



TREATMENT
ADVOCACY
CENTER

A Guide for Implementing Assisted Outpatient Treatment

JUNE 2012

**Created for mental health professionals to
implement assisted outpatient treatment for
individuals with severe mental illness**



“A Guide for Implementing Assisted Outpatient Treatment”

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Written by Rosanna Esposito, Jeffrey Geller and Kristina Ragosta

The Treatment Advocacy Center is a national nonprofit organization dedicated to eliminating barriers to the timely and effective treatment of severe mental illness. The organization promotes laws, policies and practices for the delivery of psychiatric care and supports the development of innovative treatments for and research into the causes of severe and persistent psychiatric illnesses, such as schizophrenia and bipolar disorder.

Comments on Assisted Outpatient Treatment

FROM A PARTICIPANT

I never knew I could feel so well.

FROM A PARENT

Without AOT, my son would either be in jail or dead ... It alone has made a difference for him by helping him to stay on his meds.

FROM A JUDGE

[Assisted outpatient treatment] has provided life-saving services to individuals suffering from mental illness ... and has reduced the need for action by law enforcement, medical emergency personnel, and the Courts, and lessens the trauma and anguish of family and friends.

FROM A MENTAL HEALTH PROFESSIONAL

The clients involved in [AOT] were given the opportunity to recover at home with the support of their families and, by doing so, avoided being sent to the state hospital ... The successes achieved by these individuals are inspiring; watching these people move forward in their lives was one of the most rewarding experiences of my career.

For additional testimonials please see pages 53-56.

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“A Guide for Implementing Assisted Outpatient Treatment,” including all appendices and future updates, is available online at TreatmentAdvocacyCenter.org/solution/aotguide

List of Acronyms and Abbreviations

ACT	Assertive Community Treatment
ADM	Alcohol, Drug Addiction, and Mental Health
AOT	Assisted Outpatient Treatment
CAT	Citywide Assistance Team
CIT	Crisis Intervention Team
CSB	Community Services Board
CSS	Community Support Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
ICM	Intensive Case Management
IMPACT	Integrated Multidisciplinary Program in Assertive Community Treatment
NAMI	National Alliance on Mental Illness
OPC	Outpatient Commitment
PACT	Progressive Assertive Community Treatment
PSC	Primary Service Coordinator
OMH	Office of Mental Health
SBH	Seminole Behavioral Healthcare
TACT	Tracking for AOT Cases and Treatments

About the Guide

The guide that follows is designed to provide mental health professionals with real-world examples and suggestions for successfully implementing assisted outpatient treatment (AOT) in their communities. AOT is court-ordered, community-based intervention for individuals with severe mental illness who cannot, on their own, recognize their need for treatment. While there is much discussion about the subject – much of it based on inadequate information and profound misperceptions – there are few resources describing how it actually works in practice.

The guide is the result of interviews and in-person visits with more than 200 mental health professionals, participants, families, law enforcement officials, judges, and others over a multi-year period with numerous programs using AOT across the country. We are thankful to all the individuals who generously shared their time, experiences, and information with us. We are particularly grateful to the individuals who facilitated on-site visits to selected programs and arranged meetings with numerous local stakeholders: Mark Munetz, MD, chief clinical officer at Summit County ADM Board; Fred Frese, PhD, associate professor of psychiatry, Northeast Ohio Medical University, and coordinator of the Summit Recovery Project; Cynthia Pattillo, PhD, director of court services, New Horizons Community Service Board; Queens County Assisted Outpatient Treatment Program; Sherri Wittwer, executive director, National Alliance on Mental Illness (NAMI) Utah; Jed Erickson, associate director of adult services, Valley Mental Health; Steve Blanchard, administrator, Department of Psychiatry at University of Iowa; and Michael Flaum, MD, associate professor of psychiatry at the University of Iowa College of Medicine. We also want to express our appreciation to the Threshold Foundation Restorative Justice Funding Circle and others who provided necessary support for this project.

Through our ongoing research, interviews, and visits, we learned that AOT – when properly and effectively targeted and administered – allows for the delivery of mental health services to a population who, without it, would not receive adequate care and treatment. The difference in getting, rather than not getting, mental health services appropriate to the individual's needs, safety, and well-being translates into fewer hospital admissions, shorter lengths of stay in hospitals, less time in jails and prisons, fewer violent acts, and fewer incidents of being a victim of crime. These more easily measured outcomes result in greater participation in community affairs, less stigmatization, and higher quality of life.

While it is often feared that assisted outpatient treatment will increase mental health expenditures – an especially grave concern in an era of decreasing state and county resources for mental health – the evidence indicates AOT saves jurisdictions money. AOT is not an unfunded mandate but rather a tool that more efficiently uses resources and saves county and state monies by averting crises.

More important than saving money, assisted outpatient treatment can save lives. We hope the experiences and findings contained in this guide prove helpful as you consider and implement assisted outpatient treatment in your own community.

The Treatment Advocacy Center



Introduction

“A Guide for Implementing Assisted Outpatient Treatment” is a handbook for mental health agencies, judges, and other professionals charged with implementing court-ordered outpatient treatment laws in their communities. Also known as outpatient commitment, mandatory outpatient treatment, Kendra’s Law, Laura’s Law, and by other terms, assisted outpatient treatment (AOT) has emerged in the era of disappearing psychiatric hospitals as a less-restrictive alternative to hospitalization for individuals with severe mental illness who are unable to choose community services voluntarily. A civil – not a criminal – procedure, AOT is authorized by the civil commitment sections of state statute and typically adapted to local needs, practices, and policies. When fully implemented, AOT commits patients who meet strict legal criteria to the treatment system and at the same time “commits” the treatment system to patients.

With more than four decades of use, a continuously growing body of research demonstrates the effectiveness of AOT in improving the lives and clinical outcomes of individuals with severe mental illness and in reducing the consequences of non-treatment on the communities in which they live. Studies consistently find that court-ordered outpatient treatment increases short-term treatment adherence, promotes long-term voluntary compliance, and reduces the incidents and/or duration of hospitalization, homelessness, arrests and incarcerations, victimization, violent episodes, and other consequences of non-treatment. Among its most compelling functions, AOT provides a humane and therapeutic alternative to the jails and prisons that have replaced hospitals as the primary institutional setting for individuals with acute and chronic psychiatric diseases. By providing stable mental health treatment on an outpatient basis, AOT provides an exit from the revolving door.

Despite these well-documented benefits to recipients, their families, their communities, and society at large, state mental health agencies have provided little, if any, meaningful direction for the successful creation and implementation of AOT. This absence of useful information has limited the impact of assisted outpatient treatment and its positive results. With this guide, the Treatment Advocacy Center addresses that void by distilling the real-world experiences of existing, successful AOT programs into concrete guidance, which other jurisdictions can use to reduce the consequences of non-treatment in their own communities.

BACKGROUND

In 1955, there were 558,239 psychiatric hospital beds in the United States. By 2005, there were 52,539. If corrected for the increase in population, the number of public psychiatric hospital beds has decreased by 95 percent (Torrey et al. 2008). As deinstitutionalization continues, and as inpatient treatment for severe mental illness becomes less available, more individuals are now living in the community without the medical attention they need.

One of the earliest recorded uses of AOT occurred in 1972 at St. Elizabeths Hospital in Washington, DC, in the early years of deinstitutionalization.

“At that time, the Area D Community Mental Health Center was on the grounds of the hospital under the directorship of Dr. Roger Peele. One day over lunch, Dr. Peele and Dr. Armando Saenz, a ward psychiatrist, were

trying to decide what to do with a patient scheduled for discharge but who still needed supervision with her medication. Since she could legally be committed to inpatient status, Drs. Peele and Saenz wondered why they could not commit her to outpatient care instead. They raised this option with the Mental Health Commission, and the woman's lawyer, a respected public defender named Harry Fulton, agreed to it.

“Outpatient commitment then became increasingly popular at St. Elizabeths. The *CME Newsletter* published at the hospital in December 1984 summarized the experience with 293 patients committed to outpatient care between 1972 and 1984 and reported very favorable results: “The attorney chairman of the Mental Health Commission, who had served for the past 15 years, viewed outpatient commitment as effective and as a less restrictive alternative. He found it worked best for patients who needed to stay on medication and had no insight. Families of patients have reported to him that they found outpatient commitment extremely helpful” (D. Band, et al.: “Outpatient Commitment: A 13-Year Experience.” *CME Newsletter* 5: 1-5, 1984) (Torrey 2011).

At this time, 44 states and the District of Columbia have codified AOT in their civil commitment statutes as a treatment option.

METHODOLOGY

To develop “A Guide for Implementing Assisted Outpatient Treatment” the Treatment Advocacy Center examined successful AOT program sites across the country, with particular attention paid to seven sites in urban and rural locations from different geographic regions where different mental health delivery models were being utilized.

Five locations received site visits:

- Akron, Ohio
- Columbus, Georgia
- Iowa City, Iowa
- Queens, New York
- Salt Lake City, Utah

Two additional locations were surveyed without formal site visits:

- Nevada County, California
- Seminole County, Florida

Before the visits, Treatment Advocacy Center staff researched AOT implementation by conducting interviews with program staff nationwide and developed an extensive set of questions and requests for information. The goal was to gather as much information as

possible from every stakeholder associated with the programs. A visit agenda was developed in cooperation with local representatives prior to each site visit to assure that meetings took place with all key participants. Additionally, investigators collected copies of procedural guidelines, legal forms, patient outcome tracking forms, and other resources used at the sites.

Each visit was conducted over a two-day period and included meeting with participant psychiatrists, patients, case managers, law enforcement officials, judges, attorneys, family members, and others. A psychiatrist with expertise in community-based psychiatric services and at least one Treatment Advocacy Center staff attorney participated in interviews and data collection at each site visit.



What Is Assisted Outpatient Treatment?

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. Put another way, AOT is the combination of a court order and community-based psychiatric services.

In some locations, AOT is used as a mechanism for preventing decompensation, hospitalization, incarceration, or other negative outcomes of non-treatment. 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). 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. Only Connecticut, Maryland, Massachusetts¹, New Mexico, Nevada, and Tennessee have not yet codified AOT in their statutes.

AOT is not the only form of “assisted” or “leveraged” treatment that uses some form of explicit or implicit coercion to secure treatment adherence in the community. Other examples include advance directives, assertive case management, housing conditioned on acceptance of services, representative payee, conditional release, conservatorship or guardianship, and mental health courts.

Jurisdictions that utilize civil court orders to provide outpatient psychiatric services often refer to their AOT as “programs.” This guide follows that practice despite the implication that AOT involves a separate infrastructure created for administering AOT. This is far from universally true. In many jurisdictions, AOT is simply part of the existing framework for providing outpatient mental health services. Patients are fully integrated into service programs that are offered to all public mental health recipients; no additional staff positions, funding streams, or services dedicated to the AOT recipients are created. In such “programs,” the existence of a court order is the only difference between an AOT patient and an individual who has chosen to accept services. Discrete AOT programs do exist in some locations (the most well-known being New York’s Kendra’s Law program) but are in the minority. These programs develop separate infrastructure and bureaucracy for managing and providing services to AOT patients.

AOT PROCEDURES

State laws and regulations combined with local practice determine the procedures used for engaging individuals in AOT. What follows is a generic overview of procedures in use by the seven jurisdictions studied during the preparation of this manual and by other states and counties. It provides an illustration of how AOT might operate based on this experiential data. Governing state laws and local conditions will determine implementation procedures in each specific jurisdiction.

¹ In Massachusetts, AOT treatment is available through court orders known as Rogers Orders but not through a statewide AOT statute.

Evaluation. Civil commitment on either an inpatient (hospitalization) or outpatient (AOT) basis is usually initiated with an emergency pick-up/psychiatric evaluation, sometimes called a “hold,” “72-hour emergency admission,” or “provisional hospitalization.” Each state has explicit legal requirements that must be met before an individual with severe mental illness can be accepted by a hospital or evaluation center for an involuntary psychiatric examination.² Depending on the jurisdiction, the evaluation might be initiated by a physician, law enforcement officer, judge, or other adult familiar with the individual’s condition. All states have penalties for making false statements or for providing false information to authorities; most also have penalties for falsely initiating an involuntary psychiatric examination or a civil commitment.

Petition. If the individual with severe mental illness is evaluated and determined to meet state requirements for further treatment, the examining physician or treatment facility director can file a petition with a court for a hearing on the need for mandated treatment. In some states, possible outcomes of the hearing include court-ordered hospitalization, court-ordered outpatient treatment, or dismissal. In other states, a separate AOT petition must be filed, and the hearing solely addresses the question of whether AOT should be ordered.

