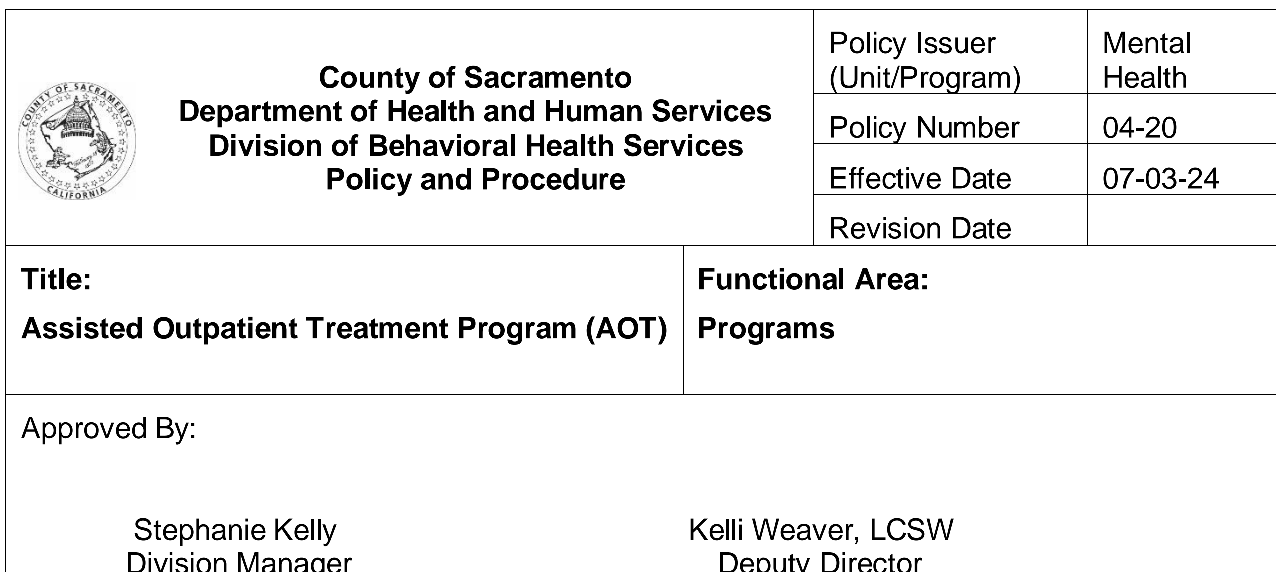


County of Sacramento Department of Health and Human Services Division of Behavioral Health Services Policy and Procedure	Policy Issuer (Unit/Program)	Mental Health
	Policy Number	04-20
	Effective Date	07-03-24
	Revision Date	

Title:	**Functional Area:**
Assisted Outpatient Treatment Program (AOT)	**Programs**

Approved By:

Stephanie Kelly
Division Manager

Kelli Weaver, LCSW
Deputy Director

Background/Context:

Assembly Bill 1421 established the Assisted Outpatient Treatment (AOT) Program also known as "Laura's Law," which permits the use of the courts and behavioral health systems, including Substance Use Prevention and Treatment (SUPT), to address the needs of individuals who have not engaged with community mental health treatment programs and need intensive engagement and support options.

Purpose:

The purpose of this policy and procedure is to detail the eligibility criteria, referral, and admission process for the AOT program.

Definitions:

AOT: Court ordered Assisted Outpatient Treatment for individuals diagnosed with severe mental illness who are experiencing a behavioral health crisis and are resistant to seeking treatment.

SmartCare: Electronic health record system for Sacramento County Department of Health Services (DHS), Division of Behavioral Health Services (BHS).

Details:

Procedure:

I. Eligibility Criteria

   A. The client must be 18 years of age or older.

   B. The client is suffering from a mental illness as defined in WIC § 5600.3(b)(2) and (b)(3) (severe in degree, persistent in duration, interferes substantially with activities of daily living, impedes stable adjustment and independent functioning).

C. The client's treatment history and current behavior determines that, at least one of the following is true:

   1. The client is unlikely to survive safely in the community without supervision and the person's condition is substantially deteriorating; or

   2. The client needs AOT to prevent relapse or deterioration that would likely result in grave disability or serious harm to self or to others.

