

A comparison of claims made by SAMHSA-funded opponents of AOT with research on AOT.

Prepared by Mental Illness Policy Org. <http://mentalillnesspolicy.org>

A “fact” sheet in opposition to AOT is being distributed to legislators by NCMHR, NYAPRS, and other SAMHSA-funded organizations that believe *psychiatric labeling (diagnosis) is a pseudoscientific practice of limited value in helping people recover.*¹ The SAMHSA funded groups only included studies that dated back 15 years or so. Many were of a pilot program with no enforcement mechanism that was never taken statewide. The opponents did not inform legislators that there are multiple studies in the last 15 years that provide a much different picture than those opponents elected to share.

Following are the claims the SAMHSA-funded groups presented to Congress and clarifying facts:

Claims made by SAMHSA-funded AOT Opponents http://ncmhr.org/downloads/NCMHR-Fact-Sheet-on-Involuntary-Outpatient-Commitment-4.3.14.pdf	Research on AOT that addresses claims
Under Involuntary Outpatient Commitment (IOC), a person with a serious mental health condition is mandated by a court to follow a specific treatment plan, usually requiring the person to take medication and sometimes directing where the person can live and what his or her daily activities must include. Proponents of IOC claim that it is effective in reducing violent behavior, incarcerations, and hospitalizations among individuals with serious mental health conditions	Studies showing AOT has reduced violent behaviors, incarcerations and hospitalizations in multiple states is readily available. Some research on AOT is attached. Research on AOT in NY is at http://mentalillnesspolicy.org/kendras-law/research/kendras-law-studies.html Research on AOT in California is at http://mentalillnesspolicy.org/states/california/lresultsin2counties.html Research on AOT in Florida is at http://mentalillnesspolicy.org/states/florida/florida-aot-results.html and research on AOT in other states is at http://mentalillnesspolicy.org/aot/outpatient-commitment-research.html
However, repeated studies have shown no evidence that mandating outpatient treatment through a court order is effective; to the limited extent that court-ordered outpatient treatment has shown improved outcomes, these outcomes appear to result from the intensive services that have been made available to participants in those clinical trials rather than from the existence of a court order mandating treatment	Extensive peer reviewed research shows mandating treatment through a court order is effective. “The increased services available under AOT clearly improve recipient outcomes, however, the AOT court order, itself, and its monitoring do appear to offer additional benefits in improving outcomes” ²
In addition, studies have shown that force and coercion drive people away from treatment.“	In support of this claim, the opponents cite a survey (not a study) by the “Well-Being Project”, part of the California Network of Mental Health Clients which was organized to oppose all involuntary treatments. Of the 331 individuals surveyed 320 were CNMHC members so CNMHC acknowledged: “Such samples are not entirely representative and these findings also cannot be generalized to the overall category of mental health clients.” When group members were asked, “Do mental health clients avoid treatment due to fear of involuntary commitment?”, 47% answered “no” and 52% “yes.” It is remarkable that in a group dedicated to opposing involuntary treatment only 53 percent said yes.”

¹ The erroneous “fact” sheet is available at <http://ncmhr.org/downloads/NCMHR-Fact-Sheet-on-Involuntary-Outpatient-Commitment-4.3.14.pdf> The position statement of these SAMHSA-funded groups that psychiatric diagnosis (“labeling”) being irrelevant to helping persons with mental illness recover is available at <http://www.ncmhr.org/press-releases/5.3.12.htm>