Hearing. A judge or magistrate conducts a hearing to determine whether or not to order AOT. Some jurisdictions have formal hearings in the courtroom; others hold them in the treatment facility where the patient received an examination or is an inpatient. The individual with severe mental illness is represented by counsel. As with any court hearing, testimony and evidence are expected to be true and “proffered in good faith.”

Evidence and testimony are presented to help the judge decide whether or not the individual’s condition meets the [state standard for AOT](#). Each state has its own criteria for who is eligible for AOT.³ In some states, criteria are identical to the standards for court-ordered inpatient treatment. In several states, the criteria for court-ordered outpatient treatment are less restrictive than those that apply to hospitalization. Less restrictive criteria typically allow commitment before the individual deteriorates to the point of being an imminent danger to self or others. Examples of less restrictive criteria are standards of “grave disability” or a “need for treatment.” A [summary of the AOT standards](#) from the state civil commitment codes is available online at the Treatment Advocacy Center website.⁴

² See [TreatmentAdvocacyCenter.org/legal-resources/state-standards](https://www.treatmentadvocacycenter.org/legal-resources/state-standards) for a state by state listing of who can initiate an emergency hold/evaluation and for the required criteria.

³ See [TreatmentAdvocacyCenter.org/legal-resources/state-standards](https://www.treatmentadvocacycenter.org/legal-resources/state-standards)

⁴ See [TreatmentAdvocacyCenter.org/legal-resources/state-standards](https://www.treatmentadvocacycenter.org/legal-resources/state-standards)

Most states also require that the court be satisfied that AOT is the *least restrictive alternative* appropriate to the individual's needs before granting the order. If a less restrictive treatment or program exists that could effectively address the person's mental health needs, the court will not issue an AOT order.

Court order. If the judge determines that the state standards for AOT are met, AOT can be ordered. The order will typically include the length of time the patient will receive community treatment.

The order often includes a *treatment plan*, which is commonly developed by mental health professionals and the patient. Depending on individual state law, the treatment plan might be developed prior to the hearing, concurrent with the hearing, or even after the hearing and submitted to the court for ratification. Treatment plans are tailored to the specific needs of the individual and might include some, all, or a combination of the following: medication; assertive community treatment (ACT); case management services; blood or urinalysis tests to determine compliance with prescribed medications; individual or group therapy; day or partial-day programs; educational and vocational training; supervised living; alcohol or substance abuse treatment; or other services prescribed to treat the individual's mental illness and to assist the person in living and functioning in the community.

Noncompliance. In order for AOT to be effective, there must be some consequence for failure to comply with the treatment order. In most states, the consequence for non-compliance is an evaluation and possible inpatient hospitalization in a psychiatric facility. After this intervention, the AOT order may be continued to its given expiration date, modified in some manner (such as a change in a required service), or – if the patient no longer meets the standards for AOT – dismissed. A very few states permit a patient to be held in contempt of court or jailed for failing to comply with the issued court order. These measures are rarely used because the intent of using AOT to keep people out of the criminal justice system is defeated if they are jailed.

Renewal or expiration. Prior to the expiration of the court order, an application can be filed to extend the period of AOT. The permitted length of an extended order depends on state law. Research indicates that patients benefit most from AOT that is at least six months in duration; even better results are found for patients who receive court orders for 12 months or longer (Swartz et al. 2009).

Patient rights. State civil commitment laws establish patient rights for both court-ordered inpatient treatment and court-ordered outpatient treatment. Those rights often include the right to legal counsel in hearings, to present evidence and cross-examine witnesses, to appeal a treatment order, and not to be deemed legally incapacitated for other purposes solely on the determination of the need for AOT.



Who Is a Candidate for Assisted Outpatient Treatment?

Assisted outpatient treatment (AOT) is “intended to benefit severely mentally ill [adults] who need ongoing psychiatric care to prevent relapse, rehospitalization, and/or dangerous behavior, and who have difficulty following through with community-based treatment” (Swartz et al. 2001). In most cases, these individuals suffer from schizophrenia, bipolar disorder, major depression with psychotic features, or other severe brain disorder. Candidates for AOT usually have also been noncompliant with prescribed medication, have multiple inpatient psychiatric hospitalizations, and/or have histories of violence (Torrey and Kaplan 1995). Many individuals with severe mental illness who are subject to AOT orders would have been hospitalized in the past. Now, psychiatric medications make community-based treatment a viable option for some. The inadequate availability of psychiatric hospital beds makes community-based treatment a necessity for others.

For many of these individuals, relapse and its consequences stem from a lack of adherence to prescribed medications, a development that typically results from an impaired awareness of illness – a neurological syndrome called “anosognosia.” The condition affects approximately 50 percent of individuals with schizophrenia and 40 percent of individuals with bipolar disorder.⁵ Since individuals with this condition do not believe they are sick, they do not seek treatment and often reject it.

TARGET POPULATION CHARACTERISTICS

Each state AOT law clearly defines the target population that AOT is designed to serve. The standards for eligibility vary from state to state⁶ but often include that a person is 18 years of age or older; has a severe mental illness; refuses voluntary community treatment services; has or will experience some harm from the lack of treatment; and is able to survive safely in the community when compliant with prescribed treatment.

State standards for who qualifies for AOT traditionally fall into one of three categories: dangerousness, grave disability, or need-for-treatment. The so-called “dangerousness” standard requires that an individual with severe mental illness demonstrate an immediate, physical danger to self or others before a court can intervene and order treatment. States that rely exclusively on dangerousness tend to use AOT infrequently; by the time an individual’s condition has deteriorated to the level of dangerousness, inpatient hospitalization is often necessary for care and treatment.

Despite widespread misconceptions to the contrary, the great majority of states have laws that permit intervention based on other criteria that are broader than the familiar “dangerousness to self or others” standard. The specifics vary but generally include a second standard, referred to as “grave disability,” that focuses on the person’s inability to meet his or her basic survival needs.

⁵ For more information, see backgrounders on “Anosognosia” at [TreatmentAdvocacyCenter.org](https://treatmentadvocacycenter.org) and a video at [TreatmentAdvocacyCenter.org/video-gallery](https://treatmentadvocacycenter.org/video-gallery)

⁶ See a summary of your state AOT placement standards online at [TreatmentAdvocacyCenter.org/legal-resources/state-standards](https://treatmentadvocacycenter.org/legal-resources/state-standards)

Nearly half the states also permit AOT on a “need-for-treatment” basis. These standards are typically based on a person’s inability to provide for needed psychiatric care or a person’s inability to make an informed medical decision, or the need to prevent further psychiatric or emotional deterioration.

Research Findings on AOT Benefits

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. Specifically, the 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. Following are summaries of key findings:

Assisted outpatient treatment reduces hospitalization.

Several studies have clearly established the effectiveness of AOT in decreasing hospitalization.

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, 26-29).

A randomized controlled study in North Carolina (part of the so-called Duke Study) in 1999 demonstrated that intensive routine outpatient services alone, without a court order, did not reduce hospital admission. However, when the same level of services (at least three 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 was reduced by 20 days compared to individuals receiving the services alone. The results were even more dramatic for the subset of 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 the services alone. 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" (Swartz et al. 1999).

A 1986 study in Washington, DC, found that the average patient's number of hospital admissions decreased from 1.81 per year before AOT to 0.95 per year after AOT (Zanni and deVeau 1986). In a more recent Washington, DC, study of 115 patients, AOT decreased hospitalizations by 30 percent over two years. The savings in hospital costs for these 115 patients alone was \$1.3 million (Zanni and Stavis 2007). In Ohio, the decrease in hospital admissions was from 1.5 to 0.4 (Munetz et al. 1996) and in Iowa, from 1.3 to 0.3 over a 12-month period (Rohland 1998).

In an AOT program in Florida, AOT reduced hospital days from 64 to 37 days per patient over 18 months, a 42 percent decrease. The savings in hospital costs averaged \$14,463 per patient (Esposito et al. 2008).

Only two studies have failed to find court-ordered outpatient treatment effective in reducing admissions. One was a Tennessee study in which "outpatient clinics [were] not vigorously

enforcing the law,” and thus non-adherence had no consequences (Bursten 1986). The second was a Bellevue Hospital (New York City) study that pre-dated the enactment of Kendra’s Law and was based on a small AOT pilot program at that hospital (Policy Research Associates 1998). The study authors acknowledged that they could not “draw wide-ranging conclusions ... [due to] the modest size of [the] study group.” As in the Tennessee study, there were no consequences to an individual for non-adherence, calling the significance of the findings into serious question. Although not statistically significant because of the small study group, the Bellevue study suggests that the court orders did in fact help reduce the need for hospitalization. Patients in the control group spent a median of 101 days in the hospital, while patients in the court-ordered group spent a median of 43 days in the hospital during the study.

Assisted outpatient treatment reduces homelessness.

A tragic consequence for many individuals with untreated mental illness is homelessness. At any given time, there are more people with untreated severe psychiatric illness 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 (New York State Office of Mental Health 2005).

Assisted outpatient treatment reduces arrests and incarceration.

In March 2012, the Department of Justice, Office of Justice Programs, Crime Solutions program rated AOT as an “effective” evidence-based program for preventing crime based on the available research (CrimeSolutions.gov).

A study of New York State’s Kendra’s Law program published in 2010 concluded that the “odds of arrest in any given month for participants who were currently receiving AOT were nearly two-thirds lower” than those not receiving AOT (Gilbert et al. 2010).

According to a New York State Office of Mental Health 2005 report on Kendra’s Law, arrests for AOT participants were reduced by 83 percent, plummeting from 30 percent prior to the onset of a court order to only five percent after participating in the program (New York State Office of Mental Health 2005, 18).

In a Florida report, AOT reduced days spent in jail among participants from 16.1 to 4.5 days, a 72 percent reduction (Esposito et al. 2008).

Similarly, the Duke Study in North Carolina 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 participants in long-term AOT was 12 percent, compared with 47 percent for those who had services without a court order (Swanson et al. 2001a).

Assisted outpatient treatment reduces violence, crime, and victimization.

The 2005 New York State Office of Mental Health report also found that Kendra’s Law resulted in dramatic reductions in harmful behaviors for AOT. Among AOT recipients at six months of AOT compared to a similar period of time prior to the court order: 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 these and other harmful behaviors was 44 percent (New York State Office of Mental Health 2005, 16).

A 2010 study by Columbia University's Mailman School of Public Health reached equally striking findings about the impact of Kendra's Law on the incidence of violent criminal behavior. When AOT recipients in New York City and a control group of other mentally ill outpatients were tracked and compared, the AOT patients – despite having *more* violent histories – were found four times less likely to perpetrate serious violence after undergoing treatment (Phelan et al. 2010).

The Duke Study in North Carolina 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 with individuals receiving AOT for shorter terms (0 to 179 days). Among a group of individuals characterized as “seriously violent,” 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 (Swanson et al. 2001b).

The North Carolina study further 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 (Hiday et al. 2002).

Assisted outpatient treatment improves treatment compliance.

AOT has also been shown to be effective in increasing treatment compliance. In New York, according to the 2005 New York State Office of Mental Health report, AOT led to a 51 percent increase in recipients' exhibition of good service engagement, and more than doubled the exhibition of “good” adherence to medication (New York State Office of Mental Health 2005, 11-13).

In North Carolina, only 30 percent of AOT patients refused medication during a six-month period, compared with 66 percent of patients not under AOT (Hiday and Scheid-Cook 1987). In Ohio, AOT increased attendance at 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 (Munetz et al. 1996).

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 (Van Putten et al. 1988). 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” (Rohland 1998).

The New York independent evaluation also yielded interesting findings on the likelihood of voluntary compliance after AOT is allowed to expire. For individuals who received AOT for periods of six months or less, the researchers found that post-AOT sustainability of improvements in medication adherence depended on whether intensive outpatient services were continued on a voluntary basis. Those who continued with intensive services maintained their substantial increase in medication adherence relative to the pre-AOT period (from 37 to 45 percent); those who discontinued such assistance dropped back to near the pre-AOT levels (33 percent). Patients who received AOT for more than six months, however, experienced *increased* medication adherence *whether or not intensive services were continued*. The medication adherence rate was higher for those who continued intensive services than for those who did not (50 percent vs. 43 percent), but both groups maintained substantial improvements from the pre-AOT rate (37 percent) (Swartz et al. 2009, 39-44).