D. The client has a history of lack of engagement and follow-through with treatment for mental illness, and at least one of the following is true:

   1. Client's mental illness has, at least twice within the last 36 months, been a substantial factor in necessitating psychiatric hospitalization, or receipt of services in a forensic or other mental health unit of a state prison or local correctional facility, not including any period during which the person was hospitalized or incarcerated immediately preceding the filing of the petition; or

   2. Client's mental illness has resulted in one or more acts of serious and violent behavior toward self or other, or threats or attempts to cause serious physical harm to self or other within the last 48 months, not including any period in which the person was hospitalized or incarcerated immediately preceding the filing of the petition.

E. The client has been offered an opportunity to participate in a treatment plan by the director of the local mental health department, or the director's designee, provided the treatment plan includes all the services described in WIC Article 9 Section 5348 , and the person continues to not engage in treatment or follow treatment recommendations.

F. A client's participation in the AOT program would be the least restrictive placement necessary to ensure recovery and stability.

G. It is likely the client will benefit from the AOT program.

II. Referring Party

A. Referrals can be made by the following individuals:

   1. Adult residing with client.

   2. Adult family member of client.

   3. Director of a treatment agency or provider assigned by the County Mental Health Plan.

   4. Treating mental health professionals.

   5. Probation or parole officer of the client; or

   6. Judge of a superior court.

III. Referral Process

A. The referring party may:

1. Complete the referral form and submit to DHS-MH-AOT@SacCounty.gov; or

2. Call AOT direct phone line at 916-875-6508 to request assistance with completing the form.

IV. Admission Process

A. A DHS AOT designee shall review all electronic referrals and enter them into the SmartCare Inquiry Screen as outlined below in section IV (D).

B. An AOT team member will work with the referring party to obtain additional information, if needed, to better determine the person being referred meets the initial AOT criteria.

C. An AOT team member will provide a response to the referring party within 48 business hours from receipt of referral. The response may include one of the following:

1. The referral is incomplete, and more information is needed to further process the referral. The AOT Team will work with the referring party to gather missing information to process it in a timely manner. If missing information is not provided, a referral may be denied for insufficient information or criteria,

2. The referral is complete and will be reviewed by the AOT team member to determine eligibility to participate in AOT,

3. The referral meets admission criteria, or

4. The referral was denied due to identified exclusionary criteria.

D. Upon referrals meeting admission criteria or identified as complete, the DHS AOT designee will complete the inquiry in SmartCare to assign the client to the County contracted AOT Provider.

1. SmartCare Inquiry Process

    a. The client will be in “Requested” status to the County contracted AOT provider program.

    b. The Special Population “AOT-Outreach” will be used.

E. County Contracted AOT Provider Process

1. The County contracted AOT Outreach Team will attempt to engage the identified client referred for treatment services or the referral source no later than three (3) business days after the Request for Service is completed in SmartCare.

2. Attempt to schedule a face-to-face assessment with the referred client within no later than one (1) business day to offer voluntary services.

3. Continue outreach to, and engagement with, client while providing FSP level "whatever it takes" services to engage the client in voluntary services.

4. If client accepts voluntary services, the client's Special Population status will be changed in SmartCare to reflect "AOT-Voluntary," the client will complete consent for treatment and continue with the County contracted AOT provider as a voluntary client.

5. If the client declines to participate in voluntary services, a petition may be filed by AOT with the court and the client's Special Population status will be changed in SmartCare to reflect "AOT-Court."

F. AOT Court Process

1. The County contracted AOT provider will complete and submit the following documents to the County AOT team member:

    a. AOT Checklist

    b. Declaration in Support of AOT Petition

    c. Petition for AOT

    d. Proposed AOT Treatment Plan

    e. Declaration of Custodian of Records-Telecare EHR Records

    f. County contracted AOT provider client EHR Records

    g. Have the client served with the complete petition and return the signed Proof of Service to County Counsel.

2. The County AOT team member will review the documents and complete the following actions:

    a. Submit the AOT petition to the Behavioral Health Services (BHS) Director or Designee for signature.

    b. Complete a Declaration of Custodian of Records form and submit to County Counsel with attached records from County EHR (if available).

    c. Submit the complete packet for filing the AOT petition to County Counsel by the Thursday before the anticipated hearing date.

