0.8) | N/A |
|  Percent with Any | 42.1% | 39.9% | 9.6% | N/A |
|  **Enrolled as part of subsequent eligible referral (n=16)** |
|  Mean (SD) | 1.7 (2.8) | 1.0 (1.4) | 0.4 (0.9) | N/A |
|  Percent with Any | 56.3% | 43.8% | 25.0% | N/A |
|  **Never enrolled (n=286)** |
|  Mean (SD) | 1.8 (3.3) | 1.2 (2.2) | 0.3 (1.1) | N/A |
|  Percent with Any | 47.6% | 36.0% | 11.2% | N/A |
| **First 1 year of eligible referrals: Referred by May 17, 2016 (at least 3 years of follow-up available)** |
|  **All Individuals, Regardless of Enrollment Status (n=241)** |
|  **Mean (SD)** | **1.5 (2.2)** | **1.2 (2.8)** | **0.4 (1.2)** | **0.2 (1.2)** |
|  **Percent with Any** | **46.1%** | **36.9%** | **18.3%** | **6.8%** |
|  **Enrolled as part of 1st eligible referral (n=113)** |
|  Mean (SD) | 1.5 (2.2) | 1.2 (2.5) | 0.3 (1.0) | 0.1 (0.6) |
|  Percent with Any | 49.6% | 36.3% | 16.8% | 4.4% |
|  **Enrolled as part of subsequent eligible referral (n=7)** |
|  Mean (SD) | 1.7 (3.3) | 1.1 (1.2) | 1.0 (1.5) | 0.9 (1.5) |
|  Percent with Any | 57.1% | 57.1% | 57.1% | 52.9% |
|  **Never enrolled (n=121)** |
|  Mean (SD) | 1.4 (2.1) | 1.1 (2.1) | 0.5 (1.3) | 0.3 (1.6) |
|  Percent with Any | 42.1% | 36.4% | 17.4% | 5.0% |

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| **Table S6. Joint DMH-Law Enforcement Team Mobile Crisis Services by Year****All Eligible Individuals, Based on First Eligible Referral; Pre-Referral Year and Post-Referral Year(s)** |
|  | **Pre-Referral Year** | **1st Year Post** | **2nd Year Post** | **3rd Year Post** |
| **First 3 years of eligible referrals: Referred by May 17, 2018 (at least 1 year of follow-up available)** |
|  **All Individuals, Regardless of Enrollment Status (n=982)** |
|  **Mean (SD)** | **0.8 (2.3)** | **0.7 (2.1)** | **N/A** | **N/A** |
|  **Percent with Any** | **26.7%** | **23.8%** | **N/A** | **N/A** |
|  **Enrolled as part of 1st eligible referral (n=464)** |
|  Mean (SD) | 0.7 (2.4) | 0.6 (1.6) | N/A | N/A |
|  Percent with Any | 23.7% | 23.9% | N/A | N/A |
|  **Enrolled as part of subsequent eligible referral (n=26)** |
|  Mean (SD) | 0.9 (2.1) | 1.3 (3.4) | N/A | N/A |
|  Percent with Any | 26.9% | 30.8% | N/A | N/A |
|  **Never enrolled (n=492)** |
|  Mean (SD) | 0.9 (2.3) | 0.7 (2.4) | N/A | N/A |
|  Percent with Any | 29.5% | 23.4% | N/A | N/A |
| **First 2 years of eligible referrals: Referred by May 17, 2017 (at least 2 years of follow-up available)** |
|  **All Individuals, Regardless of Enrollment Status (n=573)** |
|  **Mean (SD)** | **0.7 (2.2)** | **0.6 (2.2)** | **0.3 (2.0)** | **N/A** |
|  **Percent with Any** | **22.3%** | **20.1%** | **12.2%** | **N/A** |
|  **Enrolled as part of 1st eligible referral (n=271)** |
|  Mean (SD) | 0.7 (2.7) | 0.5 (1.5) | 0.2 (0.7) | N/A |
|  Percent with Any | 19.9% | 20.7% | 10.7% | N/A |
|  **Enrolled as part of subsequent eligible referral (n=16)** |
|  Mean (SD) | 1.2 (2.6) | 1.3 (4.0) | 4.2 (11.0) | N/A |
|  Percent with Any | 31.3% | 18.8% | 37.5% | N/A |
|  **Never enrolled (n=286)** |
|  Mean (SD) | 0.6 (1.6) | 0.7 (2.6) | 0.2 (0.6) | N/A |
|  Percent with Any | 24.1% | 19.6% | 12.2% | N/A |
| **First 1 year of eligible referrals: Referred by May 17, 2016 (at least 3 years of follow-up available)** |
|  **All Individuals, Regardless of Enrollment Status (n=241)** |
|  **Mean (SD)** | **0.6 (2.2)** | **0.6 (2.5)** | **0.4 (2.9)** | **0.3 (1.3)** |
|  **Percent with Any** | **19.9%** | **19.5%** | **11.6%** | **10.0%** |
|  **Enrolled as part of 1st eligible referral (n=113)** |
|  Mean (SD) | 0.8 (2.9) | 0.4 (1.1) | 0.2 (1.0) | 0.3 (1.6) |
|  Percent with Any | 19.5% | 21.2% | 9.7% | 8.8% |
|  **Enrolled as part of subsequent eligible referral (n=7)** |
|  Mean (SD) | 1.7 (3.3) | 0.6 (1.1) | 6.9 (16.0) | 1.0 (2.6) |
|  Percent with Any | 42.9% | 28.6% | 42.9% | 14.3% |
|  **Never enrolled (n=121)** |
|  Mean (SD) | 0.4 (1.2) | 0.7 (3.3) | 0.2 (0.5) | 0.2 (0.9) |
|  Percent with Any | 19.0% | 17.4% | 11.6% | 9.9% |

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| **Table S7. EOTD Crisis Homeless Services by Year****All Eligible Individuals, Based on First Eligible Referral; Pre-Referral Year and Post-Referral Year(s)** |
|  | **Pre-Referral Year** | **1st Year Post** | **2nd Year Post** | **3rd Year Post** |
| **First 3 years of eligible referrals: Referred by May 17, 2018 (at least 1 year of follow-up available)** |
|  **All Individuals, Regardless of Enrollment Status (n=982)** |
|  **Mean (SD)** | **0.7 (1.6)** | **0.4 (1.1)** | **N/A** | **N/A** |
|  **Percent with Any** | **26.7%** | **15.9%** | **N/A** | **N/A** |
|  **Enrolled as part of 1st eligible referral (n=464)** |
|  Mean (SD) | 0.8 (1.8) | 0.4 (1.0) | N/A | N/A |
|  Percent with Any | 29.5% | 17.9% | N/A | N/A |
|  **Enrolled as part of subsequent eligible referral (n=26)** |
|  Mean (SD) | 1.3 (1.8) | 0.8 (1.5) | N/A | N/A |
|  Percent with Any | 46.2% | 34.6% | N/A | N/A |
|  **Never enrolled (n=492)** |
|  Mean (SD) | 0.6 (1.4) | 0.3 (1.1) | N/A | N/A |
|  Percent with Any | 23.0% | 13.0% | N/A | N/A |
| **First 2 years of eligible referrals: Referred by May 17, 2017 (at least 2 years of follow-up available)** |
|  **All Individuals, Regardless of Enrollment Status (n=573)** |
|  **Mean (SD)** | **0.7 (1.4)** | **0.4 (1.1)** | **0.1 (0.8)** | **N/A** |
|  **Percent with Any** | **26.5%** | **16.9%** | **4.7%** | **N/A** |
|  **Enrolled as part of 1st eligible referral (n=271)** |
|  Mean (SD) | 0.8 (1.6) | 0.4 (1.1) | 0.1 (0.5) | N/A |
|  Percent with Any | 29.2% | 19.2% | 5.5% | N/A |
|  **Enrolled as part of subsequent eligible referral (n=16)** |
|  Mean (SD) | 1.3 (2.0) | 0.8 (1.2) | 1.1 (3.7) | N/A |
|  Percent with Any | 43.8% | 37.5% | 18.8% | N/A |
|  **Never enrolled (n=286)** |
|  Mean (SD) | 0.5 (1.7) | 0.3 (1.0) | 0.1 (0.4) | N/A |
|  Percent with Any | 23.1% | 13.6% | 3.0% | N/A |
| **First 1 year of eligible referrals: Referred by May 17, 2016 (at least 3 years of follow-up available)** |
|  **All Individuals, Regardless of Enrollment Status (n=241)** |
|  **Mean (SD)** | **0.6 (1.4)** | **0.3 (0.9)** | **0.1 (1.0)** | **0.1 (0.4)** |
|  **Percent with Any** | **22.4%** | **15.8%** | **4.6%** | **5.0%** |
|  **Enrolled as part of 1st eligible referral (n=113)** |
|  Mean (SD) | 0.8 (1.8) | 0.4 (0.9) | 0.1 (0.3) | 0.04 (0.2) |
|  Percent with Any | 29.2% | 18.6% | 5.3% | 3.5% |
|  **Enrolled as part of subsequent eligible referral (n=7)** |
|  Mean (SD) | 0.7 (1.0) | 0.9 (1.2) | 2.1 (5.7) | 0.9 (1.6) |
|  Percent with Any | 42.9% | 42.9% | 14.3% | 28.6% |
|  **Never enrolled (n=121)** |
|  Mean (SD) | 0.3 (0.9) | 0.2 (0.8) | 0.1 (0.3) | 0.1 (0.3) |
|  Percent with Any | 14.9% | 11.6% | 3.3% | 5.0% |

