The Evolution of Assisted Outpatient Treatment (AOT)

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Thinking Carefully About Assisted Outpatient Treatment
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
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
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
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
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”

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

<table>
<thead>
<tr>
<th></th>
<th>Odds Ratio</th>
<th>95% CI</th>
<th>p value</th>
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<tbody>
<tr>
<td>Control (n=135)</td>
<td>1.00</td>
<td></td>
<td></td>
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<tr>
<td>OPC (n=129)</td>
<td>0.64</td>
<td>(0.46 – 0.88)</td>
<td>p&lt;0.01</td>
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Key finding from 1990s Duke Mental Health Study randomized trial of outpatient commitment in NC

SUBGROUP ANALYSIS: Percent of participants rehospitalized in 12 months by days of outpatient commitment received

- Controls: 48%
- <180 days OPC: 50%
- 180+ days OPC: 32%
Duration of AOT Order and Intensity of Treatment Matter

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

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

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

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
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

What do AOT recipients themselves think of AOT?

Subjective quality of life

Endorsement of personal benefit

Formal preference assessments
Racial disparities in AOT

“Queue-jumping” in AOT
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
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

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.”

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.
Thank you!
Questions?