3. County Counsel will complete the following:

    a. Review the packet for accuracy and completeness.

b. File the AOT packet with the Court.

c. Send a Proof of Service regarding the petition for AOT to the County contracted AOT provider representative to serve the client. The County contracted AOT provider representative will then sign the proof of service and return it to County Counsel.

d. Represent County BHS and the County contracted AOT provider in the AOT Court proceedings.

4. Court Hearing Process

a. The client is assigned a Public Defender to represent them in their AOT Court proceedings.

b. The criteria are reviewed by both County Counsel and Public Defender to determine eligibility for AOT.

c. Superior Court Judge provides a ruling on appropriateness for AOT.

d. If granted, client is ordered to participate in 180 days of AOT services provided by Telecare OASIS and to attend regularly scheduled review hearings to monitor progress.

e. County contracted AOT provider will provide progress reports during review hearings.

f. At the end of 180 days, a petition can be renewed if appropriate and will be refiled with the Court for an additional 180 days if approved by the Judge.

g. If the renewal is not granted by the Judge, the petition is dismissed, and the client is discharged from AOT. The client may remain in voluntary services with the County contracted AOT provider if they wish and continue to meet criteria for FSP services. They may also be transitioned to a lower level of care if appropriate and the client chooses to receive services with another provider.

h. Clients who engage in the treatment process and are ready to step down at the end of their petition period will receive a “Graduation” certificate.

Reference(s)/Attachments:

Attachment A – Sacramento County Assisted Outpatient Treatment (AOT) Referral Form

Attachment B – AOT Workflow

Attachment C - AOT Court Process

Attachment D – AOT Assessment Checklist

Attachment E – Court Review Progress Report

AOT WIC 5346 (b) (2)

Distribution:

Enter X	DL Name	Enter X	DL Name
X	Behavioral Health Staff	X	Publish to Intranet
X	Adult Program Contractors	X	Publish to Internet
X	Mental Health Treatment Center Staff		

Contact Information:

BHS-DHS@saccounty.gov

SACRAMENTO COUNTY ASSISTED OUTPATIENT TREATMENT (AOT) REFERRAL FORM

Email to AOT Referral Box: dhs-mh-aot@saccounty.gov

IF THIS IS A PSYCHIATRIC EMERGENCY, PLEASE CALL 988

*INSUFFICIENT DETAILS MAY DELAY THE REFERRAL

Attach recent photo here

REFERRING PARTY INFORMATION Per WIC 5346 (b)(2)

DATE COMPLETED: AGENCY NAME: NAME:

PHONE: EMAIL: FAX:

Relation to Candidate: ☐ Adult Residing with Candidate ☐ Adult Family Member of Candidate ☐ Director of Treating Agency ☐ Treating Mental Health Professional ☐ Candidates Assigned Peace Officer, Parole Officer, Probation Officer ☐ Judge/Court

INDIVIDUAL COMPLETING REFERRAL (if different than referring party):

AOT CANDIDATE INFORMATION Per WIC 5346 (a)

SSN# (if known): XREF# (if known) PATID# (if known)

LAST NAME: FIRST NAME: GENDER:

DOB: APPROX. HEIGHT: APPROX. WEIGHT: HAIR COLOR: EYE COLOR:

ADDRESS: CITY: ZIP:

PHONE NUMBER: PREFERRED LANGUAGE: CANDIDATE SERVED IN THE U.S. MILITARY YES ☐ NO ☐

PHYSICAL HEALTH ISSUES AND MEDICATION:

MENTAL HEALTH DIAGNOSIS:

LIST MENTAL HEALTH MEDICATIONS:

RACE/ETHNICITY: ☐ WHITE/NON-HISPANIC ☐ HISPANIC ☐ NATIVE AMERICAN/ALASKAN ☐ AFRICAN AMERICAN ☐ ASIAN ☐ UNKNOWN ☐ MULTIRACE ☐ OTHER:

LIVING SITUATION:

HOMELESS HOMELESS SHELTER HOSPITAL HOUSING/APT JAIL/CORRECTIONAL FACILITY SOBER LIVING ENVIROMENT

PSYCHIATRIC FACILITY WITH FAMILY/ADULT UNKNOWN Current Location:

INSURANCE: CHECK ALL THAT APPLY

MED-ICAL MEDICARE PRIVATE NONE OTHER UNKNOWN

BENEFITS: CHECK ALL THAT APPLY AND INDICATE AMOUNTS

GA RECIPIENT $ V.A. $ SSI $ SSDI $ PENDING ☐ UNKNOWN ☐ OTHER $ NONE ☐

HIGH RISK CONCERNS CHECK ALL THAT APPLY

HISTORY/ACCESS TO WEAPONS HISTORY OF FIRE SETTING REGISTERED SEX OFFENDER

CONSERVATORSHIP YES ☐ NO ☐ IS THERE A PETITION TO END CONSERVATORSHIP? Yes No Unknown

IF YES, PLEASE INCLUDE NAME AND PHONE NUMBER OF THE CONSERVATOR

SUBSTANCE USE ☐ NEVER USED ☐ CURRENTLY USING ☐ PAST USE ☐ UNKNOWN AGE FIRST USED ___________

LIST TYPE (S) OF SUBSTANCE USED & FREQUENCY:

INDIVIDUAL RECEIVED SUBSTANCE USE TREATMENT: ☐ YES ☐ NO IF YES, TREATMENT PROGRAM:

COMPLIANCE WITH MENTAL HEALTH MEDICATION

☐ TAKES MEDS REGULARLY ☐ SOMETIMES TAKES MEDS ☐ NEVER TAKES MEDS ☐ NO MEDICATIONS PRESCRIBED

☐ MEDS MOST OF THE TIME ☐ RARELY TAKES MEDS ☐ REFUSES MEDS ☐ UNKNOWN OTHER:

IS THE INDIVIDUAL CURRENTLY RECEIVING MENTAL HEALTH SERVICES?

☐ YES ☐ NO IF YES, AGENCY: PHONE:

TYPE OF SERVICES PROVIDED:

SACRAMENTO COUNTY

SACRAMENTO COUNTY BEHAVIORAL HEALTH SERVICES
ASSISTED OUTPATIENT TREATMENT (AOT) REFERRAL FORM

Attachment A

Last NAME: **FIRST NAME:** **XREF#** **Avatar#**

	LIST DATES OF INCARCERATION		DESCRIBE REASON FOR INCARCERATION
NO. OF ARRESTS IN THE PAST 36 MONTHS			
NO. OF PSYCH HOSPITALIZATIONS IN THE PAST 36 MONTHS	LIST DATES OF ADMISSION & DISCHARGE		DESCRIBE REASON FOR ADMISSION

	LIST NUMBER & DATE OF OCCURANCE		DESCRIBE THREATS, ACTS OF VIOLENCE, AND ATTEMPTED VIOLENCE
NUMBER OF SERIOUS ACTS, THREATS of, OR ATTEMPTS OF VIOLENCE IN THE LAST 48 MONTHS TOWARDS SELF			
NUMBER OF SERIOUS ACTS, THREATS of, OR ATTEMPTS OF VIOLENCE IN THE LAST 48 MONTHS TOWARDS OTHERS	LIST NUMBER & DATE OF OCCURANCE		DESCRIBE THREATS, ACTS OF VIOLENCE, AND ATTEMPTED VIOLENCE

Attachment A

Please complete the information below in as much detail as possible, if more space is needed, please attach an additional sheet.

Last Name: First Name: XREF# AVATAR #

Describe candidate's **IMMEDIATE RISK & SAFETY CONCERNS** and most concerning behavior that occurred including anger to self and others

Describe how the candidate is **UNLIKELY TO SURVIVE SAFELY IN THE COMMUNITY WITHOUT SUPERVISION AND DETERIORATING (5346(a)(3)(a))**

Describe how the candidate **NEEDS ASSISTED OUTPATIENT TREATMENT TO PREVENT RELAPSE OR DETERIORATION THAT WOULD LIKELY RESULT IN GRAVE DISABILITY OR SELF HARM TO SELF OR OTHERS** (5436(a)(3)(B)