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| **Table S8. Urgent Care Center Crisis Services by Year****All Eligible Individuals, Based on First Eligible Referral; Pre-Referral Year and Post-Referral Year(s)** |
|  | **Pre-Referral Year** | **1st Year Post** | **2nd Year Post** | **3rd Year Post** |
| **First 3 years of eligible referrals: Referred by May 17, 2018 (at least 1 year of follow-up available)** |
|  **All Individuals, Regardless of Enrollment Status (n=982)** |
|  **Mean (SD)** | **1.1 (2.1)** | **0.9 (1.8)** | **N/A** | **N/A** |
|  **Percent with Any** | **39.2%** | **33.3%** | **N/A** | **N/A** |
|  **Enrolled as part of 1st eligible referral (n=464)** |
|  Mean (SD) | 1.1 (2.0) | 0.9 (1.7) | N/A | N/A |
|  Percent with Any | 39.2% | 37.5% | N/A | N/A |
|  **Enrolled as part of subsequent eligible referral (n=26)** |
|  Mean (SD) | 0.7 (1.1) | 1.3 (1.7) | N/A | N/A |
|  Percent with Any | 30.1% | 50.0% | N/A | N/A |
|  **Never enrolled (n=492)** |
|  Mean (SD) | 1.2 (2.3) | 0.8 (1.9) | N/A | N/A |
|  Percent with Any | 40.0% | 28.5% | N/A | N/A |
| **First 2 years of eligible referrals: Referred by May 17, 2017 (at least 2 years of follow-up available)** |
|  **All Individuals, Regardless of Enrollment Status (n=573)** |
|  **Mean (SD)** | **1.0 (1.9)** | **0.8 (1.7)** | **0.5 (1.5)** | **N/A** |
|  **Percent with Any** | **36.5%** | **33.5%** | **19.4%** | **N/A** |
|  **Enrolled as part of 1st eligible referral (n=271)** |
|  Mean (SD) | 1.1 (2.1) | 1.0 (1.8) | 0.5 (1.6) | N/A |
|  Percent with Any | 38.0% | 38.0% | 20.3% | N/A |
|  **Enrolled as part of subsequent eligible referral (n=16)** |
|  Mean (SD) | 0.6 (1.0) | 1.4 (1.8) | 0.8 (1.3) | N/A |
|  Percent with Any | 31.3% | 50.0% | 50.0% | N/A |
|  **Never enrolled (n=286)** |
|  Mean (SD) | 0.9 (1.7) | 0.7 (1.5) | 0.5 (1.4) | N/A |
|  Percent with Any | 35.3% | 28.3% | 16.8% | N/A |
| **First 1 year of eligible referrals: Referred by May 17, 2016 (at least 3 years of follow-up available)** |
|  **All Individuals, Regardless of Enrollment Status (n=241)** |
|  **Mean (SD)** | **0.9 (1.5)** | **0.9 (1.7)** | **0.6 (1.5)** | **0.5 (1.8)** |
|  **Percent with Any** | **39.4%** | **34.4%** | **21.0%** | **17.0%** |
|  **Enrolled as part of 1st eligible referral (n=113)** |
|  Mean (SD) | 1.0 (1.9) | 0.9 (1.7) | 0.5 (1.4) | 0.5 (1.8) |
|  Percent with Any | 41.6% | 37.2% | 20.4% | 21.2% |
|  **Enrolled as part of subsequent eligible referral (n=7)** |
|  Mean (SD) | 0.9 (1.2) | 0.9 (1.9) | 0.4 (0.5) | 1.1 (1.6) |
|  Percent with Any | 42.9% | 28.6% | 42.9% | 42.9% |
|  **Never enrolled (n=121)** |
|  Mean (SD) | 0.7 (1.2) | 0.8 (1.8) | 0.6 (1.7) | 0.5 (1.9) |
|  Percent with Any | 37.2% | 32.2% | 19.8% | 11.6% |

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| **Table S9. Outpatient Crisis Services by Year****All Eligible Individuals, Based on First Eligible Referral; Pre-Referral Year and Post-Referral Year(s)** |
|  | **Pre-Referral Year** | **1st Year Post** | **2nd Year Post** | **3rd Year Post** |
| **First 3 years of eligible referrals: Referred by May 17, 2018 (at least 1 year of follow-up available)** |
|  **All Individuals, Regardless of Enrollment Status (n=982)** |
|  **Mean (SD)** | **1.0 (1.9)** | **1.4 (2.8)** | **N/A** | **N/A** |
|  **Percent with Any** | **43.9%** | **41.1%** | **N/A** | **N/A** |
|  **Enrolled as part of 1st eligible referral (n=464)** |
|  Mean (SD) | 1.0 (2.0) | 1.9 (3.3) | N/A | N/A |
|  Percent with Any | 45.5% | 52.2% | N/A | N/A |
|  **Enrolled as part of subsequent eligible referral (n=26)** |
|  Mean (SD) | 0.9 (1.7) | 1.2 (2.5) | N/A | N/A |
|  Percent with Any | 34.6% | 34.6% | N/A | N/A |
|  **Never enrolled (n=492)** |
|  Mean (SD) | 0.9 (1.7) | 0.9 (2.0) | N/A | N/A |
|  Percent with Any | 42.9% | 31.1% | N/A | N/A |
| **First 2 years of eligible referrals: Referred by May 17, 2017 (at least 2 years of follow-up available)** |
|  **All Individuals, Regardless of Enrollment Status (n=573)** |
|  **Mean (SD)** | **0.9 (1.8)** | **1.0 (2.1)** | **0.7 (2.5)** | **N/A** |
|  **Percent with Any** | **42.4%** | **37.3%** | **22.9%** | **N/A** |
|  **Enrolled as part of 1st eligible referral (n=271)** |
|  Mean (SD) | 0.9 (1.5) | 1.4 (2.7) | 0.9 (3.1) | N/A |
|  Percent with Any | 44.6% | 49.8% | 27.3% | N/A |
|  **Enrolled as part of subsequent eligible referral (n=16)** |
|  Mean (SD) | 0.8 (1.6) | 0.5 (1.0) | 1.9 (3.3) | N/A |
|  Percent with Any | 31.3% | 25.0% | 37.5% | N/A |
|  **Never enrolled (n=286)** |
|  Mean (SD) | 0.9 (1.6) | 0.6 (1.2) | 0.5 (1.7) | N/A |
|  Percent with Any | 41.0% | 26.2% | 17.8% | N/A |
| **First 1 year of eligible referrals: Referred by May 17, 2016 (at least 3 years of follow-up available)** |
|  **All Individuals, Regardless of Enrollment Status (n=241)** |
|  **Mean (SD)** | **1.0 (1.8)** | **1.0 (2.1)** | **0.8 (3.2)** | **0.9 (2.9)** |
|  **Percent with Any** | **44.8%** | **34.9%** | **20.1%** | **22.0%** |
|  **Enrolled as part of 1st eligible referral (n=113)** |
|  Mean (SD) | 1.0 (1.7) | 1.4 (2.8) | 1.0 (4.2) | 0.6 (1.5) |
|  Percent with Any | 49.6% | 47.8% | 22.1% | 24.8% |
|  **Enrolled as part of subsequent eligible referral (n=7)** |
|  Mean (SD) | 1.0 (1.9) | 0.1 (0.4) | 1.0 (1.9) | 8.0 (11.9) |
|  Percent with Any | 28.5% | 14.3% | 28.6% | 71.4% |
|  **Never enrolled (n=121)** |
|  Mean (SD) |  1.0 (1.8) | 0.6 (1.2) | 0.6 (1.8) | 0.7 (2.0) |
|  Percent with Any | 41.3% | 24.0% | 19.0% | 16.5% |

### *Hospitalization of AOT-referred clients who met eligibility criteria*

Table S10 show the average number of acute psychiatric hospital days experienced by AOT-eligible individuals in the year prior to their first eligible referral and in each year subsequent to that referral. These numbers include forensic inpatient days but do not include hospitalizations at non-acute facilities (IMDs, psychiatric health facilities, skilled nursing facilities, and state hospitals.). The tables are structured identically to Tables S1-S9, as described in the sections above.

Of the 982 eligible individuals from the first three years of referrals to the AOT program, 464 enrolled as part of their first eligible referral. As with crisis services, we would expect acute hospital days to be lower post-referral solely due to regression to the mean, because clients often are referred to and eligible for AOT due to a recent history of extensive hospitalization. We also might expect hospital days to be lower among clients who enroll in AOT services, as a result of receiving appropriate outpatient care that might prevent the need for hospitalization. However, we conversely might expect receipt of appropriate hospitalizations to be higher among individuals who enroll in AOT, because attentive outpatient providers will be aware of the need for a hospitalization and take steps to facilitate admission. It is not possible to disentangle the potential effects of decreased need for hospitalization from increased access to needed hospitalization using administrative data that only show whether a hospitalization occurred. Additionally, because we do not have an equivalent comparison group, we cannot determine whether any decrease in hospital days relative to the pre-referral year is due to AOT vs. a decrease that would have occurred in the absence of eligible referral to the AOT program. Though we report the results of significance tests for pre-post comparisons discussed in the text, the statistical significance of a difference does not mean that the difference can be attributed to the AOT program.

Clients who enrolled in services had an average of 15.1 acute hospital days in the post-referral year (SD=30.4), compared with 11.0 in the pre-referral year (SD=22.2) (t=2.9, p=0.004) (Table S10). As in the previous sections, these averages include individuals who were never hospitalized. Acute hospitalization was experienced by 49.6% of enrolled individuals in the post-referral year, compared with 48.9% in the pre-referral year (chi-sq=77.8; p<0.001) (Table S10). Clients with any hospitalization in the post-referral year averaged 30.3 days of hospitalization (SD=37.4; median=18; IQR=8,37), while those with any hospitalization in the pre-referral year averaged 22.5 days (SD=27.4; median=13; IQR=6,26).

