

AOT 101

County of Los Angeles

Department of Mental Health

Countywide Engagement Division

Assisted Outpatient Treatment (AOT-LA)

October 14th, 15th and 21st, 2020



Recap of Day 2

- Discussed the 4 outcomes following a petition being filed by DMH
- Discussed the paths and steps that leads to a petition being heard and decided on by the court
- Discussed WIC 5346(d)(3) and WIC 5346(f)
- Discussed reasons to extend and how to request extensions
- Discussed reason to disenroll from AOT and how to request for disenrollment
- Discussed graduation criteria

- Afterhours/Crisis Number

Day 3 Objectives

- Navigating AOT other level of care (ERS)
- Explain AOT specific measurements
- Explain petition 6 month recommendation for termination and extension
- Explain progress report writing
- Demonstrate ability to draft progress report
- Explain declaration writing
- Explain testifying in AOT court



Higher Level of Care



Different Level of Care

Enriched Residential Services facilities

- ERS facilities are designed to provide supportive on-site mental health services with a recovery-based intensive and supportive services in community housing.
 - Licensed facilities
 - Unlocked placement
 - 24/7 capacity for emergencies and specialized programming
 - LMHP, MH Workers, certified drug and alcohol counselors, family and peer support advocates
- The program targets those individuals who require on-site mental health and supportive services to transition to stable community placement and prepare for more independent community living.
 - Must have a primary diagnosis of a serious and persistent mental illness
 - Must not require treatment in a locked setting; must be stable if being discharged from a hospital
 - Must require the intensity of services provide by this level of care
- Some Restrictions
- It is a voluntary program

Conservatorship

- Upon client's hospitalization, provider advocates to the hospital treatment team for evaluation for conservatorship.
- Provide a letter and documentation regarding client's hospitalization history and decompensation.

Referral Process for ERS

1. Consult with AOT FSP Coordinator regarding referring the client to AOT ERS.
2. Provider will need to submit a packet to AOT FSP Coordinator, who will make ERS referral.
3. Email sent by AOT ERS Coordinator to referred ERS agency and existing FSP provider.
4. ERS provider is responsible for consulting with FSP provider and scheduling a time the ERS provider, FSP provider and client can meet for an interview.
5. ERS provider will provide written notification of their acceptance or decline of referral.
6. If accepted arrangements are made for date of admittance and transportation.
7. FSP provider is to continue to provide services to client until the client has physically arrived at ERS and is admitted into the facility.

ERS Referral Packet

- Face sheet
- Medical history and physical (H&P)
- Psychosocial history including the AIA, client treatment plan, medication list and progress notes
- Psychiatric evaluation (with diagnosis)
- PPD or chest x-ray results within the past year
- Minimum of 14 days of Interdisciplinary progress notes
- Minimum of 14 days of Psychiatrist's progress notes
- Forensic history
- Registered sex offender status
- COVID Status (test, screening, temperature checks, medical clearance)
- If hospitalized at time of the referral, documentation will also need to be obtained from the hospital:
 - Medication and administration sheets including PRN sheets
 - Current labs, x-rays and drug screen
 - Restraint and seclusions
 - Hospital progress notes

Questions and Answers



Measures

Outcomes Measures Application (OMA) Overview

- The Outcomes Measures Application (OMA) was developed in response to the Mental Health Services Act.
- Need to be completed for AOT FSP Clients

Client Programs Group

- Group Name= TAY, Adult, Older Adult
- Program Name= “AOT-LA-FSP”

AOT Measures

The following 4 Measures/Survey are **Mandatory** for all enrolled AOT clients.

Monthly Reporting Tool (MRT)

Multnomah Community Ability Scale
(MCSA)

AOT Client Self Report Survey

Clinician-Rated Client Treatment
Goals Measure Survey

- **Monthly Reporting Tool (MRT)**

- Complete monthly.
- Use combined MRT/MCAS PDF form.
- Indicate on form if client has not been seen for the month due to hospitalization, incarcerated, unable to locate; first page still needs to be completed.
- Email survey to AOTLAOE@dmh.lacounty.gov by the first week of the following month.

Example: Completing survey for the month of **May** due in **June**.

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH AOT – LA MONTHLY REPORTING TOOL

MRT is due monthly even if unable to see the client for the month. Complete the top portion of the first page and answer questions from #1-21 that can be answered, e.g client is incarcerated during the entire month answer # 1 and 11; hospitalized answer # 1, 14 and 15.

Program Status:	
Authorized Admit	Court Order
Authorized Graduation	Voluntary Settlement Agreement
Questions/Items	Voluntary Treatment Plan

This reporting tool is designed to provide information for Assisted Outpatient Treatment – Los Angeles clients enrolled in either Full Service Partnership or Enriched Residential Services programs and must be submitted monthly by the end of the first week of the following month through secure email to AOTLAOE@dmh.lacounty.gov. Complete the form with as much information as possible and report on missing information in the table below. Please ensure that all information is accurate and complete prior to submission.

Reporting Month and Year: Jan 2018

Agency Name:

Client Name: John Doe

Program Status: Court Order

Authorized Admit Date:

Authorized Graduation/Discharge Date:

Questions/Items	Select a Drop-down Option	Total #
1. What was the client's housing status?		
2. Total number of appointments* scheduled for client:	Total appt Scheduled = Canceled + Kept + Missed	6
3. Total number of canceled appointments:	Appt Canceled are appointments that have been scheduled and the cit calls to cancel or you cancel for any reason	2
4. Total number of appointments client kept:	Appt Kept are appointments that have been scheduled and the cit shows up	2
5. Total number of appointments client missed:	Appt Missed are appointments that have been scheduled and the cit doesn't call to cancel and is a no show	2
6. Is the client currently adherent to medications?		
7. While receiving services with your agency, did client require a settlement agreement or court order due to noncompliance with the voluntary treatment plan?		
8. While under a settlement agreement was the client compliant with the terms of the settlement agreement?		
9. While under a court order did the client comply with the terms of the court order?		
10. Did the client have contact with law enforcement?		
11. Was the client incarcerated? If so, how many days during the month?		