² June 2009 D 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

	Scientific research shows involuntary interventions do not drive people from treatment. “Eighty-three per cent (95%) of people who were involuntarily committed and regained capacity gave retrospective approval.” ³ “Patients who underwent mandatory treatment reported higher social functioning and slightly less stigma, rebutting claims that mandatory outpatient care is a threat to self-esteem” ⁴
By its very nature, outpatient commitment may undermine the treatment alliance and increase consumers’ aversion to voluntary involvement with services,” according to a study cited in “Opening Pandora’s Box: The Practical and Legal Dangers of Involuntary Outpatient Commitment,” published in <i>Psychiatric Services</i> .	This was not a study. As the author’s point out, it is a “review of therapeutic claims” from 2001, and therefore does not reflect any research in last 13 years. Numerous studies show AOT does not increase aversion to treatment . “75% (of individuals in AOT) reported that AOT helped them gain control over their lives...81% said AOT helped them get and stay well...90% said AOT made them more likely to keep appointments and take medication...87% of participants interviewed said they were confident in their case manager’s ability to help them..88% said they and their case manager agreed on what is important for them to work on”. ⁵
There is ample evidence that intensive services provided on a <i>voluntary</i> basis can bring tremendous improvements in outcomes such as reduced hospitalizations, reduced arrests, longer tenure in stable housing, and reduced symptoms;	True. And those willing to participate in voluntary services are ineligible for AOT
there is no evidence that mandating outpatient services through a court order has any additional benefit.	This is a repeat of a claim made above. Opponents cite no evidence in support of it. Research quoted above shows that court orders to make a difference.
Involuntary outpatient treatment has high costs with minimal returns,	The cost of AOT is minimal and limited to the court costs and program administration. The court and administrative costs are the only incremental costs needed to enable people to access services that are already available to them. The court costs have been estimated to be under \$5000 per patient. An extensive study showed that by reducing the use of expensive incarceration and inpatient commitment and hospitalization, that AOT saves 50%, allowing more money to be invested in care for others. “In New York City net costs declined 50% in the first year after assisted outpatient treatment began and an additional 13% in the second year. In non NYC counties, costs declined 62% in the first year and an additional 27% in the second year.” This was in spite of the fact that Psychotropic drug costs increased during the first year after initiation of assisted outpatient treatment, by 40% and 44% in the city and five-county samples, respectively. The increased community based mental health costs were more than offset by the reduction in inpatient and incarceration costs. Cost declines associated with assisted outpatient treatment were about twice as large as those seen for voluntary services ⁶
is not likely to reduce violent behavior,	Numerous studies show AOT reduces violence. “For those who received AOT, the odds of any arrest were 2.66 times greater (p<.01) and the odds of arrest for a violent offense 8.61 times greater (p<.05) before AOT than they were in the period during and shortly after AOT. The group never receiving AOT had nearly double the odds (1.91, p<.05) of

³ The British Journal of Psychiatry (2009) 195: 403-407. doi: 10.1192/bjp.bp.109.065151

⁴ February 2010 Columbia University. Phelan, Sinkewicz, Castille and Link. Effectiveness and Outcomes of Assisted Outpatient Treatment in New York State Psychiatric Services, Vol 61. No 2

⁵ NYS OMH: Kendra’s Law, Final Report on Status of AOT March 2005

⁶ Swanson: The Cost of Assisted Outpatient Treatment: Can It Save States Money? Am J Psychiatry, July 2013

	<p>arrest compared with the AOT group in the period during and shortly after assignment.”⁷</p> <p>“55% fewer recipients engaged in suicide attempts or physical harm to self...47% fewer physically harmed other...46% fewer damaged or destroyed property...43% fewer threatened physical harm to others.”⁸</p> <p>“Kendra’s Law has lowered risk of violent behaviors, reduced thoughts about suicide and enhanced capacity to function despite problems with mental illness. Patients given mandatory outpatient treatment - who were more violent to begin with - were nevertheless four times less likely than members of the control group to perpetrate serious violence after undergoing treatment.”⁹</p>
and there are alternatives that are more effective and efficient.	The ‘alternatives’ are only for patients willing to accept treatment. They do not help those who are unwilling or unable to accept treatment.
<p>No evidence that using court orders to mandate outpatient treatment is effective.</p> <p>Two systematic reviews have been done of studies concerning involuntary outpatient commitment. Both reached the same conclusion: there is no evidence that mandating outpatient treatment is more effective than providing such treatment on a voluntary basis. The RAND review concluded in 2001 that the existing studies: [did] not prove that treatment works better in the presence of coercion or that treatment will not work in the absence of coercion.</p>	The Rand Study was published in 2001, and only relied on studies up until 2000. It is 15 years old and does not reflect any of the studies done since then.
<p>More recently, a review by the Cochrane Collaborative concluded: Based on results from this review, there is no strong evidence to support the claims made for compulsory community treatment that make it so attractive for legislators. It does not appear to reduce health service use or improve patients’ social functioning. It also does not significantly reduce perceived coercion.</p>	The Cochrane Study was done in 2005 and kind of updated in 2010. But because of their selection criteria, it only included 10 papers that covered just two studies over 15 years old: a 1999 North Carolina study and the 1998 Bellevue pilot study. More recent studies are not included.
<p>IOC has consistently been found to not be a substitute for comprehensive mental health services. In the late 1990s, Jeffrey W. Swanson, Ph.D., and colleagues conducted a field study in North Carolina that found that IOC can be effective only if combined with other intensive treatment. The authors concluded, “In this study, participants were provided with additional intensive mental health services beyond what was typically available in North Carolina’s service delivery system.</p>	No one ever claimed that AOT is a substitute for mental health services. AOT is a way to make those services available to people who would not be able to access them without a court order.
<p>A study of IOC conducted in the mid-1990s at Bellevue Hospital in New York City found that, “[o]n all major outcome measures, no statistically significant differences were found between the two groups” (IOC and control groups).⁹ A later study of Kendra’s Law—New York’s IOC law that requires the provision of intensive services for IOC participants—found improved outcomes, but did not assess whether providing these services on a voluntary basis would be equally effective as providing them through a court order.</p>	The Bellevue Pilot Program was conducted over 20 years ago. The pilot program had numerous problems. For example, there was no enforcement mechanism or consequences for non-compliance. Researchers learned much from the pilot program and did not take it statewide. Instead, they fixed the problems and introduced it as Kendra’s Law. Numerous studies have proven Kendra’s Law reduces arrest, homelessness, incarceration and suicide. Quoting a study of a 20 year old pilot program is akin to quoting a study of a Model T and concluding based on it, that cars today can’t go more than 20 miles per hour.
The most recent study, done in the United Kingdom,	This UK program is radically different from AOT in the US.