Clients who never enrolled in services also had a higher average number of acute hospital days in the post-referral year (mean=20.9, SD=42.9) than in the pre-referral year (mean=13.2, SD=26.9) (t=4.0, p=0.0001), though the percentage of clients hospitalized was identical in both years (49.6%). A selection effect could contribute to this observed difference, with some clients unable to enroll in AOT outpatient services as a result of requiring an extended hospitalization during the outreach and engagement period.

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| **Table S10. Days of Acute Hospitalization by Year (includes forensic inpatient days)****All Eligible Individuals, Based on First Eligible Referral; Pre-Referral Year and Post-Referral Year(s)** |
|  | **Pre-Referral Year** | **1st Year Post** | **2nd Year Post** | **3rd Year Post** |
| **First 3 years of eligible referrals: Referred by May 17, 2018 (at least 1 year of follow-up available)** |
|  **All Individuals, Regardless of Enrollment Status (n=982)** |
|  Mean (SD) | 12.1 (25.6) | 17.8 (37.1) | N/A | N/A |
|  Percent with Any | 49.2% | 49.4% | N/A | N/A |
|  **Enrolled as part of 1st eligible referral (n=464)** |
|  Mean (SD) | 11.0 (22.2) | 15.1 (30.4) | N/A | N/A |
|  Percent with Any | 48.9% | 49.6% | N/A | N/A |
|  **Enrolled as part of subsequent eligible referral (n=26)** |
|  Mean (SD) | 9.7 (18.3) | 9.5 (20.4) | N/A | N/A |
|  Percent with Any | 46.2% | 42.3% | N/A | N/A |
|  **Never enrolled (n=492)** |
|  Mean (SD) | 13.2 (26.9) | 20.9 (42.9) | N/A | N/A |
|  Percent with Any | 49.6% | 49.6% | N/A | N/A |
| **First 2 years of eligible referrals: Referred by May 17, 2017 (at least 2 years of follow-up available)** |
|  **All Individuals, Regardless of Enrollment Status (n=573)** |
|  Mean (SD) | 10.8 (21.7) | 17.1 (38.6) | 7.9 (27.6) | N/A |
|  Percent with Any | 45.9% | 46.4% | 24.3% | N/A |
|  **Enrolled as part of 1st eligible referral (n=271)** |
|  Mean (SD) | 10.3 (21.0) | 13.0 (24.9) | 9.2 (35.3) | N/A |
|  Percent with Any | 45.4% | 46.9% | 25.1% | N/A |
|  **Enrolled as part of subsequent eligible referral (n=16)** |
|  Mean (SD) | 8.6 (14.7) | 4.8 (12.5) | 7.3 (12.7) | N/A |
|  Percent with Any | 31.3% | 31.3% | 43.8% | N/A |
|  **Never enrolled (n=286)** |
|  Mean (SD) | 11.4 (22.7) | 21.6 (48.5) | 6.8 (18.4) | N/A |
|  Percent with Any | 47.2% | 46.9% | 22.4% | N/A |
| **First 1 year of eligible referrals: Referred by May 17, 2016 (at least 3 years of follow-up available)** |
|  **All Individuals, Regardless of Enrollment Status (n=241)** |
|  Mean (SD) | 9.2 (18.2) | 16.6 (38.3) | 8.3 (30.7) | 6.3 (20.3) |
|  Percent with Any | 42.7% | 43.6% | 22.4% | 20.3% |
|  **Enrolled as part of 1st eligible referral (n=113)** |
|  Mean (SD) | 10.8 (22.5) | 12.1 (24.5) | 8.7 (39.4) | 5.5 (17.7) |
|  Percent with Any | 44.2% | 43.4% | 21.2% | 19.5% |
|  **Enrolled as part of subsequent eligible referral (n=7)** |
|  Mean (SD) | 10.9 (16.7) | 9.3 (18.2) | 5.7 (6.0) | 15.9 (31.5) |
|  Percent with Any | 42.9% | 57.1% | 57.1% | 71.4% |
|  **Never enrolled (n=121)** |
|  Mean (SD) | 7.7 (13.1) | 21.2 (48.2) | 8.0 (21.0) | 6.5 (21.9) |
|  Percent with Any | 41.3% | 43.1% | 21.5% | 18.2% |

## Client Engagement and Satisfaction among FSP-Enrolled AOT Clients

Client self-report survey forms were distributed to AOT treatment providers on May 13, 2017, with the request that providers ask clients to complete surveys every 3 months, starting 3 months post-enrollment. Surveys were provided in all DMH threshold languages, and could be read to clients if needed. Very few surveys were submitted for ERS clients; therefore, analyses here are restricted to FSP enrollments.

There was some lag in when survey completion began. No enrollments for which treatment ended prior to January 1, 2018 had a completed client survey (the earliest treatment end date associated with a completed survey was January 9, 2018). Therefore, analyses exclude any enrollments that ended prior to January 1, 2018.

To allow time to complete analyses for the FY 2018-19 state report and this final report, UCLA requested that DMH submit all client surveys completed through December 31, 2019 by February 2020, and December 31, 2019 was treated as the end of the follow-up period for which surveys were due. Analyses therefore only include clients who had been enrolled for at least three months prior to the December 31, 2019 cutoff. However, in 6 cases DMH sent UCLA a survey that had been completed between January 1, 2020 and February 12, 2020; rather than exclude those surveys, the follow-up period for those individuals was extended to February 12, 2020.

The resulting sample of enrollments for which a survey should have been completed consists of 398 FSP enrollments across 388 unique clients. These enrollments have enrollment dates ranging from March 28, 2016 and October 2, 2019. Table C1 shows the percent of enrollments for which at least one survey was submitted, by treatment provider and overall. Overall, 127 of the 398 enrollments (31.9%) resulted in at least one completed client survey. The percent of enrollments with at least one completed survey ranged from 0% (Hillview, Masada Homes, and Pacific Asian Counseling Services) to 69.7% (Exodus Recovery).

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| **Table C1. Percent of enrollments with at least one completed client self-report survey, by provider** |
| **Provider** | **Percent with****Completed Survey(s)** | **Number with****Completed Survey(s)** | **Number with****Survey(s) Due** |
| Behavioral Health Services | 14.7% | 5 | 34 |
| Exodus Recovery | 69.7% | 23 | 33 |
| Hathaway Sycamores | 48.7% | 19 | 39 |
| Hillview Mental Health | 0% | 0 | 13 |
| IMCES | 19.2% | 5 | 26 |
| Masada Homes | 0% | 0 | 22 |
| Pacific Asian Counseling Services | 0% | 0 | 30 |
| Percy Village | 100% | 3 | 3 |
| Shields for Families | 12.5% | 2 | 16 |
| SSG | 24.4% | 11 | 32 |
| SSG Silver | 40.0% | 2 | 5 |
| San Fernando Valley MHC | 8.3% | 2 | 24 |
| Starview | 50.0% | 8 | 16 |
| Step Up on 2nd | 25.0% | 4 | 16 |
| Tarzana Treatment Center | 51.5% | 17 | 33 |
| Telecare | 34.8% | 8 | 23 |
| Tessie Cleveland | 54.6% | 18 | 33 |
| **TOTAL** | **31.9%** | **127** | **398** |

This survey completion rate is low, and clients who were able and willing to complete surveys differ from those who did not complete surveys. When providers submitted non-completed surveys for clients that noted the reason the survey had not been done—those surveys are not included in Table C1, which shows only completed surveys—the reasons fall into the following categories: client refusal; client mental status; missed appointment; refusal to engage or meet with provider; loss of contact; hospitalization; conservatorship; and incarceration. Given those reasons, we do not expect the completed surveys to be representative of all AOT FSP enrollments; rather, they are representative of those clients who were doing well enough to complete a survey when asked.

Table C2 presents survey results using the most recent survey completed as part of each enrollment where any surveys were completed (n=127; 124 for WAI-S due to three partially completed surveys). On Perceptions of AOT, on average, clients rated 8.4 out of 10 in terms of whether they felt like they were doing better than before FSP (SD=2.2). On Perceived Coercion, clients rated 3.6 out of 5 in terms of feeling like they were in control of their receipt of mental health services, indicating that they did not feel highly coerced by the program in spite of the potential for involuntary treatment (SD=1.7). On the Working Alliance Inventory-Short Form, FSP cases rated their working alliance with their AOT providers as strong, with an average total score of 4.0 out of 5 (SD=0.7). There was some variability across subscales, with clients rating their working alliance as a 4.0 on the task subscale (SD=0.8), 4.1 on the bond subscale (SD=0.8), and 3.8 on the goal subscale (SD=0.8).

The three rightmost columns show scores broken down by the voluntary status of the enrollment: voluntary (n=98; 96 for WAI-S), court order or settlement enrollment prior to enrollment (n=19; 18 for WAI-S), or court order or settlement agreement while enrolled (n=10). Clients who enrolled following a court order or settlement agreement reported feeling less control over their receipt of mental health services (mean=2.9, SD=2.1) than those who enrolled voluntarily (mean=3.8, SD=1.6) (t=-2.2, p=0.03). Clients enrolled following a court order or settlement agreement also gave lower ratings on Perceptions of AOT, though the difference was not significant (8.1 vs. 8.6, t=-0.9, p=0.37); court-ordered clients still reported feeling better than before AOT. Clients who enrolled after a court order or settlement agreement also still rated their working alliance with their providers positively, though WAI-S scores were significantly lower (total score 3.6) than for voluntary clients (total score 4.1) (t=-2.5, p=0.01), with differences fairly consistent across subscales.