12. Did client engage in employment services programs?		
13. Was the client able to gain employment?		
14. Was the client hospitalized for psychiatric reasons? If so, how many days during the month?		
15. Was the client hospitalized for medical reasons? If so, how many days during the month?		
16. Did the client express suicidal ideation? If so, how often?		
17. Did the client attempt suicide? If so, how often?		
18. Did the client express homicidal ideation? If so, how often?		
19. Was the client victimized**? If so, how often?		
20. Did the client demonstrate violent behavior (physically aggressive behaviors)? If so, how often?		
21. Provide the total MCAS-R score (Include MCAS-R form).		0

Missing Data Fields	
Missing Item #	Reason

Type # corresponding to the missing item

Provide a reason to why you were unable to complete the missing item. e.g client UTL, incarcerated, hospitalized...etc.

*An appointment is a planned field or clinic visit where the client is expected to meet with a treatment team member.

Complete Missing Data Fields when you are unable to complete the form to its entirety for any reason.

- **Multnomah Community Ability Scale (MCAS)**
 - Complete monthly.
 - Use combined MRT and MCAST form.
 - Based on client's current functioning at the time of completion.
 - Goal to see change in client's functioning throughout time in treatment.
 - Email survey to AOTLAOE@dmh.lacounty.gov by the first week of the following month.

Example: Completing survey for the month of **May** due in **June**.

MULTNOMAH COMMUNITY ABILITY SCALE (REVISED)

Monthly Status:

Name ID# Ethnicity Gender Age
 Program Rater

INSTRUCTIONS: This scale measures the symptoms and functional abilities of people who have severe and persistent mental illness. To complete, the primary clinician should circle the appropriate number for each question that corresponds to the person's functioning during the past month. Please rate the person's actual functioning, given current medications, services and supports. Rate recent behavior, not potential behavior.

- Admit
- Tx Planning
- Graduated AOT
- Completed MIST
- D/C HLOC
- Discharged
- Lateral Discharge

- First MCAS completed following clients admission
- During the course of treatment following the 1st submission
- Final MCAS, if client is discharging from AOT due to graduating
- Final MCAS, if client is discharging to a higher level of care (ERS/ conserved)
- Final MCAS, if client is discharging for any other reason than graduating.

Section 1 HEALTH	This section pertains to those physical, mental, and emotional symptoms that may interfere with overall health and functioning. Over the past 30 days:
<p>1-PHYSICAL HEALTH: Has the person experienced limitations due to physical health problems? NOTE: Limitations may be from chronic health problems and/or frequency and severity of acute illnesses.</p> <p>1. Extreme health limitations 3. Moderate health limitations 5. No limitations 2. Marked health limitations 4. Slight health limitations</p>	
<p>2-COGNITIVE FUNCTIONING: Did the person have cognitive impairments due to mental retardation, developmental disability, dementia, head injury, or other brain damage? NOTE: Impaired cognitive functioning may be due to a variety of factors and should be distinguished from limitations due to mental illness.</p> <p>1. Extremely impaired cognitive functioning 3. Moderately impaired cognitive functioning 5. No impairments or does not apply 2. Markedly impaired cognitive functioning 4. Slightly impaired cognitive functioning</p>	
<p>3-THOUGHT PROCESSES: Did the person have impaired thought processes as shown by symptoms such as hallucinations, delusions, tangentiality, loose associations, response latencies, ambivalence, or incoherence?</p> <p>1. Extremely impaired thought processes 3. Moderately impaired thought processes 5. No impairments 2. Markedly impaired thought processes 4. Slightly impaired thought processes</p>	
<p>4-MOOD: Did the person have impairments in the range, level, or appropriateness of mood as evidenced by symptoms such as pronounced mood swings, depression, rage, mania, or incongruence?</p> <p>1. Extremely impaired mood 3. Moderately impaired mood 5. No impairments 2. Markedly impaired mood 4. Slightly impaired mood</p>	
<p>5-RESPONSE TO STRESS: Was the person's response to stress impaired? NOTE: Consider pronounced responses to stress; or no response to events that should be of concern; or symptoms such as agitation, perseveration, extreme anxiety, inability to problem-solve, etc.</p> <p>1. Extremely impaired response 3. Moderately impaired response 5. No impairments 2. Markedly impaired response 4. Slightly impaired response</p>	
SUMMED SCORE FOR SECTION ONE	
0	

Section 2 ADAPTATION	This section pertains to the person's functioning in daily life and how he/she has adapted to living with mental illness. Over the past 30 days:
<p>6-ABILITY TO MANAGE MONEY: How often was the person successful in managing money and controlling expenditures? NOTE: rate from 1 to 3 if someone else managed the person's money.</p> <p>1. Never or almost never managed money successfully 3. Sometimes managed money successfully 5. Almost always or always managed money successfully 2. Seldom managed money successfully 4. Often managed money successfully</p>	
<p>7-INDEPENDENCE IN DAILY LIVING: How often did the person independently perform activities of daily living? Examples include maintaining personal hygiene, meeting daily nutrition needs, cleaning personal living space, and managing daily tasks. NOTE: Rate from 1 to 3 if the person's living situation provided meals and cleaning services.</p> <p>1. Never or almost never performed independently 3. Sometimes performed independently 5. Almost always or always performed independently 2. Seldom performed independently 4. Often performed independently</p>	
<p>8-ACCEPTANCE OF DISABILITY: How much of the time was the person able to accept (as opposed to deny) his/her psychiatric disability?</p> <p>1. Never or almost never accepts accepted disability 3. Sometimes accepts accepted disability 5. Almost always or always accepts accepted disability 2. Seldom accepts accepted disability 4. Often accepts accepted disability</p>	
SUMMED SCORE FOR SECTION TWO	
0	

