Assisted Outpatient Treatment
(aka Involuntary Outpatient Commitment): The Data and the Controversy

Marvin Swartz, MD
Department of Psychiatry and Behavioral Sciences
Duke University School of Medicine
email: marvin.swartz@duke.edu

Disclosures

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- NIMH
- the MacArthur Research Network on Mandated Community Treatment
- The New York State Office of Mental Health

Basic facts about **Involuntary Outpatient Commitment**

- Outpatient version of involuntary commitment to a psychiatric hospital
  - Extends state's civil commitment authority from the institutional setting to community-based MH care
  - Civil court order that requires the patient to comply with recommended treatment and receive services, e.g., medication and intensive case management, but also (arguably) "commits the system" to treat the patient
  - "Treatment plan wrapped in a legal order"
- Leveraged community treatment
  - Sanction for not complying with court-ordered outpatient treatment: police transport to a mental health facility for evaluation
  - Involuntary hospitalization, if criteria met
  - No forced medication in outpatient setting

TYPES of Involuntary Outpatient Commitment

- **Conditional release** from hospital (40 states[1])
  - Early 20th century, started as trial release
- **Alternative to hospitalization** for people meeting inpatient commitment criteria (33 states[1])
  - Least restrictive alternative
- **Preventive outpatient commitment** (10 states[1])
  - Court-ordered treatment authorized at a lower threshold than inpatient commitment criteria with the purpose of preventing further deterioration

[1] Melton et al., 2007

Involuntary Outpatient Commitment CRITIQUE

Availability of appropriate services with aggressive outreach might obviate the need

Should not be used as a substitute for inadequacies in service systems

Applying coercion to patient blames the victim for service deficiencies.

Systems of care should be held accountable for gaps in care.

"Civil libertarians have made it almost impossible to treat psychotic individuals who refuse care. These misguided activists have created a morass of legal obstacles that prevents us from helping many psychotic individuals until they have a finger on a trigger....
It's time to reverse course. Mandatory treatment for those too ill to recognize they need help is far more humane than our present mandatory nontreatment."

--E. Fuller Torrey

E. Fuller Torrey, MD
Treatment Advocacy Center

Favors OPC

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"Civil libertarians have made it almost impossible to treat many psychotic individuals who refuse care….until **they have a finger on a trigger....**

--E. Fuller Torrey

Favors Mandated Community Treatment

Robert Bernstein, PhD
Bazelon Center for MH Law

Opposes OPC

" The Bazelon Center opposes outpatient commitment. There is no evidence that it improves public safety….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."

-- Position statement on outpatient commitment, Judge David Bazelon Center for Mental Health Law

Involuntary Outpatient Commitment DEBATE

"The medication militia…have embarked on a deadly Chemical Crusade to forcibly inject many of us…with these powerful neurotoxins, sometimes for life…Involuntary Outpatient Commitment [OPC] is literally fascism…a profound violation of core values of liberty and freedom."

— Support Coalition

Involuntary Outpatient Commitment
DEBATE

"Today, the forced drugging common inside of institutions has climbed over the walls and is now out in our communities. Citizens in the USA & parts of the world, living peacefully at home, are now court ordered to take powerful psychiatric drugs against their will. Typically these are "neuroleptic drugs" that can cause structural brain damage and even kill."

David Oaks
MindFreedom

Involuntary Outpatient Commitment
DEBATE

"Laws change for a single reason, in reaction to highly publicized incidents of violence. People care about public safety. I am not saying it is right, I am saying this is the reality... So if you're changing [OPC] laws in your state, you have to understand that... You have to take the debate out of the mental health arena and put it in the criminal justice/public safety arena."

— D. J. Jaffe

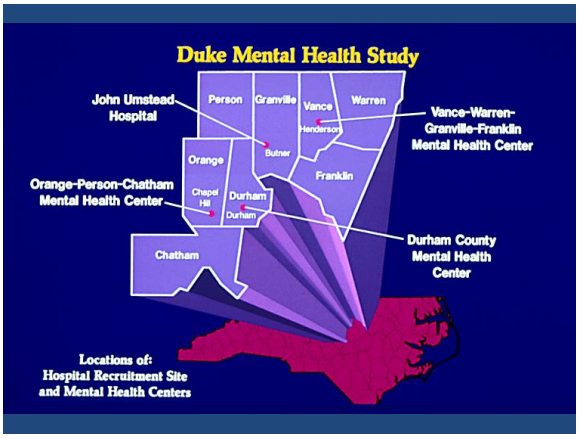
Criteria for OPC in N.C.