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| **Table C2. Client satisfaction surveys (FSP) for 2-year period of 2018-2019, Mean (SD).** |
|  | **All Enrollments (n=127)** | Voluntary Enrollments (n=98) | Court Order/Settlement Before Enrolled (n=19) | Court Order/Settlement While Enrolled (n=10) |
| **Perceptions of AOT (scored from 0 to 10; higher scores indicate client feels better than before AOT)** |
| **Total Score** | **8.4 (2.2)** | 8.6 (2.1) | 8.1 (2.6) | 7.3 (2.8) |
| **Perceived Coercion (scored from 0 to 5; higher scores indicate client feels that they have control over their receipt of mental health services)** |
| **Total Score** | **3.6 (1.7)** | 3.8 (1.6) | 2.9 (2.1) | 2.9 (1.9) |
| **Working Alliance Inventory, Short Form (scored from 0 to 5; higher scores indicate client reports a stronger working alliance with their AOT provider) (n=125 for All; 96 for Voluntary; 18 for Court Order Before Enroll)** |
| Task | **4.0 (0.8)** | 4.1 (0.7) | 3.7 (1.1) | 3.9 (0.8) |
| Bond | **1.1 (0.8)** | 4.2 (0.7) | 3.8 (1.2) | 4.0 (0.7) |
| Goal | **3.8 (0.8)** | 3.9 (0.7) | 3.4 (0.9) | 3.7 (0.8) |
| **Total Score** | **4.0 (0.7)** | 4.1 (0.6) | 3.6 (0.9) | 3.9 (0.7) |

## Treatment Goals Progress and Family Involvement among FSP-Enrolled Clients

The provider-rated treatment goals survey was developed based on initial interviews with each treatment provider, with the purpose of capturing progress that might not be reflected in utilization data, MCAS scores, or MRT data. On this survey, providers were asked to rate clients’ improvement on the specific treatment goals that made up each client’s treatment plan. Survey forms were distributed to AOT treatment providers on May 13, 2017, with the request that providers complete a survey for each client every 6 months, starting 6 months post-enrollment. If a client was discharged before the next survey was due, they were asked to complete a survey for the client based on their status at discharge. Very few surveys were submitted for ERS clients; therefore, analyses here are restricted to FSP enrollments.

There was some lag in when survey completion began. No enrollments for which treatment ended prior to August 13, 2017 (3 months after the surveys were distributed) had a completed client survey (the earliest treatment end date associated with a completed survey was August 22, 2017). Therefore, analyses exclude any enrollments that ended prior to August 13, 2017.

To allow time to complete analyses for the FY 2018-19 state report and this final report, UCLA requested that DMH submit all client surveys completed through December 31, 2019 by February 2020, and December 31, 2019 was treated as the end of the follow-up period for which surveys were due. Analyses therefore only include clients who had been enrolled for at least three months prior to the December 31, 2019 cutoff. However, in 8 cases DMH sent UCLA a survey that had been completed between January 1, 2020 and February 12, 2020; rather than exclude those surveys, the follow-up period for those individuals was extended to February 12, 2020.

In considering whether a survey should have been completed as part of an enrollment, we restricted our examination to clients who were enrolled for 6 or more months. The resulting sample of enrollments for which a survey should have been completed consists of 347 FSP enrollments across 341 unique clients. These enrollments have enrollment dates ranging from March 28, 2016 and October 2, 2019.

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| **Table P1. Enrollments with at least one completed provider-rated treatment goals survey, by provider** |
| **Provider** | **Percent with****Completed Survey(s)** | **Number with****Completed Survey(s)** | **Number with****Survey(s) Due** |
| Behavioral Health Services | 17.9% | 5 | 28 |
| Exodus Recovery | 85.2% | 23 | 27 |
| Hathaway Sycamores | 50.0% | 17 | 34 |
| Hillview Mental Health | 0.0% | 0 | 13 |
| IMCES | 25.0% | 5 | 20 |
| Masada Homes | 0.0% | 0 | 18 |
| Pacific Asian Counseling Services | 6.9% | 2 | 29 |
| Percy Village | 66.7% | 2 | 3 |
| Shields for Families | 30.8% | 4 | 13 |
| SSG | 38.7% | 12 | 31 |
| SSG Silver | 60.0% | 3 | 5 |
| San Fernando Valley MHC | 13.0% | 3 | 23 |
| Starview | 66.7% | 10 | 15 |
| Step Up on 2nd | 66.7% | 8 | 12 |
| Tarzana Treatment Center | 60.7% | 17 | 28 |
| Telecare | 70.0% | 14 | 20 |
| Tessie Cleveland | 92.9% | 26 | 28 |
| **TOTAL** | **43.5%** | **151** | **347** |

Table P1 shows the percent of these enrollments for which at least one provider-rated treatment goals survey was submitted, by treatment provider and overall. Overall, 151 of the 347 enrollments (43.5%) resulted in at least one completed provider-rated treatment goals survey. This is a higher response rate than the client self-report surveys, which is to be expected given that providers can complete a survey about a client even if the client is unavailable or unwilling. The percent of enrollments with at least one completed survey ranged from 0% (Hillview, Masada Homes) to 92.2% (Tessie Cleveland).

Table P2 shows provider responses to questions about family involvement in treatment, from the subset of surveys identified as 6-month surveys (by definition range is from 1-7 months post-enrollment; one survey completed 8 months post-enrollment was treated as 6-month survey because 12-month survey done at 13 months) (n=109). Providers were asked: Did you meet or talk with a client’s family member or other support person as part of the treatment planning (if 1st survey) or since the previous survey (if not 1st survey)? (Check all that apply). Of the 109 enrollments (across 108 unique clients, one of whom was enrolled twice) for whom a 6-month survey was completed, for 60 (55.1%) the provider reported meeting or talking with a family member and for 8 (7.3%) the provider reported meeting with a non-family support person. There was some overlap (5 individuals, 4.6%) between these two groups, resulting in a total of 63 enrollments (57.8%) for which providers reported meeting or talking with either a family member and/or a non-family support person. For 26 enrollments (23.9%), providers reported that the client refused family involvement; for 5 (4.6%) they reported the family was not open to being involved; and for 11 (10.1%) they reported that the client has no contact with family.

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| **Table P2. Did provider meet or talk with client’s family member or other support person as part of treatment planning (prior to 6-month survey) (n=109)?** |
| **Response option (check all that apply)** | **Number**  | **Percent** |
| Met with family member | 60 | 55.1% |
| Met with non‐family support person | 8 | 7.3% |
| Client refuses family involvement | 26 | 23.9% |
| Family not open to being involved | 5 | 4.6% |
| Client has no contact with family | 11 | 10.1% |

Table P3 shows the extent to which providers rated the client as having shown improvement toward the goals in the client’s treatment plan. For each goal in the plan, providers rated improvement on a scale of 1 to 7 since the date the goal was added to the treatment plan: (1) Worsened/deteriorated; (2) No change; not engaged in working on goal; (3) Displays some willingness to work on goal; (4) Minor improvement or progress; (5) Moderate improvement or progress; (6) Substantial improvement or progress; or (7) Goal completely met. Because the treatment plan can include multiple goals, Table P3 is based on the average degree of improvement reported for each client enrollment, and presents the mean and standard deviation of that average improvement level across all enrollments for each survey period. Results are shown for different survey intervals; notably, the sample size decreases with each subsequent survey period. The 6-month survey period is defined as surveys completed between 2-7 months post-enrollment; the 12-month survey period is defined as surveys completed between 8-13 months post-enrollment; and so on, with small adjustments in instances where an individual’s first survey was completed at 8 months, for example, but a subsequent 12-month survey was done. Results are not shown beyond 24 months due to the vanishingly small sample sizes at that point.

Among the 106 enrollments for which treatment goal improvement was rated at around 6 months, the average improvement rating was 3.2 (SD=1.4), slightly above a score of 3, which corresponds to the client showing some willingness to work on the goal. Average improvement ratings were higher on surveys completed at later intervals, again reflecting a smaller sample of clients who were still enrolled at these later points: 3.6 (SD=1.5) for the 71 surveys with ratings at around 12 months; 3.9 (SD=1.4) for the 42 surveys with ratings at around 18 months; and 4.1 (SD=0.8) for the 11 surveys with ratings at around 24 months. At these later intervals, average improvement is around a score of 4, which corresponds to minor improvement or progress. Notably, these are averages across client enrollments, with some clients showing no improvement or worsening and some rated as completely meeting their goals; additionally, they are based on averages across the multiple goals in clients’ treatment plans, and clients may show moderate, substantial, or complete improvement on some goals while not making progress on others.

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| **Table P3. Average provider rating of improvement on client treatment goals, by survey period, on a scale of 1 (worsened/deteriorated) to 7 (goal completely met).** |
| **Survey Period** | **Sample Size** | **Mean (SD)** |
| 6 months (2-7 months post-enrollment) | 106 | 3.2 (1.4) |
| 12 months (8-13 months post-enrollment) | 71 | 3.6 (1.5) |
| 18 months (14-19 months post-enrollment) | 42 | 3.9 (1.4) |
| 24 months (20-25 months post-enrollment) | 11 | 4.1 (0.8) |

## Medication Adherence

***Medication Compliance at Referral.*** EOTD has also been tracking whether individuals were compliant with medications at the time of their AOT referral. Data was not collected on this item before April 2016. Table M1 indicates medication compliance across all referrals (all cases) and compliance in their first referral.

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| **Table M1. Medication Compliance Across All Referrals and the First Referral** |
| **Medication Compliance** | **All Cases****N** | **All Cases****%** | **First Referral****N** | **First Referral****%** |
| **None Prescribed** | 69 | 3% | 61 | 3% |
| **Refuses Medications** | 669 | 29% | 590 | 29% |
| **Never** | 130 | 6% | 109 | 5% |
| **Rarely** | 242 | 10% | 205 | 10% |
| **Sometimes** | 262 | 11% | 226 | 11% |
| **Most of the Time** | 57 | 2% | 52 | 3% |
| **Regularly** | 157 | 7% | 135 | 7% |
| **Unknown** | 164 | 7% | 147 | 7% |
| **Missing** | 539 | 23% | 511 | 25% |

***Medication Compliance During Treatment.***

During the course of our evaluation, two issues were raised around speed of access to and availability of psychiatrists. Long delays in receipt of medication by those who need it are highly problematic. We evaluated whether participants were able to see a psychiatrist and if people were adherent to their medication beginning in January 2017. We did not code a person as non-medication adherent if no medication was necessary but examined them separately.