Section 3 SOCIAL SKILLS	This section pertains to the ability of the person to engage in interpersonal relationships and meaningful activity. Over the past 30 days:
<p>9-SOCIAL ACCEPTABILITY: How did people in the general community react to the person?</p> <p>1. Very negative reactions 3. Mixed reactions 5. Very positive reactions 2. Fairly negative reactions 4. Fairly positive reactions</p>	
<p>10-SOCIAL INTEREST: How often did the person initiate social interaction or respond to others' initiation of social interaction? NOTE: Do not consider the quality of the interaction, only the frequency.</p> <p>1. Never or almost never initiated or responded 3. Sometimes initiated or responded 5. Almost always or always initiated or responded 2. Seldom initiated or responded 4. Often initiated or responded</p>	
<p>11-SOCIAL EFFECTIVENESS: How effectively did the person interact with others? NOTE: 'Effectively' refers to how successfully and appropriately the person behaved in social settings, i.e., how well he/she minimized interpersonal friction, met personal needs, and achieved interpersonal goals in a socially acceptable manner.</p> <p>1. Very ineffectively interacted 3. Mixed effectiveness of interaction 5. Very effectively interacted 2. Ineffectively interacted 4. Effectively interacted</p>	
<p>12-SOCIAL NETWORK: How extensive was the person's social network? A social network may consist of interested family, friends, acquaintances, professionals, co-workers, etc. NOTE: Rate the size of the network, not the social acceptability.</p> <p>1. Very limited network 3. Moderately extensive network 5. Very extensive network 2. Limited network 4. Extensive network</p>	
<p>13-MEANINGFUL ACTIVITY: How often was the person involved in meaningful activities that were satisfying to him or her? NOTE: Meaningful activities may include hobbies, taking a class, going to movies as well as volunteer work or paid employment.</p> <p>1. Never or almost never involved 3. Sometimes involved 5. Almost always or always involved 2. Seldom involved 4. Often involved</p>	
SUMMED SCORE FOR SECTION THREE	
0	

Section 4 BEHAVIOR	This section pertains to those behaviors that are identified with successful community integration and with treatment outcomes. Over the past 30 days:
<p>14-MEDICATION ADHERENCE: How often did the person adhere to his/her prescribed medication regimen? NOTE: Rate from 1 to 3 if someone else managed the person's medications.</p> <p>1. Never or almost never adhered 3. Sometimes adhered 5. Almost always or always adhered or medications not prescribed 2. Seldom adhered 4. Often adhered</p>	
<p>15-ENGAGEMENT WITH TREATMENT: How often did the person participate in the treatment process? Examples include keeping appointments, following treatment plans, and completing negotiated tasks.</p> <p>1. Never or almost never participated 3. Sometimes participated 5. Almost always or always participated 2. Seldom participated 4. Often participated</p>	
<p>16-ALCOHOL/DRUG ABUSE: How often did the person abuse drugs and/or alcohol? NOTE: "Abuse" means use to an extent that interferes with functioning.</p> <p>1. Always or almost always abused 3. Sometimes abused 5. Almost never abused or did not use 2. Often abused 4. Seldom abused</p>	
<p>17-IMPULSE CONTROL: How often did the person have episodes of loss of control? NOTE: Examples include anger outbursts, aggressive actions, suicidal behavior, inappropriate sexual behavior, reckless or bizarre actions, etc.</p> <p>1. Very frequently lost control or severe episode 3. Sometimes lost control 5. Almost never or never lost control 2. Often lost control 4. Seldom lost control</p>	
SUMMED SCORE FOR SECTION FOUR	
0	

TOTAL SCORE	Combined sum section scores.	0
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▪ **Client Self-Report Survey**

- To be completed by the client (staff can assist client in completing).
- Have in 12 languages: English, Arabic, Armenian, Cambodian, Cantonese, Farsi, Korean, Mandarin, Russian, Spanish, Tagalog, Vietnamese.
- At 3 months intervals.
 - 3 months post admission
 - 6 months post admission
 - 9 months post admission (if extended)
 - 12 months post admission (if extended)
- Complete surveys as close as reasonable to the specific timing.
- If a survey is early or late, still do the next survey at the scheduled time.
- If you rarely see a client, it may make sense to do a survey early when you do see them.
- Email survey to AOTLAOE@dmh.lacounty.gov by the first week of the following month.

Example: Completing survey for the month of **May** due in **June**.

Available in 12 languages: Arabic, Armenian, Cambodian, Cantonese, English, Farsi, Korean, Mandarin, Russian, Spanish, Tagalog, Vietnamese

SECTION 1. TO BE COMPLETED BY CLINIC STAFF AFTER THE CLIENT COMPLETES THE SURVEY.

INSTRUCTIONS FOR STAFF:

- (1) This survey is to be completed by the client every 3 months after beginning treatment. Please try to complete surveys as close as reasonable to the timing below. If one survey is early or late, still try to do the next survey according to the correct timing based on admission date. If you almost never see a client, it may make sense to do the survey early when you do happen to see them.
- 3 months after admission
 - 6 months after admission
 - 9 months after admission (if renewed)
 - 12 months after admission (if renewed)
- (2) If possible, please have a staff member other than the client's primary service provider administer the survey to the client. Indicate in the field above whether the assisting staff member was:
- (a) One of the client's primary providers
 - (b) Another provider who works with the client
 - (c) A provider who never works with the client
 - (d) An administrative staff person
 - (e) DMH evaluation volunteer
- (3) This survey is being used to help evaluate and improve the AOT-LA program. The client's responses are intended for the AOT evaluation team, **NOT** for the clinic in which the client is being treated.
- (4) For assistance, call the AOT evaluation team at [310-794-1277](tel:310-794-1277) or email aot.evaluation@ucla.edu.

Date Survey Completed by Client	
Authorized Admit Date	
Intended Survey Month (3, 6, 9, or 12)	[Select Target Date for This Survey]
Agency Name	[Select Agency Name]
Client Name	
Language in which survey completed	[Select Language]
Did staff read questions to the client?	[Select Yes or No]
Did staff record responses for the client?	[Select Yes or No]
Role of staff member assisting with survey (see options under instruction (2) above)	[Select Role]
Reason Not Completed (if applicable)	

AOT Client Self-Report, completed every 3 months after starting treatment

SECTION 2. TO BE COMPLETED BY CLIENT. IF NEEDED, STAFF CAN READ TO CLIENT AND RECORD RESPONSES.

