ASSISTED OUTPATIENT TREATMENT

Effectiveness, implementation, and ethical considerations

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CIT ECHO
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Mr. T.

SCOTT THORPE

LAURA WILCOX
(1982 – 2001)

- 41 Y/O MALE
- LIVES ALONE; UNSTABLE EMPLOYMENT
- CLIENT OF A COUNTY-BASED PUBLIC BEHAVIORAL HEALTH DEPARTMENT
- RECEIVING COUNSELING FOR AGORAPHOBIA, ANXIETY, DEPRESSION, AND SOME PARANOID SYMPTOMS
- REGULAR CANNABIS USER
- CHRONIC BACK PAIN; HAS PRESCRIPTION FOR OPIOID ANALGESIC
- HX OF 1 ARREST FOR DRUNK DRIVING
- ANGER DIRECTED AT MH CLINIC AND STAFF; IS SEEKING ADDITIONAL HELP AND ATTENTION
- FAMILY AND GIRLFRIEND "CONCERNED"
- STOPPED TAKING PRESCRIBED MEDS.
- FREQUENTS GUN SHOWS; LEGALLY POSSESSES NUMEROUS FIREARMS

Questions to ponder

- Did mental illness cause the shooting?
  - Was it the *major* cause?
  - How did mental illness contribute?
- Was this shooting predictable? Preventable?
  - If so, what could or should law enforcement or mental health professionals have done?
  - Would court-ordered outpatient treatment have prevented the shooting?
- Should Thorpe have been legally prohibited from purchasing or possessing guns?
  - If so, what record should have disqualified him?
  - If he did have a gun-disqualifying record, would a background check have deterred him?

SCOTT THORPE

LEGAL DISPOSITION OF HOMICIDE CHARGE

- INCOMPETENT TO STAND TRIAL
- COMMITTED TO SECURE FORENSIC FACILITY
- RESTORED TO COMPETENCY 2 YEARS LATER; PLEADED GUILTY TO MURDER

NICK AND AMANDA WILCOX

ADVOCATES

- CA. AB-1421 "LAURA'S LAW" (2002): CALIFORNIA'S INVOLUNTARY OUTPATIENT CIVIL COMMITMENT LAW
- CA. AB 1014 "GUN VIOLENCE RESTRAINING ORDER" (2014): CALIFORNIA'S RISK-BASED FIREARM REMOVAL LAW

Key elements of outpatient commitment or "assisted outpatient treatment"

- Civil court order that requires certain people with a serious mental illness to comply with recommended outpatient treatment and receive services
  - Also "commits the system" to the patient: creates accountability
- "Treatment plan wrapped in a legal order"
  - Services under AOT typically include intensive case management or assertive community treatment, medication, psychosocial treatment, and access to subsidized housing
- Sanction for non-adherence: non-criminalizing police transport to a mental health facility for evaluation, hopeful persuasion, or involuntary hospitalization if needed
  - No forced medication in outpatient setting

Legal authority and historical context of AOT

- Extends state's civil commitment authority from the institutional setting to community-based mental health care
- Emerged in USA after deinstitutionalization as a legal intervention to try to break the cycle of "revolving door" admissions.
- Began as a form of conditional release from hospital

Types of outpatient commitment statutes

- Conditional release from hospital (40 states[1])
  - Also known as “trial visit” or “visit to discharge”
- Alternative to hospitalization for people meeting inpatient commitment criteria, i.e., dangerousness (16 states[2])
  - Least restrictive alternative
- Preventive outpatient commitment (36 states and DC[2])
  - Court-ordered treatment authorized at a lower threshold than inpatient commitment criteria with the purpose of preventing further deterioration
- No outpatient commitment (3 states: MA, CT, MD, NM)

[1] Melton et al., 2007; [2]LawAtlas.org, 2016;

Criteria for OPC in North Carolina

- Presence of a serious mental illness
- Capacity to survive in the community with available supports
- Clinical history indicating a need for treatment to prevent deterioration that would predictably result in dangerousness
- Mental status that limits or negates the individual's ability to make informed decisions to seek or comply voluntarily with recommended treatment

Disagreement over AOT: Two opposing views of mandating treatment in the community

- "Mandatory treatment for those too ill to recognize they need help is far more humane than our present mandatory non-treatment."
  --E. Fuller Torrey

- "Failure to engage people with serious mental illnesses is a service problem, not a legal problem. Outpatient commitment is not a quick-fix that can overcome the inadequacies of under-resourced and under-performing mental health systems. Coercion, even with judicial sanction, is not a substitute for quality services."
  -- Bazelon Center for Mental Health Law


Recovery-land
Case Mgr.
Outpatient Commitment
Serious Mental Illness World
untreated symptoms
unemployed homeless
involuntary hospitalization
police encounters jail

Recovery-land

APA Position Statement Key Statements

- Involuntary outpatient commitment, if systematically implemented and resourced, can be a useful tool to promote recovery through a program of intensive outpatient services
  - designed to improve treatment adherence,
  - reduce relapse and re-hospitalization,
  - and decrease the likelihood of dangerous behavior or severe deterioration
  - among a sub-population of patients with severe mental illness.