**FSP.** There were 348 people who saw a psychiatrist and were medication adherent for at least one month, 231 who saw a psychiatrist and were not adherent for at least one month, and 144 who had not seen a psychiatrist and were not adherent for at least one month. Twenty-six people had a month where they were not prescribed a medication because it was not required, 20 who had seen the psychiatrist that month, 3 that had not, and 3 where that information was not provided. Of the 26 individuals who were not prescribed a medication, 9 were under an involuntary order and 17 were not. Seven people who graduated, 3 of whom were under an involuntary order and 4 who were not were not prescribed a medication. Ten people who were discharged were not prescribed a medication; four of these were involuntary, six were voluntary.

There were 79 individuals who did not see a psychiatrist in their first month and 110 who did not see a psychiatrist at least once during the first 3 months of treatment.

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| **Table M2. Medication compliance among FSP enrollees.** |
|  | **All With Data** | **Graduated** | **Discharged** | **Active** |
|  | **N** | **Medication** **Compliant** **N (%)** | **N** | **Medication** **Compliant** **N (%)** | **N** | **Medication** **Compliant** **N (%)** | **N** | **Medication** **Compliant** **N (%)** |
| **Enrolled** | 455 | 348 (76%) | 150 | 128 (85%) | 186 | 111 (60%) | 130 | 116 (89%) |
| **Involuntary** | 96 | 74 (77%) | 26 | 23 (88%) | 45 | 27 (60%) | 31 | 28 (90%) |
| **Voluntary** | 363 | 275 (76%) | 124 | 105 (85%) | 144 | 84 (58%) | 99 | 88 (89%) |

**ERS.** There were 8 individuals across 12 months of participating in services who did see a psychiatrist that month (2 involuntary, 6 voluntary participants). These largely seemed to relate to intakes as 6 did not see one in the first month and 3 did not in their second. Participants who graduated ERS were all reported as compliant with medication as were those in active treatment. Only those who were discharged were reported as not being compliant with medication after seeing a psychiatrist.

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| **Table M3. Medication compliance among ERS enrollees.** |
|  | **All With Data** | **Graduated** | **Discharged** | **Active** |
|  | **N** | **Medication** **Compliant** **N (%)** | **N** | **Medication** **Compliant** **N (%)** | **N** | **Medication** **Compliant** **N (%)** | **N** | **Medication** **Compliant** **N (%)** |
| **Enrolled** | 79 | 66 (84%) | 34 | 34 (100%) | 39 | 26 (66%) | 6 | 6 (100%) |
| **Involuntary** | 22 | 18 (82%) | 10 | 10 (100%) | 12 | 8 (75%) | 0 | 0 (100%) |
| **Voluntary** | 57 | 48 (84%) | 24 | 24 (100%) | 27 | 18 (67%) | 6 | 6 (100%) |

# Effectiveness

Effectiveness has been evaluated based on provider monthly reports and some utilization data. AOT has been very effective for a subset of clients, but less effective for the majority.

## Hospitalization

Statistics on hospitalization and crisis service use are presented in the Service Use section above.

## Physical Health

Physical health issues were rated on a 5-point scale from 1 = *Extreme health limitations* to 5 = *No limitations*, meaning that higher scores indicate better health. The physical health of participants was rated quite highly and individuals who graduated had better overall health than those who were discharged. Given the high rates of physical health issues that are a known concern for this population, we suggest that regular trainings on the MCAS items be provided by webinar so that providers are better able to rate these issues. Individuals in ERS facilities were in slightly better health than those in FPS upon arrival, at graduation, or upon discharge.

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| **Table E1. Physical health at enrollment, graduation, or discharge.** |
|  | **Enrollment (First Month with Data)** | **Graduation** | **Discharge** |
|  | **N** | **Mean (SD)** | **N** | **Mean (SD)** | **N** | **Mean (SD)** |
| **FSP-Enrolled** | 376 | 4.23 (1.09) | 115 | 4.37 (.92) | 95 | 3.84 (1.38) |
|  **Involuntary** | 74 | 4.45 (.88) | 13 | 4.54 (.78) | 23 | 3.78 (1.28) |
|  **Voluntary** | 302 | 4.18 (1.14) | 102 | 4.35 (.94) | 72 | 3.86 (1.42) |
| **ERS-Enrolled** | 93 | 4.69 (.74) | 35 | 4.91 (.37) | 36 | 4.83 (.56) |
|  **Involuntary** | 26 | 4.73 (.53) | 8 | 4.88 (.35) | 12 | 4.92 (.29) |
|  **Voluntary** | 67 | 4.67 (.81) | 27 | 4.93 (.38) | 24 | 4.79 (.66) |

## Substance Use

Upon referral, among those enrolled there was data on 559 individuals. Of those, 48% (N = 271) were identified as currently using substances, 25% as past users (n = 142), 12% as never using, and 14% as unknown status (n = 81). Upon enrollment, 41% of the 374 FSP enrollees were reported to not be using any substances, which is slightly less than the rates based on information in the referral, but it is important to note that 32 who were identified as current users upon referral were noted to not be using during their first month in FSP. This could indicate that providers are either unaware of their substance use or that participants have somehow stopped using before enrollment. For example, as 17 of these were identified as being current users of methamphetamine, it seems more likely that in some cases those providers were not aware of their use. Across all reports, substance use was reported for 57% of FSP participant reports and 34% of ERS participant reports. Greater attention, resources, and support for addressing co-occurring substance use issues are clearly needed for those referred to AOT.

MCAS scores of substance are rated from 1 (Always or almost always abused) to 5 (Almost never abused or did not use), meaning that higher scores indicate less abuse of substances.

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| **Table E2. Substance use at enrollment, graduation, or discharge.** |
|  | **Enrollment (First Month with Data)** | **Graduation** | **Discharge** |
|  | **N** | **Mean (SD)** | **N** | **Mean (SD)** | **N** | **Mean (SD)** |
| **FSP-Enrolled** | 374 | 3.54 (1.49) | 115 | 4.10 (1.17) | 94 | 3.35 (1.63) |
|  **Involuntary** | 73 | 3.68 (1.51) | 13 | 4.31 (.95) | 22 | 3.95 (1.53) |
|  **Voluntary** | 301 | 3.50 (1.48) | 102 | 4.08 (1.20) | 72 | 3.17 (1.63) |
| **ERS-Enrolled** | 94 | 4.27 (1.17) | 35 | 4.56 (1.01) | 36 | 3.72 (1.54) |
|  **Involuntary** | 26 | 4.54 (.81) | 8 | 4.63 (1.06) | 12 | 4.42 (1.24) |
|  **Voluntary** | 68 | 4.16 (1.28) | 27 | 4.55 (1.02) | 24 | 3.38 (1.58) |

## Employment

**FSP.** There were 500 people with at least one report about their employment status (93% of those enrolled in FSP), 97 of whom were involuntarily enrolled (93%) and 409 (93%) who had a voluntary enrollment. Twenty percent of those enrolled in FSP were reported to be employed at some point while participating in AOT. Employment was slightly higher among those who were enrolled voluntarily at 20%, though 16% of those enrolled involuntarily were as well.

Among those who graduated and had employment data (n =183), 27 were enrolled involuntarily and 160 were enrolled voluntarily. Alternatively, of 204 individuals with any data on their employment status and were discharged, 50 were involuntarily enrolled and 189 were enrolled voluntarily. Among active participants, there were 31 who enrolled involuntarily, and 99 enrolled voluntarily. The rates below suggest that employment was more common about those who were voluntary and graduated and least likely among those who were voluntary and discharged.

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| **Table E3. FSP number and percent employed, overall and by graduation/discharge/active status, N (%).** |
|  | **All with Data** | **Graduated** | **Discharged** | **Active** |
|  | **N** | **Employed****N (%)** | **N** | **Employed****N (%)** | **N** | **Employed****N (%)** | **N** | **Employed****N (%)** |
| **Enrolled** | 500  | 98 (20%) | 183 | 46 (25%) | 204 | 24 (12%) | 130 | 28 (22%) |
|  **Involuntary** | 97 | 16 (16%) | 27 | 3 (11%) | 45 | 5 (11%) | 31 | 8 (26%) |
|  **Voluntary** | 409 | 82 (20%) | 157 | 43 (27%) | 162 | 19 (12%) | 99 | 20 (20%) |

In terms of those who participated in employment services, 17% of FSP participants were involved in these services for at least one month. There were slightly more voluntary than involuntary participants among those who graduated and slightly fewer among voluntary participants who were discharged relative to those who were involuntary.

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| **Table E4. FSP participation in employment services, overall and by graduation/discharge/active status, N (%).** |
|  | **All with Data** | **Graduated** | **Discharged** | **Active** |
|  | **N** | **Participated****N (%)** | **N** | **Participated****N (%)** | **N** | **Participated****N (%)** | **N** | **Participated****N (%)** |
| **Enrolled** | 453 | 78 (17%) | 149 | 27 (18%) | 185 | 26 (14%) | 130 | 25 (19%) |
|  **Involuntary** | 96 | 17 (18%) | 26 | 4 (15%) | 45 | 7 (16%) | 31 | 6 (19%) |
|  **Voluntary** | 361 | 61 (17%) | 123 | 23 (19%) | 143 | 19 (13%) | 99 | 19 (20%) |

**ERS.** There were 111 participants in ERS that had data about their employment status, however, 13 individuals had study ids that did not match any enrollments and were not included in the analysis below. The only persons who were employed while in ERS were those who eventually graduated and none of the active participants nor those who were discharged are employed or in employment services.