Assisted outpatient treatment improves substance abuse treatment outcomes.

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 not receiving AOT. Furthermore, the prevalence 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) (New York State Office of Mental Health 2005, 16).

Assisted outpatient treatment reduces caregiver stress.

A study published in 2004 examined the impact of AOT on those who serve as primary caregivers for people with severe mental illness (typically, family members). The level of reported stress was compared for caregivers of individuals who received AOT of at least six months, those who received brief AOT, and those who received no AOT. The results indicated that extended AOT (six months or more) significantly reduced caregiver stress. Not surprisingly, improved treatment adherence was also found to reduce caregiver stress. Notably, the study showed that AOT operates as an independent factor from treatment adherence in reducing stress. That is, AOT “contributes significantly to reduced caregiver strain, over and above its effect on treatment adherence” (Groff et al. 2004).

Steps for Effectively Implementing AOT

The following checklist was developed from the experience, suggestions, and research of sites where AOT is already effectively implemented. It provides a representative model that may be used in its entirety or selectively to create a new AOT option that reflects local needs, practices, and realities.

Implementation Checklist

- Know the law
- Collect information and contact existing AOT practitioners
- Ensure leadership support
- Identify stakeholders and establish community partnerships
- Develop a project team
- Designate an AOT coordinator
- Create the process
- Anticipate common questions
- Educate mental health agency staff
- Educate and inform other stakeholders
- Select the first AOT candidate wisely
- Develop assessment forms
- Develop outcome tracking tools
- Evaluate patient and program outcomes
- Seek ongoing input from within agency and beyond
- Make modifications based on findings
- Create promotional tools
- Highlight successes for policymakers and the public at large

Know the law. Implementation needs to begin with reviewing the civil commitment laws and regulations in your state to determine the availability of AOT (or not), the legal standards for qualifying a patient to participate, the procedures outlined for how an AOT order can be issued, and other guidelines. A state-by-state overview of the placement standards for AOT is

provided at the Treatment Advocacy Center website.⁷ Additionally, because state laws can change in any legislative season, your state’s civil commitment code should always be consulted to determine whether changes have occurred.

Collect information and contact existing AOT practitioners. With laws on the books in 44 states and their use for nearly four decades, a significant body of information and resources exists that can be accessed for guidance or adaptation when developing an AOT option in your county. The appendices to this manual provide numerous forms, templates, testimonials, and presentations about AOT and are an excellent place to start. State mental health directors and/or state National Alliance on Mental Illness (NAMI) executive directors may be able to identify community mental health centers using AOT in your state that you may visit or interview. Professionals administering AOT in another state may also be helpful.

The Treatment Advocacy Center website (TreatmentAdvocacyCenter.org) provides a wealth of information and resources including data on the consequences of non-treatment, state-specific civil commitment information, legal articles, case studies, videos about AOT and anosognosia, research on AOT effectiveness, and more.

Comprehensive information about the most well-known AOT program, Kendra’s Law, is offered on the New York State Office of Mental Health’s website (<http://bi.omh.ny.gov/aot/about?p=what>). The state maintains a robust collection of data, reports, procedural details, and historical background about its AOT program.

Ensure leadership support. A key predictor of AOT program success is leadership endorsement from the executive director and chief medical officer of the community mental health center that will be utilizing AOT. If these officials are not already familiar with them, familiarizing these individuals with the benefits of AOT for the patient and the community will be helpful. Support from leaders in the mental health community and the judiciary is also critical. Sharing success stories from other jurisdictions, providing copies of studies that document AOT benefits that are listed in the bibliography to this manual, and sharing videos that show the positive impact of AOT in the lives of real people will be illuminating. The 30-minute documentary video, “[Stopping the Revolving Door – A Civil Approach to Treating Severe Mental Illness](#),” and “[One Family’s Journey](#)” may be viewed online or by requesting the DVD from the Treatment Advocacy Center. A California program is featured in “[Assisted Outpatient Treatment: The Nevada County Experience, Laura’s Law](#).”⁸

Identify stakeholders and establish community partnerships. Most of the programs profiled in this manual had well-established, collaborative relationships with stakeholders in mental health issues. The agencies were able to leverage other people and organizations who all wanted to help individuals with severe mental illness. Some of the stakeholder groups met on a regular basis to identify and cooperatively resolve mental health issues in their local communities. The existing relationships made it easier to communicate about the design and implementation plans for AOT.

⁷ See TreatmentAdvocacyCenter.org/legal-resources/state-standards

⁸ Videos are available at TreatmentAdvocacyCenter.org/video-gallery

Stakeholders may include:

- ❑ **Mental health professionals**
 - CEO/president of community mental health agency
 - Medical director
 - AOT coordinator
 - Case management supervisor
 - Supervisor at crisis stabilization unit or ER conducting emergency evaluations
 - Person from agency who testifies at hearings
 - Psychiatrists
 - Social workers
 - Psychologists
- ❑ **State hospitals and psychiatric units in general hospitals**
 - State or regional hospital CEOs or their assigned representative(s)
 - State or regional hospital liaison(s) for discharges to community
 - Emergency services personnel and responders
 - Key intake/evaluation/discharge staff
- ❑ **Law enforcement and corrections**
 - Chief of police, officers, or deputies on the beat
 - Law enforcement personnel responsible for pick-ups/transport
 - Jail liaison(s) to mental health center or jail mental health official
 - Crisis Intervention Team (CIT)
- ❑ **Legal system and judiciary**
 - Judge or magistrate responsible for hearings
 - District attorney or other attorney who argues for petition
 - Public defender or other attorney who argues against petition
 - Court clerk who tracks petitions
 - Court officer
- ❑ **Patients, family members, community members**
 - Patients likely to be in program
 - Patients' family members
 - Self-help groups (e.g., Dual Diagnosis Support Group)
 - Advocacy organizations (e.g., NAMI)
 - Local establishments for persons without resources (food pantry, shelters, etc.)
 - Homeless outreach workers
 - Public libraries⁹

⁹ The impact of deinstitutionalization of mentally ill individuals on public libraries was documented in a report in the March/April 2009 issue of *Public Libraries*.

Develop a project team. While it is important to have open dialogue with all stakeholders about creating an AOT procedure, it is essential to have a small multidisciplinary team tasked with planning the details. Ideally, to reflect how important the project is, the lead official from the mental health agency or the local stakeholders' group should be the one to invite members to be part of this select group. The team should comprise of the five or six most-essential players for the daily AOT operations, or their representatives (e.g., the agency medical director, AOT coordinator, the hospital point person for patient discharge, the judge/magistrate responsible for AOT hearings, the public defender, and the state attorney/county prosecutor). Other stakeholders can and should be invited to give input as the process develops.

Designate an AOT coordinator. It is helpful to identify an individual in the mental health agency or organization who will act as AOT coordinator and have primary responsibility for program/patient oversight, program education and outreach, and communication with other stakeholders. This appointee also can serve as the agency expert and point person on AOT issues, maintain outcome data, troubleshoot, or help coordinate patient care. Some existing AOT sites have filled this position informally with an existing staff member and others more formally with a new full-time or part-time position, depending on the needs of the community mental health center. (See [Appendix 1](#) for a sample job description.)

Whoever fills the role, the AOT coordinator must be knowledgeable about the laws, policies, procedures, and paperwork associated with court-ordered outpatient treatment. To acquire this knowledge, the coordinator could:

- ❑ Attend any existing state trainings on civil commitment laws.
- ❑ Become familiar with the court paperwork and the court personnel.
- ❑ Network with key stakeholders.
- ❑ Observe current AOT procedures in another jurisdiction.
- ❑ Obtain or create a procedural flow chart for how AOT works.

Create the process. State law, regulation, and local custom will dictate most of the procedures for using AOT (e.g., who can petition and on what basis, when a hearing is held, how the hearing proceeds, how a treatment plan is created, what happens in the event of noncompliance, etc.). Identifying and mapping the steps and participants involved at each stage will improve efficiency and avoid confusion. Steps toward creating a process could include:

- ❑ Developing a fictitious “candidate” to walk through the entire process in order to see where logistics need to be further refined;
- ❑ Creating a flow chart that identifies each step of the process, its timing, and who is responsible for the step;
- ❑ Creating your own templates for the most commonly encountered situations if your state does not provide them (e.g., emergency evaluation, court hearings, and treatment planning issues). Samples are provided in [Appendix 2](#).

Anticipate common questions. During our site visits, we asked what challenges were faced during implementation. A few issues occurred at more than one site. It can help

implementation efforts to identify, prepare for, and – where possible – resolve common issues before they become problems. Since established AOT programs have already worked through many of these issues, it may be helpful to contact one or more of them to learn what steps they took to resolve them. Treatment Advocacy Center staff members are a good source for more detailed information on these issues.

- ❑ **Civil liberties**
 - Does AOT protect civil liberties?
- ❑ **Procedures**
 - What is the best way to coordinate transitions from inpatient/emergency settings to AOT?
 - How will an emergency room know if there is an AOT order in place for a patient who shows up? Who does the ER contact to coordinate with AOT services?
 - How should families be involved in giving testimony, in providing information on prior treatment and service history, and in creating the treatment plan?
 - How will the HIPAA (Health Insurance Portability and Accountability Act of 1996) and other patient record confidentiality rules be followed?
- ❑ **Legal system**
 - What can be done to facilitate service of process for potential AOT candidates who have no residence?
 - Is it possible to have a consistent set of judges who become familiar with AOT and offer consistent application of law?
 - What steps are involved in enforcing an AOT order?
 - At the AOT hearing, will there be representation both for and against the proposed AOT so that the judge has complete information for the decision?
- ❑ **Resources**
 - How much money does AOT cost?
 - How much money does AOT save?
 - Is AOT an unfunded mandate?
 - Does AOT siphon resources from other clients?
 - Does AOT give priority to certain patients over others?

Educate mental health agency staff. While conducting site visits, we found strong familiarity with and acceptance of AOT from staff throughout the mental health agencies responsible for providing the community services ordered by the court. Case managers, administrators, and outreach staff all had good working knowledge of what assisted outpatient treatment is, what it

is not, and how it works. This type of information should be presented to staff on an ongoing basis – before, during, and after implementation. Tips for educating agency staff include:

- ❑ Developing and encouraging a team approach *prior* to starting AOT;
- ❑ Training key individuals as mentors;
- ❑ Holding a training session for all staff involved in the AOT process and/or interacting with patients or prospective patients. Training can include education about the state law, the AOT procedure, how AOT patient services are similar to or different from others, testimonials from patients on their experiences, or videos such as “[Stopping the Revolving Door](#)” or “[Assisted Outpatient Treatment: The Nevada County Experience, Laura’s Law](#)”; and,
- ❑ Using the agency’s intranet to provide AOT information to all staff regardless of whether they are directly involved with its implementation.

Educate and inform other stakeholders. Successful AOT programs also typically have high levels of knowledge, cooperation, and buy-in among stakeholders who have a shared understanding of the goals and potential benefits of AOT. Education can overcome well-intentioned but common misunderstandings about AOT. All stakeholders should be familiar with the basics of AOT, including general procedures, responsibilities of those involved, and desired outcomes. Education needs to begin early and be ongoing. Stakeholders who will be involved in daily AOT operations should be informed and trained *prior* to filing the first petition for an AOT order. All stakeholders, whether involved on a daily basis or not, will benefit from ongoing information and education before, during, and after implementation.

Techniques for educating stakeholders:

- ❑ Present at stakeholder meetings and conferences.
- ❑ Place articles in stakeholder publications and newsletters.

Additional techniques for educating specific stakeholder groups:

- ❑ For judges, magistrates, and attorneys who will be involved in the AOT process and for those who regularly interact with individuals with severe mental illnesses:
 - Share letters, data, and other information from judges and attorneys who have used AOT (see [Appendix 3](#)).
 - Provide facts about anosognosia.¹⁰
 - Create opportunities for meetings with patients who likely will benefit from AOT.
 - Provide details about the rationale behind treatment plans and how various services within them will benefit recipients.

¹⁰ See “Anosognosia” backgrounders at [TreatmentAdvocacyCenter.org](https://treatmentadvocacycenter.org) and “Anosognosia” videos at [TreatmentAdvocacyCenter.org/video-gallery](https://treatmentadvocacycenter.org/video-gallery)

- Provide a sample attorney checklist for AOT hearings (see [Appendix 2](#)).
- For law enforcement officials:
 - Create a short (2-5 minutes) presentation on AOT for roll call meetings.
 - Develop materials or a presentation for new-officer training programs.
 - Provide materials for ongoing law enforcement training programs, such as CIT.
 - Visit with officers when they transport individuals to the community mental health center for evaluation or admission. (An AOT coordinator is well-suited for this task.)