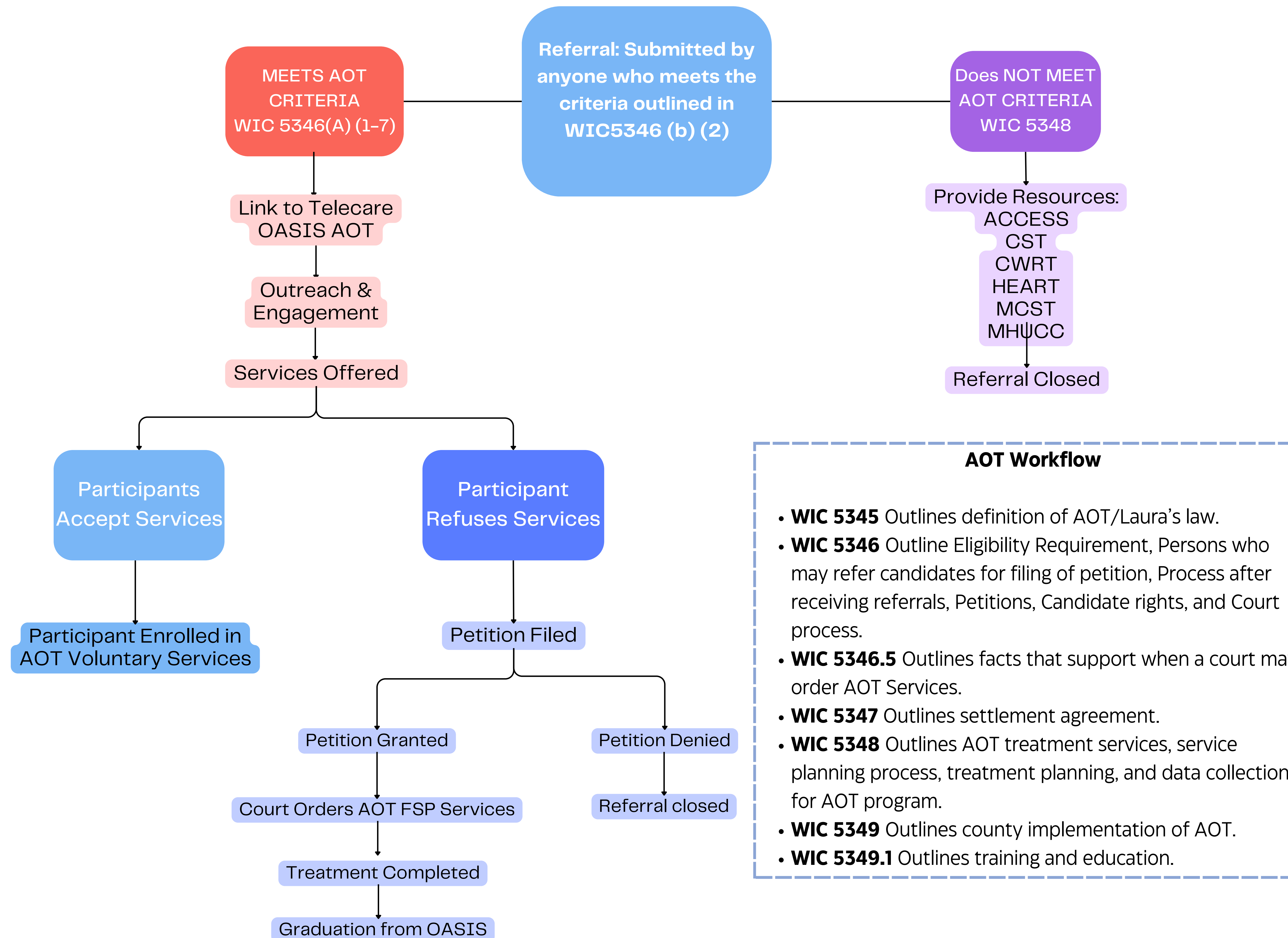
Describe the candidate's **HISTORY OF NON-COMPLIANCE WITH TREATMENT** (has been offered the opportunity to participate in treatment and fails to engage)

For Administrative Use Only	DATE REVIEWED:	ATTEMPTED TO CONTACT REFERRING PARTY ON:	
CANDIDATE MET AOT CRITERIA ☐	CANDIDATE DID NOT MEET AOT CRITERIA ☐	REFERRING PARTY INFORMED DATE:	STAFF NAME:

SACRAMENTO COUNTY

AOT Referral

Attachment B



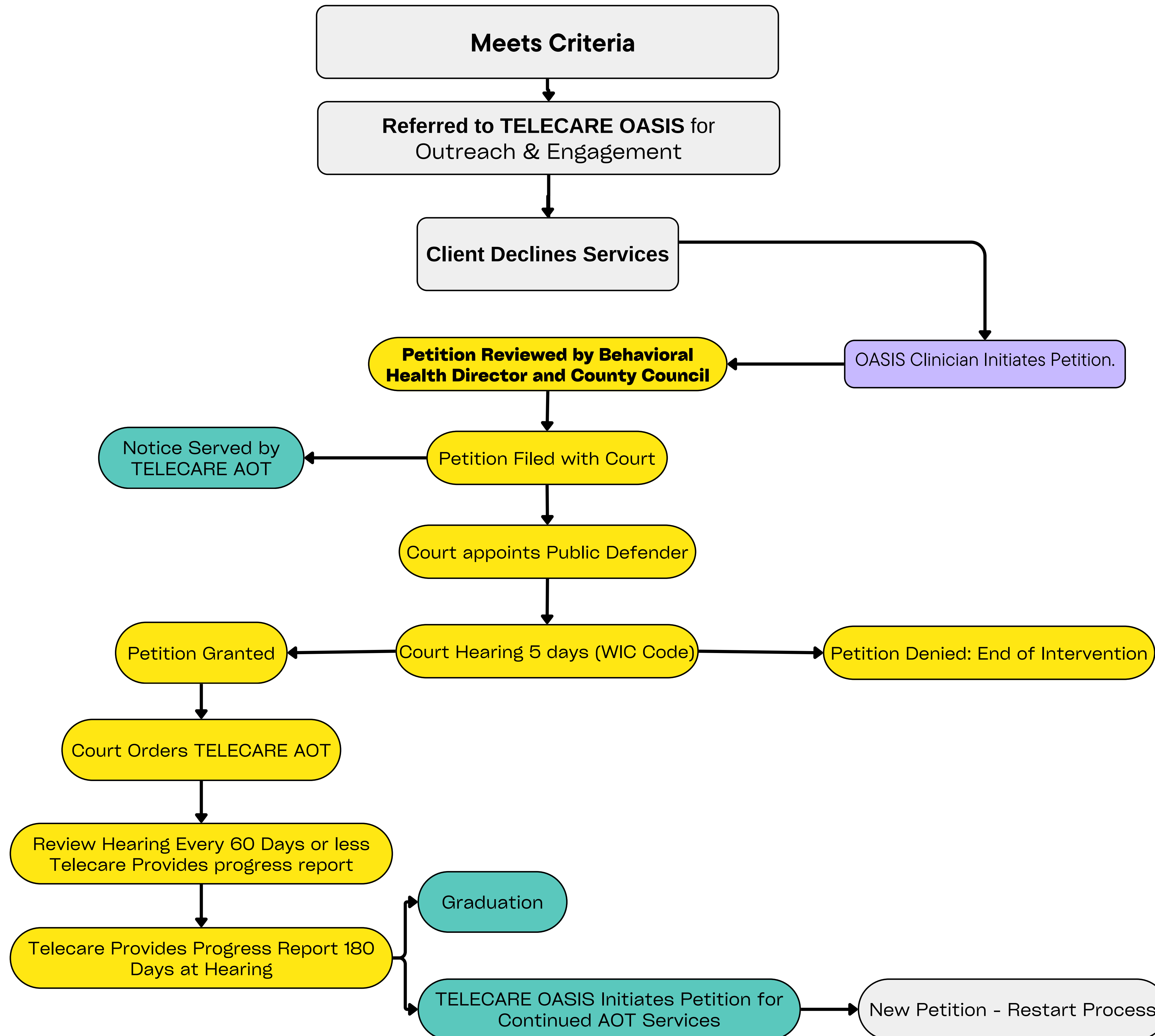
AOT Workflow

- **WIC 5345** Outlines definition of AOT/Laura's law.
- **WIC 5346** Outline Eligibility Requirement, Persons who may refer candidates for filing of petition, Process after receiving referrals, Petitions, Candidate rights, and Court process.
- **WIC 5346.5** Outlines facts that support when a court may order AOT Services.
- **WIC 5347** Outlines settlement agreement.
- **WIC 5348** Outlines AOT treatment services, service planning process, treatment planning, and data collection for AOT program.
- **WIC 5349** Outlines county implementation of AOT.
- **WIC 5349.1** Outlines training and education.