A. Please mark YES or NO for each of the following statements.

	YES	NO
1. I feel better than I did before AOT.	[Select Response]	[Select Response]
2. I feel more calm than I did before AOT.	[Select Response]	[Select Response]
3. I feel more respected than I did before AOT.	[Select Response]	[Select Response]
4. I feel more informed than I did before AOT.	[Select Response]	[Select Response]
5. I feel more hopeful than I did before AOT.	[Select Response]	[Select Response]
6. I feel worse than I did before AOT.	[Select Response]	[Select Response]
7. I feel more upset than I did before AOT.	[Select Response]	[Select Response]
8. I feel more disrespected than I did before AOT.	[Select Response]	[Select Response]
9. I feel more confused than I did before AOT.	[Select Response]	[Select Response]
10. I feel less hopeful than I did before AOT.	[Select Response]	[Select Response]
11. I feel free to do what I want about receiving mental health services.	[Select Response]	[Select Response]
12. I am choosing to receive mental health services.	[Select Response]	[Select Response]
13. It's my idea to receive mental health services.	[Select Response]	[Select Response]
14. I have a lot of control over whether I will receive mental health services.	[Select Response]	[Select Response]
15. I have more influence than anyone else on whether I will receive mental health services.	[Select Response]	[Select Response]

* If client refuses to answer the questions, complete the first page entirely and indicate the client refused to answer the questions with any additional information regarding the refusal.

AOT Client Self-Report, completed every 3 months after starting treatment

ENGLISH

B. When answering the following questions, please think about your main service provider at this agency – the person who spends the most time with you on your treatment or service goals. Please mark the choice that best describe your feelings:

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
16. My service provider and I agree about the things I will need to do in order to improve my situation.		[Select Response]			
17. What I am doing with my service provider gives me new ways of looking at my problems.		[Select Response]			
18. I believe my service provider likes me.		[Select Response]			
19. My service provider does not understand what I am trying to accomplish in treatment.		[Select Response]			
20. I am confident in my service provider's ability to help me.		[Select Response]			
21. My service provider and I are working toward mutually agreed upon goals.		[Select Response]			
22. I feel that my service provider appreciates me.		[Select Response]			
23. My service providers and I agree on what is important for me to work on.		[Select Response]			
24. My service providers and I trust one another.		[Select Response]			
25. My service provider and I have different ideas of what my problems are.		[Select Response]			
26. My service provider and I have established a good understanding of the kind of changes that would be good for me.		[Select Response]			
27. I believe the way my service provider and I are working with my problem is correct.		[Select Response]			

AOT Client Self-Report, completed every 3 months after starting treatment

C. Please tell us about any experiences you had in the hospital, in the emergency room, or with police:

- Since you started treatment in the AOT FSP or ERS (if this is your first time filling out this survey),

OR:

- Since the last time you filled out this survey (if you've filled it out before)

	YES	NO
28. During this time, have you been hospitalized or gone to the emergency room?	[Select Respons	
<u>If you were hospitalized or went to the emergency room...</u>		
a) Did hospital or ER staff give you psychiatric medication against your will?	[Select Respons	
b) Did hospital or ER staff hold you or pin you down (only with their hands)?	[Select Respons	
c) Did hospital or ER staff put you in restraints (tie your hands or legs down)?	[Select Respons	
d) Were you put into seclusion (locked in a room for a long period of time)?	[Select Respons	
29. During this time, have you had any encounters with the police?	[Select Respons	
<u>If you had encounters with the police...</u>		
a) Did an officer give you a ticket or a fine (such as for loitering, jaywalking)?	[Select Respons	
b) Were you arrested?	[Select Respons	
c) Did an officer restrain you physically?	[Select Respons	

- **Clinician-Rated Client Treatment Goals Measure**

- Completed by the client's treatment staff.
- At 6 months intervals
 - 6 months (around the time of graduation or extension)
 - 12 months (around the time of graduation or extension)
 - Or at discharge if discharged early.
- Email survey to AOTLAOE@dmh.lacounty.gov by the first week of the following month.

Example: Completing survey for the month of **May** due in **June**.

Clinician-Rated Client Treatment Goals Measure; to be completed every 6 months

INSTRUCTIONS FOR STAFF:

(1) This survey is to be completed by the client's treatment staff every 6 months after beginning treatment. If a client is discharged prior to 6 months or 12 months, do the survey at time of discharge. Please try to complete surveys as close as reasonable to the timing below:

- (a) Discharge prior to 6 months (if discharged prior to AOT end)
- (b) 6 months after admission (around graduation or renewal point)
- (c) Discharge prior to 12 months (if renewed and discharged prior to AOT renewal end)
- (d) 12 months after admission (if renewed; around graduation from extended AOT)

(2) For assistance, call the AOT evaluation team at 310-794-1277 or email aot.evaluation@ucla.edu.

Section A. Survey Information.

Date Survey Completed	
Authorized Admit Date	
Date of Previous Survey (if applicable)	
Date of Discharge (if applicable)	
Survey Timing (a, b, c, d; see instructions)	[Select Survey Timing]
Agency Name	[Select Agency Name]
Client Name	

Section B. Family Involvement in Treatment Planning.

1. 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)	<input type="checkbox"/> Met with family member <input type="checkbox"/> Met with non-family support person <input type="checkbox"/> Client refuses family involvement <input type="checkbox"/> Family not open to being involved <input type="checkbox"/> Client has no contact with family
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Section C. Frequency of Medication Management.

2. Did the treatment plan specify that the client should see a psychiatrist or other prescribing clinician? (Yes/No)	[Select yes or no]
3. If yes, based on the treatment plan, how many times* should the client have seen the psychiatrist or other prescribing clinician?	
4. How many times* did the client actually see the psychiatrist or other prescribing clinician?	
5. Enter any comments.	

* Either *since admission* (if 1st survey) or *since the previous survey* (if not the 1st survey).

Clinician-Rated Client Treatment Goals Measure; to be completed every 6 months

Section D. Treatment Goals Progress.

