The Evolution of Assisted Outpatient Treatment (AOT)

Marvin Swartz, MD
Professor, Department of Psychiatry and Behavioral Sciences,
Duke University School of Medicine
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

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Disclaimer Slide

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Thinking Carefully About Assisted Outpatient Treatment

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A Note on Terminology

- Historically the practice of a civil court ordering a patient to adhere to mental health treatment was called ‘involuntary outpatient commitment’.
- Use of term ‘Assisted Outpatient Treatment’ started with passage of Kendra’s Law in NY (1999).
- Some object to the term and consider it to be a euphemism
- Will use term ‘Assisted Outpatient Treatment (AOT)’ for sake of consistency.

Key Elements of Assisted Outpatient Treatment (AOT)

Civil court order that requires certain patients with a serious mental illness to comply with recommended outpatient treatment and receive services

- Also “commits the system” to the patient: creates accountability.

“Treatment plan wrapped in a legal order”

- Services under AOT typically include intensive case management or assertive community treatment, medication, psychosocial treatment, and access to subsidized housing.

Sanction for non-adherence: non-criminalizing police transport to a mental health facility for evaluation, hopeful persuasion, or involuntary hospitalization if needed

- No forced medication in outpatient setting.

Legal Authority and Historical Context of AOT

Extends state's civil commitment authority from the institutional setting to community-based mental health care.

Emerged in USA after deinstitutionalization as a legal intervention to try to break the cycle of "revolving door" admissions.

Began as a form of conditional release from hospital.

Types of AOT statutes

Conditional release from hospital (40 states[1])

- Also known as “trial visit” or “visit to discharge”.

Alternative to hospitalization for people meeting inpatient commitment criteria, i.e., dangerousness (16 states[2])

- Least restrictive alternative.

Preventive outpatient commitment (35 states and DC[2])

- Court-ordered treatment authorized at a lower threshold than inpatient commitment criteria with the purpose of preventing further deterioration.

No outpatient commitment (3 states: MA, CT, MD)

[1] Melton et al., 2007; [2]LawAtlas.org, 2016;

Criteria for Involuntary Outpatient Commitment in North Carolina

- Presence of a serious mental illness
- Capacity to survive in the community with available supports
- Clinical history indicating a need for treatment to prevent deterioration that would predictably result in dangerousness
- Mental status that limits or negates the individual's ability to make informed decisions to seek or comply voluntarily with recommended treatment

Source: NC GS 122C

Disagreement over AOT: Two opposing views of mandating treatment in the community

"Mandatory treatment for those too ill to recognize they need help is far more humane than our present mandatory non-treatment."

-- E. Fuller Torrey

"Failure to engage people with serious mental illnesses is a service problem, not a legal problem. Outpatient commitment is not a quick-fix that can overcome the inadequacies of under-resourced and under-performing mental health systems. Coercion, even with judicial sanction, is not a substitute for quality services."

-- Bazelon Center for Mental Health Law

American Psychiatric Association Position Statement Key Statements on AOT

Involuntary outpatient commitment, **if systematically implemented** and **resourced**, **can be a useful tool** to promote recovery through a program of **intensive outpatient services**

designed to improve treatment adherence,
reduce relapse and re-hospitalization,
and decrease the likelihood of dangerous behavior or severe deterioration
among a sub-population of patients with severe mental illness.

Source: https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2016.3a10

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American Psychiatric Association Position Statement
Key Statements on AOT

The goal of involuntary outpatient commitment is to:

mobilize appropriate treatment resources,

enhance their effectiveness and improve an individual's adherence to the treatment plan.

Involuntary outpatient commitment should not be considered as a primary tool to prevent acts of violence.

Source: https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2016.3a10

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American Psychiatric Association Position Statement
Key Statements on AOT

Studies have shown that involuntary outpatient commitment is most effective:

> when it includes a range of medication management and psychosocial services equivalent in intensity to those provided in assertive community treatment or intensive case management programs.

States adopting involuntary outpatient commitment statutes should assure that adequate resources are available to provide such intensive treatment to those under commitment.