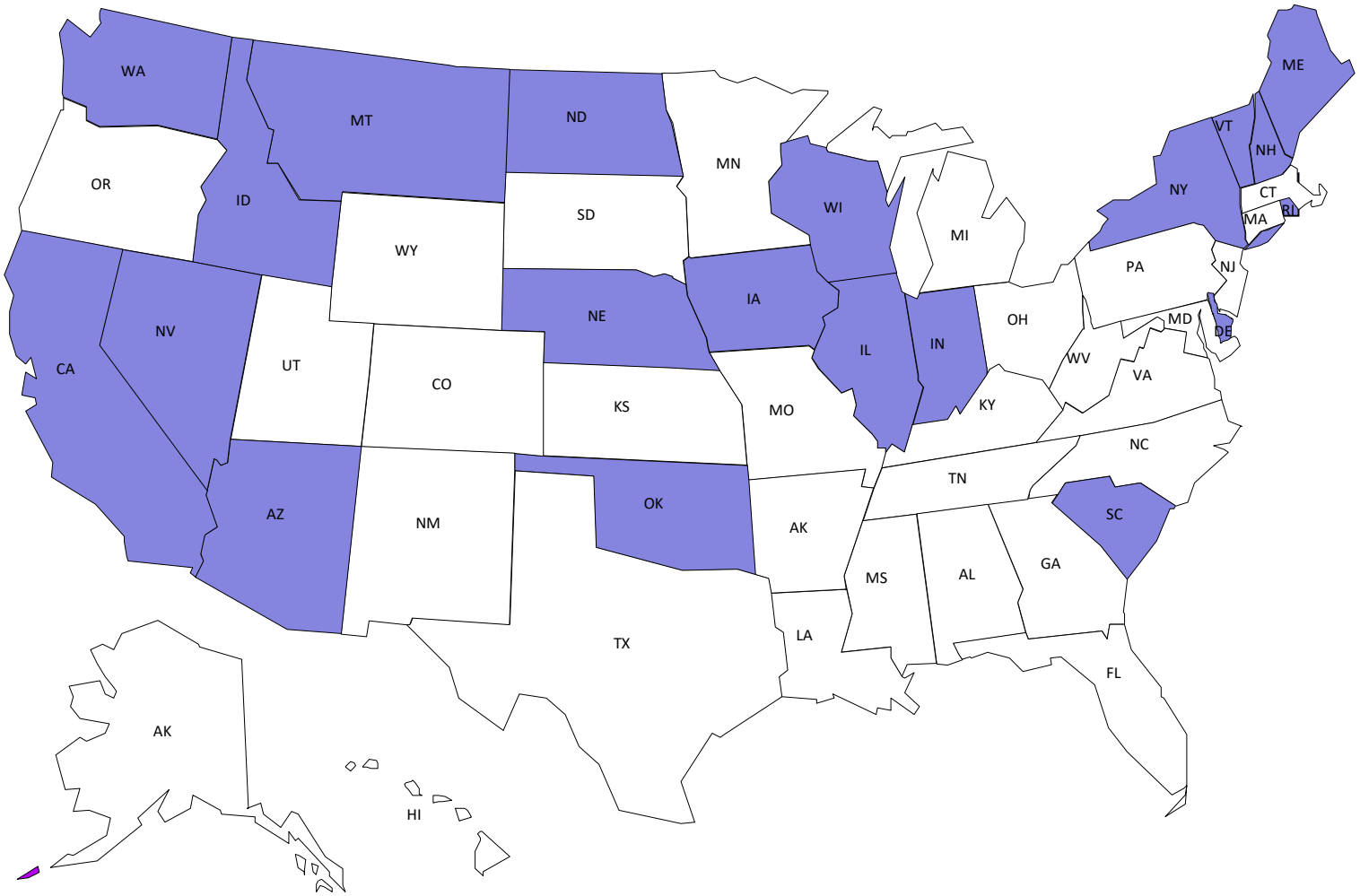
APA Position Statement Key Statements (cont.)

- The goal of involuntary outpatient commitment is to:
  - mobilize appropriate treatment resources,
  - enhance their effectiveness and improve an individual's adherence to the treatment plan.
- Involuntary outpatient commitment should not be considered as a primary tool to prevent acts of violence.

APA Position Statement Key Statements (cont.)

- Studies have shown that involuntary outpatient commitment is most effective:
  - when it includes a range of medication management and psychosocial services equivalent in intensity to those provided in assertive community treatment or intensive case management programs.
- States adopting involuntary outpatient commitment statutes should assure that adequate resources are available to provide such intensive treatment to those under commitment.

Meldrum et al. survey of AOT implementation: 20 states with "active AOT programs"



SOURCE: Meldrum ML, Kelly EL, Calderon R, Brekke JS, Braslow JT (2016). Implementation status of assisted outpatient treatment programs: a national survey. *Psychiatric Services* 67:630–635

Number of states with preventive outpatient commitment statues and active AOT programs

		PREVENTIVE OUTPATIENT COMMITMENT LAW		
		No	Yes	*Total*
ACTIVE AOT PROGRAM	No	13	17	*31*
	Yes	5	15	*20*
	Total	*18*	*32*	*50*

Meldrum et al. survey of AOT implementation: 20 states with "active AOT programs"

- AOT programs varied considerably:
  - style of implementation
  - statutory criteria applied
  - agency responsible
  - use of a treatment plan
  - monitoring procedures
  - numbers of participants involved

Meldrum et al. survey of AOT implementation: 20 states with "active AOT programs"

- Three implementation models:
  - community gateway
  - hospital transition
  - surveillance (or safety net)

Meldrum et al. survey of AOT implementation: 20 states with "active AOT programs"

- Common problems
  - inadequate resources
  - lack of enforcement power
  - inconsistent monitoring
  - weakness of interagency collaboration

- Uneven implementation of AOT programs within and across states
  - ambivalence in the community among judicial officials and mental health clinicians about the role and scope of AOT and the difficulties of implementation under existing funding constraints and statutory limitations.

How common is outpatient commitment?

- About 12% - 20% of a large, 5-site sample of outpatients with SMI in public systems of care reported experiencing outpatient commitment
  - 44-59% report receiving some form of “leveraged” outpatient treatment, with civil legal, criminal justice, or social welfare (money or housing) contingencies linked to treatment participation

    Source : Monahan et al., MacArthur Research Network

Evidence for AOT

- Randomized trials
  - Bellevue Study (Steadman et al., 2001)
  - Duke Mental Health Study (Swartz et al., 1999)
  - UK OCTET study (Burns, 2014)
- Large, quasi-experimental evaluation
  - New York AOT studies (Swartz et al., 2010; Swanson et al., 2013)
- Evidence reviews
  - RAND study (Ridgely et al. 2000)
  - UK report (Churchill et al., 2007)
  - Cochrane Collaborative reports (Kisely et al., 2011)

Evidence for AOT

Big picture summary: Evidence for the effectiveness of outpatient commitment is mixed, with success largely conditioned on:

- investment in effective implementation
- availability of intensive community-based services
- duration of the court order

(But not everyone agrees…)

-- Swanson & Swartz (2014)

Key finding from 1990s Duke Mental Health Study randomized trial of outpatient commitment in NC

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

	Odds Ratio	95% CI	p value
Control (n=135) [1.00] (n=135) (n=85) (n=47)			
OPC (n=129)	0.64	(0.46 – 0.88)	p<0.01

Swartz MS, Swanson JW, Wagner HR, Burns BJ, Hiday VA, Borum WR (1999). Can involuntary outpatient commitment reduce hospital recidivism? Findings from a randomized trial in severely mentally ill individuals. *American Journal of Psychiatry,* 156(12), 1968-1975

Key ... ental He... of o... C

Odd... ring

... value

Contr...

