Assisted Outpatient Treatment: “I’m from the Government and I’m Here to Help You...”

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Why We Should Oppose AOT

It reduces the civil liberties of some of our most disenfranchised individuals even though the available evidence suggests that is does not improve outcomes.

It increases stigma toward people with mental illness by implying they are more likely than the general population to commit violence and creates false hopes that it will reduce acts of violence.

It shifts the burden to meet the needs of service recipients away from the behavioral health system and instead requires the individual to adapt to and accept services they have found unwelcoming and/or ineffective.
The Soccer Goalie Study

Studied more than 300 goalies in their approach to defending a penalty kick
  ◦ The soccer goal is 24 feet across
  ◦ The designated kicker stands 36 feet away
  ◦ The goalie cannot move prior to the kick but must decide when the kick is made to leap left, leap right, or stay in the middle
The Soccer Goalie Study

The Results:
- Diving Left: 14.2% Success Rate
- Diving Right: 12.6% Success Rate
- Standing Still: 33.3% Success Rate

Even though they could somewhere between double or triple their success rate, only 6% of goalies choose to use the optimal strategy of standing still.
Part 1 – The Evidence
“For potentially dangerous patients, there is early indication that mandated outpatient treatment saves money...Available data on health outcomes, social functioning, well-being, and quality of life of patients receiving compulsory outpatient treatment are more equivocal.”


Reviewed 3 Studies (N = 752)

“OPC [Outpatient Commitment] did not result in significant differences compared to voluntary community treatment in any of the main outcome indices: Health service use, social functioning, mental state, quality of life, or satisfaction with care.”

The risk of victimization decreased with OPC.

• However, the authors state: “It is unclear whether this benefit is due to the intensity of the treatment or its compulsory nature.”
“In terms of Numbers Needed to Treat (NNT), it would take 85 OPC orders to prevent one re-admission, 27 to prevent one episode of homelessness and 238 to prevent one arrest.”

The Evidence: A Summary

The studies that find positive outcomes for OPC have not randomly assigned study participants to treatment or control conditions.

It is virtually impossible to determine if the positive results that were found in these studies were due to the enhanced services offered under AOT or their compulsory nature.

The only studies that have used random assignment to conditions have found no evidence that OPC results in positive outcomes, with the possible exception of lower victimization rates.
Part 2 – The Potential for Stigmatizing Mental Illness by Linking it with Violence
AOT will have no effect on high-profile acts of violence

Virtually none of the perpetrators of the high-profile acts of violence that we have witnessed over the years would have qualified for assisted outpatient treatment
Laura’s Law Criteria

A person may be placed in an assisted outpatient treatment if, after a hearing, a court finds that the following criteria have been met. The patient must:

- Be eighteen years of age or older
- Be suffering from a mental illness
- Be unlikely to survive safely in the community without supervision, based on a clinical determination
- Have a history of non-compliance with treatment that has either:
  1. Been a significant factor in his or her being in a hospital, prison or jail at least twice within the last thirty-six months; or
  2. Resulted in one or more acts, attempts or threats of serious violent behavior toward self or others within the last forty-eight months
- Have been offered an opportunity to voluntarily participate in a treatment plan by the local mental health department but continues to fail to engage in treatment
- Be substantially deteriorating
- Be, in view of his or her treatment history and current behavior, in need of assisted outpatient treatment in order to prevent a relapse or deterioration that would likely result in the person meeting California's inpatient commitment standard, which is being:
  1. A serious risk of harm to himself or herself or others; or
  2. Gravely disabled (in immediate physical danger due to being unable to meet basic needs for food, clothing, or shelter);
- Be likely to benefit from assisted outpatient treatment; and
- Participation in the assisted outpatient program is the least restrictive placement necessary to ensure the person's recovery and stability.
Our Need to Feel Safe Predisposes Us to See a Connection between Mental Illness and Violence

However, the impression has been created that the public will be safer from these events with AOT in place. This linking of AOT with the idea that it will prevent violence has only increased the false perception of the public that people with mental illnesses are more likely than the general public to commit acts of violence.
Part 3 – Who do we hold accountable?
“We find that New York State’s AOT Program improves a range of important outcomes for its recipients, apparently without feared negative consequences to recipients. The increased services available under AOT clearly improve recipient outcomes, however, the AOT court order, itself, and its monitoring do appear to offer additional benefits in improving outcomes. It is also important to recognize that the AOT order exerts a critical effect on service providers stimulating their efforts to prioritize care for AOT recipients.” [Emphasis added]

MARVIN SWARTZ, CHRISTINE WILDER, JEFFREY SWANSON, RICHARD VAN DORN, PAMELA CLARK ROBBINS, HENRY STEADMAN, LORNA MOSER, ALLISON GILBERT, JOHN MONAHAN. "ASSESSING OUTCOMES FOR CONSUMERS IN NEW YORK'S ASSISTED OUTPATIENT TREATMENT PROGRAM." PSYCHIATRIC SERVICES 61, NO. 10 (2010): 976–981.
Patt Morrison: What does work?

The long-term treatment of very severely mentally ill people — consistent, steady, low-grade outreach which is flexible and which goes on for months and years and which is based on ensuring the person gets their medicine, ensuring their social life is stabilized as best we can — that reduces the rate of relapse substantially. We've now tried to add compulsion to it and it hasn't improved the outcome. So I think the effort should go into making sure that everybody gets access to basic treatment.
Patt Morrison: It may be that getting the care you are describing would require, in this country, compulsion.

I don't think it does. One of a doctor's biggest skills is in forming a trusting relationship with scared, frightened, shy, anxious individuals, and through that encourage them, nag them, to get them to treatment. I'm shameless at it! And most of my colleagues are too. I had hoped that adding compulsion would move the proportion who do well up, but the evidence is stubbornly consistent that it doesn't.
Ironically, it appears that any positive effect that AOT has had appears to be a result of the increase in the availability and intensity of services offered rather than through the effect of compulsion. Which begs the question, why do our behavioral health systems need a “captive audience” before they provide these services?
Discussion