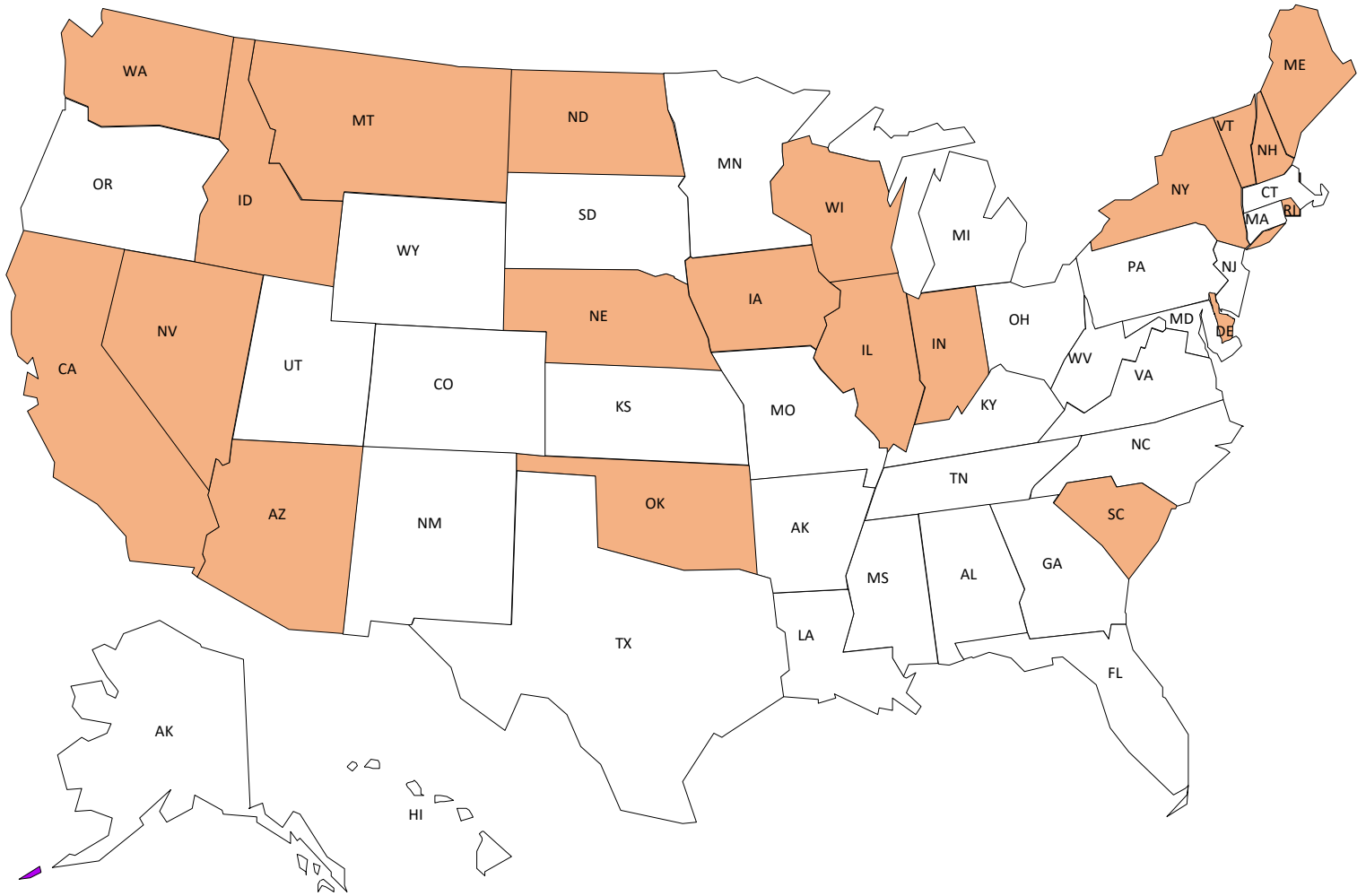
Source: https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2016.3a10

Current status, use, and context of AOT

About 12% - 20% of a large, 5-site sample of outpatients with SMI in public systems of care reported experiencing outpatient commitment

Source : Monahan et al., MacArthur Research Network

Meldrum et al. survey of AOT implementation: 20 states with "active AOT programs"



SOURCE: Meldrum ML, Kelly EL, Calderon R, Brekke JS, Braslow JT (2016). Implementation status of assisted outpatient treatment programs: a national survey. *Psychiatric Services* 67:630–635

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Meldrum et al. survey of AOT implementation: 20 states with “active AOT programs”

- AOT programs varied considerably:
  - style of implementation
  - statutory criteria applied
  - agency responsible
  - use of a treatment plan
  - monitoring procedures
  - numbers of participants involved

Meldrum et al. survey of AOT implementation: 20 states with “active AOT programs”