Select the first AOT candidate wisely. Be certain the first candidate for AOT clearly meets the statutory requirements and is likely to benefit from the AOT order. Besides meeting the needs of the patient, establishing positive outcomes from the start reinforces the benefits of AOT and may win over any skeptics among your stakeholders. As a practical matter, many AOT candidates are well known to the local mental health system as “revolving door” patients. The first candidate you select may well be an individual who is familiar to the key stakeholders and someone who clearly needs additional help to successfully engage in community-based services.

Develop assessment forms. The primary goal of AOT is to help patients achieve better outcomes, which makes accurate pre- and post-treatment assessment essential. AOT programs that succeeded at collecting patient outcome information researched records and surveyed patients about such variables as basic demographics, diagnoses, medication adherence, substance abuse, global assessment of functioning (GAF) scores, awareness of illness ratings, incidents and duration of psychiatric hospitalizations, incidents and duration of incarcerations, incidents of homelessness, etc. Assessments should be made at baseline (when the AOT order is issued) and on an ongoing basis – but no less than every six months. Assessment forms may be completed by case managers or ACT team staff and must adhere to any relevant patient information confidentiality guidelines. Sample assessment forms are located in [Appendix 4](#).

Develop outcome tracking tools. The information from the assessment forms should be maintained in a database or equivalent data tracking and reporting tool. Such an outcome tracking tool will make it easier to review cases on a systematic basis, to generate comprehensive reports for evaluating the need for resources and the effectiveness of programs; and to highlight areas for improvement. An example of an outcome tracking database is available in [Appendix 4](#). With any tracking tool, be sure that patient privacy is respected. For example, use an anonymous identification number instead of names in the records or restrict access to the database to only one or two persons who are authorized to review patient records.

Evaluate patient and program outcomes. Using the assessment forms and tracking tools referenced above, it is possible to compare pre-AOT and post-AOT outcomes. (For examples, see [Appendix 4](#) and the [New York State Office of Mental Health’s Kendra’s Law website](#).) In addition to demonstrating program effectiveness, patient and program outcomes can be persuasive data to include in funding proposals to government appropriations officials and

grant-making organizations. Providing cost-impact data (e.g., reduction in hospitalizations, arrest, and incarceration within the AOT population) can create a fiscal incentive to county and state authorities to maintain and develop the use of AOT to help more individuals.

Seek ongoing input from within the agency and beyond. Invite regular feedback from all stakeholders who are involved in the AOT process on how well it is working and where improvements can be made.

Make modifications based on findings. Use experience, input from stakeholders, and program evaluations as a basis for making necessary improvements to AOT procedures and practices. Modify the AOT procedures if the state laws or regulations are updated.

Create promotional tools. Once the AOT process is implemented, it is important to continue building awareness about why and how AOT is used to benefit patients and the community. A small “toolkit” of promotional materials for ongoing education and awareness building can be deployed in various settings and with diverse audiences.

Consider developing the following types of resources (examples in [Appendix 5](#)):

- ❑ Visual presentation that can be given in person or posted to an intranet or website
- ❑ Short written, or videotaped, or audio-recorded patient testimonials on personal experiences with AOT
- ❑ Video about AOT showing how it works in your community¹¹
- ❑ Brochure or handout on AOT basics for patients, family members, and others
- ❑ Simple outline and explanation of who is responsible for each step in the AOT procedure, including the patient
- ❑ Short explanatory article about AOT that can be reproduced in other stakeholder newsletters
- ❑ Standard templates for hearings, treatment plans, and orders if not provided already by the state (see [Appendix 2](#))

Highlight successes for policymakers and the public at large. Be an advocate for programs that work so they receive ongoing support and funding. Include patient and program outcomes in:

- ❑ Community mental health center annual reports;
- ❑ Presentations and reports to county and state officials and other funding sources; and

¹¹ Three videos are available online at [TreatmentAdvocacyCenter.org/video-gallery](https://treatmentadvocacycenter.org/video-gallery) or by requesting a DVD from the Treatment Advocacy Center: the 30-minute documentary video “[Stopping the Revolving Door – A Civil Approach to Treating Severe Mental Illness](#),” “[One Family’s Journey](#),” and “[Assisted Outpatient Treatment: The Nevada County Experience, Laura’s Law](#).”

- ❑ Publications and local media using articles, letters to the editor, opinion pieces, and interviews.

Case Studies from AOT Sites

Visits to five sites that use AOT between January 2008 and May 2008, along with interviews and interactions with other sites, discovered common practices and qualities in successful AOT programs:

- Frequent and solid communication between provider agencies and doctors, law enforcement, attorneys, and the court
- Leadership and staff who are dedicated to treating individuals with the most severe mental illness
- Tracking and evaluation of patient outcomes in order to determine the need for resources, effectiveness of programs, and to identify areas for individual and system changes
- Stakeholders who understand the AOT process and the law, including the standard for commitment
- Representation for both the petitioner and the potential AOT recipient at the AOT hearing
- Practices for fostering compliance with court orders
- Buy-in from the local Department of Mental Health and the top executive of the community service provider

The following case studies incorporate observations from the visiting teams, interviews with stakeholders, and statements provided directly by the programs, which may vary in style or terminology.



Akron, Ohio

FACILITY

Summit County Alcohol, Drug Addiction and Mental Health Services (ADM) Board

Official site visit meetings and interviews

Included representatives from the county ADM Board clinical staff; Community Support Services (CSS) case managers, psychiatrists and nurses and adult intake unit; NAMI of Summit County; Akron Police Department and CIT; Ohio CIT; Summit County Probate Court magistrates, practicing attorneys, and court clerk; Summit County Sheriff's Office; Northeast Ohio Medical University; Ohio Criminal Justice Coordinating Center of Excellence research staff; Portage Path Psychiatric Emergency Services; Summa Health Systems; Ohio Psychiatric Physicians Association; Summit Consumer Peer Support Network; and Choices, a consumer-run social center.

Estimated number of AOT patients

Eighty to 100 individuals are under outpatient commitment orders on any given day.

Team structure

Includes a case manager, lawyer, law enforcement, psychiatrist, probate court, and ADM.

Overview

In Summit County, Ohio, thousands of individuals with severe mental illness have benefited from AOT, known there as outpatient commitment or OPC.

More than 15 years ago, county mental health officials established a new framework for court supervision of mentally ill people who are receiving community-based care. While well-designed on paper, the ultimate success of this program comes from the way that all participating agencies work together to uphold the program's purpose. AOT thrives in Summit County because judges, lawyers, mental health professionals, caseworkers, and law enforcement officers all recognize the clinical benefits of AOT and also share the same strong desire to see individuals with serious mental illness stay as functioning members of their communities. These parties meet together no less than quarterly.

The outpatient commitment process in Summit County typically begins with the release of a person from inpatient care. (The law also permits outpatient commitment without a preceding hospitalization.) The court assesses all relevant information to carefully balance the patient's need for continued supervised treatment against his/her ultimate right to return to the community without restrictions. When an individual is placed under an order of outpatient commitment in Summit County, it is a commitment to the ADM Board. The treatment plan is developed by the treating mental health professionals.

Case managers from a private non-profit agency who assist these patients in the community readily acknowledge that this continuation of court-ordered treatment greatly increases treatment compliance and decreases practical problems for patients. The understanding by an individual that he or she is subject to an ongoing court order and may be ordered back for further evaluation is a sufficient inducement for most patients to comply with their treatment plans.

Statutory history

The existing civil commitment law passed in 1988. The process for creating the law involved input from patient advocates and others within the mental health community, including attorneys with advocacy agendas.

Who can file a petition for AOT?

Although any person with reliable or actual knowledge of the individual's condition can commence commitment proceedings by filing an affidavit with the court,¹² the process for a hospitalized patient generally begins with the medical director of a hospital applying to the court.

Common patient characteristics

Many of the individuals placed under an OPC order in Summit County have been previously hospitalized and suffer from schizophrenia. According to the Summit County ADM guidelines related to OPC:

For the purpose of treating individuals in the least restrictive environment consistent with their needs, the Mental Health Act of 1988 allows for the commitment of persons, who are deemed to be mentally ill and subject to court ordered hospitalization, to the ADM Board. Under the direction of the Chief Clinical Officer, the Board then determines the least restrictive setting consistent with that person's needs. The law therefore encourages the use of community-based alternatives to hospitals for persons subject to court ordered hospitalization.

The Summit County ADM Board encourages the use of such alternatives for two overlapping patient populations:

- A. As an alternative to an acute hospitalization at the time of presentation (i.e., without an initial period in the hospital). This is referred to as "outpatient commitment at the front door." These people are not willing to be treated on a voluntary basis, have an acute problem which is deemed likely to respond to a brief period of involuntary, community based treatment and their dangerousness is such that they are believed to be safely cared for in a community based (hospital-alternative) setting. Use of

¹² OHIO REV. CODE ANN. § 5122.11

“outpatient commitment” with this group of individuals is largely based on the nature of their acute presentation and the availability of community alternatives to the hospital that can safely meet their needs.

- B. As a means to discharge from hospital (or avoid the need for hospitalizing) those individuals who are believed to require a probate court mandate for treatment in order to participate with that treatment necessary to allow them to live and function safely in a community setting. Historically, without court ordered treatment, these individuals have demonstrated that they repeatedly suffer relapses of their mental illness resulting in the need for involuntary hospitalization. For purposes of clarity, these commitments will be referred to as “sustaining outpatient commitments.”¹³

Hearings

- ❑ Once per week for inpatient
- ❑ Once per month for outpatient (“renewals”) with an average 8-10 cases handled at that hearing
- ❑ Held at a CSS facility
- ❑ Commitment hearing typically averages 10 minutes in duration (20 minutes for a long one); renewals generally take less time.
- ❑ Doctor/physician testifies at hearing.

NOTE: The officials we met with had long-term involvement with the mental health treatment system: 20-30 years for magistrate; 20-30 years for ADM attorney; 4-5 years for patient representative.

Average length of commitment

The initial commitment is for 90 days.

Renewal process

- ❑ Renewals can be for 90 days to two years.
- ❑ Patients can stipulate to an extension; about 50 percent stipulate, and about 50 percent go to hearing.
- ❑ 25 percent of renewal requests are denied.
- ❑ Court holds renewal hearings monthly at CSS facility.
- ❑ Court holds weekly inpatient hearings at the hospital.

¹³ Summit County ADM Board, *Guidelines for Patients Committed to the Board* (“Outpatient Commitment”), CP 03.03.11

Outcome data

The effectiveness of AOT in decreasing hospital admissions in Summit County was clearly established more than a decade ago when the county documented a decrease from 1.5 to 0.4 admissions per year before and after AOT (Munetz et al. 1996). AOT also increased patients' compliance with outpatient psychiatric appointments from 5.7 to 13.0 per year and attendance at day treatment sessions from 23 to 60 sessions per year (Munetz et al. 1996).

Summary of Ohio civil commitment law

For both inpatient and outpatient:

OHIO REV. CODE ANN. SECTION 5122.01 (B) "Mentally ill person subject to hospitalization by court order" means a mentally ill person who, because of the person's illness:

1. Represents a substantial risk of physical harm to self as manifested by evidence of threats of, or attempts at, suicide or serious self-inflicted bodily harm;
2. Represents a substantial risk of physical harm to others as manifested by evidence of recent homicidal or other violent behavior, evidence of recent threats that place another in reasonable fear of violent behavior and serious physical harm, or other evidence of present dangerousness;
3. Represents a substantial and immediate risk of serious physical impairment or injury to self as manifested by evidence that the person is unable to provide for and is not providing for the person's basic physical needs because of the person's mental illness and that appropriate provision for those needs cannot be made immediately available in the community; or
4. Would benefit from treatment in a hospital for the person's mental illness and is in need of such treatment as manifested by evidence of behavior that creates a grave and imminent risk to substantial rights of others or the person.



Columbus, Georgia

FACILITY

**New Horizons Community Services Board (CSB);
West Central Georgia Regional Hospital**

Official site visit meetings and interviews

Included representatives from New Horizons CSB leadership team; county probate court judge and practicing attorneys; program staff from New Horizons group home, day programs, emergency services; NAMI Columbus; consumers who have experienced outpatient commitment and their families; the state hospital; and the Muscogee County jail.