(1) List each goal from the client's treatment plan; (2) Indicate date the goal was created; (3) Indicate whether it is a long-term or short-term goal; and (4) Rate the client's level of improvement or progress toward each goal since the goal was added to the treatment plan using the improvement scale below:

- | | |
|--|--|
| 1. Worsened/deteriorated | 5. Moderate improvement or progress |
| 2. No change; not engaged in working on goal | 6. Substantial improvement or progress |
| 3. Displays some willingness to work on goal | 7. Goal completely met |
| 4. Minor improvement or progress | |

Goal	Date Goal Created	Long or Short	Improvement Since Goal Created
		[Select]	[Rate improvement since goal created]
		[Select]	[Rate improvement since goal created]
		[Select]	[Rate improvement since goal created]
		[Select]	[Rate improvement since goal created]
		[Select]	[Rate improvement since goal created]
		[Select]	[Rate improvement since goal created]



Progress Report Writing



ASSISTED OUTPATIENT TREATMENT PROGRESS REPORT

The Honorable Lisa R. Jaskol
Superior Court of Los Angeles
Department 103
5925 Hollywood Blvd
Los Angeles, CA 90028

Written notification of significant changes or noncompliance is to be sent promptly to the AOT Coordinators and Counsel

NAME:	20HWMHXXXXXX, can be found on minute orders
DOB:	
DATE:	
CASE NO:	
Petition Granted Date:	Date of initial minute order granting the petition
Petition Termination Date:	

Treating AOT Agency	
Agency Name:	Enrollment Date:
Clinician Name:	Case Manager Name:
Clinician Telephone Number:	Psychiatrist/Nurse Practitioner Name:

CURRENT PLACEMENT:

- Home Sober Living/B&C ERS Substance Residential/ Hospital CRTP Jail Homeless
Other Residential

Place of Residence (Address):

This progress report is to update you on (Client's Name) progress with mental health services since his last hearing on (date). (Client's Name) was scheduled for individual therapy on (dates) in which he attended (2 of the 4) appointments. (Reason for the missed appointments.) His next scheduled appointment is (date). (Include any details about client's compliance or lack of compliance with therapeutic services). (Client's Name) was also programmed for case management appointments on (dates) and he attended all appointments. (Include any details about client's compliance or lack of compliance with case management needs; indicate the CM needs being addressed as of last hearing). (Client's Name) meet with his assigned psychiatrist on (date) and was provided a prescription of (medication names and dosage). He is next scheduled to see the psychiatrist/NP on (date). (Include any details about client's compliance or lack of compliance with medication support and appointments).

(Provide information about the client's progress towards treatment goals; changes in behavior and symptoms; contact with law enforcement, arrest, crisis response, hospitalizations, eviction notifications and placement changes since the last hearing.)

Provide any other information you want the court team and Judge to be aware of. If you would like the Judge to praise or address any particular concerns, please provide the details and request.

Clinician Name, Title
Signature
Date

- Needs to be completed for all AOT court ordered client (sustained/VSA)
- Due on Wednesday at Noon to the AOT FSP Coordinator the week the client is due in court
- Needs to be submitted each time the client is scheduled for a progress report hearing
- Needs to be submitted with the most up to date information (should be completed the same week of court)
- Information provided should be since the client's last progress hearing,
- hospitalization, incarcerations, AWOLS/AMA from placement needs to be reported following the occurrence, email AOT FSP Coordinator

Is identified on initial minute order granting the petition, if unsure of date ask AOT FSP Coordinator

ASSISTED OUTPATIENT TREATMENT
PROGRESS REPORT

The Honorable Lisa R. Jaskol
Superior Court of Los Angeles
Department 103
5925 Hollywood Blvd
Los Angeles, CA 90028

Written notification of significant changes or noncompliance is to be sent promptly to the AOT Coordinators and Counsel

NAME: Jane Doe
DOB: 5/10/1987
DATE: 9/16/2020
CASE NO: 20HWMH10083
Petition Granted Date: 05/29/2020
Petition Termination Date: 11/20/2020

Jane experiences difficulties managing stressors and triggers, evidenced by verbal aggression and displacement of blame for her behaviors. Jane continues to visit Skid Row and minimizes the impact of current health crisis (Covid-19), reporting thoughts that it is a “hoax”, and declining to utilize safety measures to mitigate risks to herself, staff and the community. It would be helpful for Jane to continue to meet with Star View psychiatry for medication updates and support to monitor psychiatric services.

John Tate
John Tate, LCSW
9/16/2020

Treating AOT Agency	
Agency Name: Star View Community Services	Enrollment Date: 6/3/2020
Clinician Name: John Tate	Case Manager Name: Jane Atkins
Clinician Telephone Number: 888-888-8888	Psychiatrist/Nurse Practitioner Name: Dr. Boyd

CURRENT PLACEMENT:

- Home Sober Living/B&C ERS Substance Residential/ Hospital CRTP Jail Homeless
Other Residential

Place of Residence (Address): Help is on the Way-5821 West Blvd, Los Angeles, Ca 90036

This progress report is to update all parties with respect to Jane Doe's progress with mental health services since his/her last hearing on 9/4/20. Jane Doe was scheduled for individual therapy on 9/8/2020 and 9/15/2020 in which she attended (2) of the (2) appointments. Her next scheduled appointment is: 9/23/20. There are no concerns with engagement and participation since last court hearing. Jane Doe was also scheduled for case management appointments on 9/11/20, 9/15/20, and 9/16/20 and she attended all appointments. Jane has experienced some ambivalence toward following through with tasks to access case management in needs in the areas of SSI and housing. However, according to support counselor, this week, Jane has been more receptive and engaged in case management services. Jane meet with her assigned psychiatrist on 9/2/20 and was provided a prescription of Zoloft 25mg. She is next scheduled to see the psychiatrist on 10/7/20. Jane reported being interested in working with her community psychiatrist through Wesley Health Center and reported a scheduled appointment on 9/13/20. However, during her session on 9/16/20, she reported that she has decided to continue her psychiatric services at Star View Community Services with Dr. Boyd.

Jane made progress toward her treatment objectives and was noticeably calmer and approachable stating her family visited her during Labor Day. Jane experienced difficulties managing stressors and reflecting on past experiences, being triggered when discussing housing history and previous eviction. She continues to display a pattern of verbal aggression and displacement of blame onto previous housing staff for her current situation and presents with limited accountability for behaviors; which present current barriers for treatment progress. Jane made progress by working with support counselor (case manager) to address issues related to housing and her CES assessment. She expressed interest and actively participated in following up with SSI application and has been more cooperative in accessing community resources with the treatment team. Jane was more cooperative with treatment team and participating in treatment sessions since last court hearing.