- Common problems
  - inadequate resources
  - lack of enforcement power
  - inconsistent monitoring
  - weakness of interagency collaboration

- Uneven implementation of AOT programs within and across states
  - ambivalence in the community among judicial officials and mental health clinicians about the role and scope of AOT and the difficulties of implementation under existing funding constraints and statutory limitations

Evidence for AOT's Effectiveness

- Big picture summary: Evidence for the effectiveness of outpatient commitment is mixed, with success largely conditioned on:
- investment in effective implementation
- availability of intensive community-based services
- duration of the court order

- (But not everyone agrees…)

-- Swanson & Swartz (2014)

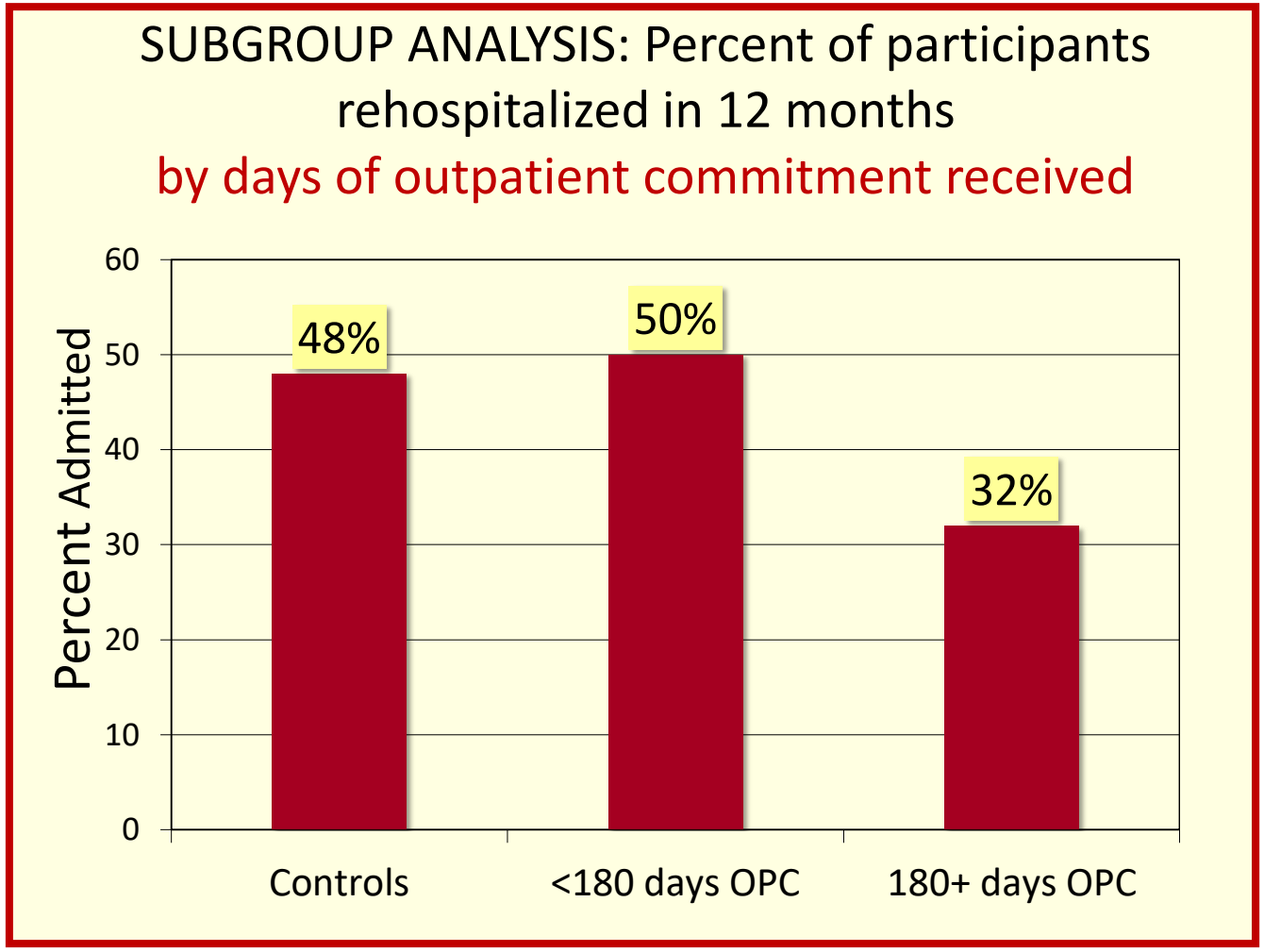
Key finding from 1990s Duke Mental Health Study randomized trial of outpatient commitment in NC