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



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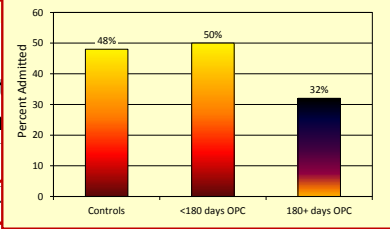
OPC group 0.64 (0.46 – 0.88) p<0.01

SUBGROUP ANALYSIS: Percent of participants rehospitalized in 12 months, **by days of outpatient commitment received**



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

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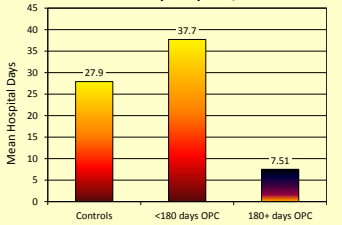
Mean psychiatric **hospital days** in 12 months by days of OPC



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

Reduced odds of any violent behavior in 1 year associated with extended outpatient commitment (Duke Mental Health Study)

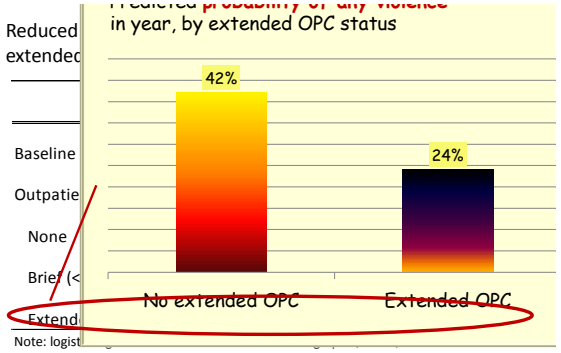
	Odd Ratio	95% CI	P value
Baseline history of violence	1.915	(1.262 - 2.906)	<0.01
Outpatient commitment			
None	1.000	(1.000 - 1.000)	
Brief (<179 days)	0.986	(0.500 - 1.945)	
Extended (180 days or more)	0.347	(0.152 - 0.792)	<0.05

Note: logistic regression model controlled for demographic, social, and clinical characteristics including substance misuse.

Source: Swanson JW, Swartz MS, Borum RB, Hiday VA, Wagner HR, Burns BJ (2000). Involuntary out-patient commitment and reduction of violent behaviour in persons with severe mental illness. British Journal of Psychiatry, 176, 324-331.

Reduced
extended

Predicted probability of any violence in year, by extended OPC status



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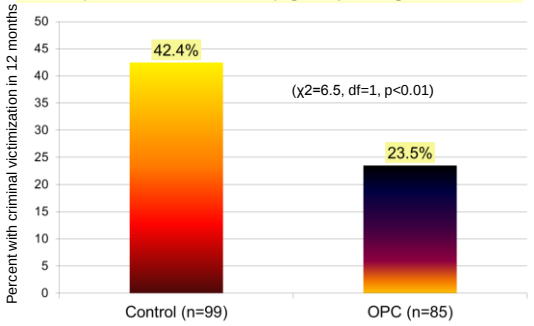
Source: Swanson JW, Swartz MS, Borum RB, Hiday VA, Wagner HR, Burns BJ (2000). Involuntary out-patient commitment and reduction of violent behaviour in persons with severe mental illness. British Journal of Psychiatry, 176, 324-331.

Percent who were **crime victims in 12 months**, by randomized study group assignment



Hiday VA, Swanson JW, Swartz MS, Wagner HR, Borum WR (2002). The impact of outpatient commitment on victimization of persons with severe mental illness. *American Journal of Psychiatry,* Vol 159(8), 1403-1411.