⁷ May 2011 Arrest Outcomes Associated With Outpatient Commitment in New York State Bruce G. Link, et al. Ph.D. Psychiatric Service

⁸ March 2005. NYS OMH “Kendra’s Law: Final Report on Status of AOT

⁹ (February 2010 Columbia University. Phelan, Sinkewicz, Castille and Link. Effectiveness and Outcomes of Assisted Outpatient Treatment in New York State Psychiatric Services, Vol 61. No 20

<p>found:</p> <p>In well-coordinated mental health services the imposition of compulsory supervision does not reduce the rate of readmission of psychotic patients. We found no support in terms of any reduction in overall hospital admission to justify the significant curtailment of patients' personal liberty.</p> <p>This continued research shows that “after more than 20 years of mandates and programs, outpatient commitment remains a costly, coercive, and unproven approach.”</p>	<p>The UK program does not involve the use of courts or judges. It is a mechanism used to discharge individuals from hospitals. It is not similar to AOT</p>
<p>Moreover, IOC has not been shown to prevent violence. Dr. Swanson of Duke University, who has studied Kendra's Law extensively, told <i>Behavioral Healthcare</i>: “[P]eople who understand what outpatient commitment is would never say this is a violence prevention strategy.”</p>	<p>Numerous research have shown that AOT reduces violence. They are quoted above (and attached). They were not done by Swanson. The DOJ certified AOT as an effective crime prevention program.¹⁰</p>
<p>IOC is a costly program that needs significant resources to have an impact. However, research has shown that, for the cost, there is minimal impact. It would take 27 IOC orders to prevent one instance of homelessness, 85 to prevent one (hospital) readmission, and 238 to prevent one arrest.</p>	<p>The incremental cost of AOT is under \$5000 each and is attributable to the court cost and program management costs. The statistics quoted are imputed from Cochrane report which as previously noted, did not include results from any studies subsequent to 1999</p>
<p>Notably, the 2005-2006 Fiscal Year budget for Kendra's Law operations was \$32 million, and that same budget included an additional \$125 million to expand case management services, to improve service access and utilization, and to increase the availability of other mental health services and supports.</p>	<p>This is a misrepresentation. The \$125 million was allocated for all mentally ill in New York State, not just those in Kendra's Law. That allocation was 10 years ago. Kendra's Law is operating effectively today without incremental funds.</p>
<p>Other mental health interventions are effective</p>	<p>We agree that other mental health interventions are effective for those who volunteer for them.</p>
<p>Research has shown that other interventions are efficient and effective in achieving the same goals as IOC. Three examples of such interventions are Peer-Run Crisis Respite Centers (PRCRs), supported housing, and mobile crisis teams. In Peer-Run Crisis Respite Centers, usually located in houses in residential neighborhoods rather than on distant and sprawling hospital campuses, people can live for a while during a mental health crisis. Run by individuals who are in recovery from a mental health condition – peers administer, staff and operate the center; and at least 51 percent of the board members identify as peers – PRCRs offer a nonmedical, trauma-informed environment that approximates the feeling of being at home. A randomized controlled trial of a PRCR (Greenfield, Stoneking, Humphreys, Sundby, & Bond, 2008, pp. 142-143) found that the average rate of improvement in symptom ratings was greater in the alternative than in the hospital comparison group, and that the peer-run alternative group had much greater service satisfaction. The cost was significantly less: \$211 per day for PRCR versus \$665 per day for hospitalization. The study authors concluded that this alternative was “at least as effective as standard care” and a “promising and viable alternative.”</p> <p>This use of outpatient commitment is not a substitute for intensive treatment; it requires a substantial commitment of treatment resources to be effective.”</p>	<p>We note that there is no research showing the peer respite centers deliver better outcomes than non-peer respite and supporters do not claim it does. Opponents of AOT do not cite any research that peer run respite centers reduce meaningful measures like reducing homelessness, arrest, incarceration, suicide, or hospitalization.</p>