SUBGROUP ANALYSIS: Percent of participants rehospitalized in 12 months

by days of outpatient commitment received

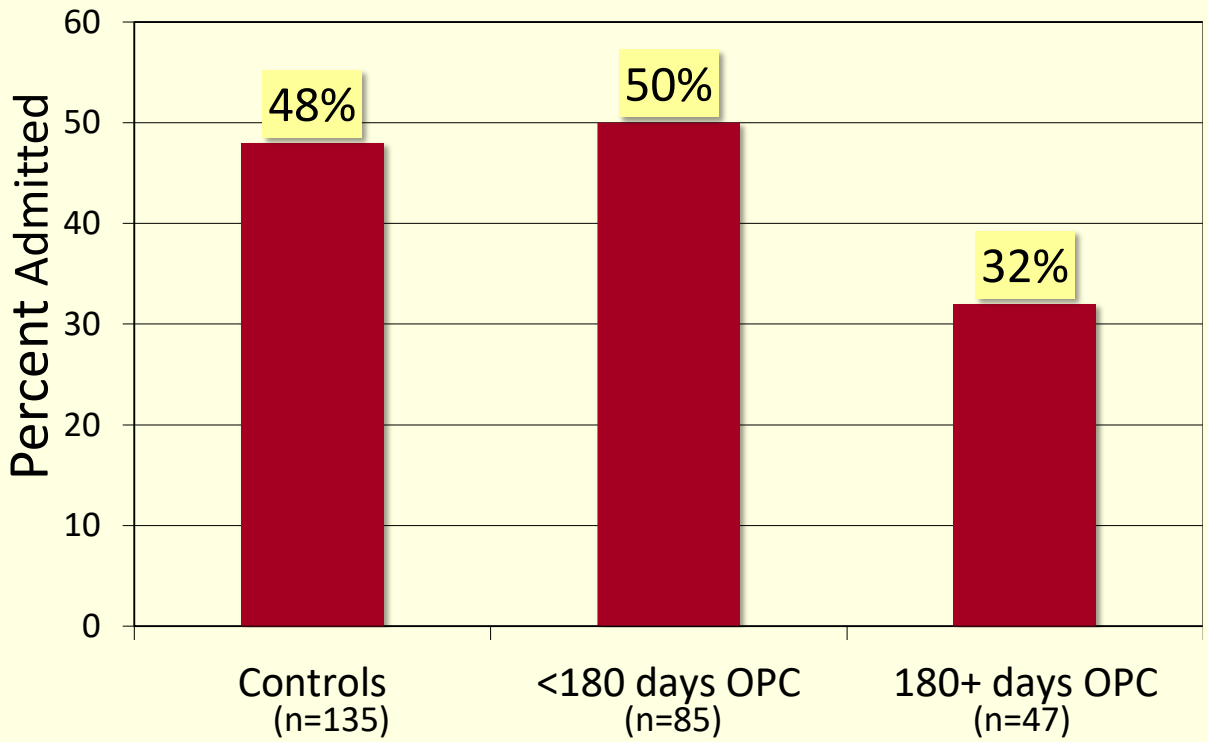


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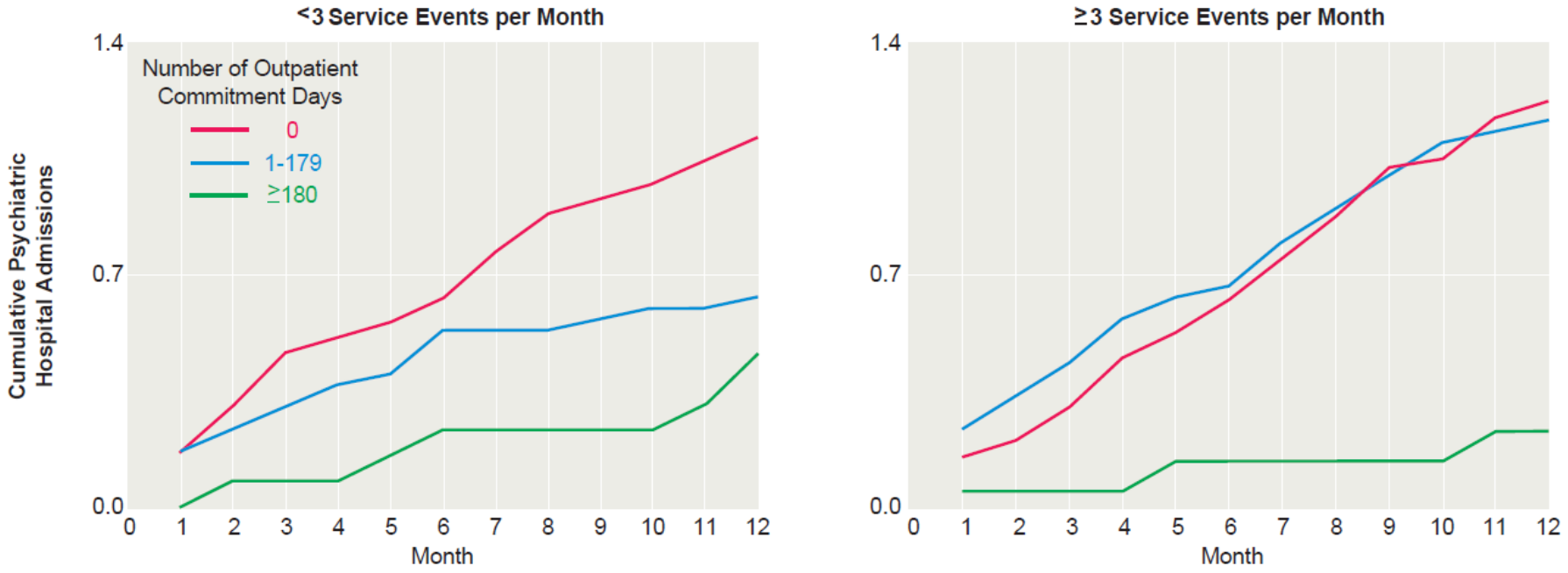
FIGURE 1. Cumulative Mean Psychiatric Hospital Admissions Among Subjects With a Psychotic Diagnosis, by Level of Outpatient Service Use