Case Study and Break out Session



Petition Extension



Petitions

- Petitions Granted via VSA or petition sustained
- Petition, is not to exceed 180 days
 - If it has been determined that the condition of the client requires further AOT, the provider can submit a declaration to the court, prior to the expiration of the period of the initial AOT order, for an order authorizing continued AOT for a period not to exceed 180 days from the date of the order. (Petition Extension)
 - No limit as long as criteria remains (Day 1)
- Petition Extension-the extension of Court jurisdiction for another 180 days
- Request to extend court jurisdiction, is based on clinical teams recommendation
 - Provider will need to complete documentation for filing with court and possibly testify in court
- 6 Month Court Termination date- Court appointed, should always be a Friday

Approaching Court 6 Month Termination Date

- At 5 months the AOT FSP Coordinator will email providers informing that the client's 6 month court Termination is approaching and request for providers recommendations.
- Providers are requested to provide a response in a timely manner so preparation can begin if a declaration is needed.
- Providers requesting extension, are asked to update the last existing declarations: diagnosis, symptoms, hospitalizations/incarcerations, deterioration.
 - Can start from scratch
- Two weeks prior to court Termination Date extension declaration is due.

Planning for 6 Month Court Termination Date

Request for Court jurisdiction to be extended for another 6 months

- hospitalization
- police contact due to MI
- threats or acts of violence to self or other
- deterioration
- no insight into mental health
- it is believed that the client will discontinue all mental health services upon court termination

Request for Court to terminate jurisdiction and client remains in AOT FSP voluntarily

- no deterioration over the last 6 months,
- but there is justifiable reason that it is believed that the client should remain in AOT services

Request for Court to terminate jurisdiction and client is stepped down in level of care

- No deterioration
- no hospitalizations
- No police contact
- No threats or acts of violence to self or others
- client is/has been working on and meeting some if not all treatment goals
- and is willing to step down in services

Extension Declaration

Provider is to identify a
affiant for the extension
declaration

- Licensed MH provider
- Has meet/evaluated the client
- Understands and knows the case
- Available and willing to testify in court

Affiant updates the last
written declaration

- Submits a finalized version to the AOT FSP Coordinator for review and corrections
- Finalized version to be submitted two weeks prior to termination date

Submission of
documents

- One week prior to termination date provider is to email all clinical progress notes to CC, PD and AOT FSP Coordinator
- Affiant emails CC, CV/Resume

Court Date

- Affiant and client to appear in court
- Affiant to bring a hard copy of clinical progress notes to court
 - Client signs VSA or
 - Hearing occurs, affiant testifies or
 - If client is not present, current petition terminates and a hearing for new petition can be heard in absentee or continued



Declaration Writing

Important Notes

The writer of the declaration needs to meet the following criteria:

- A licensed mental health provider
- Needs to have met and assessed the client; and have a understanding of the client's case
- Needs to be available to attend court on the date in which the current petition terminates
- Needs to be willing to testify in court at the client's extension hearing if the client contests the petition

Important Notes:

- Writer has the choice of utilizing the original declaration and updating current information or starting from scratch
- It is critical that the declaration is submitted two weeks prior to current petition termination date to ensure time for any corrections and to allow for processing and filing time with DMH, County Counsel and the Court
- Extension hearing is a set date that can not be changed, writer needs to be available
- Submit the declaration 2 weeks prior to the client's court termination date to the AOT FSP Coordinator

Ensure that these two lines appear as is

#4: has two options: 1) "No more than 10 days prior to submission of the petition, I personally examined the Candidate and herein state the facts and reason why I believe the Candidate meets the criteria for Assisted Outpatient Treatment per WIC 5346(a)." or 2) "Within 10 days of the filing of this petition, I made appropriate attempts to elicit the cooperation of the Candidate, but have not be successful in persuading Candidate to submit to an examination. However, I have reason to believe that the Candidate meets the criteria for Assisted Outpatient treatment and I am willing and able to examine the Candidate and Testify at the hearing on this petition."

1 MARY C. WICKHAM, County Counsel
2 EDWARD MORRISSEY, Acting Assistant County Counsel
3 CRAIG KIRKWOOD, JR., Senior Associate County Counsel (SBN: 260018)
4 500 West Temple Avenue, 6th Floor
5 Los Angeles, California 90012
6 Telephone: (213) 974-1751, Fax: (213) 680-2165
7 Attorneys for Department of Mental Health

8 SUPERIOR COURT OF THE STATE OF CALIFORNIA
9 FOR THE COUNTY OF LOS ANGELES, MENTAL HEALTH

10 In the Matter of

11 Jane Doe

12 AOT Candidate.

CASE NO.: 20HWMHXXXXXX

CONFIDENTIAL AFFIDAVIT OF
MONIQUE PADILLA, LMFT, LICENSED
MENTAL HEALTH TREATMENT
PROVIDER IN SUPPORT OF COURT
ORDER FOR ASSISTED OUTPATIENT
TREATMENT
(WIC §5346(b)(5)(B))

DATE: [Redacted]
DEPT.: 103
TIME: 1:30 p.m.

17 I, Monique Padilla, LMFT, declare as follows:

- 18 1. I have personal knowledge of the facts set forth herein, except as to those stated on
19 information and belief and, as to those, I am informed and believe them to be true. If called as a
20 witness, I could and would competently testify to the matters stated herein.
- 21 2. I am a licensed mental health treatment provider in the State of California.
- 22 3. I am currently employed by the County of Los Angeles Department of Mental
23 Health.
- 24 4. No more than 10 days prior to submission of the petition, I personally examined the
25 Candidate and herein state the facts and reasons why I believe the Candidate meets the criteria for
26 Assisted Outpatient Treatment per WIC 5346(a).
- 27 5. Based on a review of Candidate's history and reported symptoms in medical

20HWMHXXXXXX case number

Writer's name and license

Leave court date blank

Writer's full name and license

Writer's employers name

Writer's name and license

#5: Add any additional symptoms that client has presented with over the past 5 to 6 months

#7: Delete any hospitalization outside of 36 months from the existing paragraph -Add any new hospitalizations or jail mental health episodes -Add any new acts or threats of violence towards self or others

Update to current Diagnosis

#6: Add any additional safety concerns and update any information to pertain to the current time frame