¹⁰ Available at <https://www.crimesolutions.gov/ProgramDetails.aspx?ID=228>

<p>Supportive housing affords individuals with SMI the chance to live in their own apartments or homes, scattered in mainstream areas and buildings throughout the community, in addition to a flexible array of support services, including case management, life skills training, homemaker services, substance abuse treatment, and employment supports. A study of the Pathways to Housing program in Philadelphia, which provides supportive housing to formerly homeless individuals with serious mental illness and substance abuse disorders, found that the program reduced participants' shelter episodes by 88 percent, hospitalization episodes by 71 percent, crisis response center episodes by 71 percent, and prison system episodes by 50 percent.</p>	<p>We agree that housing is an important service for those in AOT and those who are not. AOT makes those unwilling or unable to accept housing, more willing and able. Further, most housing programs will not accept someone who is highly symptomatic and disruptive. AOT makes individuals with serious mental illness more likely to be accepted by those who run housing programs.</p>
<p>Mobile crisis services provide community-based psychiatric assistance (including psychiatric nurses, social workers, and paraprofessionals rather than law enforcement) to people in crisis situations. A national survey of mobile crisis services found that the services prevented hospitalization 55 percent of the time compared to only 28 percent for regular police intervention.</p>	<p>We agree that mobile crisis services are important.</p>
<p>The effectiveness of these voluntary, evidence-based services for individuals with serious mental health conditions has been widely demonstrated, but they are not sufficiently available to meet the need in any state.</p>	<p>We agree more services are needed. However, AOT is only for those who refuse voluntary services. You could have an extensive, robust community treatment system and some people will still refuse treatment. As one pundit put it, "If you build it, they will not come."</p>
<p>Rather than investing in unproven strategies like involuntary outpatient treatment, we should invest in voluntary services—such as supportive housing, supported employment, peer-run crisis respites, and mobile crisis services—that have a proven track record of success. Additionally, offering individuals the services that they need early on, in order to prevent crises and the need for high-end services, is a far more effective approach than waiting for individuals to fail and then providing services on a coercive basis (with the effect of driving many individuals away from the service system)</p>	<p>Voluntary services and AOT serve two mutually exclusive populations. AOT serves those who are unwilling or unable to volunteer, while voluntary programs serve those who can. AOT turns those who won't volunteer for treatment into those who can be treated.</p> <p>We can not hide our head in the sand and believe that everyone is well enough to volunteer for services. Headlines and jails are filled with the folly of that practice.</p>
<p>Given the limited impact of IOC when compared to the high cost, it is imperative that the resources of the United States be used to fund programs that have a positive and significant impact on improving the lives of persons with serious mental health conditions, and not on IOC.</p>	<p>AOT has a positive impact on rates of homelessness, suicide, arrest, incarceration and hospitalization. It cuts cost in half by allowing people who would otherwise be hospitalized or incarcerated receive less expensive community care. By reducing the use of more expensive jails, prisons, hospitals and inpatient commitment, AOT frees up funds that can be used to help all patients.</p>

9 Recent Independent Kendra's Law Studies

Independent Study	Findings
May 2011 Arrest Outcomes Associated With Outpatient Commitment in New York State Bruce G. Link, et al. Ph.D. Psychiatric Services	For those who received AOT, the odds of any arrest were 2.66 times greater ($p < .01$) and the odds of arrest for a violent offense 8.61 times greater ($p < .05$) before AOT than they were in the period during and shortly after AOT. The group never receiving AOT had nearly double the odds (1.91, $p < .05$) of arrest compared with the AOT group in the period during and shortly after assignment."
October 2010: Assessing Outcomes for Consumers in New York's Assisted Outpatient Treatment Program Marvin S. Swartz, M.D., Psychiatric Services	Consumers who received court orders for AOT appeared to experience a number of improved outcomes: reduced hospitalization and length of stay, increased receipt of psychotropic medication and intensive case management services, and greater engagement in outpatient services.
February 2010 Columbia University. Phelan, Sinkewicz, Castille and Link. Effectiveness and Outcomes of Assisted Outpatient Treatment in New York State Psychiatric Services, Vol 61. No 2	Kendra's Law has lowered risk of violent behaviors, reduced thoughts about suicide and enhanced capacity to function despite problems with mental illness. <i>Patients given mandatory outpatient treatment - who were more violent to begin with - were nevertheless four times less likely than members of the control group to perpetrate serious violence after undergoing treatment.</i> Patients who underwent mandatory treatment reported higher social functioning and <i>slightly less stigma</i> , rebutting claims that mandatory outpatient care is a threat to self-esteem.
March 2005 N.Y. State Office of Mental Health "Kendra's Law: Final Report on the Status of Assisted Outpatient Treatment. "	<p>Danger and Violence Reduced</p> <ul style="list-style-type: none"> • 55% fewer recipients engaged in suicide attempts or physical harm to self • 47% fewer physically harmed others • 46% fewer damaged or destroyed property • 43% fewer threatened physical harm to others. • Overall, the average decrease in harmful behaviors was 44%. <p>Consumer Outcomes Improved</p> <ul style="list-style-type: none"> • 74% fewer participants experienced homelessness • 77% fewer experienced psychiatric hospitalization • 56% reduction in length of hospitalization. • 83% fewer experienced arrest • 87% fewer experienced incarceration. • 49% fewer abused alcohol • 48% fewer abused drugs <p>Consumer participation and medication compliance improved</p> <ul style="list-style-type: none"> • Number of individuals exhibiting good adherence to meds increased 51%. • The number of individuals exhibiting good service engagement increased 103%. <p>Consumer Perceptions Were Positive</p> <ul style="list-style-type: none"> • 75% reported that AOT helped them gain control over their lives • 81% said AOT helped them get and stay well • 90% said AOT made them more likely to keep appointments and take meds. • 87% of participants said they were confident in their case manager's ability. • 88% said they and case manager agreed on what is important to work on. <p>Effect on mental illness system</p> <ul style="list-style-type: none"> • Improved Access to Services. AOT has been instrumental in increasing accountability at all system levels regarding delivery of services to high need individuals. Community awareness of AOT has resulted in increased outreach to individuals who had previously presented engagement challenges to mental health service providers. • Improved Treatment Plan Development, Discharge Planning, and Coordination of Service Planning. Processes and structures developed for AOT have resulted in improvements to treatment plans that more appropriately match the needs of individuals who have had difficulties using mental health services in the past. • Improved Collaboration between Mental Health and Court Systems. As AOT processes have matured, professionals from the two systems have improved their working relationships, resulting in greater efficiencies, and ultimately, the conservation of judicial, clinical, and administrative resources. o There is now an organized process to prioritize and monitor individuals with the

