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## In This Issue



This issue of the *Residents' Journal* features articles on the theme of advocacy in psychiatry. Nina V. Kraguljac, M.D., M.A., and Sourav Sengupta, M.D., M.P.H., discuss the role of advocacy in residency training and provide information on opportunities for residents to engage in advocacy efforts. Joanna Quigley, M.D., presents the results of a survey on residents' perceptions, knowledge, and practices related to advocacy. John O. Lusins III, M.D., and Kavara S. Vaughn, M.D., discuss the role of the chief resident as advocate. Alik S. Widge, M.D., Ph.D., outlines the importance of advocacy to the career of the aspiring academic psychiatrist. Last, Annemarie Mikowski, D.O., shares with us the eye-opening experience of a group of residents who participated in a suicide prevention community walk.

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# Assisted Outpatient Treatment: Preventive, Recovery-Based Care for the Most Seriously Mentally Ill

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Mental health systems are struggling to provide care for the seriously ill, with conservative estimates reporting that approximately 30% of the homeless (1) and 20% of the prison population (2) are severely mentally ill. An important contributing factor to these poor outcomes is that almost 50% of those with severe mental illness (defined in this article as schizophrenia, schizoaffective disorder, bipolar disorder, and depressive disorder with psychotic features) in the United States are untreated (3). Although this population only comprises about 4.5% of the general population, this still amounts to a substantial 13 million Americans affected (4).

Not surprisingly, the percentage of untreated severely mentally ill individuals closely mirrors the 40%–50% of individuals in this population who suffer from anosognosia and possess significant deficits in self-awareness (5). While intensive case management practices, such as Assertive Community Treatment/Full Service Partnerships, have been successful in providing care for clients who are amenable to voluntary services, individuals who lack insight remain difficult to engage. Studies have shown that these individuals possess deficits in the frontal lobe and in executive functioning, which impairs their capability for objective self-reflection (6). Research has also revealed a clear link between lack of insight and treatment nonadherence (7), which has been associated with poorer clinical outcomes in terms of illness relapse, response to treatment, hospitalizations, and suicide attempts (8, 9). Without the capacity to recognize their need for help, this subset of the mentally ill frequently declines care, resulting in revolving-door hospitalizations as well as incarceration and victimization or violence (10). While voluntary care is clearly ideal, the difficult reality is that the mentally ill are a heterogeneous group with varying needs.

## Assisted Outpatient Treatment

Assisted outpatient treatment programs, also known as outpatient commitment, arose in response to the challenges of caring for the severely mentally ill. To date, versions of outpatient commitment laws have been enacted in 44 states, most notably in New York via Kendra's Law. These court-ordered programs are community-based, recovery-oriented, multidisciplinary services for seriously ill individuals who have a history of poor adherence to voluntary treatment and repeated hospitalizations and/or incarcerations. Despite regional differences, the challenging patient population receiving services from assisted outpatient treatment and the goals of treatment are generalizable. In most states, mentally ill individuals who decline treatment must meet strict criteria for involuntary treatment; i.e., they must be deemed a danger to themselves, others, or gravely disabled. Rather than waiting until these outcomes are imminent, assisted outpatient treatment engages high-risk individuals through earlier and less restrictive treatment in the community.

Establishing flexible and therapeutic relationships with clients within the evidence-based paradigm of assertive community treatment is the foundation of effective assisted outpatient treatment. In California, comprehensive outpatient services are offered 24/7 at a client-to-clinician ratio of 10:1. Service plan goals are concrete and individualized, and every effort is made to involve patients in their care, empowering their sense of self-worth and independence. The assisted outpatient treatment team is a mobile unit, and the location of services varies depending on client needs. Provided services include psychotherapy, medication management, crisis intervention, nursing, and substance abuse counseling as well as

support for housing, benefits, education, and employment. Providers often maintain contact with clients on a daily basis, and any member of the treatment team, including psychiatrists, psychologists, nurses and case workers, can provide services and support.