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| **Table E5. ERS number and percent employed, overall and by graduation/discharge/active status, N (%).** |
|  | **All with Data at Enrollment** | **Graduated** | **Discharged** | **Active** |
|  | **N** | **Employed****N (%)** | **N** | **Employed****N (%)** | **N** | **Employed****N (%)** | **N** | **Employed****N (%)** |
| **Enrolled** | 98 | 4 (4%) | 41 | 4 (18%) | 54 | 0 (0%) | 6 | 0 (0%) |
|  **Involuntary** | 25 | 1 (4%) | 11 | 1 (15%) | 15 | 0 (0%) | 0 | 0 (0%) |
|  **Voluntary** | 73 | 3 (4%) | 30 | 3 (19%) | 39 | 0 (0%) | 6 | 0 (0%) |

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| **Table E6. ERS participation in employment services, overall and by graduation/discharge/active status, N (%).** |
|  | **All with Data at Enrollment** | **Graduated** | **Discharged** | **Active** |
|  | **N** | **Participated****N (%)** | **N** | **Participated****N (%)** | **N** | **Participated****N (%)** | **N** | **Participated****N (%)** |
| **Enrolled** | 98 | 7 (7%) | 41 | 7 (17%) | 54 | 0 (0%) | 6 | 0 (0%) |
|  **Involuntary** | 25 | 2 (8%) | 11 | 2 (18%) | 15 | 0 (0%) | 0 | 0 (0%) |
|  **Voluntary** | 73 | 5 (7%) | 30 | 5 (17%) | 39 | 0 (0%) | 6 | 0 (0%) |

## Mental Health Functioning

Providers completed monthly ratings of participants’ clinical status using the 17-item Multnomah Community Ability Scale (MCAS). Providers who were unable to enter a score on the MCAS because a participant was incarcerated, hospitalized, or could not be located often entered a 0 to demonstrate their effort to provide a rating. In those instances, we provided credit for their completion of a report but did not include those scores in our mean ratings of MCAS items, subscales, or total score. Each of the items are rated on a 5-point scale with anchors tied to the domain of each item, with lower scores indicating poorer mental health and higher scores indicating better mental health. There are 4 subscales (ranging from 3-5 items per subscale), outlined below. Although FSP is intended to be a lower-level of care compared to ERS, scores were generally higher upon enrollment for those in ERS facilities than those in FSP facilities. This suggests that ERS facilities are assisting those at higher levels of function than those in FSP and possibly indicate a gap in services for those who need a higher level of care than FSP/ERS but do not rise to the need for psychiatric hospitalization. We present the scores of individuals upon enrollment, the month that they graduated, and the month that they were discharged to describe their overall functioning at each of these stages. We do not provide statistical comparisons.

**Subscale I – Health.** The average scores of those admitted to FSP are lower by over two points relative to those who enrolled in ERS for the Health subscale. These differences persist as graduates of FSP are about 2 points lower and those who are discharged are almost 3 points lower than those in ERS.

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| **Table E7. MCAS Health Subscale score at enrollment, graduation, or discharge, mean (SD).** |
|  | **Enrollment (First Month with Data)** | **Graduation** | **Discharge** |
|  | **N** | **Mean (SD)** | **N** | **Mean (SD)** | **N** | **Mean (SD)** |
| **FSP-Enrolled** | 377 | 15.64 (3.71) | 116 | 18.28 (3.85) | 100 | 13.47 (4.78) |
|  **Involuntary** | 74 | 15.31 (3.51) | 13 | 18.23 (3.68) | 23 | 14.13 (4.12) |
|  **Voluntary** | 303 | 15.72 (3.76) | 103 | 18.29 (3.89) | 77 | 13.27 (4.97) |
| **ERS-Enrolled** | 94 | 17.77 (3.30) | 35 | 20.26 (2.39) | 38 | 16.26 (3.17) |
|  **Involuntary** | 26 | 17.65 (2.68) | 8 | 19.25 (1.49) | 13 | 16.54 (3.38) |
|  **Voluntary** | 68 | 17.81 (3.52) | 27 | 20.56 (2.55) | 25 | 16.12 (3.13) |

**Subscale II – Adaptation.** Scores on the Adaptation subscale were relatively similar between those in FSP and ERS, though ERS was slightly higher upon enrollment, graduation, and discharge with only one exception, for those who were discharged while under a court-order.

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| **Table E8. MCAS Adaptation Subscale score at enrollment, graduation, or discharge, mean (SD).** |
|  | **Enrollment (First Month with Data)** | **Graduation** | **Discharge** |
|  | **N** | **Mean (SD)** | **N** | **Mean (SD)** | **N** | **Mean (SD)** |
| **FSP-Enrolled** | 396 | 7.40 (2.61) | 119 | 9.04 (2.92) | 104 | 6.37 (2.40) |
|  **Involuntary** | 77 | 6.82 (2.51) | 15 | 8.53 (2.83) | 25 | 6.56 (2.48) |
|  **Voluntary** | 319 | 7.55 (2.61) | 104 | 9.12 (2.94) | 79 | 6.28 (2.39) |
| **ERS-Enrolled** | 94 | 7.95 (2.42) | 34 | 9.26 (2.42) | 38 | 7.08 (2.11) |
|  **Involuntary** | 26 | 7.85 (2.39) | 7 | 9.29 (1.50) | 13 | 6.38 (2.02) |
|  **Voluntary** | 68 | 7.99 (2.45) | 27 | 9.26 (2.63) | 25 | 7.44 (2.10) |

**Subscale III – Social Skills.** The scores of social skills were 2-3 points higher among those who enrolled in ERS compared to those in FSP. Individuals who were enrolled involuntarily were rated lower in these skills compared to those who were voluntary.

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| **Table E9. MCAS Social Skills Subscale score at enrollment, graduation, or discharge, mean (SD).** |
|  | **Enrollment (First Month with Data)** | **Graduation** | **Discharge** |
|  | **N** | **Mean (SD)** | **N** | **Mean (SD)** | **N** | **Mean (SD)** |
| **FSP-Enrolled** | 401 | 11.38 (3.67) | 122 | 14.27 (4.70) | 104 | 9.74 (3.60) |
|  **Involuntary** | 78 | 10.73 (3.93) | 15 | 12.67 (5.15) | 25 | 9.44 (3.62) |
|  **Voluntary** | 323 | 11.54 (3.59) | 107 | 14.50 (4.61) | 79 | 9.84 (3.61) |
| **ERS-Enrolled** | 94 | 13.72 (3.41) | 35 | 16.71 (3.95) | 38 | 12.29 (3.81) |
|  **Involuntary** | 26 | 13.00 (3.01) | 8 | 15.75 (3.88) | 13 | 12.31 (4.27) |
|  **Voluntary** | 68 | 14.00 (3.53) | 27 | 17.00 (4.00) | 25 | 12.28 (3.63) |

**Subscale IV – Behavior.** Individuals enrolled in FSP were about 3-4 points lower in terms of their behavioral control compared to those enrolled in ERS. Individuals who were enrolled involuntarily were rated as having less behavioral control than those enrolled voluntarily in FSP but the inverse was true among those enrolled in ERS.

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| **Table E10. MCAS Behavior Subscale score at enrollment, graduation, or discharge, mean (SD).** |
|  | **Enrollment (First Month with Data)** | **Graduation** | **Discharge** |
|  | **N** | **Mean (SD)** | **N** | **Mean (SD)** | **N** | **Mean (SD)** |
| **FSP-Enrolled** | 401 | 11.76 (3.70) | 122 | 14.52 (4.49) | 104 | 10.06 (3.75) |
|  **Involuntary** | 78 | 10.99 (4.10) | 15 | 13.53 (5.15) | 25 | 9.64 (3.55) |
|  **Voluntary** | 323 | 11.94 (3.58) | 107 | 14.65 (4.40) | 79 | 10.19 (3.82) |
| **ERS-Enrolled** | 94 | 14.68 (3.64) | 35 | 17.37 (2.52) | 38 | 12.22 (3.92) |
|  **Involuntary** | 26 | 14.69 (3.31) | 8 | 17.63 (2.92) | 13 | 13.58 (3.18) |
|  **Voluntary** | 68 | 14.68 (3.78) | 27 | 17.30 (2.45) | 25 | 11.54 (4.14) |

**Total MCAS Score.** Individuals who graduated from FSP and ERS had the highest total MCAS scores for the month that they graduated. Individuals were about 7 points higher upon enrollment in ERS, about 6 points higher upon graduation, and about 8 points higher upon discharge compared to those in FSP.

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| **Table E11. MCAS Total score at enrollment, graduation, or discharge, mean (SD).** |
|  | **Enrollment (First Month with Data)** | **Graduation** | **Discharge** |
|  | **N** | **Mean (SD)** | **N** | **Mean (SD)** | **N** | **Mean (SD)** |
| **FSP-Enrolled** | 397 | 47.12 (11.14) | 119 | 57.24 (11.71) | 105 | 40.35 (12.28) |
|  **Involuntary** | 78 | 45.37 (11.76) | 15 | 56.20 (11.43) | 24 | 42.67 (12.87) |
|  **Voluntary** | 319 | 47.55 (10.96) | 104 | 57.38 (11.79) | 81 | 39.67 (12.09) |
| **ERS-Enrolled** | 94 | 54.12 (10.29) | 34 | 63.32 (10.12) | 38 | 48.19 (10.31) |
|  **Involuntary** | 26 | 53.19 (7.92) | 8 | 60.75 (8.65) | 13 | 49.33 (10.87) |
|  **Voluntary** | 68 | 54.47 (11.09) | 27 | 64.12 (10.56) | 25 | 47.63 (10.21) |

## Victimization

Initially, victimization was assessed in the monthly reporting tool for when a formal report needed to be filed, which occurred twice and only among those in FSP before January 2017. Beginning in January 2017, the threshold was just if providers were aware of their client being victimized. In FSP 8 participants were identified for the highest frequency of victimization of 4 or more times a month, 50 were identified as being victimized 1-3 times, and two more simply as yes without a rating of the frequency. In ERS facilities, there were only reports ever of victimization, 1 for an involuntary participant and 1 for a voluntary participant. We will report the aggregated FSP data below as we present other outcomes but with these caveats in mind and that the rates of victimization seem unusually low given the high rates of victimization that are endemic to this population.