New York City Pilot AOT Program Treatment Evaluation Study

- New York enacted a pilot statute to be tested in NYC
- Bellevue Hospital Study of pilot NYC Law (pre-Kendra's Law)—by order of Legislature.
- Consumers randomly received AOT + Enhanced Services vs. Enhanced Services Alone.
- **Findings**: No differences between AOT vs. Enhanced Services
- **Limitations**: Law was in start-up and sample was small.
- Accompanied by fierce opposition the law was headed to sunset

The New York Times
nytimes.com

March 23, 2000

"In an incident that has gnawed at New Yorkers' sense of security, Kendra Webdale was killed in January 1999 when Andrew Goldstein, a 30-year-old schizophrenic, picked her up on the platform of a 23rd Street subway station and threw her into the path of an oncoming train."

New York passed AOT statute named "Kendra's Law"

The Carrot: NY Kendra's Law Fiscal Changes

$32 million directly allocated yearly in support of the OPC program

- $15 million -- medication grant program
- $4.4 million -- prison and jail discharge managers
- $2.4 million -- oversight programs
- $9.55 million -- new case management slots
- $0.65 million -- drug monitoring

$125 million yearly for enhanced community services

- Used to increase ICM and ACT
- Used to develop Single Point of Access Program (SPOA)

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 duration: 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

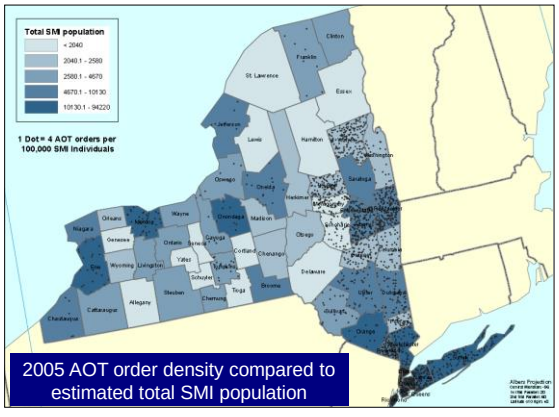
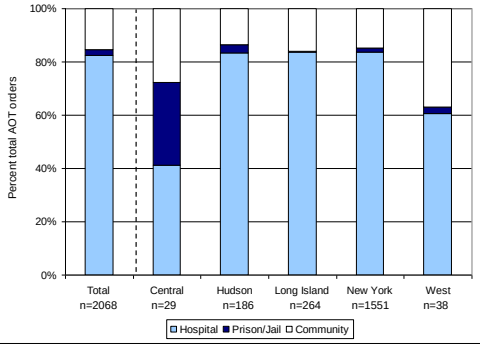


Exhibit 1.3. Origin of AOT orders, 2002-2007, for various regions of New York.



Source: OMH evaluation data

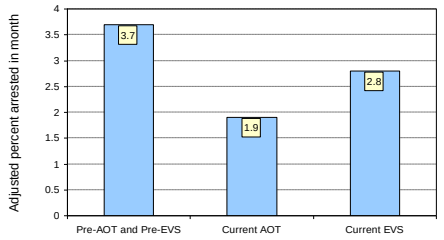
New York State Assisted Outpatient Treatment (AOT) Evaluation Study

	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** (ACT team or intensive case manager) **compared to participants receiving ACT or ICM alone (without AOT)**

Exhibit 3.2. Adjusted* percent arrested in month by current receipt of AOT and EVS



*Adjusted arrest rate estimates were produced using multivariable time-series regression analysis, controlling for time, region, age, sex, race, education, and diagnosis. Months spent in hospital are excluded from analysis.

Source: 6-county interviews and Division of Criminal Justice Services.

Are Minorities Over-represented in the AOT Program in NYC?

The New York Times
nytimes.com

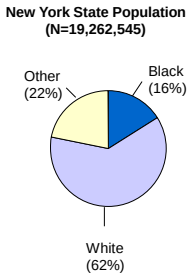
April 7, 2005

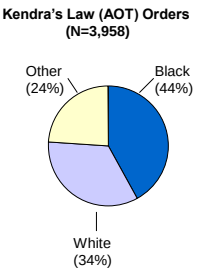
Racial Disproportion Seen in Applying 'Kendra's Law'

By Michael Cooper

ALBANY, April 6 - State officials say the statute, known as Kendra's Law, has been a great success, and Gov. George E. Pataki wants to make it permanent when it comes up for renewal in June. But an analysis of state data by a group that opposes its compulsory-treatment provision found that the law has been disproportionately applied to black New Yorkers.