In 2008, Nevada County became the first and only county in California to fully implement an assisted outpatient treatment program in order to promote ongoing treatment adherence in the community. Although the procedural process varies slightly between states, Nevada County's treatment process begins with a referral submitted to mental health agencies by family members, cohabitants, treatment providers, or peace officers. If the individual meets the eligibility criteria (Figure 1), the treatment team develops a preliminary care plan, which is strategically revised throughout the process to meet the needs and desires of the client. If the individual voluntarily engages with court-supervised treatment, a petition is no longer necessary. However, if the client contests the petition, a public defender is assigned and the court proceeds with a hearing. If granted, the assisted outpatient treatment order is valid for up to 180 days. Regular status hearings, held at least every 60 days, enable the court to both ensure that the client is engaged in treatment and that the treatment team is providing necessary support and services. Importantly, assisted outpatient treatment does not affect existing laws regulating the administration of involuntary medications. If patients decline to engage with the treatment team, they are assessed for the appropriateness of a 72-hour hold for further evaluation and care at a local hospital.

While all assisted outpatient treatment programs involve interactions with law enforcement and the court system, a

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unique feature of Nevada County's program is its degree of systemic integration. During planning, the behavioral health department held meetings with various stakeholders, including representatives from the mental health board, superior court, county counsel, public defender's office, law enforcement, advocacy groups (such as the National Alliance on Mental Illness), and members of the community. As a result of this collaboration, the assisted outpatient treatment team works closely with all involved parties, enhancing the efficiency and impact of these intensive, wrap-around mental health services.

## Results From the Nevada County Assisted Outpatient Treatment Program

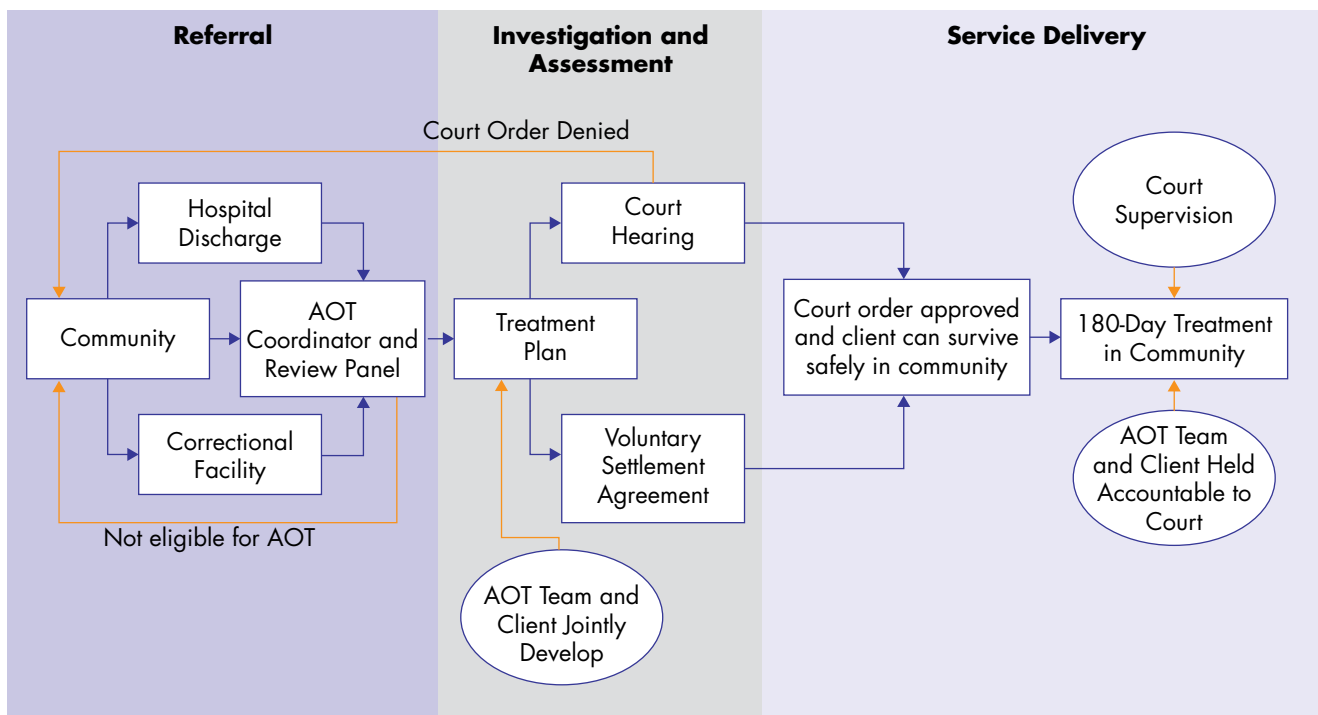
Given the difficult target population, one of the most compelling measures of success for Nevada County's assisted outpatient treatment program is the number of people who voluntarily engage in treatment and avoid court-ordered intervention. Between 2008 and 2010, with a county population of 97,000, there were 24 referrals to the program, and 19 met eligibility criteria (11). The vast majority of referrals (15 out of 19) voluntarily engaged with their care team, and a majority remained in treatment even after their court order expired. The Milestones of