Odds ratio for hospital readmission during any given month of 1-year trial

	Odds Ratio	95% CI	p value
Control (n=135)	[1.00]		
OPC (n=129)	0.64	(0.46 – 0.88)	p<0.01

Swartz MS, Swanson JW, Wagner HR, Burns BJ, Hiday VA, Borum WR (1999). Can involuntary outpatient commitment reduce hospital recidivism? Findings from a randomized trial in severely mentally ill individuals. *American Journal of Psychiatry,* 156(12), 1968-1975

Key finding from 1990s Duke Mental Health Study randomized trial of outpatient commitment in NC



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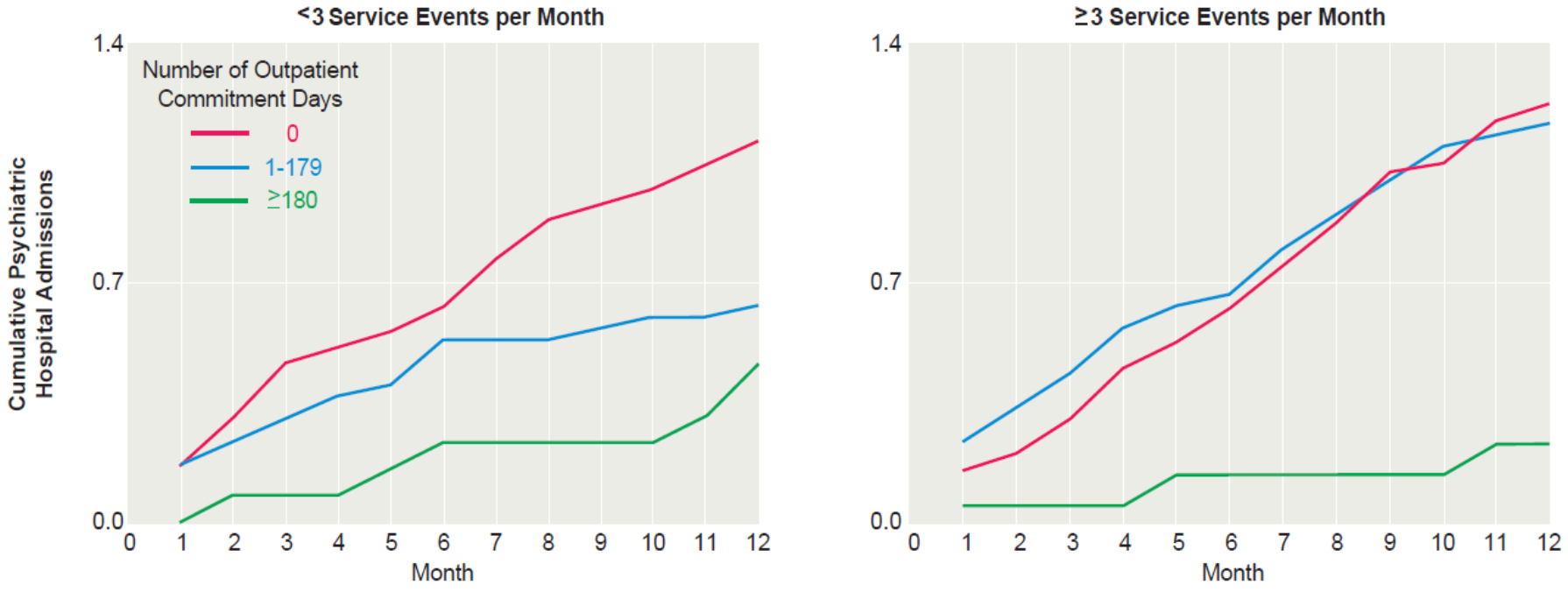
Duration of AOT Order and Intensity of Treatment Matter

SWARTZ, SWANSON, WAGNER, ET AL.