1 records, reports from the outreach and engagement team, and interview(s) with her family, I
2 believe Candidate meets the diagnostic criteria for **Schizoaffective Disorder**, a serious mental
3 disorder, as set forth in Welfare and Institutions Code section 5600.3, subdivision (b)(2) and (3).
4 Candidate's symptoms include: Hallucinations (observed on numerous occasions
5 talking/smiling/screaming to self): Disorganized Thinking/Speech/Behavior (yelling, pounding on
6 walls, slamming doors, wandering neighborhood trying to open car doors, inability to reasonably
7 plan for her own self-care and safety) Severely impaired insight (plans to go to Aunt's home, but
8 doesn't know where Aunt lives) Difficulty accomplishing activities of daily living, isolative
9 behavior: Manic Episodes (periods of expansive mood, severe agitation with accompanying
10 property destruction and assaultive behavior towards others). (ADD ADDITIONAL
11 SYMPTOMS TO THE ABOVE PARAGRAPH)
12 6. Based on a review of Candidate's history and reported symptoms, I believe
13 Candidate is unlikely to survive safely in the community without supervision because, in addition
14 to the aforementioned facts, she is hardly able to successfully accomplish activities of daily living,
15 she engages in behavior that is likely to result in additional episodes of detention by law
16 enforcement and/or psychiatric hospitalization, she continues to show evidence of poor insight and
17 unrealistic plans for release. Client is eating less and lost 9 lbs. in the past month. Candidate
18 states that she plans to get her own place or go to her Aunt's home, but doesn't know where her
19 Aunt lives. (ADD ANY ADDITIONAL SAFETY CONCERNS TO THE ABOVE
20 PARAGRAPH)
21 7. Based on information provided by the referring party and a review of Candidate's
22 available history, I am informed and believe that Candidate had involuntary psychiatric
23 hospitalizations on August 21, 2015 and September 18, 2015. One of these hospitalizations was
24 due to kicking and biting her mother. On at least two other occasions (May 29, 2015 and
25 September 12, 2015), Candidate required assessment by the Los Angeles County Department of
26 Mental Health Psychiatric Mobile Response Team, although she did not meet criteria for
27 involuntary hospitalization on those dates. (ADD ANY NEW HOSPITALIZATIONS/JAIL MAIL
28 **HEALTH. DELETE ANY DATES BEYOND 36 MONTHS OR IF THERE ARE NO**

1 HOSPITALIZATIONS, DOCUMENT ANY NEW THREATS OF VIOLVEN TOWARD SELF
2 OR OTHERS)

3 8. Department of Mental Health, Assisted Outpatient Treatment, Outreach and
4 Engagement team, made efforts to engage Candidate and offered Candidate an opportunity to
5 participate in a treatment plan. She was contacted via visits to her board and care facility most
6 recently on the following dates: September 22, September 27, and October 4, 2016. Candidate was
7 offered an opportunity to participate in a treatment plan on October 4, 2016, but declined.
8 Candidate was mandated into treatment on (date) and assigned for treatment with (agency name).
9 Since being mandated into treatment, Candidate has been seen on a (weekly/bi-weekly) basis for
10 mental health treatment consisting of individual therapy and meeting with psychiatrist on a
11 (monthly/bi-weekly) basis. (INCLUDE INFORMATION REGARDING SERVICES PROVIDED)

#9: Update this section or add additional information regarding current treatment compliance and functioning of the client if client was to stop treatment.

12 9. Based on a review of Candidate's history and reported symptoms, Candidate's
13 condition continues to show evidence of deterioration which results in impaired interpersonal
14 interactions, poor decision making, continued delusional thinking, which are likely to result in
15 psychiatric or forensic detention. Candidate continues to present with sleep disturbances and
16 difficulty with activities of daily living. Candidate's insight remains poor and she is unable to
17 verbalize any concrete or realistic plan for self-care, mental health treatment or housing upon
18 discharge from her current residential placement. (UPDATE AND/OR ADD INFORMATION
19 REGARDING CURRENT TREATMENT COMPLIANCE AND FUNCTIONING IF CLIENT
20 WAS TO STOP TREATMENT)

21 10. Participation in Assisted Outpatient Treatment would be the least restrictive
22 placement necessary to ensure the Candidate's recovery and stability. Candidate's history
23 demonstrates Candidate has not fully engaged voluntarily in outpatient psychiatric treatment.

24 11. In view of the Candidate's treatment history and current behavior, I believe
25 Candidate is in need of extended Assisted Outpatient Treatment in order to prevent a relapse or
26 deterioration that would be likely to result in grave disability or serious harm to herself, or others.

Add the word "extended"

27 12. Candidate has a mental health condition known to respond to the proposed services,
28 and based on a review of Candidate's history and reported symptoms, I believe it is likely

#8: Add the sentence "Candidate was mandated into treatment on (date) and assigned for treatment with (agency name). Since being mandated into treatment, Candidate has been on a (weekly/bi-weekly) basis for mental health treatment consisting of (individual/group therapy) and meeting with psychiatrist on a (monthly/bi-weekly) basis."

#8: Also include information regarding services provided

Add the word "extended"