Estimated number of AOT patients

Forty to 45 individuals are on outpatient commitment (OPC) at any given time.

Team structure

Includes a medical director and additional psychiatrist or psychologist from the provider agency, court, CSB, sheriff, and attorney.

Overview

The use of AOT in Columbus, Georgia, involves coordination among several health care professionals, law enforcement (CIT), legal professionals, and the court. Psychiatrists, clinical psychologists, social workers, and related professionals (psychiatric nurses, licensed counselors specializing in substance abuse, marital and family therapists, etc.) are involved.

Statutory history

In Georgia, the use of OPC began in 2000, when it was decided that CSBs could petition for outpatient commitment as well as hospitals. This decision made use of the existing OPC statute. In Columbus, initiation of OPC orders was prompted after a patient stalked a superior court judge. The egregious case prompted a receptive judge to begin actively using the law.

Who can file a petition for AOT?

The state hospital or CSB can file a petition for AOT. Patients in the hospital, jail, and community all may be candidates.

Common patient characteristics

Patients commonly have a lack of insight, are among most ill of those with mental illness, and have trouble staying out of the hospital and/or jail. Not many are Axis II patients.

Hearings

Hearings occur on the first Wednesday of the month at 11:00 a.m. at the probate court. The commitment and involuntary medication hearings occur simultaneously. Testimony is generally allowed from anyone with an interest in the hearing.

Court process

Hearings are always formal, even if the individual stipulates. All parties acknowledge the importance of the respondent agreeing in front of the judge because it increases the likelihood of compliance. These OPC hearings are usually somewhat longer than inpatient hearings as the respondent has more ability to stay on point due to an improved mental status.

Average length of commitment

Most OPC orders are for one year.

Renewal process

Sixty days prior to expiration of the order, a petition must be filed for a new hearing. The original OPC order is reviewed every 90 days.

Summary of Georgia civil commitment law

For outpatient:

GA. CODE ANN. § 37-3-1(12.1). "Outpatient" means a person who is mentally ill and:

1. Who is not an inpatient but who, based on the person's treatment history or current mental status, will require outpatient treatment in order to avoid predictably and imminently becoming an inpatient;
2. Who because of the person's current mental status, mental history, or nature of the person's mental illness is unable voluntarily to seek or comply with outpatient treatment; and
3. Who is in need of involuntary treatment.



Iowa City, Iowa

FACILITY

University of Iowa; Community Mental Health Center for Mid-Eastern Iowa

Official site visit meetings and interviews

Included University of Iowa Hospital and Clinics administrators, case managers, psychiatrists and nurses and adult intake unit; Johnson County Human Services; Community Mental Health Center director and staff; Integrated Multidisciplinary Program in Assertive Community Treatment (IMPACT) staff and coordinators; NAMI Iowa families and consumers; jail diversion program coordinator and staff; Johnson County clerks of court, Johnson County counsel, and Johnson County mental health advocate.

Estimated number of AOT patients (per year)

There are approximately 250 commitment orders each year.

Team structure

Includes psychiatrists, registered nurses, and a mental health advocate.

Overview

Johnson County, Iowa, proves that collaboration among stakeholders in the mental health community is the key to helping the sickest patients get needed treatment to prevent the “revolving door syndrome.” The University of Iowa and the Community Mental Health Center for Mid-Eastern Iowa hosted us. The implementation of outpatient commitment in Johnson County is an accepted, common practice developed within the framework of the existing civil commitment law. The success of this program is a result of stakeholders’ desire to ensure that participants receive a comprehensive set of services including treatment that the individual would not likely seek or obtain in the absence of a court order. The effectiveness of this AOT program is directly related to the level of cooperation and philosophical buy-in from other participating stakeholders including service providers, law enforcement agencies, courts, and attorneys.

In Johnson County, outpatient commitment orders are used when non-compliance with treatment is both anticipated and presents a risk for dangerousness to self or others. The decision to order outpatient commitment is dependent on individual access to appropriate outpatient psychiatric treatment, community resources, and social support.

The same services are available to individuals in the community regardless of their legal status (committed versus non-committed).

“Outpatient commitment appears to improve compliance with treatment in about 80 percent of patients ... [O]utpatient commitment appears to be successful in reducing hospital and emergency room use by persons who, as a group, are characterized by having a history of medication non-compliance, a history of substance abuse, use of more than two different types of antipsychotic medications during a five year period, and use of a depot form of an antipsychotic medication” (Rohland 1998).

Statutory history

Iowa substantially revised its civil commitment statute in 1975 to ensure that individuals received coordinated treatment while guaranteeing due process.¹⁴ The changes required individuals to be treated in the least-restrictive environment possible and balanced the public’s need for protection and the individuals’ civil rights and need for treatment.

With major reductions in psychiatric beds, the use of outpatient commitment developed under the framework of the existing statute as the state worked to meet the needs of individuals with severe mental illness.

Who can file a petition for AOT?

The law allows for “any interested person” to file a petition for assisted treatment. The majority of petitions in Johnson County are filed by treating doctors or family members. Individuals often are placed under an order of outpatient commitment after inpatient commitment.

Common patient characteristics

A person with mental illness who has been revolving in and out of the state hospital as a result of non-compliance is a candidate for outpatient commitment. The majority of outpatient commitment orders are initiated when an individual is leaving the hospital as an inpatient. However, the statute does not actually require that persons be an inpatient first. Many individuals under outpatient commitment orders have been dually diagnosed. The most common diagnoses are schizophrenia and bipolar disorder.

Hearings

Initial civil commitment hearings are often held in a hospital setting. However, individuals may petition the district court directly.

Average length of commitment

Nine to 14 months is the average duration of outpatient commitments.

Renewal process

Thirty-, 60-, and 90-day renewals are possible after the initial order; renewals are often done electronically if the patient stipulates.

¹⁴ Act of June 16, 1975, ch. 139, 1975 Iowa Acts 350; Randall Bezanson, “Involuntary Treatment of the Mentally Ill in Iowa: The 1975 Legislation,” 61 *Iowa Law Rev.* 262, 275 n. 68 (1975).

Outcome data

Outcome data is collected for the 250-plus patients in Iowa ACT teams and includes number of days hospitalized, days incarcerated, days homeless, employment status, and substance abuse status. However, the approach to data collection for Johnson County is fragmented because no one entity owns all the data. The court keeps records of the number of commitments. The hospital keeps individual records on the patient. And the community mental health center keeps data on its patients. However, no outcome data is specifically recorded for individuals under an order of outpatient commitment. That said, the University of Iowa has access to commitment status for the 50-plus patients in its own (University Iowa) ACT team, IMPACT.

In a study of the Johnson County program completed in 1996, outcomes included a reduction in hospital admission rates and a decrease in number of inpatient days for those under an order of outpatient commitment (Rohland 1998).

Summary of Iowa civil commitment law

For both inpatient and outpatient:

IOWA CODE § 229.1(17). “Seriously mentally impaired” or “serious mental impairment” describes the condition of a person with mental illness and because of that illness lacks sufficient judgment to make responsible decisions with respect to the person’s hospitalization or treatment, and who because of that illness meets any of the following criteria:

1. Is likely to physically injure the person’s self or others if allowed to remain at liberty without treatment.
2. Is likely to inflict serious emotional injury on members of the person’s family or others who lack reasonable opportunity to avoid contact with the person with mental illness if the person with mental illness is allowed to remain at liberty without treatment.
3. Is unable to satisfy the person’s needs for nourishment, clothing, essential medical care, or shelter so that it is likely that the person will suffer physical injury, physical debilitation, or death.



Salt Lake City, Utah

FACILITY

University of Utah Hospital; Valley Mental Health

Official site visit meetings and interviews

Included Valley Mental Health administrators, case managers, psychiatrists and nurses and adult intake unit; University of Utah Hospital emergency room staff; Pathways program coordinator; NAMI Utah families and consumers; Salt Lake City Police Department; CIT coordinator; Salt Lake County magistrates, public defender, and court clerks.

Estimated number of AOT patients (per year)

Valley Mental Health did not differentiate between inpatient and outpatient individuals. Of the 803 individuals faced with initial applications for involuntary commitment (either inpatient or outpatient) in the given year, 363 (45 percent) received some form of involuntary commitment ranging from 30 days to six months.

During that year, 1193 individuals faced review hearings. Of those hearings, 429 (36 percent) resulted in some continuation of involuntary commitment for 30 days or longer.

Team structure

Includes social workers, case managers, a primary service coordinator (PSC), psychiatrists – a nominal ACT Team (i.e., not true to the official ACT model), CIT, and patient attorney.

Overview

Roughly half of all of the applications for commitment in the state of Utah are filed in Salt Lake County's Third District Court. University of Utah Hospital and Valley Mental Health provide structure and support to implement Utah's civil commitment statute to allow individuals to receive outpatient treatment who would otherwise cycle in and out of the hospital. Assisted outpatient treatment, called outpatient commitment in Utah, is most often used in order to facilitate continuity in the transition from the hospital to the community. Outpatient commitment "give[s] patients a sense that they are under legal obligation to follow through [with their treatment plans] as ordered" (Erickson 2008).

An AOT order in Salt Lake City may include outpatient treatment, medication, residential services (full range), assertive case management, clubhouses, substance abuse treatment, appointment of a representative payee, long-term care when necessary (mainly nursing home care).

The speculative ability or potential to return an individual to the inpatient setting helps to maintain compliance. Outpatient commitment enables patients to be supervised in a less-restrictive setting than a hospital.

Individuals receive services based on their needs, regardless of whether they are voluntary patients or under outpatient commitment. However, since individuals under an order of commitment tend to have greater needs, they are likely to receive more intensive treatment and services than other patients. Services might include supported housing, Progressive Assertive Community Treatment (PACT), case management, and short-term residential living arrangements.

A PSC is provided to all AOT patients. Additionally, some patients may have case managers who help them as advocates and skill developers.

“[P]atients are opting, as decided with their legal counsel, to ‘stipulate’ to remain under commitment and for longer periods than in times past. Their logic seems to be something along the lines of: ‘I believe that the order helps me stay in treatment and my quality of life is better when I stay in treatment. I am at liberty in the community except for the order of the court to take my prescriptions and keep my follow-up appointments. I don’t really object to that. I don’t like having to come to court frequently so I will just stipulate to a continuing order of 6 months or an indeterminate period so I will stay in treatment, but not have to appear in court frequently’” (Erickson 2008).

University Hospital and Valley Mental Health use electronic medical records. The sharing of information between treatment providers occurs throughout the process (“course of treatment”) and allows for the free flow of information. Utah statute specifically provides that records may be disclosed where disclosure is necessary to carry out the provisions of the statute.¹⁵

Statutory history

When the mental health statute was drafted, little forethought was given to the use of involuntary outpatient treatment (Erickson 2008). While permitted by state law, there was little statutory guidance, so the use of involuntary outpatient treatment evolved primarily through practice.

During deinstitutionalization in the late 1960s and ‘70s, the population of individuals in the state hospital dropped from 1500 to 350. Care was being relegated to mental health centers. At this time, Utah began to develop comprehensive mental health centers.

In 2003, Utah enacted what is commonly referred to as the “Susan Gall Involuntary Treatment Act Amendments.” The legislation, S.B. 27, modified the process by which adults were involuntarily committed to mental health programs.¹⁶ S.B. 27 eliminated the “immediate danger” standard in Utah and implemented a standard based on “substantial danger.” Additionally, the Susan Gall Amendments shortened the time period between detention and a hearing (Race-Bigelow 2004).

¹⁵ Utah Code Ann. § 62A-12-247.

¹⁶ Senate Bill 27 (2003), State of Utah, modified process by which adults are involuntarily committed to mental health programs.

Utah’s statute incorporates a definition of incompetency into its civil commitment standard. The statute, in part, requires that: “(c) [t]he patient lacks the ability to engage in a rational decision-making process regarding the acceptance of mental treatment as demonstrated by evidence of inability to weigh the possible costs and benefits of the treatment.”¹⁷

Who can file a petition for AOT?

Any “responsible person” may file a petition for an order of AOT in Utah.¹⁸ Petitions are filed with the district court of the county where the patient resides or is found. University Hospital or Valley Mental Health initiates the great majority of petitions for an order of outpatient commitment (see [Appendix 2](#)).

Common patient characteristics

The majority of outpatient commitment orders are initiated by University Hospital when an individual is transitioning into the community from the state hospital. However, the statute does not require that a person be committed to an inpatient hospital prior to being placed under an order of outpatient commitment.