FIGURE 1. Cumulative Mean Psychiatric Hospital Admissions Among Subjects With a Psychotic Diagnosis, by Level of Outpatient Service Use



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New York State Assisted Outpatient Treatment (AOT) Evaluation Study

Legislatively-mandated statewide assessment of "Kendra's Law" using administrative data and case manager reports (Swartz et al., 2010)

- Study period: 1999-2007

Design: Observational study with multivariable analysis of time series data

- Comparison: Both pre-post and propensity-matched comparison group
- Participants: 3,576 AOT placements who had Medicaid
- Outcomes: Hospital use, medications, receiving ACT/intensive case management/any case management

Swartz, MS, Swanson, JW, Steadman, HJ, Robbins, PC and Monahan J. New York State Assisted Outpatient Treatment Program Evaluation. Duke University School of Medicine, Durham, NC, June, 2009

New York State Assisted Outpatient Treatment (AOT) Evaluation Study

	First 180 days	181 days or more (renewed period)
Receipt of ACT/ICM	+ 242%	+ 282%
Medication possession	+ 47%	+ 88%
Hospital admission	- 23%	- 41%
Days hospitalized	- 10%	- 16%

Swartz, MS, Swanson, JW, Steadman, HJ, Robbins, PC and Monahan J. New York State Assisted Outpatient Treatment Program Evaluation. Duke University School of Medicine, Durham, NC, June, 2009

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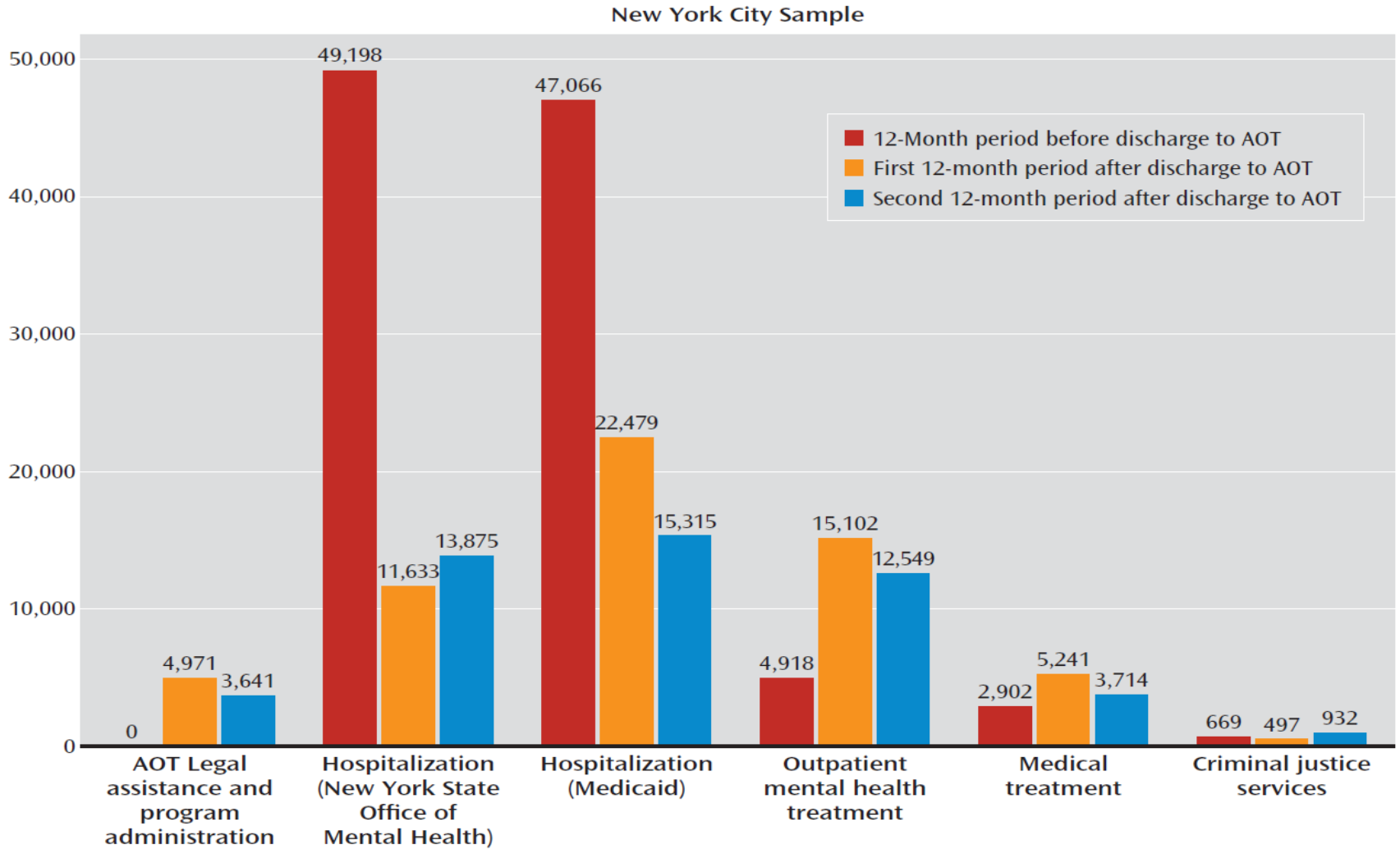
New York State Assisted Outpatient Treatment (AOT) Evaluation Study

