GETTING ASSISTED OUTPATIENT TREATMENT FOR YOUR COUNTY

What can I do to help obtain assisted outpatient treatment for my county?

You should strive to persuade the people who determine mental health policy in your county that not only is AOT needed, but that it will work. Since they must pass a resolution adopting AOT, the ultimate decision lies with the members of your county's board of supervisors. We urge you to write, call, and/or meet with them. And the more you coordinate your efforts with others in the pursuit of this treatment-ensuring program, the more your efforts will be amplified.

In order to bring AOT to your county, you should seek out assistance from other individuals and organizations interested in securing care for people with severe psychiatric disorders. Contacts, and especially visits, from representatives of groups like NAMI, police, sheriffs, judges, correctional officials, and mental health professionals should be particularly effective in getting the message out to the members of the board of supervisors of your county.

As the elected leaders of counties rely on them for advice on mental health policy, you should also promote assisted outpatient treatment with the director of your county mental health department and the members of your local mental health board. You will be playing into an interesting dynamic. The director is the expert but the members of the board of supervisors are collectively his or her bosses. And the board members, as elected officials, are accountable to you, the registered voter.

What types of services must a county provide to establish an assisted outpatient treatment program?

Any county that elects to establish an assisted outpatient treatment must have available for those placed in the program a threshold of services that, among others, includes:

1) Community-based, mobile, multidisciplinary, highly trained mental health teams that use have staff-to-client ratios of no more than one team member per ten clients under AOT orders;
2) A service planning and delivery process that includes provisions to:

A. **Determine the numbers of persons to be served, and the programs and services that will be provided to meet their needs;**

B. **Plan for outreach to families, psychiatric and psychological services, coordination and access to medications, substance abuse services, housing assistance, vocational rehabilitation, and veterans' services**

C. **Provide staff who can remove barriers to services resulting from cultural, linguistic, racial, age, and gender differences;**

D. **Offer services to older adults, persons who are physically disabled, and seriously mentally ill young adults (25 years of age or younger) who are at risk of becoming homeless; and**

E. **Provide housing that is either immediate, transitional, permanent, or all of these.**

3) Personal service coordinators, who may be part of the AOT program team, who are responsible for ensuring, to the extent feasible, that people subject to assisted outpatient treatment receive services which enable them to:

A. **Live in the least restrictive housing feasible in the local community;**
B. **Engage in the highest level of productive activities appropriate to their abilities and experience;**
C. **Access appropriate education and vocational training;**
D. **Obtain an income;**
E. **Exert as much control over their lives as possible;**
F. **Access physical health care; and**
G. **Reduce antisocial or criminal behavior.**

Will these assisted outpatient treatment services be more than my county is willing to provide?

Most, if not all, of the components of the service and delivery process in the second section above should already be part of most county mental health systems and would only have to be accessed by the AOT program. The personal service coordinators and the objectives outlined in the third section can be integrated into any high-intensity service program, like one for assisted outpatient treatment. Furthermore, the objectives of those coordinators must only be met "to the extent feasible," which makes them far less than absolute requirements.

The primary obstacle to a county establishing an AOT program is that it must have an intensive treatment team with a high staff to client ratio, which is described in the first section above. There are three basic manners in which a county can satisfy this requirement.

1) Create a team dedicated solely to the care of people in AOT. This solution would allow your county to make the greatest use of the AOT program authorized by Assembly Bill 1421.
2) Integrate assisted outpatient treatment into existing programs that meet the threshold requirements. Many counties already have programs that meet or substantially meet the service requirements, such as programs for assertive community treatment or intensive homeless outreach programs. Even if counties with these in place are not willing to establish specifically dedicated AOT teams, these programs can – often with little modification – meet the requirements for and make use of AB 1421.
3) Designate a team from existing county mental health professionals. AB 1421 does not require that every member of the team must be dedicated full-time to the care of those in assisted outpatient treatment. Any group of county-designated mental health professionals can qualify as an AOT team so long as the staff to client ratio is no more than one to ten (an average of approximately four hours total staff time per client), the team is mobile (at least some of the team members can reach clients in the community), and they can provide the level and types of services mandated by the statute. Thus a personal services coordinator and a psychiatrist on an AOT team would not have to work together on a daily basis. They would only need to be part of a team that provides the necessary AOT services. Otherwise, the AOT team members could work with other clients and in other programs. Using this approach, even the smallest county can make use of assisted outpatient treatment.

Will my county have to offer increased voluntary services if it offers assisted outpatient treatment?

Provisions of the authorizing legislation, AB 1421, require that any county providing assisted outpatient treatment must also offer the same services on a voluntary basis. This does not require that everyone asking for those services be provided with them.