SACRAMENTO COUNTY

AOT Court Process

Attachment C



Attachment D

ASSISTED OUTPATIENT TREATMENT (AOT)
ASSESSMENT CHECKLIST

Client Name:__________________________ **Client DOB:**____________**Date:**________________

AOT Team Member:__________________ **Address of Engagement:**_______________________

AOT CRITERIA
WIC *5346.*

___ (1) The person is 18 years of age or older.

___ (2) The person is suffering from a mental illness as defined in paragraphs (2) and (3) of subdivision (b) of Section 5600.3.

- Schizophrenia
- Post Traumatic Stress Disorder
- Bipolar Disorder
- Schizoaffective Disorder
- Major Depressive Disorder, Recurrent
- Borderline Personality Disorder

___ (3) There has been a clinical determination that, in view of the person's treatment history and current behavior, at least **one** of the following is true:

___ (A) The person is unlikely to survive safely in the community without supervision and the person's condition is substantially deteriorating.

- ***As evidenced by:***

___ (B) The person is in need of assisted outpatient treatment in order to prevent a relapse or **deterioration** that would be likely to result in grave disability or serious harm to the person or to others, as defined in Section 5150.

- ***As evidenced by:***

___ (4) The person has a history of lack of compliance with treatment for the person's mental illness, in that at least **one** of the following is true:

___ (A) The person's mental illness has, at least **twice** within the last 36 months, been a substantial factor in necessitating hospitalization, or receipt of services in a forensic or other mental health unit of a state correctional facility or local correctional facility, not including any period during which the person was hospitalized or incarcerated immediately preceding the filing of the petition.

- ***As evidenced by:***

___ (B) The person's mental illness has resulted in one or more acts of **serious and violent** behavior toward themselves or another, or threats, or attempts to cause serious physical harm to themselves or another within the last 48 months, not including any period in which the person was hospitalized or incarcerated immediately preceding the filing of the petition.

- ***As evidenced by:***

___ (5) The person has been offered an opportunity to participate in a treatment plan by the director of the local mental health department, or the director's designee, provided the treatment plan includes all of the services described in Section 5348, and the person continues to fail to engage in treatment.

- ***As evidenced by:***

___ (6) Participation in the assisted outpatient treatment program would be the least restrictive placement necessary to ensure the person's recovery and stability.

- ***As evidenced by:***

___ (7) It is likely that the person will benefit from assisted outpatient treatment.

- ***As evidenced by:***

NOTE:

1. The AOT Team will continually observe any symptomology and behaviors throughout intense engagement.
2. Intensely engage the client in rapport building to build trust and relationship. The AOT Team should utilize the Peer Support Specialist and skills such Motivational Interviewing to engage with the client.
3. Initiate conversation about anonymous referral, previous mental health treatment, current symptoms and willingness to voluntarily engage in mental health treatment at this time
4. If/when the client agrees to participate in mental health treatment, explain the entire Court process and linkage to service provides to them.
5. If/when the client does not agree to voluntarily engage in mental health treatment, explain the outcomes of that decision.

Attachment E

Name: Member Name

Week of: Monday Date of Current Week.

Enrollment Date: Enrollment Date

Current Residence: Address (Face Sheet)

Address (continued)

Hospitalized on: Date or N/A

Estimated Discharge Date: Date or N/A

Reason: Why were they hospitalized?

Incarcerated on: Date or N/A

Estimated Release Date: Date or N/A

Reason: Why were they incarcerated?

Whereabouts Unknown:

Last Contact: Date of last contact

Type of Contact: Face to Face ☐ Telephone ☐

Next Court Date: Date

Court Order Expiration Date: Date

Current Medications: Declines Medication ☐ **or** Accepting Medication ☐ (List Medications Below):

Meds on Face Sheet

Prescriber: Found on Face Sheet.

Next Appointment Date: Follow up date found in Prescriber Note

F2F Contacts: # of days of F2F contact

Phone Contacts: # of days of phone contacts

Family Contacts: # of days of family contact

Summary: Use titles to describe (i.e. CM, Psychiatrist, NP, LPT, etc.). Do not write in first-person. Who went out this week? Where did the service(s) take place? What happened in those services? How is the member doing? (note issues with housing, rehab/substance use, crises/red flags, successes) What is the follow up plan?/What's next?