Many individuals under outpatient commitment orders are dually diagnosed (roughly half) and many of the individuals have had previous psychiatric hospitalizations.

Hearings

Hearings occur weekly at University Hospital. The Utah statute requires the hearing “be conducted in an informal a manner [as possible] and in a physical setting that is not likely to have a harmful effect on the mental health of the proposed patient.”¹⁹

Average length of commitment

The average length of time an individual is under an order of outpatient commitment in Salt Lake County is roughly 18 months. Utah statute does not define a maximum length of time for outpatient commitment.

Renewal process

Orders are reviewed at six-month intervals to “reexamine” the commitment order using the same standards as the initial order.²⁰ The court must find that “a review has been made of the conditions justifying your Judicial Order of Commitment for an indeterminate period, as required by law. After such review, it has been determined that those conditions continue to exist. Therefore, the judicial order of commitment will continue in effect.”

¹⁷ Utah Code Ann. § 62A-15-631(10).

¹⁸ UTAH CODE ANN. § 62A-15-631.

¹⁹ UTAH CODE ANN. § 62A-15-631.

²⁰ Id.; Form used is “Notice of Continuation of Indeterminate Commitment Order.”

If individual is “doing well,” the commitment is dropped, and the court is notified (no hearing takes place).

If an order is deemed to warrant renewal, patients often stipulate to it. Such stipulation occurs frequently, and roughly half of all renewals are handled without a hearing. If the renewal goes to hearing, examiners testify.

Outcome data

The use of electronic medical records facilitates the coordination of services and collection of outcome data. Whenever the level of care for an individual changes, providers may access that information. The primary service coordinator is able to maintain and monitor an individual’s treatment plan.

The 2003 Susan Gall Amendments included a requirement that data be collected. As a result, the framework for data collection was established.

Summary of Utah civil commitment law

For both inpatient and outpatient:

UTAH CODE ANN. § 62A–15–631(10). The court shall order commitment of an individual who is 18 years of age or older to a local mental health authority if, upon completion of the hearing and consideration of the information presented in accordance with Subsection (9)(e), the court finds by clear and convincing evidence that:

1. the proposed patient has a mental illness;
2. because of the proposed patient’s mental illness he poses a substantial danger, as defined in Section 62A-15-602, of physical injury to others or himself, which may include the inability to provide the basic necessities of life such as food, clothing, and shelter, if allowed to remain at liberty;
3. the patient lacks the ability to engage in a rational decision-making process regarding the acceptance of mental treatment as demonstrated by evidence of inability to weigh the possible risks of accepting or rejecting treatment;
4. there is no appropriate less-restrictive alternative to a court order of commitment; and
5. the local mental health authority can provide the individual with treatment that is adequate and appropriate to his conditions and needs. In the absence of the required findings of the court after the hearing, the court shall forthwith dismiss the proceedings.

§ 62A-15-602 (13). “Substantial danger” means the person, by his or her behavior, due to mental illness:

1. is at serious risk to:
 - a. commit suicide;
 - b. inflict serious bodily injury on himself or herself; or
 - c. because of his or her actions or inaction, suffer serious bodily injury because he or she is incapable of providing the basic necessities of life, such as food, clothing, and shelter;
2. is at serious risk to cause or attempt to cause serious bodily injury; or
3. has inflicted or attempted to inflict serious bodily injury on another.

§ 62A-15-602 (12). “Serious bodily injury” means bodily injury which involves a substantial risk of death, unconsciousness, extreme physical pain, protracted and obvious disfigurement, or protracted loss or impairment of the function of a bodily member, organ, or mental faculty.



Queens, New York

FACILITY

Elmhurst Hospital, Queens, NY

Official site visit meetings and interviews

Included Elmhurst Hospital director of assisted outpatient treatment, New York Office of Mental Health AOT coordinator and associate director, case managers and social workers, NAMI New York, families whose loved ones were placed in AOT, Queens County justice presiding over AOT hearings, and Elmhurst Hospital counsel.

Estimated number of AOT patients (per year)

There are roughly 280²¹ outpatient commitments each year.

Team structure

Includes the ACT team, AOT coordinator (social workers), ICM (intensive case manager in the field), providers (i.e., housing, treatment providers), Mental Hygiene Legal Service attorney, and Citywide Assistance Team (CAT).

Overview

New York's law provides for involuntary outpatient commitment to community-based mental health services. The goal of the AOT program in Queens is to enable qualifying individuals to live safely in the community, to avoid repeated inpatient hospitalizations, and to ensure access to comprehensive outpatient services. In so doing, court-ordered treatment provides this small group of individuals the opportunity to engage in treatment they might otherwise be unable to access.

Assisted outpatient treatment is only available to individuals who meet certain defined criteria. Persons with psychiatric disorders can only be placed in the program by a court, which must first receive a petition from one of a defined group of individuals. The petition must give the reasons why the petitioner believes the individual meets the criteria and be accompanied by an affidavit from a physician who has examined or tried to examine the person within 10 days prior to filing the petition.

Once the court receives the petition and the physician's affidavit, the court schedules a hearing within three days. Notice of the hearing must be given to the person with mental illness and to certain other individuals. The person facing commitment proceedings is provided with free

²¹ This number is a rough estimate based on the first five years of AOT in Queens. See <http://bi.omh.state.ny.us/aot/statistics?p=under-court-order>

legal representation from the Mental Hygiene Legal Service and with extensive due process protections throughout the AOT process.

In the hearing, the court hears testimony and takes evidence from all the parties, including a doctor who has examined the person. If the individual has refused to be examined, and the court believes the individual may meet the criteria for AOT, the court may order an examination and adjourn the hearing until after it is completed.

The time frame for creating the treatment plan varies slightly depending on the identity of the petitioner. In most, if not all, instances in Queens, the petitioner will be a hospital psychiatrist working in conjunction with the New York City Department of Health and Mental Hygiene (DHMH), which operates the Queens AOT program. In these typical cases, the treatment plan will have been prepared in advance of the petition and be available for the court to review at the AOT hearing. However, New York's AOT statute also permits certain independent parties, such as a family member or private service provider, to petition the court to place a person in the local AOT program. Such a petitioner would not be acting in concert with DHMH and thus would not be able to present a treatment plan in advance. This rare circumstance limits the initial AOT hearing to the question of whether the person meets the criteria for AOT. Upon so finding, the court will order DHMH to prepare a treatment plan and appear at a second hearing within three days to present the plan for review.

Under either sequence of procedures, the person committed to AOT will be ordered to comply with the treatment plan once the court approves it. The service providers identified in the plan will be required to supply the services ordered in it as well as to monitor the patient's condition and treatment compliance.

Outpatients' compliance with the court's order is monitored through case managers, ACT teams, and other treatment providers. If an individual fails to comply with his or her treatment plan, interventions are triggered, which can ultimately result in the individual's rehospitalization for 72 hours for treatment and evaluation to determine if he or she meets the inpatient commitment criteria.

Initial AOT orders are for up to six months and each renewal can be for up to one year.

Statutory history

New York State enacted legislation to provide for involuntary outpatient commitment to community-based mental health services (also known as AOT or Kendra's Law) in 1999.²² Kendra's Law allows courts to order certain individuals with mental illness to comply with treatment while living in the community. The law took effect November 8, 1999.

Kendra's Law was an important advance in New York because it allowed individuals to be court ordered into community-based treatment. In addition, the criteria to place someone in assisted outpatient treatment is broader than the "likelihood of serious harm" standard required for inpatient commitment in New York. Kendra's Law allows someone with a specific history of

²² New York Mental Hygiene Law § 9.60

noncompliance to be ordered into treatment “to prevent a relapse or deterioration which would likely result in serious harm to the patient or others.”

Who can file a petition for AOT?

In Queens County, the petitioner is generally the hospital. Additionally, under New York State law, any of the following persons can file a petition with the court for an individual to be placed in AOT:

- any adult person living with the person
- the parent, spouse, adult sibling, or adult child of the person
- the hospital director, if the person is an inpatient
- the director in whose institution the person resides
- a treating or supervising psychiatrist
- the director of community services, his/her designee, or the social services official of the city or county in which the person is present or believed to be present
- the person’s parole or probation officer²³

The petition must be filed in the supreme or county court in the county in which the person is present or reasonably believed to be present.

Common patient characteristics

The population in Queens County is very diverse. The candidate must of course meet the outpatient legal criteria outlined below. The typical candidate for AOT is an individual who has had difficulty voluntarily accessing the system in the past. Most often individuals have been in their mid-20s to late 30s. According to the New York State Office of Mental Health:

Average age – 36.5

Gender – 72 percent male

Marital status – 75 percent single

Diagnosis – 76 percent schizophrenia; 16 percent bipolar disorder

Dual diagnosis (alcohol/substance abuse) – 41 percent
(New York State Office of Mental Health 2011b)

Hearings

Hearings occur weekly at the Queens County State Supreme Court²⁴ in Jamaica, a neighborhood in Queens.

²³ New York Mental Hygiene Law § 9.60

Average length of commitment

In Queens County, 73 percent of AOT orders last over six months. Statewide, about 80 percent of AOT orders last over six months:

County	0-6 Months	6-12 Months	12-18 Months	18-30 Months	Over 30 Months
Bronx	18%	23%	16%	22%	22%
Kings	18%	26%	16%	21%	18%
New York	21%	26%	17%	19%	16%
Queens	26%	28%	18%	16%	11%
Richmond	22%	32%	17%	16%	14%
Region Total	21%	26%	17%	19%	17%

(New York State Office of Mental Health 2011d)

Renewal process

More than half of all orders in Queens County are renewed (New York State Office of Mental Health 2011c). Independent research in New York has confirmed a positive correlation between the length of time an outpatient spends under AOT, and the likelihood that the improved outcomes achieved under AOT will be sustained after AOT is discontinued. Gains achieved under AOT periods of more than six months were found significantly more likely to be sustained than were gains achieved under AOT periods of six months or less (Swartz et al. 2009).

Outcome data

AOT has been studied in New York more than in any other state. According to the New York State Office of Mental Health (OMH):

OMH Central and Field Office staff record basic information on each court order and the status of each order in a secure electronic tracking system called Tracking for AOT Cases and Treatments (TACT). TACT is used to track important information about court-ordered recipients and is a resource for assisting in the management of the AOT program by OMH AOT program staff. In addition, TACT data are used to generate regular reports on the

²⁴ In New York, the lowest-level court is known as the “Supreme Court, Trial Division.”

volume of court orders throughout the state and the number of individuals receiving AOT.

OMH collects additional information concerning AOT recipients from their case managers and Assertive Community Treatment (ACT) teams. Case managers and ACT team members complete a standardized assessment for each AOT recipient at the onset of the court order (baseline), at the end of the initial court order (six month follow-up), and, if the court order is renewed, every six months for the duration of the order. The assessments capture: demographic characteristics of AOT recipients; their status in areas such as living situation, services received, engagement in services, and adherence to prescribed medication; incidence of significant events such as hospitalization, homelessness, arrest, and incarceration; functional impairment in the areas of self-care and social skills; and any incidence of harmful behaviors. These assessments are submitted to OMH and an AOT Evaluation Database is compiled. OMH uses the resulting data to assess outcomes for all AOT recipients as a group. Due to time lags inherent in paper-based survey data collection and processing, and the limited scope of the data collected on the standardized assessments, OMH does not use the evaluation database to monitor the clinical status of individual recipients (New York State Office of Mental Health 2011a).

Summary of New York civil commitment law

For inpatient:

60-day involuntary treatment based on medical certification:

N.Y. MENTAL HYG. LAW § 9.05(b) A certificate, as required by this article, must show that the person is mentally ill ... [and] the condition of the person examined is such that he needs involuntary care and treatment in a hospital

N.Y. MENTAL HYG. LAW § 9.37(a) The director of a hospital, upon application by a director of community services or an examining physician duly designated by him or her, may receive and care for in such hospital as a patient any person who, in the opinion of the director of community services or the director's designee, has a mental illness for which immediate inpatient care and treatment in a hospital is appropriate and which is likely to result in serious harm to himself or herself or others.

If a hearing takes place on the patient's need for treatment during the 60-day involuntary treatment:

N.Y. MENTAL HYG. LAW § 9.31(c). If it be determined [by the court] that the patient is in need of retention, the court shall deny the application for the patient's release. If it be determined that the patient is not mentally ill or not in need of retention, the court shall order the release of the patient.

