

Literature Review: Assisted Outpatient Treatment (AOT)

Authors: Amir Chapel

Institute for Social Research

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Definition: Assisted Outpatient Treatment (AOT) is a practice designed to improve treatment outcomes for people with severe mental illness whose difficulties adhering to voluntary outpatient care have left them trapped in the revolving door of the mental health and criminal justice systems (Stettin, 2014). Assisted Outpatient Treatment delivers community-based mental health services under court order to individuals with severe mental illness who have demonstrated difficulty adhering to prescribed treatment on a voluntary basis (Stettin, 2014). One may think of AOT as a combination of a court order and community based psychiatric services.

Target Population: Senate Bill 113 was signed into law in New Mexico during the 2016 legislative session, which created the authority for a district court judge in New Mexico to order people diagnosed with mental illnesses who meet certain criterion into mandatory AOT programs for up to one year. With the exception of Connecticut, Maryland, Massachusetts and Tennessee, every state and the District of Columbia have enacted laws to authorize the use of AOT (Treatment Advocacy center, 2017). Each state's AOT law clearly defines the target population that AOT is designed to serve. The state of New Mexico's criteria for AOT eligibility include:

- Eighteen years of age or older and is a resident of a participating municipality or county
- Has a primary diagnosis of a mental disorder
- Has demonstrated a history of lack of compliance with treatment for a mental disorder that has;
 - At least twice in the past 2 years been a significant factor in necessitating hospitalization or receipt of services in a mental health unit, jail, or a prison
 - Has resulted in one or more acts of serious violent behavior toward self or others or threats of, or attempts, at serious physical harm to self or others
 - Has resulted in the person being hospitalized, incarcerated or detained for six months or more
 - Is unwilling or unlikely to participate voluntarily in outpatient treatment that would enable the person to live safely in the community without court supervision
 - Is in need of assisted outpatient treatment as the least restrictive appropriate alternative to prevent a relapse or deterioration likely to result in serious harm to self or likely to result in serious harm to others
 - Will benefit from receiving AOT

Description:

This literature review summarizes existing literature and research on AOT for the target population described above. This includes a brief description of what AOT is and why it is a necessity, best practices for creating and implementing AOT programs and outcomes of AOT programs.

Research Summary:

A substantial body of research conducted in diverse jurisdictions over more than two decades establishes the effectiveness of AOT in improving treatment outcomes for its target population (Mental Illness Policy, 2017). Specifically, research demonstrates that AOT reduces the risks of hospitalization, arrest, incarceration, crime, victimization, and violence. AOT also increases treatment adherence and eases the strain placed on family members or other primary caregivers. In some locations, AOT is used as a mechanism for preventing decompensation, hospitalization, incarceration, or other negative outcomes of non-treatment (Treatment Advocacy Center, 2017). In other locations, AOT is primarily used in connection with discharge planning with court-ordered services issued to help provide treatment continuity and a smooth transition between psychiatric hospitalization and the community (or, in some cases, between jail and the community)(Treatment Advocacy Center, 2017). In

some states and communities, AOT is used for both prevention and discharge. Typically, violation of the court ordered conditions can result in an individual being evaluated and treated in a psychiatric facility

Outcomes:

Researchers in 2009 conducted an independent evaluation of New York's court-ordered outpatient treatment law (Kendra's Law) and documented a striking decline in the rate of hospitalizations among participants. During a six-month study period, AOT recipients were hospitalized at less than half the rate they were hospitalized in the six months prior to receiving AOT (i.e., the hospitalization rate dropped from 74 percent to 36 percent). Among those admitted, hospital stays were shorter: average length of hospitalization dropped from 18 days prior to AOT to 11 days during the first six months of AOT and 10 days for the seventh through twelfth months of AOT (Swartz et al. 2009).

Gilbert et al., (2010) found the odds of arrest in any given month for participants who were currently receiving AOT were significantly lower than the odds for participants in the pre-AOT and pre-voluntary agreement group (the comparison group). The odds of being arrested were approximately two-thirds lower for participants currently receiving AOT, compared with the likelihood of arrest for the comparison group. It is important to point out there was no statistically significant differences in the likelihood of arrest between those with a current voluntary agreement and those in the comparison group.

A within group analyses by Link et al., (2011) found that the risk of arrest was significantly higher for individuals during the period before AOT than during the period of AOT. The risk of arrest went up slightly in the period after AOT was discontinued, but this difference was not statistically significant. For individuals who had ever received AOT, the risk of any arrest was 2.66 times greater before AOT as it was while receiving AOT. The between group results showed that the risk of arrest among individuals in the comparison group who were never assigned to AOT was significantly higher than the risk of arrest for the AOT group while they were assigned to AOT. Compared with individuals during and shortly after the period of assignment to AOT, the comparison group who never received AOT had nearly twice the odds of being arrested. Link et al., (2011) also found in their between group analysis that individuals receiving AOT were at a significantly lower risk of arrest for a violent offense than they were before AOT. The risk of arrest for a violent offense was 8.61 times greater before AOT as it was while receiving AOT.

An initial analysis performed by Swanson et al., (2000) found there was no significant difference in the rate of violence between the group randomly assigned to involuntary outpatient commitment (OPC) and the control group (32.3 percent in the OPC group versus 36.8 percent in the control group). However, multivariate analysis showed that controlling for baseline history of violence and substance misuse, extended OPC was associated with significantly lower odds of any violent behavior during the year of the study. Treatment group members who received more than 180 days of OPC were only about one third as likely to commit a violent act during the year, compared with their control group counterparts. However, treatment group members receiving fewer than 180 days of OPC did not differ from the control group with respect to risk of violence.

In addition to the effects of AOT on risk of re-arrest and violent behavior from individuals with a serious mental illness, there have been cost savings. A recent examination of assisted outpatient treatment (AOT) implemented in Nevada County, California looked at the cost savings that resulted from 17 individuals who were enrolled in AOT during the first 2½ years of program implementation (no comparison group was included). The results showed a total cost savings of over \$500,000, attributable to decreases in hospitalizations and in jail time of the 17 individuals. For every \$1.00 invested in AOT in Nevada County, \$1.81 was saved, which means the return on every dollar spent was \$0.81 (Heggarty 2011).

Conclusion:

The involuntary treatment of such persons in acute psychiatric hospitals and intermediate care facilities places a heavy burden upon state and local taxpayers in New Mexico. Evidenced- and community-based early intervention programs such as AOT can be used as an alternative to the existing, costly mechanisms for addressing the needs of this population. Assisted Outpatient Treatment, which targets the most seriously mentally ill who refuse voluntary treatment, can reverse this cost-shifting and has the potential to save state and local taxpayers money both in the short and long term.

New Mexico's public mental health system is currently facing a number of challenges in providing care for those with a serious mental illness: limited availability of acute psychiatric beds, a reduction in available outpatient services, and pressures on New Mexico counties to avoid criminalizing those with a serious mental illness. Assisted Outpatient Treatment provides an evidenced-based approach to help deal with these challenges and is more clinically effective and cost-effective than current approaches for the seriously mentally ill who lack insight or people that are left to themselves on the street being homeless. Assisted Outpatient Treatment does not represent an expansion of involuntary services; rather, it provides services to those who are already receiving involuntary services in the least-restrictive, least expensive, community-based setting.

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