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New York State Assisted Outpatient Treatment (AOT) Evaluation Study

- Legislatively-mandated statewide assessment of “Kendra’s Law” using administrative data and case manager reports (Swartz et al., 2010)
  - Study period: 1999-2007
- Design: Observational study with multivariable analysis of time series data
  - Comparison: Both pre-post and propensity-matched comparison group
  - Participants: 3,576 AOT placements who had Medicaid
  - Outcomes: Hospital use, medications, receiving ACT/intensive case management/any case management

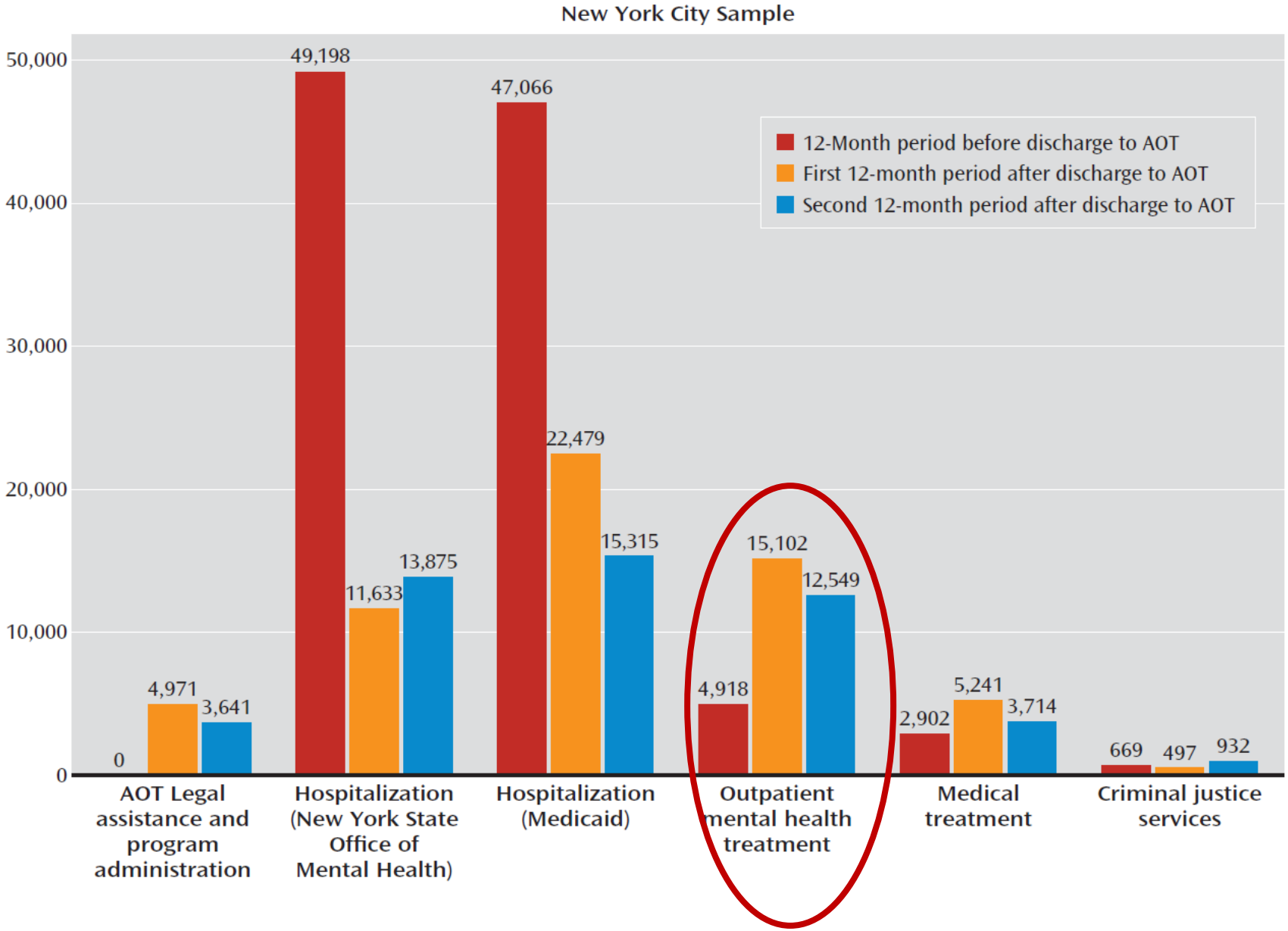
New York State Assisted Outpatient Treatment (AOT) Evaluation Study

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

New York State Assisted Outpatient Treatment (AOT) Evaluation Study

- Case manager data showing reduced hospitalization effect of adding AOT to ACT/ICM:
  - Monthly probability of hospitalization reduced 43% to 57% for participants receiving AOT plus intensive services compared to participants receiving ACT or ICM alone

Summary costs by category, Assisted Outpatient Treatment (AOT) Period, and Sample



Swanson JW, Swartz MS, Van Dorn RA, Robbins PC, Steadman HJ, McGuire TG, Monahan J (2013). The cost of Assisted Outpatient Commitment: Can it save states money? *American Journal of Psychiatry*, 170:1423-1432.