What it does mean is that intensive services, such as those in an AOT program, cannot be reserved exclusively for those under AOT orders. Rather, voluntary patients must have access – with distribution prioritized on the basis of need – to the same services offered by AOT treatment teams or to equivalent ones offered in programs not dedicated to assisted outpatient treatment. AB 1421 thus guarantees that those with the greatest need can take a place in line for the best available community services regardless of whether or not they are subject to court-ordered treatment.

Can my county create an assisted outpatient treatment program out of its existing mental health budget?

In order to create an AOT program a county's board must make a finding that no voluntary mental health program will be reduced as a result. As it is targeted at helping those prone to multiple hospitalizations, repetitive jailings, suicide, and violence – AOT is more strongly appealing to most elected officials than a typical mental health program. That political attractiveness should induce some county boards to endow it with funding fresh to its mental health system.

An assisted outpatient treatment program can also, however, be justified on the basis of its cost-effectiveness. AOT substantially reduces the single greatest cost to any mental health system, that of inpatient hospital days. Based on those savings alone, a county board of supervisors could make the finding that voluntary services will not be affected. Moreover, those placed in AOT will, for the most part, be people who are continually – if sporadically – already under the care of the mental health system. The cost of much of their care will thus be a shifting of costs rather than an increase.

What has proven the effectiveness of assisted outpatient treatment?

The Duke Studies are the largest and most respected of the controlled examinations of assisted outpatient treatment. Among the released findings of this one-year randomized trial:

1) AOT Reduces Hospitalizations

Assisted outpatient treatment for 6 months or more combined with routine outpatient services (3 or more outpatient visits per month) decreased hospital admissions by 57% and the average length of hospital stays by 20 days. [1]

2) AOT Reduces Arrests

For a subgroup with a history of multiple hospitalizations as well as prior arrests and/or violent behavior, the re-arrest rate of those in AOT for 6 months or more was one-quarter (12% versus 47%) that of those who were not under treatment orders. [2]

3) AOT Reduces Violence

Assisted outpatient treatment of 6 months or more combined with routine outpatient services reduced the incidence of violence in half (24% versus 48%).[3]

4) AOT Reduces Victimization

Over one year, 42% of those in the control group were victims of crimes, such as rape, theft, mugging, or burglary versus only 24% of those who were in AOT for 6 months or more with routine services: AOT decreased victimization by 43%.[4]

The outcome numbers from the law on which California's assisted outpatient treatment is based are equally conclusive. The first 141 people placed in assisted outpatient treatment in New York pursuant to Kendra's Law experienced:

- **129% increase in medication compliance;**
- **194% increase in case management use;**
- **107% increase in housing services use;**
- **67% increase in medication management services use;**
- **50% increase in therapy use;**
- **26% decrease in harmful behavior; and**
- **100% decrease in homelessness.[5]**

What can I do to get more information about getting assisted outpatient treatment for my county?

The Treatment Advocacy Center can answer questions about AOT, supply you with additional materials on the treatment mechanism, as well as help you join the California Treatment Advocacy Coalition, a group of advocates that lead the movement for legislation authorizing assisted outpatient treatment in California and who are now at the forefront of the effort to secure its adoption in the counties.

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FOOTNOTES

1[1] **Swartz, M.S., Swanson, J.W., Wagner, R.H., et al: Can involuntary outpatient commitment reduce hospital recidivism? *American Journal of Psychiatry*, 156:1968-1975 (1999).**

1[2] **Swanson, J.W., Swartz, M.S., Borum, R., et al: Involuntary out-patient commitment and reduction of violent behaviour in persons with severe mental illness. *British Journal of Psychiatry*, 176: 224–231 (2000).**

[3] **Swanson, J.W., Swartz, M.S., Borum, R., et al: Involuntary out-patient commitment and reduction of violent behaviour in persons with severe mental illness. *British Journal of Psychiatry*, 176: 224–231 (2000).**

[4] **Hiday V.A., Swartz. M.S., Swanson J.W. et al: Impact of outpatient commitment on victimization of people with severe mental illness. *American Journal of Psychiatry, 159*: 1403-1411 (2002).**

1[5] **New York State Office of Mental Health, Progress Report on New York State's Mental Health System (Jan. 2001), pp. 16-18.**

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TREATMENT ADVOCACY CENTER

This Guide and other materials on AB 1421 can be found at:
/StateActivity/California.htm

The Treatment Advocacy Center is a nonprofit organization dedicated to eliminating barriers to timely and humane treatment for the millions of Americans with severe brain disorders, such as schizophrenia and manic-depression (bipolar disorder). Current federal and state policies hinder treatment for psychiatrically ill individuals who are most at risk for homelessness, arrest, or suicide. As a result, an estimated 4 million individuals with severe mental illnesses are not being treated for their illness at any given time. The Center serves as a catalyst to achieve proper balance in judicial, legislative, and policy decisions that affect the lives of people with serious brain disorders.

To learn more about the efforts of the Treatment Advocacy Center or the California Treatment Advocacy Coalition, please contact:

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