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| **Table E12. Victimization of FSP enrollees, overall and by graduation/discharge/active status, N (%).** |
|  | **All with Data** | **Graduated** | **Discharged** | **Active** |
|  | **N** | **Victimized****N (%)** | **N** | **Victimized****N (%)** | **N** | **Victimized****N (%)** | **N** | **Victimized****N (%)** |
| **Enrolled** | 452 | 55 (12%) | 149 | 12 (8%) | 184 | 18 (10%) | 130 | 25 (19%) |
|  **Involuntary** | 96 | 11 (11%) | 26 | 2 (8%) | 45 | 3 (7%) | 31 | 5 (16%) |
|  **Voluntary** | 360 | 45 (13%) | 123 | 10 (8%) | 142 | 15 (11%) | 99 | 20 (20%) |

## Violence

The rates of violence for all those who were referred and met criteria were outlined above. Among those who enrolled in FSP, there was data on 499 of those who enrolled in FSP (as data on this variable was only recorded starting in 2016) but only 310 had data on their history of violence before AOT. Of the 310 with MRT FSP data, 72% had a history of violence prior to AOT. During FSP treatment, 175 individuals had a report of violence, which is 35% of those enrolled with data. Eighty-three individuals had a history of violence before FSP and were violent during their participation. Among the 116 individuals who had data for the month that they graduated AOT, 3% (n = 4) were violent the month that they graduated and of the 183 people who graduated who had data at any point while they were enrolled, 25% were violent during treatment at some point (n = 45). Individuals who were enrolled involuntarily were more likely to have an incident of violence than those participating voluntarily, though the rates of violence were still quite high. This suggests that treatment services need to include interventions that may mitigate violence.

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| **Table E13. Violence among FSP enrollees, overall and by graduation/discharge/active status, N (%).** |
|  | **All with Data** | **Graduated** | **Discharged** | **Active** |
|  | **N** | **Violence****N (%)** | **N** | **Violence****N (%)** | **N** | **Violence****N (%)** | **N** | **Violence****N (%)** |
| **Enrolled** | 499 | 175 (35%) | 183 | 45 (25%) | 202 | 86 (43%) | 130 | 45 (35%) |
|  **Involuntary** | 97 | 44 (45%) | 27 | 9 (33%) | 45 | 26 (58%) | 31 | 10 (33%) |
|  **Voluntary** | 408 | 131 (32%) | 157 | 36 (23%) | 160 | 60 (38%) | 99 | 35 (35%) |

**Note**: Voluntary and Involuntary do not sum to enrolled as these may represent multiple enrollments.

**ERS.** There were 6 individuals who had a history of violence and were violent while in their ERS and 37 who were not violent while in an ERS but had a history of it. Individuals in ERS facilities had lower rates of violence compared to those in FSP, though there were no differences in violence among those who enrolled voluntarily vs involuntarily.

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| **Table E14. Violence among ERS enrollees, overall and by graduation/discharge/active status, N (%).** |
|  | **All with Data** | **Graduated** | **Discharged** | **Active** |
|  | **N** | **Violence****N (%)** | **N** | **Violence****N (%)** | **N** | **Violence****N (%)** | **N** | **Violence****N (%)** |
| **Enrolled** | 97 | 18 (19%) | 41 | 7 (17%) | 53 | 11 (21%) | 6 | 0 (0%) |
|  **Involuntary** | 25 | 5 (20%) | 11 | 3 (27%) | 15 | 2 (13%) | 0 | 0 (0%) |
|  **Voluntary** | 72 | 13 (18%) | 30 | 4 (13%) | 38 | 9 (24%) | 6 | 0 (0%) |

## Suicidal Ideation and Attempts

There were three items that assessed suicidal ideation and attempts. Suicide attempts were quite rare and 16 individuals in FSP were noted to have made a suicide attempt across 19 months of reports, 5 among those enrolled voluntarily and 11 among those enrolled voluntarily. There was only 1 report of a suicide attempt by an involuntary participant in ERS.

Suicidal ideation was much more common, though interestingly it was more common among those who graduated FSP than those who were discharged (if individuals were enrolled involuntarily). However, among those who were voluntary, suicide ideation was more common among those discharged than those who graduated. Current participants had the highest overall rates of suicidal ideation.

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| **Table E15. Suicidal ideation among FSP enrollees, overall and by graduation/discharge/active status, N (%).** |
|  | **All with Data** | **Graduated** | **Discharged** | **Active** |
|  | **N** | **Violence****N (%)** | **N** | **Violence****N (%)** | **N** | **Violence****N (%)** | **N** | **Violence****N (%)** |
| **Enrolled** | 450 | 117 (26%) | 148 | 30 (20%) | 183 | 50 (27%) | 130 | 38 (29%) |
|  **Involuntary** | 96 | 25 (26%) | 26 | 7 (27%) | 45 | 10 (22%) | 31 | 8 (26%) |
|  **Voluntary** | 358 | 92 (26%) | 122 | 23 (19%) | 141 | 40 (28%) | 99 | 30 (30%) |

Among ERS participants, a greater proportion of those in involuntary treatment expressed suicidal ideation than those who were enrolled voluntarily. None of those who graduated while participating voluntarily nor any that were active in treatment had a report of suicidal ideation. Similar to FSP participants, those who were voluntary and discharged were more likely than those who were involuntary to have a report of suicidal ideation.

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| **Table E16. Suicidal ideation among ERS enrollees, overall and by graduation/discharge/active status, N (%).** |
|  | **All with Data** | **Graduated** | **Discharged** | **Active** |
|  | **N** | **Violence****N (%)** | **N** | **Violence****N (%)** | **N** | **Violence****N (%)** | **N** | **Violence****N (%)** |
| **Enrolled** | 82 | 9 (11%) | 34 | 3 (9%) | 42 | 6 (14%) | 6 | 0 (0%) |
|  **Involuntary** | 23 | 4 (17%) | 10 | 3 (30%) | 13 | 1 (8%) | 0 | 0 (0%) |
|  **Voluntary** | 59 | 5 (8%) | 24 | 0 (0%) | 29 | 5 (17%) | 6 | 0 (0%) |

# Community Improvement

Community improvement was evaluated on reduction of homelessness and reduction of criminal justice involvement/incarceration. There has been some reduction in each area, but it is unclear whether this improvement will be lasting.

## Homelessness

Upon their first referral, 41% of those referred were homeless. Providers completed monthly reports on the housing status of their clients after enrollment. This means that there are two critical limitations to these data. One, it only represents those who enrolled in services and secondly, providers were only asked to identify a singular housing status per month, which means that despite the fact that a participant could spend part of a month housed and homeless for part of a month, providers could only select one category. Given, the noted lack of housing resources across LA County, it is therefore unclear whether the dramatic decrease of homelessness among those who enrolled in the program represents their housing status accurately.

In terms of the demographics and housing status, we examined gender, race/ethnicity and age among those who enrolled in services among the 603 individuals who enrolled in an FSP or ERS.

Due to the small numbers of those in the ‘other’ category and those in the ‘jail’ categories, we could not complete comprehensive comparisons. However, there appear to be some race/ethnicity trends to housing status. Whites were most likely to be represented among those who were homeless or in an apartment and Hispanic/LatinX were more likely to be living with family or other adults.

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| **Table E17. Demographics by housing status: race/ethnicity.** |
| **Housing** | **Black** | **Hispanic**  | **White** | **Asian** | **Other** |
| Homeless | 28% | 29% | 34% | 7% | 2% |
| Family/adult | 13% | 48% | 23% | 14% | 1% |
| Apartment | 19% | 30% | 36% | 14% | 2% |
| MH Facility | 21% | 31% | 35% | 6% | 6% |
| Jail | 33% | 33% | 27% | 7% | 0% |

Due to the small number of transgender persons, gender comparisons will not include those who were transgender. There were no significant differences in the housing status by gender in a Chi-square comparison (Chi-square = 5.84, *p* = .21).

The average age of those referred to AOT is noted above. Individuals who were living with their families or with other adults were the youngest and individuals in their independent apartments were the oldest, while the ages were similar and intermediate for those who were homeless, in a mental health facility, or in jail. These differences were significant only between those who were living with family vs those in an apartment in a one-way ANOVA, F(4,544) = 5.96, p<.001.

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| **Table E18. Demographics by housing status: age, gender.** |
| **Housing** | **Age M (SD)** | **Gender** |
| Homeless | 35.69 (11.46) | 64% male, 34% female, 1% transgender |
| Family/adult | 32.47 (10.39) | 68% male, 32% female |
| Apartment | 38.94 (13.10) | 57% male, 41% female, 2% transgender |
| MH Facility | 35.86 (12.70) | 60% male, 40% female |
| Jail | 36.48 (10.3) | 74% male, 26% female |

**Housing and FSP.** There was data provided on 408 cases during the first month that a participant was enrolled in an FSP. However, data on housing status was not captured until January 2017 via the monthly reporting tool, therefore all those who were enrolled before this date have missing data.