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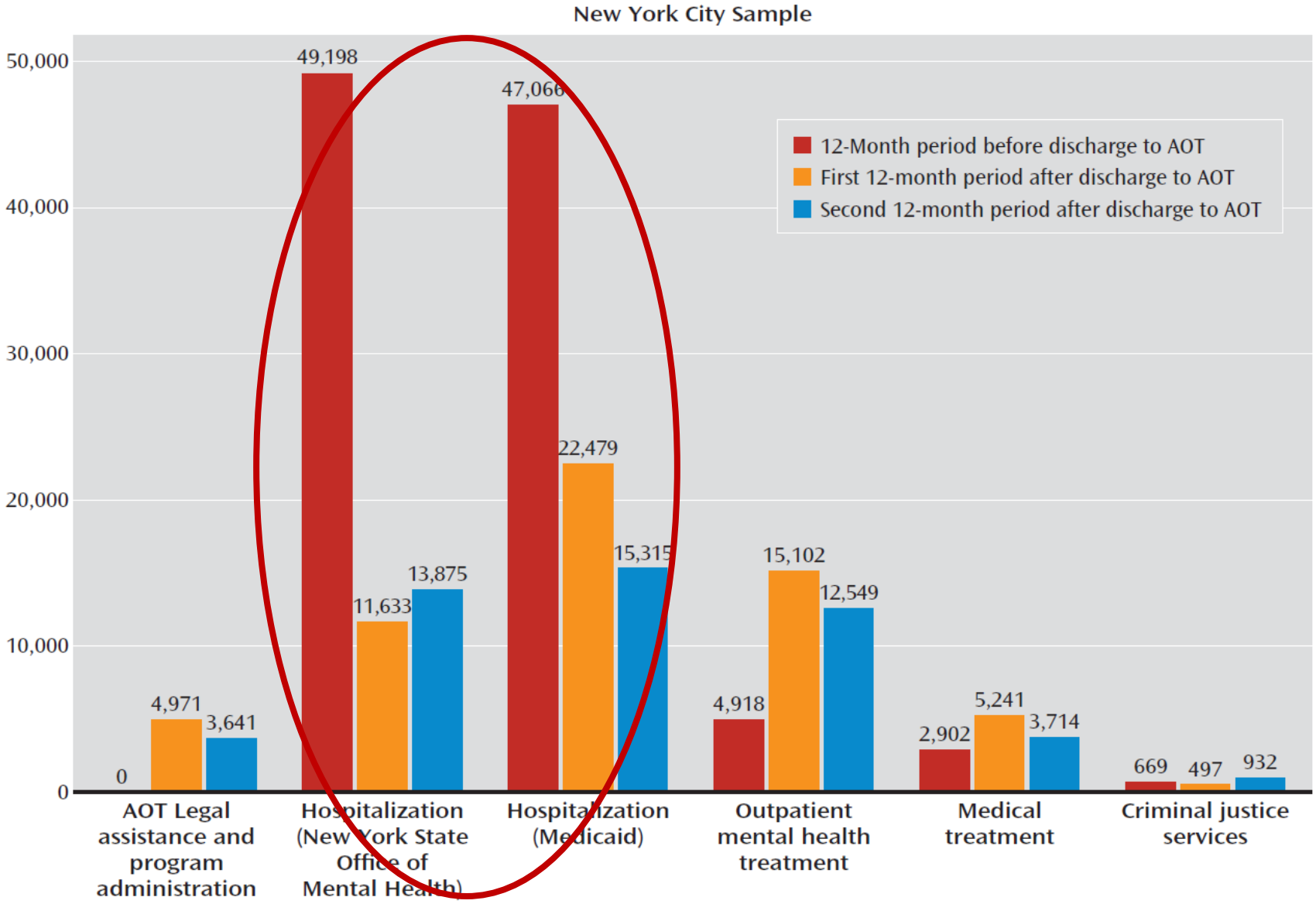

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Does outpatient commitment work?

Answer: It depends…

- What do we mean by "outpatient commitment"?
- What do we mean by "work"? (What is the goal?)
- Does it work . . . compared to what?
- Does it work . . . for whom?
- Does it work . . . where?
- Does it work . . . how? (And for how long?)
- Does it work . . . so what? (Should we do it?)

Is outpatient commitment ethical? (How can we tell?)

Beauchamp and Childress' 4 ethical principles:

(1) respect for autonomy (respecting the decision-making capacities of autonomous persons);

(2) non-maleficence (avoiding the causation of harm);

(3) beneficence (providing benefits and balancing benefits against risks); and

(4) justice (fairness in the distribution of benefits, burdens and risks).

- Beauchamp T and Childress J (2012). Principles of biomedical ethics. 7th ed. Oxford: Oxford University Press.

What do AOT recipients themselves think of AOT?

Subjective quality of life

- Swanson JW, Swartz MS, Elbogen E, Wagner HR, Burns BJ (2003). Effects of involuntary outpatient commitment on subjective quality of life in persons with severe mental illness. *Behavioral Sciences and the Law*, 21, 473-491