Case manager data showing reduced hospitalization effect of adding AOT to ACT/ICM:

- Monthly probability of hospitalization reduced 43% to 57% for participants receiving AOT plus intensive services compared to participants receiving ACT or ICM alone

Swartz, MS, Swanson, JW, Steadman, HJ, Robbins, PC and Monahan J. New York State Assisted Outpatient Treatment Program Evaluation. Duke University School of Medicine, Durham, NC, June, 2009

Summary costs by category, Assisted Outpatient Treatment (AOT) Period, and Sample



Swanson JW, Swartz MS, Van Dorn RA, Robbins PC, Steadman HJ, McGuire TG, Monahan J (2013). The cost of Assisted Outpatient Commitment: Can it save states money? *American Journal of Psychiatry*, 170:1423-1432.

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What do AOT recipients themselves think of AOT ?

Subjective quality of life

Swanson JW, Swartz MS, Elbogen E, Wagner HR, Burns BJ (2003). Effects of involuntary outpatient commitment on subjective quality of life in persons with severe mental illness. *Behavioral Sciences and the Law*, 21, 473-491

Endorsement of personal benefit

Swartz MS, Swanson JW, Monahan J (2003). Endorsement of personal benefit of outpatient commitment among persons with severe mental illness. *Psychology, Public Policy and Law*, 9:1, 70-93

Formal preference assessments

Swartz MS, Swanson JW, Hannon MJ, Wagner HR, Burns BJ, Shumway M (2003.) Preference assessments of outpatient commitment for persons with schizophrenia: Views of four stakeholder groups. *American Journal of Psychiatry*, 160, 1139-1146

Is AOT Fair?

Racial disparities in AOT

Swanson, J., Swartz, M., Van Dorn, R., Monahan, J., McGuire, T., Steadman, H., and Robbins, P. (2009). Racial disparities in involuntary outpatient commitment: Are they real? *Health Affairs*, 28, 816-826.

"Queue-jumping" in AOT

Swanson JW, Van Dorn RA, Swartz MS, Cislo AM, Wilder CM, Moser LL, Gilbert AR, McGuire TG (2010). Robbing Peter to pay Paul: Did New York State's outpatient commitment program crowd out voluntary service recipients? *Psychiatric Services* 61, 988-95.

Ethical Consideration Regarding AOT

- Outpatient commitment involves overriding some people's choices to forego mental health treatment
  - AOT should not be applied to people who are willing to seek treatment voluntarily and simply need help accessing that treatment
  - A court order alone doesn't magically remove barriers to care for persons with serious mental illness.
- There are legitimate, ethical reasons for overriding some patient's expressed choices
  - safety and welfare of the patient and others who may be affected
  - patient lacks capacity to make and communicate authentic decisions

Ethicist Dan Brock's Ethical Formulations

Justification for Overriding Patient Expressed Preference

1. when there are good reasons to doubt that the patient's manifest decision to go without treatment accurately reflects what the patient would have wanted in a non-impaired state
2. when the moral authority of the patient's treatment refusal is questionable, due to conflict with important interests of the patient
3. when the interests of persons other than the patient warrant overriding patients' choice

Brock D (1994). Good decisionmaking for incompetent patients. *Hastings Center Report.*

Can AOT Succeed?

Robert Miller writing 28 years ago… Three Things needed for AOT to succeed

1. "rigorous empirical research to determine how effective involuntary community treatment can be and for what type of patients."
2. "support from community-based clinicians"; if they don't believe in outpatient commitment, it will never be widely implemented.
3. "sufficient resources to permit adequate treatment to be provided."

Otherwise, "outpatient commitment is all too likely to remain a theoretical but not practical alternative to revolving-door hospitalizations and community neglect."

Miller RD. Outpatient civil commitment of the mentally ill. *Behavioral Sciences & the Law* 1988; 6: 99-118.

APA Position Statement--Redux

Involuntary outpatient commitment, **if systematically implemented** and **resourced**, **can be a useful tool** to promote recovery through a program of **intensive outpatient services**

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Thank you!
Questions?

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