There were 266 cases of where there was data on the housing status of those who enrolled in FSP in their first month. Of those 266, 58% (n=155) were identified as living with family/friends, 16% were living in a supported living facility or board and care (n =42), 13% were homeless (n = 34), 3% were in independent living (n =9) 2% were in jail (n =5), 2% were hospitalized (n=4) and the remaining 6% were identified as other.

In terms of the continuity of housing status between referral and enrollment with an FSP provider, among those who were homeless at the time of referral and had data for their enrollment month (n=67), only 31% were identified as homeless upon their enrollment in FSP. This is difficult to understand given that the outreach and engagement teams do not typically have the ability to house individuals during the O&E period. This discordance between participants housing status at referral and upon initiation of treatment merits further review by DMH. This could indicate the insufficiency of the MRT to capture housing status or that providers are unaware/disagree that participants are homeless. There were 102 out of 537 individuals who were identified as homeless at some point during their participation in FSP or 19%. This suggests that additional resources for housing are required.

**Housing and ERS.** By definition, those who are assigned to an ERS are provided housing. There were only two reports of 2 voluntary participants in ERS being homeless across all the reports and those reports were for the month that each was discharged from ERS. In the first month of participation (n =76), 65% were in a board and care/sober living facility (n = 49), 24% were in permanent supportive housing (n = 18), 4% each were living with family or independently (n=3 each), one was in jail, one was in transitional housing, and 1 was identified as other.

## Justice Involvement

There were two measures of involvement with police and arrest in the monthly reporting tool. Providers were asked if there was contact with law enforcement or if their clients had been incarcerated and for how long.

**Contact with Law Enforcement.**

**FSP.** Rates of contact with law enforcement were high regardless of whether the participants were voluntary or involuntary and were highest among those who were discharged, with well over half still having contact with law enforcement.

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| **Table E19. Law enforcement contact among FSP enrollees, overall and by graduation/discharge/active status, N (%).** |
|  | **All with Data** | **Graduated** | **Discharged** | **Active** |
|  | **N** | **Contact****N (%)** | **N** | **Contact****N (%)** | **N** | **Contact****N (%)** | **N** | **Contact****N (%)** |
| **Enrolled** | 499 | 218 (44%) | 183 | 57 (31%) | 203 | 119 (59%) | 130 | 43 (33%) |
|  **Involuntary** | 97 | 45 (46%) | 27 | 9 (33%) | 45 | 29 (64%) | 31 | 7 (23%) |
|  **Voluntary** | 408 | 176 (43%) | 157 | 49 (31%) | 161 | 92 (57%) | 99 | 36 (36%) |

**ERS.** Among those in ERS facilities, rates of contact with law enforcement are considerably lower. This could mean that those who enrolled in ERS were prevented from contacts by housing or that those who enrolled in ERS facilities were less likely to have contact due to other factors, but this bears exploration.

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| **Table E20. Law enforcement contact among ERS enrollees, overall and by graduation/discharge/active status, N (%).** |
|  | **All with Data** | **Graduated** | **Discharged** | **Active** |
|  | **N** | **Contact****N (%)** | **N** | **Contact****N (%)** | **N** | **Contact****N (%)** | **N** | **Contact****N (%)** |
| **Enrolled** | 98 | 20 (20%) | 41 | 2 (5%) | 54 | 18 (33%) | 6 | 0 (0%) |
|  **Involuntary** | 25 | 7 (28%) | 11 | 1 (9%) | 13 | 6 (46%) | 0 | 0 (0%) |
|  **Voluntary** | 73 | 13 (18%) | 30 | 1 (3%) | 39 | 12 (31%) | 6 | 0 (0%) |

**Incarceration.** Data on arrest was included in the MRT prior to 2017 but only reports from 2017 on have responses among those in ERS. There were reports of incarceration among those in FSP in 2015-2016.

**FSP.** While rates of arrest were considerably lower among those who graduated, the rates remained quite high among those who were discharged early.

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| **Table E21. Arrest among FSP enrollees, overall and by graduation/discharge/active status, N (%).** |
|  | **All with Data** | **Graduated** | **Discharged** | **Active** |
|  | **N** | **Contact****N (%)** | **N** | **Contact****N (%)** | **N** | **Contact****N (%)** | **N** | **Contact****N (%)** |
| **Enrolled** | 462 | 131 (28%) | 154 | 22 (14%) | 189 | 85 (46%) | 130 | 25 (19%) |
|  **Involuntary** | 96 | 21 (22%) | 26 | 1 (4%) | 45 | 16 (36%) | 31 | 4 (13%) |
|  **Voluntary** | 370 | 113 (31%) | 128 | 21 (16%) | 147 | 72 (49%) | 99 | 21 (21%) |

**ERS.** Rates of arrest were also much lower among those who were enrolled in ERS and only those who were discharged ended up having an arrest.

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| **Table E22. Arrest among ERS enrollees, overall and by graduation/discharge/active status, N (%).** |
|  | **All with Data** | **Graduated** | **Discharged** | **Active** |
|  | **N** | **Contact****N (%)** | **N** | **Contact****N (%)** | **N** | **Contact****N (%)** | **N** | **Contact****N (%)** |
| **Enrolled** | 98 | 8 (8%) | 41 | 0 (0%) | 54 | 8 (15%) | 6 | 0 (0%) |
|  **Involuntary** | 25 | 2 (8%) | 11 | 0 (0%) | 15 | 2 (13%) | 0 | 0 (0%) |
|  **Voluntary** | 73 | 6 (8%) | 30 | 0 (0%) | 39 | 6 (15%) | 6 | 0 (0%) |

# Stakeholder Satisfaction: Ethnographic Observations from Family Surveys andInterviews

Two AOT family surveys were conducted in 2018 and 2020. Responses were voluntary and anonymous, reflecting only a subset of patients. Responses to the 2018 survey were from family members of 224 clients, mostly white males, ages 24-49; mostly living at home or alone or with a friend. These respondents thought that AOT had met their expectations and been beneficial for the clients. 207 family members (93.3%) reported that the client was healthier than before treatment, while 203 family members (91.1%) reported that the client was better able to manage his behavior. 145 family members (65%) said that AOT had met their expectations “much more than expected,” 59 (26.5%) “more than expected,” and 14 (6.3%) “as much as expected.” Finally, 201 family members (89.7%) thought that the client would probably continue with treatment after his AOT enrollment ended. The 2020 survey gathered only 24 responses from the same demographic, with similar results.

Against the positive AOT experiences of this group of families must be set the negative experiences of some of the 24 families reported in interviews. It should be noted that the clients represented in these interviews were predominantly males ages 24-49, as in the surveys, but that most were young men of color, not white. Overall, these families expressed a good deal of discouragement, sometimes based on unrealistic expectations that AOT would be able to force their relative into treatment or conservatorship or on idiosyncratic perceptions of ideal treatment. The families needed and were grateful for frequent provider communication, both with the client and with the family. Also, families often expected more than a field visit once a week, which does not seem unreasonable, given the severity of the illness.

Two particular critiques presented in interviews were 1) the lack of effective follow-up in the transition from AOT to another level of care and 2) the persistent risk of incarceration. As family members explained, once a client “graduated” from AOT, participation in continued treatment was voluntary, a point stressed to them by the court and by provider staff. For many clients who had enrolled in AOT under court order, particularly those who had been homeless prior to enrollment, graduation was tantamount to release. Family members stated the belief that the client will always need some form of coercion to receive treatment because of a lack of insight into his/her illness and a distrust of the health care/social services system, conflated in their minds with criminal justice. As one mother recounted of her son, who had been recommended to enroll in drug rehabilitation following his completion of AOT,

“He never did that because it was all voluntary. Then, we would leave the courtroom, we would go out into the hallway and he would tell the doctor and myself right there: nope, they can’t force me to. He would even cuss at us. Now you can’t force me to. I am not going to—I am not going to. You can’t stop me. You know, you can’t force me. You can’t make me. And of course, we couldn’t make him because the judge didn’t court mandate it.”

A second problem voiced by family members related to clients whose behavior led to criminal charges. Despite their attempts, and EOTD’s, to advocate for these individuals, repeated incarceration, rather than mental health services, was often the outcome. In one case, a young black enrolled in AOT was discharged by the provider after committing a violent offense. Although he was stabilized at a hospital and the judge recommended he be released to an IMD bed in a locked facility, no such beds were available, so he was returned to jail indefinitely. As his mother said:

“So they told us….by the end of March or sooner, you could be moving (to a new outpatient treatment center). And then yesterday I get a phone call from him [in jail]…“Mom, there’s like a hundred people in here.” And he’s on a bed, he’s on the top-top of a three-tier bed. They want you to know you’re in jail. Whether you’re innocent or not, they don’t care. And that’s the whole consensus. They don’t care you are in jail, you are locked up, you are incarcerated.”

On balance, stakeholder experiences have been mixed, spanning the gamut from very satisfied to dissatisfied and disappointed.

# Conclusion

The AOT program since its inception has accepted a significant number of severely mentally ill individuals and referred many to FSP or ERS treatment programs, under court orders. The majority of these individuals received more services after referral than previously, indicating they have received at least some benefit. However, our observations point to many concerns about inadequate resources, about inadequate continuity of care, about client attrition, about the degree to which the contract providers understand and implement aspects of the program and the full extent to which they provide needed services, such as frequent field visits and medication adjustments to clients. We are also concerned about the lack of coordination between AOT provider staff and hospital discharge planners. Finally, we remain troubled that the mechanisms for getting potential clients released from incarceration and into MIST or AOT programs seem no longer to be operating, leaving many severely mentally ill individuals subsisting in severely suboptimal conditions in county jails.

1. Follow-up for utilization analyses was cut off at May 17, 2019 to allow time for claims data to be fully up-to-date, due to data reporting lags; claims data were extracted by DMH Clinical Informatics and delivered to UCLA on January 23, 2020 allowing 8 months for claims to be entered by providers. [↑](#footnote-ref-1)