1 Candidate will benefit **extended** Assisted Outpatient Treatment.

2 I declare under penalty of perjury under the laws of the State of California that the
3 foregoing is true and correct.

4 DATED: **[REDACTED]**

8 Date of submission

6 By

7 **MONIQUE PADILLA, LMFT**

Writer's signature and full name and license typed

26 Writer's full name and license



Testifying



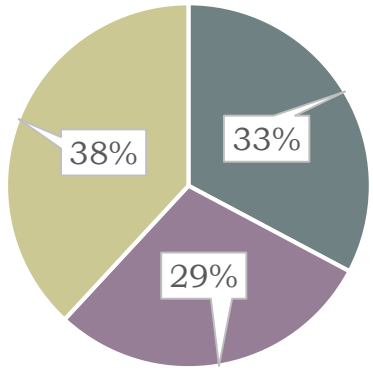
Testifying in Court

Communication with County Counsel prior
to court hearing

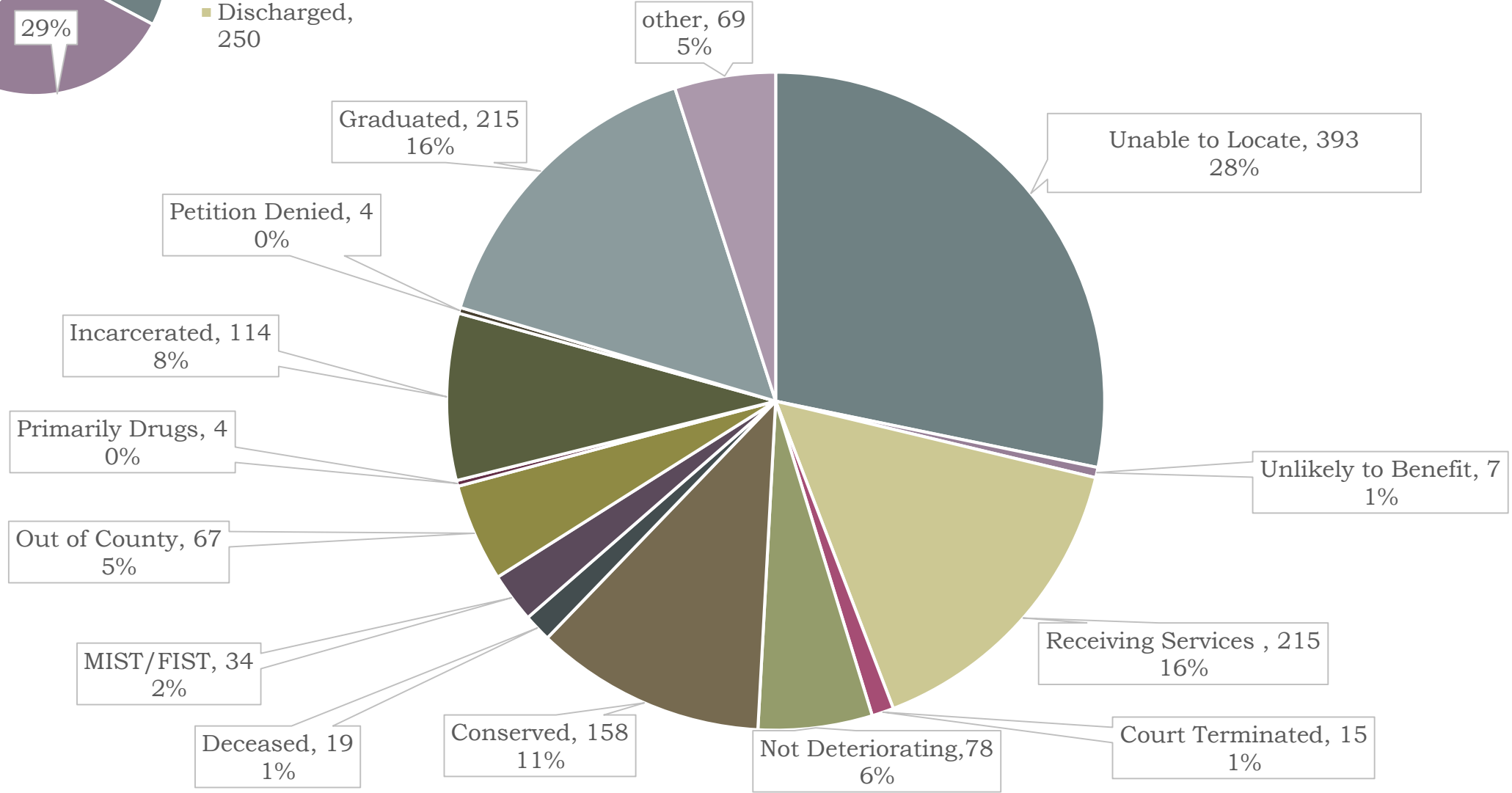
Notes to review on stand

Testify to content of affidavit

Outcomes



- Graduated, 215
- Cancelled, 191
- Discharged, 250



Questions and Answers

Qualtrics Question from Day 1

True or **False**, To meet AOT Criteria an individual has to have had at least 3 documented hospitalizations due to MH or forensic MH episodes in the past 3 years and have had serious, violent behavior towards self or another.

True or False, To meet criteria for AOT, you must be unlikely to survive safely in the community without supervision, are deteriorating, and have a history of non-compliance of treatment.

A provider can close an AOT-FSP case without the AOT committee approval under which of the following circumstances (pick one)

-If a client cannot be located for 30 days, and you have tried to locate them 1x per week in the past four weeks.

-If a client is refusing services after warm handoff for at least 30 days.

-**None of the above**

-All of the above

Qualtrics Question from Day 2

During a 5346(d)(3) where a client is court ordered to be evaluated in a hospital for no more than 72 hours, the order allows the client to be medicated.. True or **False**

If the Court terminates the AOT jurisdiction, can the client remain in AOT –FSP services? **Yes** or No

A Client is eligible for disenrollment for all of the following reasons except:

- Conservatorship established
- In Residential Treatment for the next 180 days
- Unable to locate
- Long Term Incarceration
- Refusing services**

The client Self-Report survey is completed by the client at 3-month intervals. If your survey is late, do you still complete the next survey at the scheduled time, or do you adjust your 3 month intervals to reflect the last date of completion?

- Complete next survey at originally scheduled time**
- Adjust 3-month interval of completion to reflect the last date completed

MRT is to be filled out monthly even if the client has been missing from services for the entire monthly. **True** or False

Qualtrics Question Day 3

Petition Extensions are given in 180 day increments. **True** or False

The writer of the declaration has to be:

- A)A licensed mental health clinician
- b) Have assessed the client and understands the case
- c) Available to attend court on the date which the current petition terminates
- d) Willing to testify in court if client contests petition
- e) All of the above**
- f) Only a licensed mental health clinician

In a declaration, it is important to include information regarding current treatment compliance and functioning of the client, if the client wants to stop treatment. **True** of False

A declaration must be submitted how many weeks prior to current petition termination date to ensure time for processing and filing.

- a) 1 weeks
- b) 2 weeks**
- c) 3 weeks
- d) 4 weeks

True or **False**, an extension hearing can be changed if needed.

Countywide Engagement Division Assisted Outpatient Treatment (AOT-LA)

Linda Boyd, MH Program Manager 213-738-4431 lboyd@dmh.lacounty.gov

Monique Padilla, MH Clinician, (AOT FSP Coordinator) 213-351-5481 mpadilla@dmh.lacounty.gov

Malik Tate, MHC Supervisor (Lomita Office) 213-222-3794 mtate@dmh.lacounty.gov

Staci Atkins, MHC Supervisor (Little Tokyo Office) 213-276-5360 satkins@dmh.lacounty.gov

