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ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

**OFFICE OF BEHAVIORAL HEALTH, DISABILITY, AND AGING POLICY**

# Evaluation of the Assisted Outpatient Treatment Grant Program for Individuals with Serious Mental Illness: Implementation Report

Prepared for
**the Office of the Assistant Secretary for Planning and Evaluation (ASPE)**
**at the U.S. Department of Health & Human Services**

by
**RTI International**

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**Duke University School of Medicine**

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# EVALUATION OF THE ASSISTED OUTPATIENT TREATMENT GRANT PROGRAM FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS:

# IMPLEMENTATION REPORT


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## ACKNOWLEDGMENTS

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# EXECUTIVE SUMMARY

## ES.1. Introduction

Assisted outpatient treatment (AOT) is a civil court process that authorizes community-based treatment for people with serious mental illness at risk of relapse or deterioration because they do not voluntarily comply with prescribed treatment. At present, AOT is authorized in 47 states and the District of Columbia. Despite broad statutory support, AOT is used inconsistently and, when used, can be implemented differently across jurisdictions, including as conditional release for involuntarily hospitalized individuals, as an alternative to hospitalization for individuals who meet inpatient commitment criteria, or as an alternative status for individuals who do not meet inpatient criteria. While statutory and implementation variation exists across jurisdictions, generally, to be placed under an AOT order, individuals must be at least 18 years of age, diagnosed with mental illness, assessed to be unlikely to be able to live safely in the community without supervision, have a history of treatment non-compliance resulting in psychiatric hospitalization or incarceration, or have committed serious acts or threats of violence to self or others. Once an AOT order is finalized by a court, recipients are engaged in a comprehensive community-based treatment plan and procedures for monitoring adherence to the plan.

The 2016 Substance Abuse and Mental Health Services Administration (SAMHSA) grant program, entitled "Assisted Outpatient Treatment Grant Program for Individuals with Serious Mental Illness," which funded 17 AOT programs across the nation, required an independent evaluation of its implementation and outcomes. The U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Planning and Evaluation awarded a contract to RTI International with a subcontract to Policy Research Associates, Inc. (PRA) of Delmar, New York, and to Duke University Medical Center of Durham, North Carolina to complete the evaluation.

The areas of investigation for the implementation evaluation included:

- **AOT programs and civil court processes**: Are there differences across the pilot programs, their implementation, and the civil court procedures utilized?
- **Target populations**: Who did the programs intend to serve and who are they actually serving?
- **Service infrastructures and clinical approaches**: What existing and newly established clinical service infrastructures are supporting AOT program participants?
- **Stakeholder involvement**: What stakeholders were involved in the development and implementation of the AOT program and have their roles changed over time? What stakeholders are involved in the civil court process, and what are their roles?
- **Person-centered practices and procedural justice**: To what extent do the programs retain due processes and choices for individuals and families?
- **Innovation**: What are some of the innovative practices and arrangements to implementing AOT that have emerged from the pilot grants?
- **Evaluation capacities**: What is the data collection capacity of the program sites? What supports will need to be in place to collect valid and complete data surrounding the nature, intensity, and quality of services and health and social outcomes if the site is also selected for the outcome evaluation?

## ES.2. Methods

While SAMHSA funded 17 AOT pilot programs across the nation, the implementation evaluation focuses specifically on six of those 17 programs. The six programs and their implementation locales are: AltaPointe Health Systems Incorporated in Fairhope, Alabama; Cook County Health and Hospital System in Chicago, Illinois; Hinds County Mental Health Commission in Jackson, Mississippi; Doña Ana County in Las Cruces, New Mexico; Alcohol, Drug Addiction and Mental Health Services Board of Cuyahoga County (ADAMHSBCC) in Cleveland, Ohio; and the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) in Oklahoma City and Tulsa, and Rogers, Washington, Ottawa, and Delaware Counties, Oklahoma. These program sites were selected by the HHS AOT program advisory committee per several criteria, including but not limited to geographic diversity, AOT program type, AOT program size, data availability, and suitability for the subsequent outcome evaluation. To address the required areas of investigation for the implementation evaluation we used a variety of qualitative information, including interviews and observations, supplemental materials, and the original grant applications, obtained from site visits to the six selected sites. The 2-day site visits were conducted by three-person teams. Data was examined using the *integrated*-Promoting Action of Research Implementation in Health Services (i-PARIHS) framework, which allowed us to focus on the core constructs of facilitation, innovation, recipients, and context to capture the dynamic and multifaceted nature of AOT implementation across sites.

## ES.3. Findings

### *ES.3.1. AOT Programs and Civil Court Processes*

The six sites included in the evaluation developed and implemented a range of AOT programming, including preventive and non-preventive step-up (i.e., from the community to an AOT order), step-down (i.e., from an inpatient setting to an AOT order), and mixed approaches (i.e., a combination of both step-up and step-down approaches), in addition to varying pre-AOT and post-AOT civil court processes. All site visit state statutes included eligibility criteria that were preventive in nature, thus allowing for an AOT order in situations where decompensation has not yet occurred, but is likely. Five of the six states--all but the Cook County Health and Hospital System site in Illinois--are using a mixed approach to AOT; yet within this mixed approach, sites are differentially emphasizing step-up and step-down approaches.