The group, New York Lawyers for the Public Interest, concluded that blacks were nearly five times as likely as whites to be the subject of court orders stemming from Kendra's Law. Examining court orders for treatment that have been issued since the law took effect, the group found that 42 percent of the 3,958 orders for treatment were *invoked against* blacks, who make up 16 percent of the state's population, while 34 percent of the orders applied to whites, who make up 62 percent.





What does this mean?

"It's important to know if our mental health policy is disproportionately **taking away the freedom** of groups of people who have historically been oppressed."

-- John A. Gresham, Senior Litigation Counsel, New York Lawyers for the Public Interest, *New York Times*, April 2005

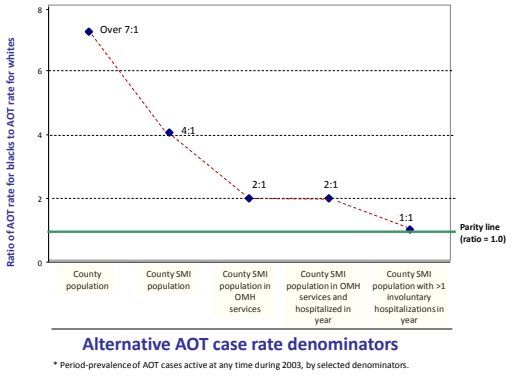
Racial Disparities In Involuntary Outpatient Commitment: Are They Real?

Disparities in outpatient commitment must be understood through the settings where commitment is initially considered.

by Jeffrey Swanson, Marvin Swartz, Richard A. Van Dorn, John Monahan, Thomas G. McGuire, Henry J. Steadman, and Pamela Clark Robbins

ABSTRACT: In this paper we explore racial disparities in outpatient civil commitment, using data from Kendra's Law in New York State. Overall, African Americans are more likely than whites to be involuntarily committed for outpatient psychiatric care in New York. However, candidates for outpatient commitment are largely drawn from a population in which blacks are overrepresented: psychiatric patients with multiple involuntary hospitalizations in public facilities. Whether this overrepresentation under court-ordered outpatient treatment is unfair depends on one's view: is it access to treatment and a less restrictive alternative to hospitalization, or a coercive deprivation of personal liberty? [*Health Affairs* 28, no. 3 (2009): 816–826; 10.1377/hlthaff.28.3.816]

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.

Racial Bias in AOT Program? Summary of Findings

- We find that the over-representation of African Americans in the AOT Program:
  - is a function of African Americans' higher likelihood of being uninsured,
  - higher likelihood of being served by the public mental health system (rather than by private mental health professionals),
  - and higher likelihood of having a history of psychiatric hospitalization.
- We find no evidence that the AOT Program is disproportionately selecting African Americans or other minorities for court orders.

Overall Summary of Findings

- NYS's AOT Program improves a range of important outcomes for its recipients.
- The ***increased services available under AOT clearly improve recipient outcomes***,
- The AOT ***court order and its monitoring do appear to offer additional benefits in improving outcomes*****.**
- The AOT order exerts a critical effect on service providers.

Article

The Cost of Assisted Outpatient Treatment: Can It Save States Money?

Jeffrey W. Swanson, Ph.D.
Richard A. Van Dorn, Ph.D.
Marvin S. Swartz, M.D.
Pamela Clark Robbins, B.A.
Henry J. Steadman, Ph.D.
Thomas G. McGuire, Ph.D.
John Monahan, Ph.D.

Objective: The authors assessed a state's net costs for assisted outpatient treatment, a controversial court-ordered program of community-based mental health services designed to improve outcomes for persons with serious mental illness and a history of repeated hospitalizations attributable to nonadherence with outpatient treatment.

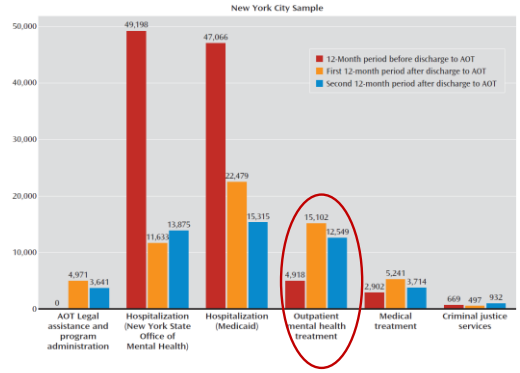
Method: A comprehensive cost analysis was conducted using 36 months of observational data for 634 assisted outpatient treatment participants and 255 voluntary recipients of intensive community-based treatment in New York City and in five counties elsewhere in New York State. Administrative, budgetary, and service claims data were used to calculate and summarize costs for program administration, legal and court services, mental health and other medical treatment, and criminal justice involvement. Adjusted effects of assisted outpatient treatment and voluntary intensive services on total service costs were examined using multivariate time-series regression analysis.