	<p>greatest need;</p> <ul style="list-style-type: none"> o AOT ensures greater access to services for individuals whom providers have previously been reluctant to serve; o Increased collaboration between inpatient and community-based providers.
<p>July 2013: The Cost of Assisted Outpatient Treatment. Can it Save States Money? American Journal of Psychiatry</p>	<ul style="list-style-type: none"> • In New York City net costs declined 50% in the first year after assisted outpatient treatment began and an additional 13% in the second year. In non NYC counties, costs declined 62% in the first year and an additional 27% in the second year. This was in spite of the fact that Psychotropic drug costs increased during the first year after initiation of assisted outpatient treatment, by 40% and 44% in the city and five-county samples, respectively. The increased community based mental health costs were more than offset by the reduction in inpatient and incarceration costs. Cost declines associated with assisted outpatient treatment were about twice as large as those seen for voluntary services
<p>October 2010: Changes in Guideline-Recommended Medication Possession After Implementing Kendra's Law in New York, Alisa B. Busch, M.D Psychiatric Services</p>	<p>In all three regions, for all three groups, the predicted probability of an M(edication) P(ossesion) R(atio) $\geq 80\%$ improved over time (AOT improved by 31–40 percentage points, followed by enhanced services, which improved by 15–22 points, and "neither treatment," improving 8–19 points). Some regional differences in MPR trajectories were observed.</p>
<p>October 2010 Robbing Peter to Pay Paul: Did New York State's Outpatient Commitment Program Crowd Out Voluntary Service Recipients? Jeffrey Swanson, et al. Psychiatric Services</p>	<p>In tandem with New York's AOT program, enhanced services increased among involuntary recipients, whereas no corresponding increase was initially seen for voluntary recipients. In the long run, however, overall service capacity was increased, and the focus on enhanced services for AOT participants appears to have led to greater access to enhanced services for both voluntary and involuntary recipients.</p>
<p>June 2009 D 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</p>	<p>We find that New York State's AOT Program improves a range of important outcomes for its recipients, apparently without feared negative consequences to recipients.</p> <ul style="list-style-type: none"> • Racial neutrality: We find no evidence that the AOT Program is disproportionately selecting African Americans for court orders, nor is there evidence of a disproportionate effect on other minority populations. Our interviews with key stakeholders across the state corroborate these findings. Court orders add value: The increased services available under AOT clearly improve recipient outcomes, however, the AOT court order, itself, and its monitoring do appear to offer additional benefits in improving outcomes. • Improves likelihood that providers will serve seriously mentally ill: It is also important to recognize that the AOT order exerts a critical effect on service providers stimulating their efforts to prioritize care for AOT recipients. • Improves service engagement: After 12 months or more on AOT, service engagement increased such that AOT recipients were judged to be more engaged than voluntary patients. This suggests that after 12 months or more, when combined with intensive services, AOT increases service engagement compared to voluntary treatment alone. • Consumers Approve: Despite being under a court order to participate in treatment, current AOT recipients feel neither more positive nor more negative about their treatment experiences than comparable individuals who are not under AOT.
<p>1999 NYC Dept. of Mental Health, Mental Retardation and Alcoholism Services. H. Telson, R. Glickstein, M. Trujillo, Report of the Bellevue Hospital Center Outpatient Commitment Pilot</p>	<ul style="list-style-type: none"> • Outpatient commitment orders often assist patients in complying with outpatient treatment. • Outpatient commitment orders are clinically helpful in addressing a number of manifestations of serious and persistent mental illness. • Approximately 20% of patients do, upon initial screening, express hesitation and opposition regarding the prospect of a court order. After discharge with a court order, the majority of patients express no reservations or complaints about orders. • Providers of both transitional and permanent housing generally report that outpatient commitment help clients abide by the rules of the residence. More importantly, they often indicate that the court order helps clients to take medication and accept psychiatric services. • Housing providers state that they value the leverage provided by the order and the access to the hospital it offers.