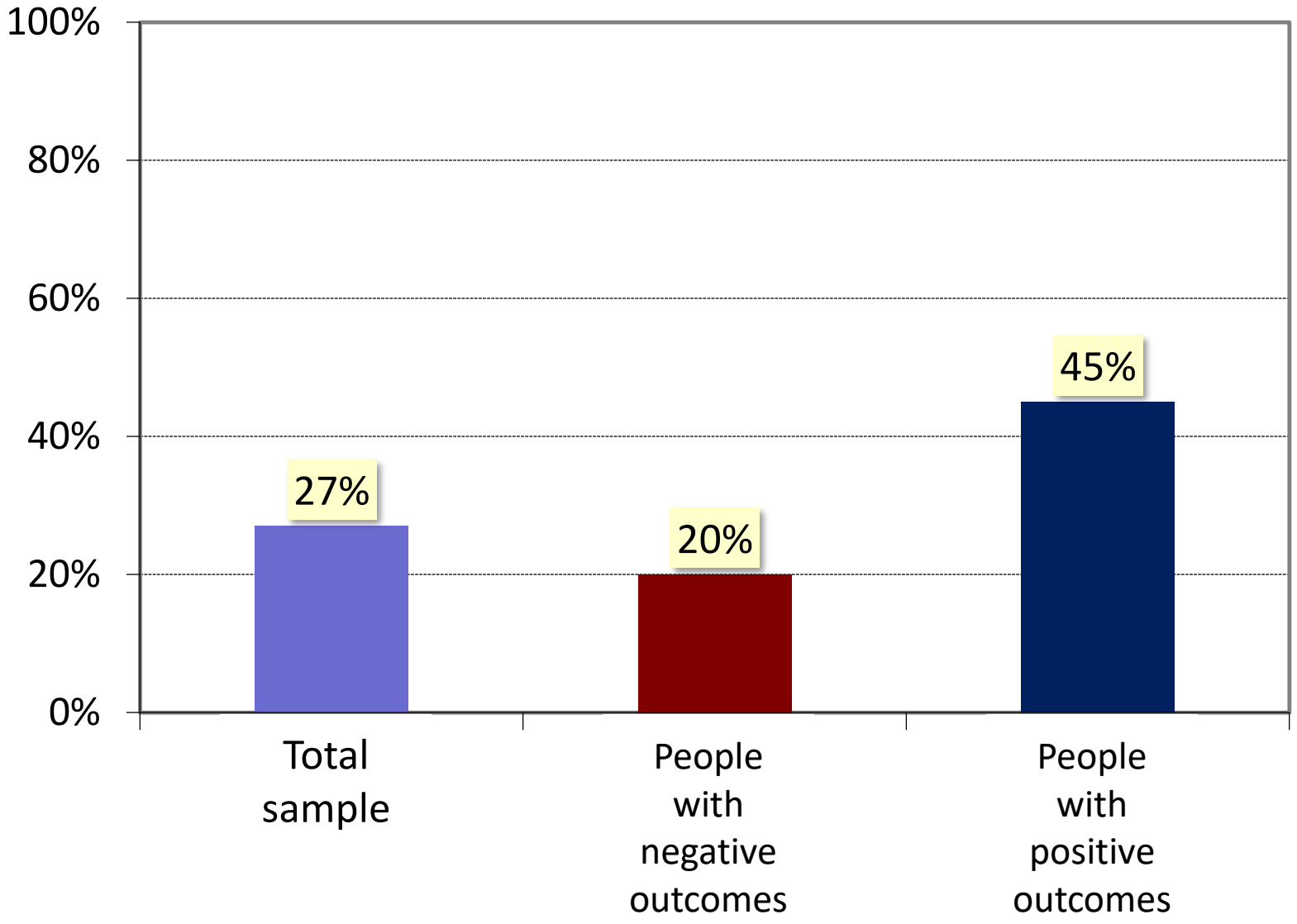
Endorsement of personal benefit

- Swartz MS, Swanson JW, Monahan J (2003). Endorsement of personal benefit of outpatient commitment among persons with severe mental illness. *Psychology, Public Policy and Law*, 9:1, 70-93

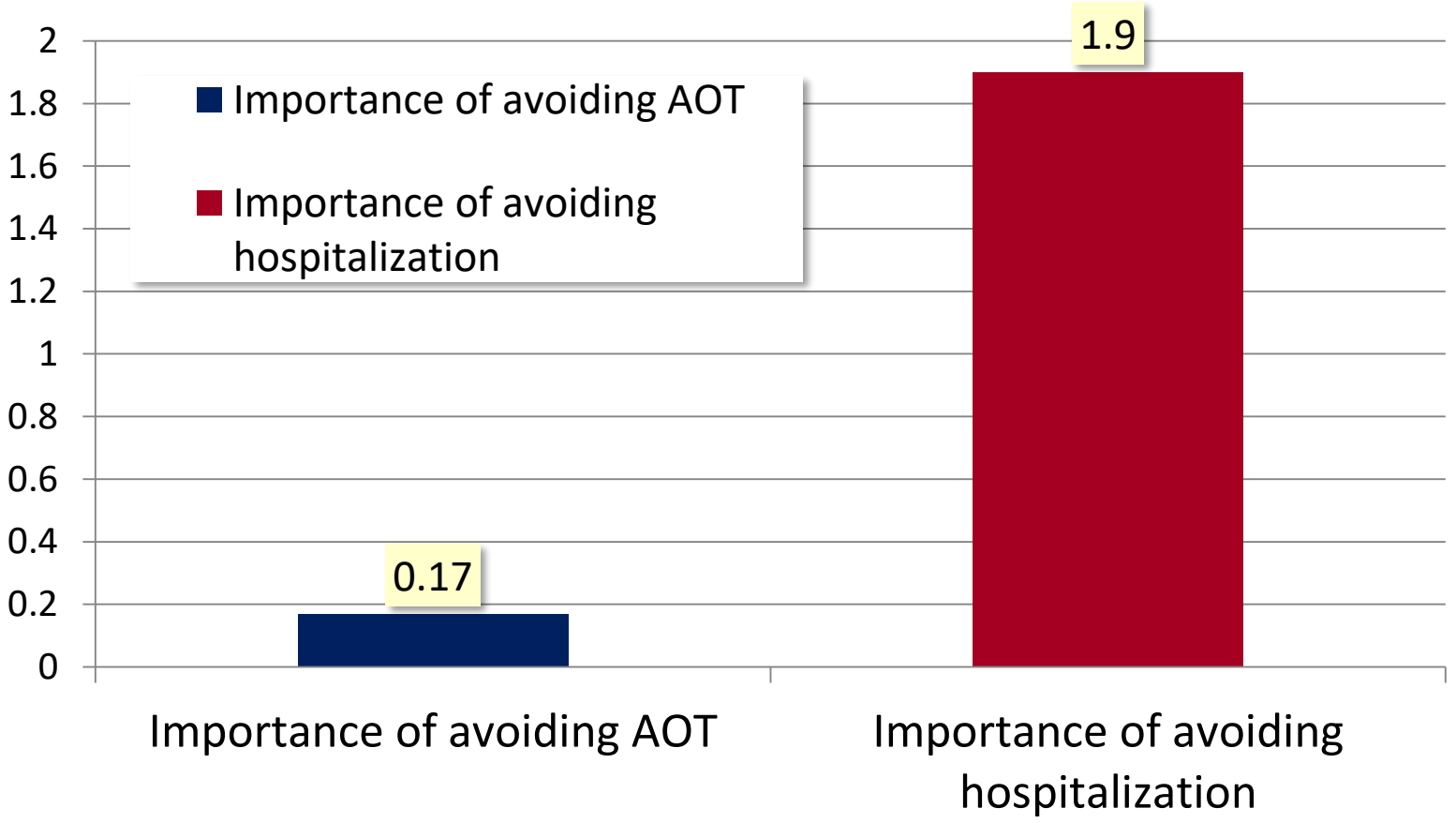
Formal preference assessments

- Swartz MS, Swanson JW, Hannon MJ, Wagner HR, Burns BJ, Shumway M (2003.) Preference assessments of outpatient commitment for persons with schizophrenia: Views of four stakeholder groups. *American Journal of Psychiatry*, 160, 1139-1146