Results: In the New York City sample, net costs declined 43% in the first year after assisted outpatient treatment began and an additional 13% in the second year. In the five-county sample, costs declined 17% in the first year and an additional 27% in the second year. Psychotropic drug costs increased during the first year after initiation of assisted outpatient treatment, by 40% and 44% in the city and five-county samples, respectively. Regression analyses revealed significant declines in costs associated with both assisted outpatient treatment and voluntary participation in intensive services, although the cost declines associated with assisted outpatient treatment were about twice as large as those seen for voluntary services.

Conclusions: Assisted outpatient treatment requires a substantial investment of state resources but can reduce overall service costs for persons with serious mental illness. For those who do not qualify for assisted outpatient treatment, voluntary participation in intensive community-based services may also reduce overall service costs over time, depending on characteristics of the target population and local service system.

(*Am J Psychiatry 2013; 170:1423–1432*)

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.

What do OPC recipients **think** of OPC?

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

Oxford Community Treatment Order **Evaluation Trial** (OCTET)

- Conducted in the UK--third randomized trial of AOT
- OCTET subjects (after involuntary hospitalization) randomly assigned to be released either to:
  - **Experimental condition**: community treatment order, the UK equivalent of involuntary outpatient commitment authorized under the 2007 Mental Health Act.
  - **Control condition**: authorized "leave of absence from hospital," a form of conditional release authorized under Section 17 of UK's 1983 Mental Health Act.
  - To achieve 'legal equipoise' OCTET investigators were prohibited from conducting a trial comparing compulsory and strictly voluntary treatment

Oxford Community Treatment Order **Evaluation Trial** (OCTET)

- **Primary outcome** was readmission to the hospital during the 12 month follow-up period.
- **Secondary outcomes** included length of time to the first readmission, number of readmissions, total amount of time spent in hospital, clinical functioning, and social functioning.
- **No significant differences** were found across any of the outcomes at the 12 month follow-up.

Oxford Community Treatment Order **Evaluation Trial** (OCTET)

- Seemed to provide evidence of the lack of benefit of AOT— 'the tie-breaker'
- Critics of this study argue that it *was not* a clear replication of the previously conducted RCTs
- Lacked a true 'voluntary' treatment arm and had high rates of drop outs

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Can OPC be Effective and For Whom?

- OPC is a complex community intervention, not easily evaluated in a randomized trial design (Drug A v. Drug B).
- A fair-minded reading of the literature on outpatient commitment's effectiveness would be that **OPC *can be* effective** assuming:
  - **Effective implementation**
  - **Provision of intensive community-based services**
  - **Adequate duration of the court order**

Position Statement on OPC—American Psychiatric Association (1)

- 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.

Position Statement on OPC—American Psychiatric Association (2)

- 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**.

Position Statement on OPC—American Psychiatric Association (3)

- Involuntary outpatient commitment **should be available in a preventive form** and should not be exclusively reserved for patients who meet the criteria for involuntary hospitalization.
- The preventive form should be available to help **prevent relapse or deterioration** for patients who currently may not be dangerous to themselves or others (and therefore are not committable to inpatient treatment) but whose relapse would likely lead to severe deterioration and/or dangerousness

Position Statement on OPC—American Psychiatric Association (4)

- **Assessment of the likelihood of relapse**, deterioration, and/or future dangerousness to self or others:
  - Should be based on a clearly delineated clinical history of such episodes in the past several years **based on available clinical information**.

Is OPC a Remedy for Acts of Severe Violence—like Colorado, Arizona or VT?

- Data available indicate OPC can reduce minor acts of violence
- Acts of serious violence are far too infrequent to study accurately
- Might infer that improving treatment adherence may reduce serious violence—but there is no evidence.
- OPC law should be considered on merits of improving treatment adherence and reducing relapse not as violence prevention per se.


That's all, folks!