**Reduction in harmful events when Laura's Law
implemented in Nevada County, California**

Key Indicator	Pre-AOT	Post-AOT	Improvement
Hospitalization	1404 days	748 days	46.7%
Incarceration	1824 days	637 days	65.1%
Homelessness	4224 days	1898 days	61.9%
Emergency Contacts	220 contacts	123 contacts	44.1%

**Reduction in costs when Laura's Law
implemented in Nevada County, California**

Key Indicator	Pre-AOT	Post-AOT	Improvement
Hospitalization	\$346,950	\$133,650	\$213,300
Incarceration	\$78,150	\$2,550	75,600

Summary: Nevada County gave individuals under court order access to services and found Laura's Law implementation saved \$1.81-\$2.52 for every dollar spent

**Reduction in harmful events when Laura's Law
implemented in Los Angeles County**

Key Indicator	Percentage Decrease
Incarceration	Reduced 78%
Hospitalization	Reduced 86%
Hospitalization after AOT ended	Reduced 77%
Milestones of Recovery Scores	Increased

**Reduction in costs when Laura's Law
implemented in Los Angeles County**

Laura's Law cut taxpayer costs 40 percent in Los Angeles.

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Source for Nevada County Data: Michael Heggarty, Behavioral Health Director, Nevada County. "The Nevada County Experience," Nov. 15, 2011.

Source for Los Angeles County Data: County of Los Angeles. "Outpatient Treatment Program Outcomes Report" April 1, 2010 – December 31, 2010. Cost data from: Michael D. Antonovich, Los Angeles County Fifth District Supervisor, Los Angeles Daily News, December 12, 2011.

*Prepared by Mental Illness Policy Org.
3/2012 <http://lauras-law.org>*

Assisted outpatient treatment (AOT) research by outcome

SUMMARY: Forty-four states permit the use of assisted outpatient treatment (AOT), also called outpatient commitment. AOT is court-ordered treatment (including medication) for individuals who have a history of medication noncompliance, as a condition of their remaining in the community. Studies and data from states using AOT prove that it is effective in reducing the incidence and duration of hospitalization, homelessness, arrests and incarcerations, victimization, and violent episodes. AOT also increases treatment compliance and promotes long-term voluntary compliance. The six states that do not have AOT are Connecticut, Maryland, Massachusetts, New Mexico, Nevada, and Tennessee.

Assisted outpatient treatment reduces hospitalization

Several studies have clearly established the effectiveness of AOT in decreasing hospital admissions. Data from the New York Office of Mental Health on the first five years of implementation of Kendra's Law indicate that of those participating, 77 percent fewer experienced hospitalization (97 percent versus 22 percent).¹

A randomized controlled study in North Carolina (hereinafter —the North Carolina study||), demonstrated that intensive routine outpatient services alone, without a court order, did not reduce hospital admission. When the same level of services (at least 3 outpatient visits per month, with a median of 7.5 visits per month) were combined with long-term AOT (six months or more), hospital admissions were reduced 57 percent and length of hospital stay by 20 days compared with individuals without court-ordered treatment. The results were even more dramatic for individuals with schizophrenia and other psychotic disorders; for them, long-term AOT reduced hospital admissions by 72 percent and length of hospital stay by 28 days compared with individuals without court-ordered treatment. The participants in the North Carolina study were from both urban and rural communities and —generally did not view themselves as mentally ill or in need of treatment.||²

In Washington, D.C., admissions decreased from 1.81 per year before AOT to 0.95 per year after AOT.³ In a more recent Washington study of 115 patients, AOT decreased hospitalization by 30 percent over two years. The savings in hospital costs for these 115 patients alone was \$1.3 million.⁴ In Ohio, the decrease was from 1.5 to 0.4⁵ and in Iowa, from 1.3 to 0.3.⁶

In an earlier North Carolina study, admissions for patients on AOT decreased from 3.7 to 0.7 per 1,000 days.⁷ In a small AOT program in Florida, AOT reduced hospital days from 64 to 37 days per patient over 18 months. The savings in hospital costs averaged \$14,463 per patient.⁸

Only two studies have failed to definitively find AOT effective in reducing admissions. One was a Tennessee study in which it was evident that —outpatient clinics are not vigorously enforcing the law|| and thus nonadherence had no consequences.⁹