Percent of participants endorsing personal benefit of AOT after 12 months

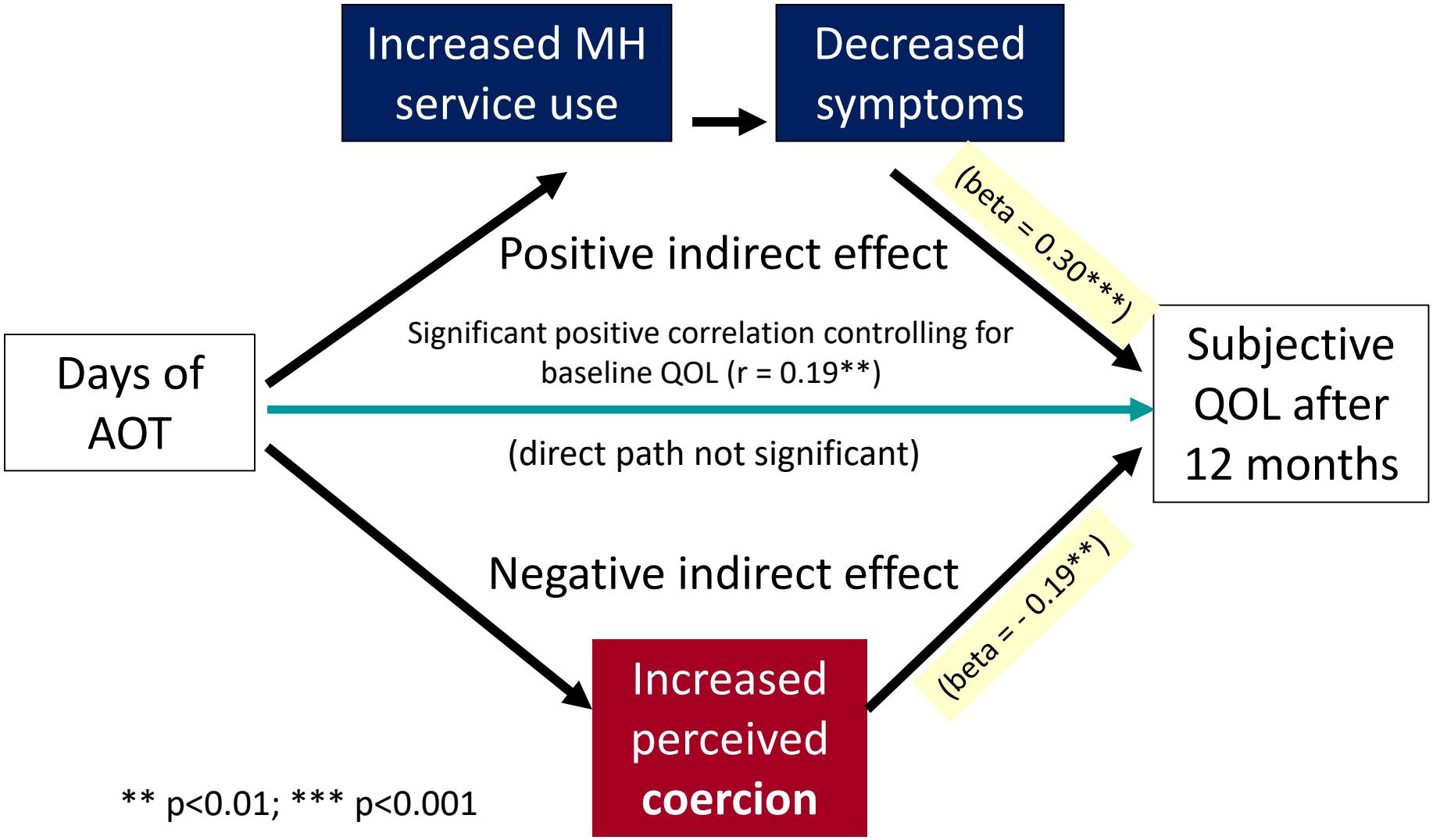


Regression utility weights (subjective preferences) for outcomes in vignettes about AOT



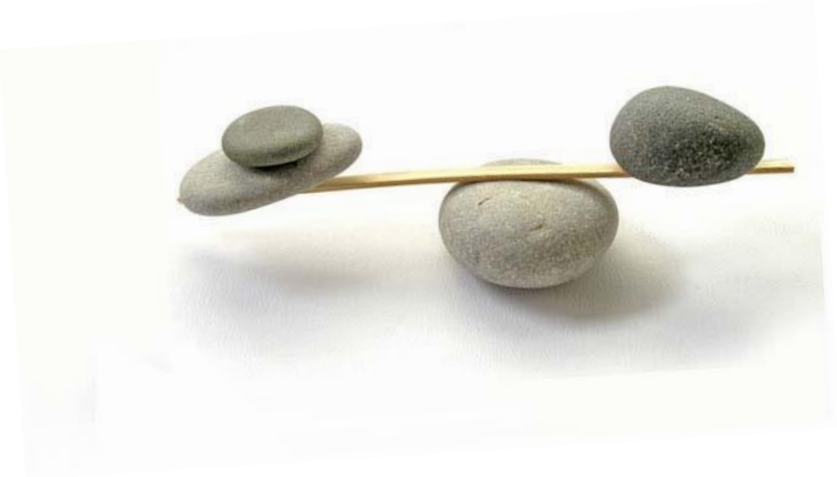
Utility weights represent the change in subjects' rating of the outcome vignette that is attributable to endorsement of a positive outcome. Positive coefficients denote a positive utility for the outcome.

Direct and indirect effects of AOT on quality of life



Source: Adapted from Swanson JW, Swartz MS, Elbogen E, Wagner HR, Burns BJ (2003). Effects of involuntary outpatient commitment on subjective quality of life in persons with severe mental illness. *Behavioral Sciences and the Law,* 21, 473-491.

Is AOT fair?