Recovery Scale was used to assess markers of mental health recovery. Because of out-of-county incarceration or an inability to locate individuals, Milestones of Recovery Scale data were only available for 16 of the 19 individuals who received services. Of these clients, 14 had pre-assisted outpatient treatment scores in the "struggling" category, compared with only eight individuals posttreatment. While five of the 19 clients engaged in treatment were employed prior to treatment, six were employed following treatment.

Assisted outpatient treatment also produced significant cost savings for Nevada County as a result of decreased hospitalizations and incarcerations (Figure 2). The year prior to assisted outpatient

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FIGURE 1: Eligibility Criteria and Procedural Process of Assisted Outpatient Treatment (AOT) in California<sup>o</sup>



### AOT Eligibility (California):

1. Be mentally ill and at least 18 years old.
2. Have a history of poor treatment compliance leading to at least two hospitalizations or incarcerations in the last 36 months, or violent behavior at least once in the last 48 months.
3. Have been offered and to have declined voluntary in the past.
4. Clinical determination needs to indicate that they are unlikely to survive safely in the community without supervision.
5. Participation in AOT needs to be the least restrictive measure necessary to ensure recovery and stability.
6. Condition needs to be substantially deteriorating and must likely benefit from treatment.
7. Not being placed in AOT must likely result in the patient being harmful to self/others and/or gravely disabled.

<sup>o</sup> Data are drawn from criteria as described by the California Psychiatric Association ([www.sdcounty.ca.gov/hhsa/programs/bhs/documents/Lauras\\_Law\\_AB1421.pdf](http://www.sdcounty.ca.gov/hhsa/programs/bhs/documents/Lauras_Law_AB1421.pdf)) and New York State Office of Mental Health (<http://bi.omh.ny.gov/aot/files/AOTReport.pdf>).

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treatment implementation, the 19 participants who received services accounted for 514 days of psychiatric hospitalization. After initiation of treatment, the number of inpatient days for these individuals decreased to 198 days, representing a 61% drop in hospitalization days. Similarly, 521 days of pre-assisted outpatient treatment incarcerations fell to just 17 days posttreatment, representing a 97% reduction in incarceration days. With estimated daily hospitalization costs of \$675 and incarceration costs of \$150 per day, the assisted outpatient treatment program resulted in a 45% net savings for Nevada County during the 31-month period of this assessment and saved \$1.81 for every \$1 invested.

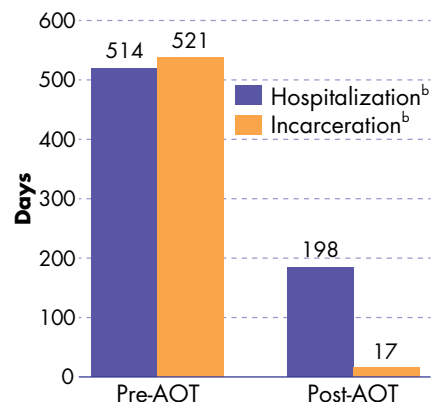
## Conclusions

The unfortunate irony of psychiatric care today is that oftentimes the patients who are most in need of services are too disorganized and ill to seek assistance themselves. Subsequently, these high-risk clients frequently only receive treatment after they are involuntarily hospitalized or placed in other restrictive settings of care, including the criminal justice system.