The second was a study of the Bellevue Pilot Program in New York City in which the authors acknowledged that a —limit on [the study's] ability to draw wide-ranging conclusions is the modest size of [the] study group.|| Additionally, during the period of the study, there was no procedure in place to transport individuals to the hospital for evaluation if they did not comply with treatment orders. As in the Tennessee study, nonadherence to a treatment order had no consequences. Although not statistically significant because of the small study group, the New York study suggests that the court orders did in fact help reduce the need for hospitalization. Patients in the court-ordered group spent a median of 43 days in the hospital during the study, while patients in the control group spent a median of 101 days in the hospital. The difference just misses statistical significance at the level of $p = 0.05$.¹⁰

Assisted outpatient treatment reduces homelessness

A tragic consequence for many individuals with untreated mental illnesses is homelessness. At any given time, there are more people with untreated severe psychiatric illnesses living on America's streets than are receiving care in hospitals. In New York, when compared to three years prior to participation in the program, 74 percent

fewer AOT recipients experienced homelessness.¹

Assisted outpatient treatment reduces arrests

Arrests for New York's Kendra's Law participants were reduced by 83 percent, plummeting from 30 percent prior to the onset of a court order to only 5 percent after participating in the program. When compared with a similar population of mental health service recipients, participants in the program were 50 percent more likely to have had contact with the criminal justice system prior to their court order.¹

The North Carolina study found that for individuals who had a history of multiple hospital admissions combined with arrests and/or violence in the prior year, long-term AOT reduced the risk of arrest by 74 percent. The arrest rate for individuals in long-term AOT was 12 percent, compared with 47 percent for those who had services without a court order.¹¹

In the Florida study, AOT reduced days spent in jail among participants from 16.1 to 4.5 days, a 72 percent reduction.⁸

Assisted outpatient treatment reduces violence

Kendra's Law resulted in dramatic reductions in the incidence of harmful behaviors for AOT recipients at six months in AOT as compared to a similar period of time prior to the court order. Among individuals participating in AOT, 55 percent fewer recipients engaged in suicide attempts or physical harm to self; 47 percent fewer physically harmed others; 46 percent fewer damaged or destroyed property; and 43 percent fewer threatened physical harm to others. Overall, the average decrease in harmful behaviors was 44 percent.¹

The North Carolina study found that long-term AOT combined with intensive routine outpatient services was significantly more effective in reducing violence and improving outcomes for severely mentally ill individuals than the same level of outpatient care without a court order. Results from that study showed a 36 percent reduction in violence among severely mentally ill individuals in long-term AOT (180 days or more) compared to individuals receiving less than long-term AOT (0 to 179 days). Among a group of individuals characterized as seriously violent (i.e., committed violent acts within the four-month period prior to the study), 63.3 percent of those not in long-term AOT repeated violent acts, while only 37.5 percent of those in long-term AOT did so. Long-term AOT combined with routine outpatient services reduced the predicted probability of violence by 50 percent.¹²

Assisted outpatient treatment reduces victimization

The North Carolina study demonstrated that individuals with severe psychiatric illnesses who were not on AOT "were almost twice as likely to be victimized as were outpatient commitment subjects." Twenty-four percent of those on AOT were victimized, compared with 42 percent of those not on AOT. The authors noted "risk of victimization decreased with increased duration of outpatient commitment" and suggested that "outpatient commitment reduces criminal victimization through improving treatment adherence, decreasing substance abuse, and diminishing violent incidents" that may evoke retaliation.¹³

Assisted outpatient treatment improves treatment compliance

AOT has also been shown to be extremely effective in increasing treatment compliance. In New York, the number of individuals exhibiting good service engagement increased by 51 percent (from 41 percent to 62 percent), and the number of individuals exhibiting good adherence to medication increased by 103 percent (from only 34 percent to 69 percent).¹

In North Carolina, only 30 percent of patients on AOT orders refused medication during a six-month period compared to 66 percent of patients not on AOT orders.¹⁴ In Ohio, AOT increased compliance with outpatient psychiatric appointments from 5.7 to 13.0 per year; it also increased attendance at day treatment sessions from 23 to 60 per year.⁴

AOT also promotes long-term voluntary treatment compliance. In Arizona, "71 percent [of AOT patients] . . . voluntarily maintained treatment contacts six months after their orders expired" compared with "almost no patients" who were not court-ordered to outpatient treatment.¹⁵ In Iowa "it appears as though outpatient commitment promotes treatment compliance in about 80 percent of patients while they are on outpatient commitment. After commitment is terminated, about three-quarters of that group remained in treatment on a

voluntary basis."⁶

Assisted outpatient treatment improves substance abuse treatment

Individuals who received a court order under New York's Kendra's Law were 58 percent more likely to have a co-occurring substance abuse problem compared with a similar population of mental health service recipients. The incidence of substance abuse at six months in AOT as compared to a similar period of time prior to the court order decreased substantially: 49 percent fewer abused alcohol (from 45 percent to 23 percent), and 48 percent fewer abused drugs (from 44 percent to 23 percent).¹