N.Y. MENTAL HYG. LAW § 9.01. As used in this article: “in need of care and treatment” means that a person has a mental illness for which in-patient care and treatment in a hospital is appropriate. “in need of involuntary care and treatment” means that a person has a mental illness for which care and treatment as a patient in a hospital is essential to such person’s welfare and whose judgment is so impaired that he is unable to understand the need for such care and treatment.

N.Y. MENTAL HYG. LAW § 9.01. “need for retention” means that a person who has been admitted to a hospital pursuant to this article is in need of involuntary care and treatment in a hospital for a further period.

N.Y. MENTAL HYG. LAW § 9.01. “likelihood to result in serious harm” or “likely to result in serious harm” means

1. a substantial risk of physical harm to the person as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that the person is dangerous to himself or herself, or
2. a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm.

CASE LAW: Although not explicitly in the state’s code, a strong majority of the New York courts addressing the issue have held that in order to retain a patient for involuntary psychiatric care under New York law, a hospital must establish that the patient (1) is mentally ill, (2) is in need of continued, supervised care and treatment, and (3) poses a substantial threat of physical harm to himself and/or others (e.g., *Anonymous v. Carmichael*, 727 N.Y.S.2d [N.Y. App. Div. 2001]).

For outpatient:

N.Y. MENTAL HYG. LAW § 9.60(c). Criteria for Assisted Outpatient Treatment. A patient may be ordered to obtain assisted outpatient treatment if the court finds that:

1. The patient is eighteen years of age or older; and
2. The patient is suffering from a mental illness; and
3. The patient is unlikely to survive safely in the community without supervision, based on a clinical determination; and
4. The patient has a history of lack of compliance with treatment for mental illness that has:
 - a. At least twice within the last thirty-six months been a significant factor in necessitating hospitalization in a hospital, or receipt of services in a forensic or other mental health unit of a correctional

facility, not including any period during which the person was hospitalized or incarcerated immediately preceding the filing of the petition or;

- b. 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 within the last forty-eight months, not including any period in which the person was hospitalized or incarcerated immediately preceding the filing of the petition; and
5. The patient is, as a result of his or her mental illness, unlikely to voluntarily participate in the recommended treatment pursuant to the treatment plan; and
6. In view of the patient's treatment history and current behavior, the patient is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to the patient or others as defined in section 9.01 of this article; and
7. It is likely that the patient will benefit from assisted outpatient treatment; and
8. If the patient has executed a health care proxy as defined in article 29-C of the Public Health Law that any directions included in such proxy shall be taken into account by the court in determining the written treatment plan.



Nevada County, California

FACILITY

Turning Point Providence Center is contracted with Nevada County Behavioral Health to provide multidisciplinary, outpatient treatment through the Assertive Community Treatment (ACT) model. Within these services, AOT is provided to a small number of individuals who meet specific criteria under the law.

Estimated number of AOT patients

Before implementing Laura's Law, Nevada County estimated that one out of 25,000 people per year would meet criteria resulting in an AOT court order. The actual number has been slightly less. The county's population is approximately 100,000. An average of three individuals per year have received treatment as a result of an AOT order. To date, 32 people have been referred for evaluation for the Turning Point Providence Center AOT program since its inception; 10 received AOT as a result of a court-issued order.²⁵

Team structure

Includes the ACT team, personal services coordinator, psychiatrists, psychologists, therapists, and case workers. Each individual is paired with a mobile treatment team that serves participants in their homes, workplaces, and other settings where they might need support.

Overview

Assisted outpatient treatment, known as Laura's Law in California, was initiated in Nevada County in 2008 as a strategy for engaging qualifying individuals who meet the law's criteria for treatment before their non-treatment results in psychiatric crisis and its consequences. The program is featured in "[Assisted Outpatient Treatment: The Nevada County Experience, Laura's Law](#)," a video produced by the Behavioral Health Services, Health and Human Services Agency, Nevada County, California.

The success of Nevada County's AOT program is rooted in the use and preventative nature of the law. Laura's Law connects individuals who otherwise would not engage with the mental health system with the services most likely to prevent psychiatric crisis. According to Nevada County Judge Tom Anderson, "The practical experience in Nevada County is that utilizing Laura's Law halts decompensation in qualified patients, saves the county costs that typically result from untreated mental illness, and avoids serious harm to the patient and others."

Typically, AOT participation begins when a request is made for a Laura's Law investigation by a concerned family member, care provider, or other entity authorized by the law to initiate

²⁵ Many of the individuals in the Nevada County program are referred to Turning Point under settlement agreements. After an AOT petition is filed, but before the conclusion of the hearing on it, the person who is the subject of the petition may waive the right to a hearing and enter into a settlement agreement. If the court approves it, the settlement agreement has the same force and effect as a court order for AOT.

proceedings. Once the request is made, an assessment (“investigation”) is conducted to evaluate whether the candidate meets the criteria for court-ordered outpatient treatment. During the investigation period, the treatment team is able to gauge the level of potential engagement – both the strengths the patient has and the challenges he/she is likely to encounter – and continue to build the therapeutic relationship. As part of this process, the candidate is offered a choice of accepting or rejecting services. Most individuals involved in the AOT program have a history of not participating in mental health services and are unlikely to seek help or even acknowledge they have a mental illness. If the individual meets all criteria under the law and does not accept services, the team moves forward with the petition process. The court may then order a psychiatric evaluation, and a hearing is scheduled and held.

Alternatively, if the candidate begins participating in treatment and shows signs of stability (e.g., a reduction of symptoms, making lifestyle changes as evidenced by actions such as seeking housing, or experiences a reduction in stressors), a petition is unlikely to be filed.

Nevada County’s program received national recognition in July 2011 when the National Association of Counties presented it with an Achievement Award in Health for innovation that “modernizes county government and increase(s) its services.” The program earlier in the same year was recognized with a Challenge Award for innovation from the California State Association of Counties. In the first 30 months of its AOT program, Nevada County estimates that for every dollar spent they save \$1.81 (Anderson 2012).

Statutory history

AB 1421, commonly called Laura’s Law, was signed into law in 2002 and took effect in 2003. The law amended the California Welfare and Institutions Code (W & I Code) to authorize the use of court-ordered outpatient treatment for qualifying individuals. The state law is unique in that it established Laura’s Law as a county option. To date, only Nevada County – where Laura Wilcox, the namesake of the law, lived and was killed by a man with untreated mental illness – has fully implemented it. Los Angeles County has a small pilot program.

Who can file a petition for AOT?

The law provides that the county mental health director may petition the court for an order authorizing AOT. A request may be made to the county mental health department for the filing of a petition by family members, cohabitants, designated treatment providers or their supervisors, or peace officers.

Common patient characteristics

In addition to the criteria outlined in the W & I Code 5346 (a) (i.e., “ ... 18 years or older ... suffering from a mental illness ... history of lack of compliance,” etc.), the most prominent characteristic among those referred is lack of insight or awareness of the psychiatric condition. In addition, strained relationships or estranged relationships with family, friends, and neighbors are common among AOT recipients.

Hearings

AOT hearings are held at the local district courthouse on an as-needed basis after a petition is filed and notice is provided.

The court holds status hearings no less than every 60 days. The status hearings provide an opportunity for the court to oversee the delivery of services. As a result, the court is able to substantiate that the proper levels of care and support are being provided.

Average length of commitment

The initial court order is for 180 days, which is the current average for the AOT orders in Nevada County.

Renewal process

With experience, Turning Point staff has become aware of the potential need for treatment beyond the initial commitment period to support long-term recovery and prevent relapse. The director of the AOT program may apply to the court prior to the initial order's expiration for an additional period of AOT of no more than 180 days. The procedures and requirements for obtaining a renewal order are the same as for obtaining an initial order.

Outcome data

The outcomes from Nevada County's AOT program indicate improved level of engagement and recovery among those referred. Most candidates with a history of lack of engagement in treatment are now stable and succeeding with housing, relationships, and community involvement, and are on a path to recovery.

Nevada County reports that among its current and former participants:

- ❑ Hospitalization days were reduced 61 percent (from 514 days prior to being part of the AOT program to 198 days).
- ❑ Incarceration days were reduced 97 percent (521 days prior to being part of the AOT program to 17 days).

Summary of California civil commitment law*

CALIF. WELF. & INST. CODE § 5346. (a) In any county in which services are available as provided in Section 5348, a court may order a person who is the subject of a petition filed pursuant to this section to obtain assisted outpatient treatment if the court finds, by clear and convincing evidence, that the facts stated in the verified petition filed in accordance with this section are true and establish that all of the requisite criteria set forth in this section are met, including, but not limited to, each of the following:

1. The person is 18 years of age or older.
2. The person is suffering from a mental illness[.]

3. There has been a clinical determination that the person is unlikely to survive safely in the community without supervision.
4. The person has a history of lack of compliance with treatment for his or her mental illness, in that at least one of the following is true:
 - a. The person's mental illness has, at least twice within the last 36 months, been a substantial factor in necessitating hospitalization, or receipt of services in a forensic or other mental health unit of a state correctional facility or local correctional facility, not including any period during which the person was hospitalized or incarcerated immediately preceding the filing of the petition.
 - b. The person's mental illness has resulted in one or more acts of serious and violent behavior toward himself or herself or another, or threats, or attempts to cause serious physical harm to himself or herself or another within the last 48 months, not including any period in which the person was hospitalized or incarcerated immediately preceding the filing of the petition.
5. The person has been offered an opportunity to participate in a treatment plan by the director of the local mental health department, or his or her designee, provided the treatment plan includes all of the services described in Section 5348, and the person continues to fail to engage in treatment.
6. The person's condition is substantially deteriorating.
7. Participation in the assisted outpatient treatment program would be the least restrictive placement necessary to ensure the person's recovery and stability
8. In view of the person's treatment history and current behavior, the person is in need of assisted outpatient treatment in order to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to himself or herself, or to others, as defined in Section 5150.
9. It is likely that the person will benefit from assisted outpatient treatment.

**This standard only applies in counties that have adopted provisions established by Assembly Bill 1421 (2002) (Laura's Law); otherwise outpatient commitment is only permitted via the conservatorship process.*



Seminole County, Florida

FACILITY

Seminole Behavioral Healthcare (SBH)²⁶

Estimated number of AOT patients

Approximately 18 to 25 individuals with severe mental illness at any given time are on involuntary outpatient placement (IOP) orders.

Team structure

All AOT clients are monitored by the SBH Acute Care Team, a seven-member committee responsible for monitoring the county's more severely impaired clients. It is chaired by the medical director for outpatient services and includes staff from the crisis stabilization unit, residential programming and psychosocial rehab, as well as the forensic team. There is one care manager who coordinates the treatment plans for individuals on AOT. Clients are discussed as needed at weekly case management treatment team meetings, and all cases are reviewed monthly at the ACT team meeting.

Overview

SBH is the Florida state leader in utilizing AOT, known as "involuntary outpatient placement (IOP)" under Florida law. Seminole Behavioral Healthcare started using the IOP law in 2005, the year it became effective, by creating a model program and tracking patient outcomes.

Patients in the model IOP program were treated with existing services and funding. SBH did obtain grant funds to help hire a short-term coordinator to initiate the program and to collect outcome data. After the grant was completed, SBH continued to utilize outpatient orders using existing staff and programming to meet the needs of these clients without any additional funding. SBH is now a vital resource to other counties seeking to help patients using involuntary outpatient placement in Florida.

Statutory history

Florida reformed its state mental illness treatment law, known as the Baker Act, in 2004 to allow involuntary outpatient placement. Before passage of this law, inpatient commitment was the only option available for people with severe mental illness who did not voluntarily accept needed treatment. The changes were made in order to help people who were continually entering and exiting the mental health system without gaining stability.

²⁶ The Seminole Behavioral Healthcare AOT site was included after the completion of the other five site visits. Treatment Advocacy Center staffers visited the site on multiple occasions. Additionally, the site was selected for inclusion in this guide because it continues to be the state leader and has continued to track patient and program outcomes.

The bill sponsor also recognized that AOT was needed to provide more effective outpatient treatment so that existing services could be used more wisely. “For instance, in one 24-month period, 540 people were evaluated under the Baker Act eight or more times. That means eight or more times they reached the point of crisis. Not only is this dangerous and unproductive, it is prohibitively expensive. For example, in 2002, Florida spent \$81,000 to Baker Act one individual 41 times” (Simmons 2004).