The Nevada County assisted outpatient treatment program takes a patient-oriented, multidisciplinary approach to provide community-based services for the severely mentally ill who are historically the most difficult to engage. Objective measures of the program demonstrate that it is cost-efficient and has resulted in overall improvement in clinical functioning, as well as fewer hospitalization and incarceration days. These findings are attributable to effective collaboration between county systems, evidence-based clinical practices, and comprehensive and individualized care management.

In an era of health reform and decreased medical spending, ensuring treatment for the most vulnerable mentally ill individuals is instrumental in maximizing the

FIGURE 2: Outcomes of Nevada County Assisted Outpatient Treatment (AOT) Program<sup>a</sup>



<sup>a</sup> Data are drawn from statistics as reported by the Nevada County Behavioral Health Department.

<sup>b</sup> Data represent number of days.

efficient use of limited resources. Nevada County's assisted outpatient treatment program provides an innovative example of an efficacious and cost-effective model of service delivery for seriously ill individuals that is preventive, recovery-oriented, and evidence-based care.

*Dr. Tsai is a fourth-year resident in the San Mateo County Psychiatry Residency Training Program, San Mateo, Calif. The author thanks Carol Stanchfield, Program Director of Turning Point Providence Center, and the Nevada County Behavioral Health Department.*

## References

1. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration: Current Statistics on the Prevalence and Characteristics of People Experiencing Homelessness in the United States. <http://homeless.samhsa.gov/channel/hrc-facts-characteristics-and-prevalence-of-homelessness-556.aspx>
2. American Psychiatric Association: Psychiatric Services in Jails and Prisons, 2nd ed. Washington, DC, American

Psychiatric Publishing, 2000

3. Kessler RC, Berglund PA, Bruce ML, Koch JL, Laska EM, Leaf PJ, Manderscheid RW, Rosenheck RA, Walters EE, Wang PS: The prevalence and correlates of untreated serious mental illness. *Health Serv Res* 2001; 36:1009–1017
4. National Institute of Mental Health: Prevalence of Serious Mental Illness Among U.S. Adults by Age, Sex, and Race, 2008. [http://www.nimh.nih.gov/statistics/SMI\\_AASR.shtml](http://www.nimh.nih.gov/statistics/SMI_AASR.shtml)
5. Amador XF, Flaum M, Andreasen NC, Strauss DH, Yale SA, Clark SC, Gorman JM: Awareness of illness in schizophrenia and schizoaffective and mood disorders. *Arch Gen Psychiatry* 1994; 51:826–836
6. Kaspis C, Amador XF, Yale SA: Neuropsychological and defensive aspects of poor insight and depression in schizophrenia. *Schizophr Res* 1996; 18:117–118
7. Olfson M, Marcus SC, Wilk J, West JC: Awareness of illness and nonadherence to antipsychotic medications among persons with schizophrenia. *Psychiatr Serv* 2006; 57:205–211
8. Novick D, Haro JM, Suarez D, Perez V, Dittmann RW, Haddad PM: Predictors and clinical consequences of non-adherence with antipsychotic medication in the outpatient treatment of schizophrenia. *Psychiatr Res* 2010; 176:109–113
9. Lindenmayer JP, Liu-Seifert H, Kulkarni PM, Kinon BJ, Stauffer V, Edwards SE, Chen L, Adams DH, Ascher-Svanum H, Buckley PF, Citrome L, Volavka J: Medication nonadherence and treatment outcome in patients with schizophrenia or schizoaffective disorder with suboptimal prior response. *J Clin Psychiatry* 2009; 70:990–996
10. Lamb HR, Weinberger LE: Meeting the needs of those persons with serious mental illness who are most likely to become criminalized. *J Am Acad Psychiatr Law* 2011; 39: 549–554
11. Nevada County Behavioral Health Department. <http://www.mynevadacounty.com/nc/hhsa/bh/Pages/Home.aspx>