Consensus statement

In 2007, then leaders of American psychiatry published a consensus statement. It said: —Involuntary outpatient treatment is an underused strategy for violent patients. . . . Broader use of mandatory treatment after [hospital] release—as the newer generation of outpatient commitment statutes enables—should be helpful for involuntary patients who are unlikely to adhere to treatment and likely as a result to present a substantial violence risk.||¹⁶

ENDNOTES

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- Treatment Advocacy Center (www.treatmentadvocacycenter.org) Briefing paper: Assisted outpatient treatment (AOT) (updated 8/2009) page 5



Program Profile

Assisted Outpatient Treatment (AOT)

Evidence Rating: **Effective - More than one study**

Program Description

Program Goals

Assisted outpatient treatment (AOT), also known as outpatient commitment (OPC), is a civil legal procedure whereby a judge can order an individual with a serious mental illness to follow a court-ordered treatment plan in the community. AOT is intended for adults diagnosed with a serious mental illness who are unlikely to live safely in the community without supervision and treatment, and who also are unlikely to voluntarily participate in treatment. The goal of AOT is to improve access and adherence to intensive behavioral health services in order to avert relapse, repeated hospitalizations, arrest, incarceration, suicide, property destruction, and violent behavior.

Forty-four states have statutes permitting some form of OPC or AOT (Robbins et al. 2010). One example is New York State's "Kendra's Law." The law, passed in 1999, which was proposed by the New York State Attorney General, was named for a young woman who was killed after being pushed in front of a New York City subway by a man with a history of serious mental illness and hospitalizations. The intent of the law was not only to authorize court-ordered community treatment but also to require mental health authorities to provide resources and oversight necessary so that high-risk individuals with serious mental illness may experience fewer incidents and can live in a less restrictive alternative to incarceration or involuntary hospitalization.

Key Personnel

AOT is designed to ensure that service providers and county administrators deliver appropriate services to high-risk, high-needs individuals. Case managers, Assertive Community Treatment (ACT) team members, other clinical service providers, county personnel and attorneys, recipient advocates, and family members are among those who participate in AOT-related activities.

Under New York State's Kendra's Law, local AOT coordinators were created to monitor and oversee the implementation of AOT for each county and New York City. These local coordinators accept and investigate reports of individuals who may require AOT and arrange for the preparation of treatment plans and filing of petitions for AOT in local courts. Existing local programs are responsible for oversight and monitoring of clients by providing case management services. The case managers and ACT team members are in charge of directly monitoring an AOT recipient's level of compliance and delivery of services by other providers pursuant to the court order. Case managers and ACT team members report to local AOT coordinators on an individual's treatment status.

Target Population

Under New York's Kendra's Law, a person may be ordered to receive AOT if: the person is eighteen or older; suffers from a mental illness; has a history of lack of compliance with treatment that has at least twice within the last 36 months been a significant factor in necessitating hospitalization, or incarceration; or within the last 48 months, resulted in one or more acts or threats of serious violent behavior toward self or others and is unlikely to survive safely in the community without supervision. It must also be established that AOT is the least restrictive alternative. For some individuals, a voluntary service agreement may be signed in lieu of a formal court order. Individuals must agree to receive enhanced voluntary services, which usually include case management or ACT.

Program Components

Kendra's Law established mechanisms so that local mental health systems give individuals entering AOT priority access to case management and other mental health services that are essential to treating an individual's mental illness, avoiding relapse that would lead to arrest, incarceration, violence, self-harm, or rehospitalization, and helping the individual live in the community. Mandatory treatment plans are developed and implemented to ensure that comprehensive, community-based services are provided to AOT recipients by mental health officials. There is a wide range of services that can be included in the treatment plan, such as case management, medication management, individual or group therapy, day programs, substance abuse testing and services, housing or housing support services, and urine or blood toxicology (to ensure adherence to medication).

In many States, no court order goes into effect unless a treatment plan has been submitted to the court. The length of the court order can vary by individual. Court orders may not last longer than 6 months unless they are renewed by the court. When the court order expires, and it is not renewed, individuals continue receiving voluntary services. Noncompliance can lead to a temporary hold to evaluate for involuntary hospitalization.

Evaluation Outcomes

Program Snapshot

Age: 18 - 50

Gender: Both

Race/Ethnicity: Black, Asian/Pacific Islander, White, Other

Geography: Rural, Suburban, Urban

Setting (Delivery): Inpatient/Outpatient

Program Type: Cognitive Behavioral Treatment, Group Therapy, Individual Therapy, Wraparound/Case Management, Violence Prevention

Targeted Population: Mentally Ill Offenders

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