The IOP criteria were designed to apply only to those with a history of noncompliance with prescribed treatment combined with either repeated Baker Act admissions or serious violence – a small subgroup of the people who meet existing criteria for involuntary examination.

Who can file a petition for AOT?

A petition for involuntary outpatient placement may be filed by the administrator of a receiving facility or the administrator of a treatment facility.²⁷

Common patient characteristics

Diagnostically, almost all clients have schizophrenia, schizoaffective disorder, or bipolar disorder. Fifty percent have co-occurring substance use disorders. Two-thirds are male, and the average age is around 40. The youngest was 22 years old; the oldest, 68. One-third have had significant contact with the criminal justice system.

Hearings

Hearings take place before a general master. The client is almost always present and, on occasion, family members and law enforcement may be present to testify. The state attorney uses a predicate developed by the general masters to obtain testimony from the psychiatrist. The psychiatrist testifies that the individual meets all the criteria and informs the court that a treatment plan has been developed with input from the client. The treatment plan may be as simple as complying with medication and keeping appointments but can involve substance abuse treatment, residential/group home placement, and/or psychosocial rehab. The client is represented by a public defender or a private attorney. Most clients do testify on their own behalf. Quite often they agree to the plan of treatment.

Average length of commitment

Most individuals are committed for six months. Approximately five percent have been terminated early, usually because they have not been compliant and were sent to the state hospital. A few individuals were terminated early because they no longer needed the court order to remain engaged in treatment. An extension is requested in approximately 10 percent of cases; most extensions last less than six additional months.

Renewal process

The procedures for continued involuntary outpatient placement involve an evaluation using the same legal criteria as the initial order (except that the time periods in FLA. STAT. §

²⁷ FLA. STAT. § 394.4655(3).

394.4655(1)(e)1 do not apply). Renewals may be for an additional six months but are often of shorter duration. Frequently, the extension is requested to monitor the client through stressful transitions such as a change in housing, medication adjustment, or personal stresses, such as deaths in their support system or acute physical health problems. The extension is terminated once these issues are resolved.

Outcome data

Between June 1, 2005, and November 30, 2006, 36 people participated in the model IOP program. Prior to their placement, the majority of the patients had been offered community health services but had not actively engaged in them. They were not adhering to prescribed medications. In the year prior to receiving IOP, participants averaged 117 days of hospitalization and 23 days of incarceration. After placement in the program, the participant group experienced significant reductions in hospitalization days (43 percent), hospitalization costs (\$303,728 cumulative), incarceration days (72 percent), and incarceration costs (\$14,455 cumulative).

Summary of Florida civil commitment law

FLA. STAT. § 394.4655(1). *Criteria for involuntary outpatient placement.* A person may be ordered to involuntary outpatient placement upon a finding of the court that by clear and convincing evidence:

1. The person is 18 years of age or older;
2. The person has a mental illness;
3. The person is unlikely to survive safely in the community without supervision, based on a clinical determination;
4. The person has a history of lack of compliance with treatment for mental illness;
5. The person has:
 - a. At least twice within the immediately preceding 36 months been involuntarily admitted to a receiving facility or treatment facility ... , or has received mental health services in a forensic or correctional facility. The 36-month period does not include any period during which the person was admitted or incarcerated; or
 - b. Engaged in one or more acts of serious violent behavior toward self or others, or attempts at serious bodily harm to himself or herself or others, within the preceding 36 months;
6. The person is, as a result of his or her mental illness, unlikely to voluntarily participate in the recommended treatment plan and either he or she has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of

placement for treatment or he or she is unable to determine for himself or herself whether placement is necessary;

7. In view of the person's treatment history and current behavior, the person is in need of involuntary outpatient placement in order to prevent a relapse or deterioration that would be likely to result in serious bodily harm to himself or herself or others, or a substantial harm to his or her well-being as set forth in s. 394.463(1);
8. It is likely that the person will benefit from involuntary outpatient placement; and
9. All available less restrictive alternatives that would offer an opportunity for improvement of his or her condition have been judged to be inappropriate or unavailable[.]

Testimonials

PATIENT EXPERIENCES

“I never knew I could feel so well.”

– Patient, Seminole County, Florida

"Being forced to do it by OPC made me realize what could happen next time. Jail or suicide are the only two alternatives until you get it. OPC did feel like being back in the armed service. But OPC was a place where I could not be in denial. The loss of denial allowed me to accept services. Services helped me get skills back. Skills allow me to function."

– Patient, 50s, Columbus, Georgia

"OPC order forces me into treatment; treatment puts me in a place where I can 'hear' what people are saying; people tell me I'm heading for a bad place, a really bad place; this information motivates me to change; and that's recovery for me."

– Patient, 20s, Columbus, Georgia

"[AOT helps by] getting things together more quickly, but we don't broadcast it."

– Patient, Summit County, Ohio

MENTAL HEALTH PROFESSIONAL AND PSYCHIATRIST EXPERIENCES

“Since it was a new program I was not sure if it was going to assist my client. The program is working and is very helpful for treatment of the client, to maintain taking meds, staying in the program and to remain in the community Excellent program.”

*– Case manager, Seminole County, Florida,
in response to anonymous program survey*

“We have witnessed many amazing turnarounds and successes.”

*– Excerpt from public testimony of Dr. Mary Barber,
medical director of the Ulster County Mental Health Department and
AOT psychiatrist for Ulster County (April 8, 2005, public hearing
in New York City on Kendra's Law)*

“The clients involved in [AOT] were given the opportunity to recover at home with the support of their families and, by doing so, avoided being sent to the state hospital. Most clients truly appreciated the changes in their lives and continued to comply with treatment recommendations, which resulted in additional improvements even after

their court orders were completed. The successes achieved by these individuals are inspiring; watching these people move forward in their lives was one of the most rewarding experiences of my career.”

*– Valerie Westhead, MD, medical director for outpatient services,
Seminole County, Florida*

“In Texas, we refer to AOT as involuntary court-ordered outpatient treatment. AOT has been used as a clinical tool to assist in the continuity of care for persons whom we serve. [AOT] has always been a productive and constructive tool. It is a proven clinical approach which has shown consistent benefits in the long term.”

*– Gilbert Gonzales, director, Crisis Services/Jail Diversion,
San Antonio, Texas*

“I was the original director once the state AOT law was passed. I use it often. Hard clinical research is indicated such that it can be readily perceived as a true, evidence-based, practice by physicians and physicians-in-training. [AOT is an] excellent tool for clinicians and excellent ‘insurance’ for patients. What most surprised me about using AOT was the patient's recognition of its value for them.”

*– Daniel Garza, MD, Assisted Outpatient Treatment Program,
Elmhurst Hospital Center, Queens County, New York State, 2004*

“The program works well here because our dedicated staff and participating providers are strongly committed to providing the comprehensive treatment that our patients need to remain well.”

*– Daniel Garza, MD, Assisted Outpatient Treatment Program,
Elmhurst Hospital Center, Queens County, New York State*

“[C]oerced care need not be an oxymoron. To achieve that, coercion, whenever it is used, must be the least intrusive possible, and should always contain elements of procedural justice such as genuine concern, good faith, respect, listening to the patient's side of the story, and involvement of important persons in the patient's life in the decision making process.”

– Darold Treffert, MD, Wisconsin

“As a forensic psychiatrist, I can attest that AOT is viewed as an efficacious alternative to incarceration for many mentally ill individuals with criminal justice system contact. Many AOT patients have informed staff and judge alike “AOT was the glue that kept them together,” attributing AOT to helping transform their lives.”

– Excerpt from public testimony of Antonio A. Abad, MD, president of the Association of Hispanic Mental Health Professionals, New York (New York State Assembly Standing Committee on Mental Health, Mental Retardation, and Developmental Disabilities, April 8, 2005)

FAMILY MEMBER EXPERIENCES

“It is the only thing that has worked for my son.”

– One mother’s public testimony at an April 8, 2005, public hearing in New York City on Kendra’s Law

“Without AOT, my son would either be in jail or dead. It alone has made a difference for him by helping him to stay on his meds.”

– Anonymous mother interviewed by NAMI New York

“While the process was long, complex and heart-wrenching, [AOT] worked for our family and finally connected my mother with the services she desperately needed to maintain stability in her life. Though her illness has forever changed her, it no longer controls her. Today she lives independently, enjoys gardening and has dinner with my brother every Sunday. The issue of how to provide care for some of the most vulnerable members of society – the seriously mentally ill who suffer from schizophrenia or bipolar disorder – has plagued mental health systems everywhere. Recently, a slew of high-profile tragedies has shined a light on the potential benefits of Laura’s Law. Both New York state and Nevada County have implemented such programs and obtained impressive results, achieving significant reductions in psychiatric hospitalizations, incarcerations, homelessness and violent behavior.”

– Gary Tsai, MD, family member and psychiatrist in “Ignore the Severely Mentally Ill, Court Disaster” San Francisco Chronicle, October 23, 2011

“I know from both the personal and professional perspective how important Kendra’s Law is.”

– Chief of Police Michael Biasotti, family member and law enforcement officer, New York

JUDGE AND LAWYER EXPERIENCES

“I don’t like that you have to do it with a court order but if that’s what it takes, I’m willing to do that because I want people to have a better life ... I know they can do that.”

– Judge Polly Jackson Spencer, Bexar County, Texas, in “Stopping the Revolving Door: A Civil Approach to Treating Severe Mental Illness”

“Laura’s Law has provided life-saving services to individuals suffering from mental illness ... and has reduced the need for action by law enforcement, medical emergency personnel, and the Courts, and lessens the trauma and anguish of family and friends.”

*– Judge Tom Anderson, Nevada County, California,
letter to the Orange County Board of Supervisors*

“Despite initial concerns about workload both for the court system and the MHLS attorneys, all of the parties involved have contributed to a smooth running system ... We are very pleased at how this program has worked out in New York City, and it has allowed us to bring to bear on their treatment the coordinated resources of the legal and clinical system.”

*– William Martin, Esq., general counsel for Mental Hygiene,
letter to Seminole County Sheriff Eslinger (2002)*

“Our probate court uses outpatient commitment more frequently than most other Ohio counties, which means we have a more active civil commitment docket than many other counties. But even though we have a more active civil commitment docket than other counties, these cases still do not burden our dockets.”

*– Judge Randy Rogers, Butler County, Ohio,
letter to Seminole County Sheriff Eslinger (2002)*

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Appendices

Appendices are available online at TreatmentAdvocacyCenter.org/aotguideappendices or on CD by request through the website.

Appendix 1: Sample AOT coordinator descriptions

AOT coordinator job description – New York

AOT coordinator position – Seminole County, FL

Appendix 2: Sample forms for procedures, evaluations, court applications and orders, treatment plans, patient expectations

Doctor testimony checklist and attorney questions – Seminole County, FL

Court order – Johnson County, IA

Court psychiatric evaluation – Johnson County, IA

Subpoena, application, court order – Queens, NY

Treatment plan – Queens, NY

Application for continued commitment – Summit County, OH

Emergency evaluation forms – Summit County, OH

Notice of expiration form – Summit County, OH

Patient expectations – Summit County, OH

Subpoena for medical expert testimony – Summit County, OH

Treatment plan update – Summit County, OH

Emergency applications – Salt Lake City, UT

State commitment forms – Salt Lake City, UT

Commitment based on 5th standard – WI

AOT conditions form – WI

Commitment form – WI

Appendix 3: Legal system experiences with AOT, letters from judges and attorneys

Judge Tom Anderson – Nevada County, CA

Anderson, Stanchfield and Heggarty – Nevada County, CA

William Martin, Esq. – New York, NY

Judge Randy Rogers – Butler County, OH

Fritz Mielke, Esq. – Waukesha County, WI

Judge Ralph Ramirez – Waukesha County, WI

Appendix 4: Sample patient assessment and outcome measurement forms, database

Assessment form – Seminole County, FL

Database for assessment and outcome tracking – Seminole County, FL

OMH baseline assessment form – NY

OMH follow-up assessment form – NY

Quarterly outcome report – Summit County, OH

Appendix 5: Sample pamphlets, guides, presentations, guidelines

AOT pamphlet – Seminole County, FL

“Baker Act FAQs” – FL

AOT presentation – Seminole County, FL

“Guide to Kendra’s Law” 3rd edition – NY

“Guide to Laura’s Law” – CA

“Frequently Asked Questions” – NY

AOT presentation – Ulster County, NY

Guidelines for outpatient commitment – Summit County, OH

AOT Laura’s Law presentation – Nevada County, CA



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