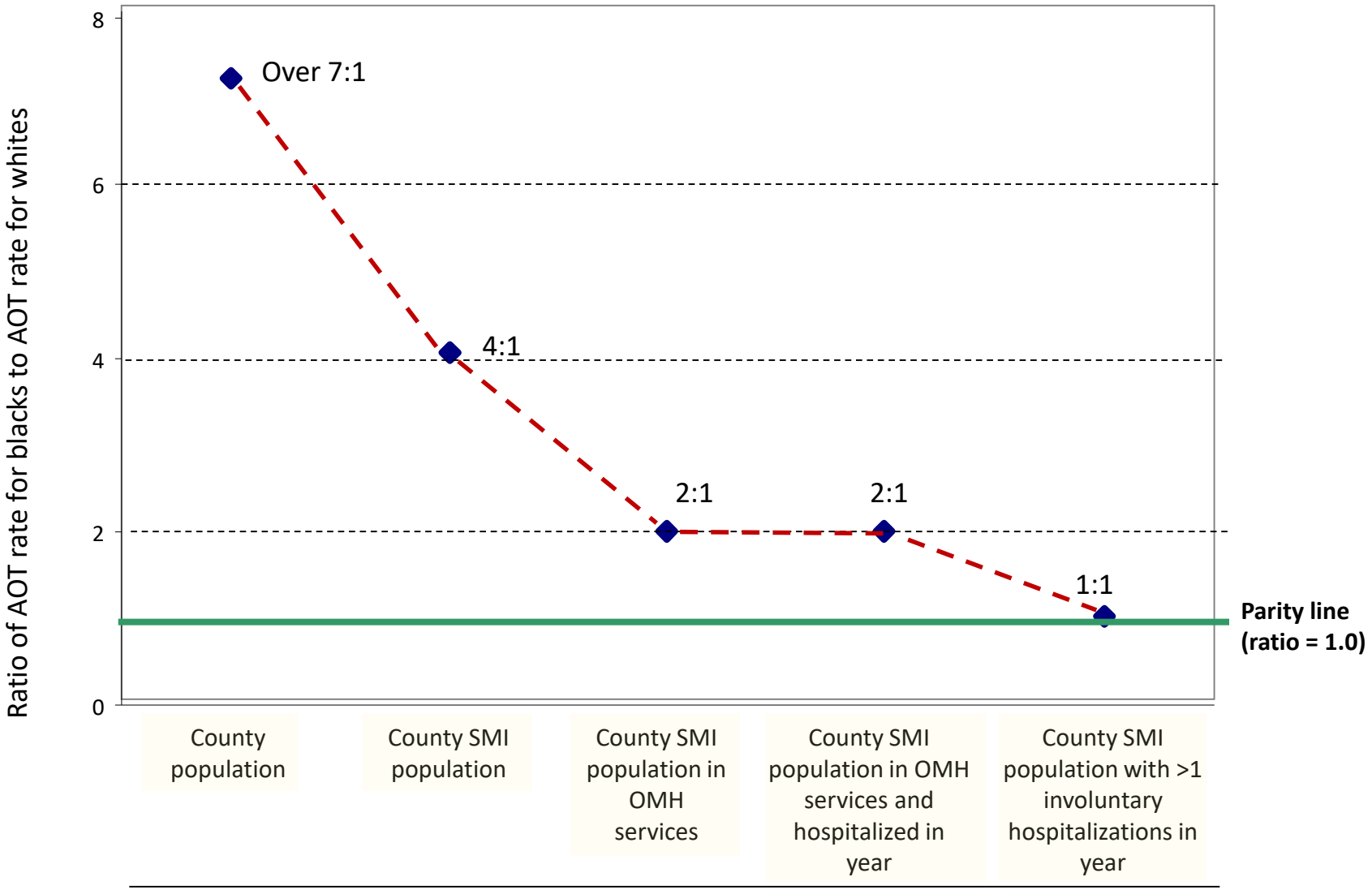
Racial disparities in AOT

- Swanson, J., Swartz, M., Van Dorn, R., Monahan, J., McGuire, T., Steadman, H., and Robbins, P. (2009). Racial disparities in involuntary outpatient commitment: Are they real? *Health Affairs*, 28, 816-826.

"Queue-jumping" in AOT

- Swanson JW, Van Dorn RA, Swartz MS, Cislo AM, Wilder CM, Moser LL, Gilbert AR, McGuire TG (2010). Robbing Peter to pay Paul: Did New York State's outpatient commitment program crowd out voluntary service recipients? *Psychiatric Services* 61, 988-95.

AOT racial disparity indices in New York County: Ratios of AOT rates* for blacks compared to whites, using alternative denominators



* Period-prevalence of AOT cases active at any time during 2003, by selected denominators.

Ethical considerations in outpatient commitment policy and practice

- Outpatient commitment involves overriding some people's choices to forego mental health treatment.
  - AOT should not be applied to people who are willing to seek treatment voluntarily and simply need help accessing that treatment.
  - A court order alone doesn't magically remove barriers to care for persons with serious mental illness.
- There are legitimate, ethical reasons for overriding some patient's expressed choices
  - safety and welfare of the patient and others who may be affected
  - patient lacks capacity to make and communicate authentic decisions

Ethicist Dan Brock's 3 scenarios for overriding patient choice

1. when there are good reasons to doubt that the patient's manifest decision to go without treatment accurately reflects what the patient would have wanted in a non-impaired state;
2. when the moral authority of the patient's treatment refusal is questionable, due to conflict with important interests of the patient;
3. when the interests of persons other than the patient warrant overriding patients' choice.

Robert Miller writing 30 years ago…

Three things needed for outpatient commitment to succeed:

1. "rigorous empirical research to determine how effective involuntary community treatment can be and for what type of patients."
2. "support from community-based clinicians"; if they don't believe in outpatient commitment, it will never be widely implemented.
3. "sufficient resources to permit adequate treatment to be provided."

Otherwise, "outpatient commitment is all too likely to remain a theoretical but not practical alternative to revolving-door hospitalizations and community neglect."

Miller RD. Outpatient civil commitment of the mentally ill. *Behavioral Sciences & the Law* 1988; 6: 99-118.

Questions for discussion:

Where are we now on Miller's "three things" need for outpatient commitment to succeed?

1. Rigorous empirical research?
2. Support from community-based clinicians?
3. Sufficient resources to permit adequate treatment to be provided?

What other ingredients might be needed in the "recipe" for success of outpatient commitment (or AOT)?

Further statutory reform?

More systematic implementation?

Public education and stakeholder buy-in?

Role of law enforcement