Variation in civil court procedures was common, as expected, due to statutory variation, including AOT initiation (i.e., length of time from petition to commitment, requirements for who is allowed to examine the respondent and whether or not that individual is required to testify, whether judicial reviews of the treatment plan are required, and whether or not the respondent can waive their right to appear) and post-initiation processes (i.e., use of judicial status hearings and judicial reviews of changes to treatment plans, responses to non-compliance via the use of pick-up orders or sanctions, and AOT renewals). One constant AOT initiation process was that respondents were statutorily guaranteed access to legal representation. Still, respondents' access to legal representation did vary across sites. At AltaPointe Health Systems, for example, a respondent might not meet their guardian ad litem until immediately prior to a hearing. At Cook County Health and Hospital System, for example, the Guardianship and Advocacy Commission attorneys are part of the development of the agreed-order process and routinely meet with their clients on the state hospital units.

### *ES.3.2. Target Populations*

Individuals under an outpatient civil commitment order generally matched each state's AOT statute. However, there were instances where implementing sites utilized additional AOT criteria that were not statutorily required, or implemented other clinical or judicial criteria that has the potential to narrow the population of those eligible for AOT. For example, Cook County Health and Hospital System uses a more restrictive standard for eligibility, where candidates must have a minimum of two inpatient hospitalizations in the past 12 months, as they believe this is an indication of a lack of success in treatment. As another example, at the Cuyahoga

County (Ohio) program, where the dedicated service to be delivered under an AOT order is Assertive Community Treatment (ACT), respondents must meet dual-eligibility requirements--both ACT and AOT--to receive services. Another example of how a site is implementing changes to the AOT process not specified in the state's statute that might affect the subsequent patient population relates to the use of AOT at Doña Ana County as a voluntary agreement to participate in community-based outpatient treatment. Hospital treatment teams with AltaPointe Health Systems ask for the respondent to agree to outpatient commitment to speed up discharge from the hospital, but clinical need is prioritized over a respondent's potential refusal with being placed on outpatient commitment. Finally, ineligible classes are specified by statutes in Alabama, Illinois, Mississippi, and Oklahoma, and exclude individuals with co-occurring disabilities (e.g., developmental) or dependencies (e.g., chemical).

#### *ES.3.3. Service Infrastructures and Clinical Approaches*

The primary evidence-based service being delivered at all six implementing sites studied for this report was ACT. ACT fidelity, in addition to the availability of other evidence-based services, including the presence of other intensive and evidence-based step-down services varied across the sites. All sites appeared to be demonstrating high ACT fidelity with regards to frequency of clinical contact; however, there was less fidelity with regards to requirements for team members and substance use treatment capacity. For example, two programs (AltaPointe Health Systems and Hinds County Mental Health Commission) did not have a full-time psychiatrist assigned to their treatment teams providing ACT services to AOT recipients and AltaPointe Health Systems also was not utilizing an integrated dual disorder treatment (IDDT) approach to address the co-occurring nature of substance use and mental health problems. Another difference between sites was the bundling of ACT and AOT as a single treatment modality, as opposed to the more traditional use of AOT as a court order, separate from treatment. In sites that have created or utilize a single treatment team there is a danger that the AOT and ACT needs of recipients will be conflated. Moreover, at sites bundling ACT and AOT there is the potential that post-AOT step-downs to ACT alone may result in transferring the client to a new ACT team unless the AOT team delivering ACT services decides to keep the individual without a court order, or exert some pressure to keep an AOT order so as to not disrupt service continuity. If this is the case, however, AOT teams may eventually run into capacity issues as the AOT caseload grows. Finally, examples of other evidence-based services available under AOT orders, or available as a step-down from an AOT order include Illness Management Recovery, Cognitive Behavioral Therapy, Motivational Interviewing, IDDT, Individual Placement and Support (IPS), and Housing First. Lack of housing and transportation options in some counties pose an obstacle for the successful implementation of AOT.

#### *ES.3.4. Stakeholder Involvement*

Across sites, a variety of stakeholders participated in both the development and implementation of AOT programs and were perceived as crucial across two stages of the AOT program: during the pre-implementation period and during the ongoing-implementation and modification of the AOT program. All sites reported strong judicial involvement, including from judges and magistrates and also from those providing legal representation during the civil process. All sites also had pre-implementation and ongoing-implementation involvement from both outpatient and inpatient treatment providers. Stakeholder involvement from law enforcement, National Alliance on Mental Illness (NAMI) or peer advisory groups, and local Housing Authorities was less consistent across sites, often to the detriment of the implementation, per stakeholders who addressed the issue during the site visits. Unlike past implementations of AOT, there appeared to be little opposition to its implementation across sites, particularly from professional advocacy groups.

#### *ES.3.5. Person-Centered Practices and Procedural Justice*

Acknowledging that AOT is one of the most divisive contemporary issues in mental health policy, ranging from its effectiveness to its probity on legal and ethical grounds, most of the evaluated AOT sites made a concerted effort to address a range of stakeholders' perspectives related to their programs' fairness and effectiveness,

while also attempting to minimize the perception that AOT and its judicial process more generally was an attempt to criminalize client's behavior. All sites incorporated patient involvement in creating and modifying the treatment plan (though ADAMHSBCC was an exception, as patient involvement was carried out by the external treatment provider and court system and not the AOT program itself) and some sites stressed the importance of allowing patients the opportunity to create and then incorporate a psychiatric advance directive into their court-ordered treatment plan. According to sites, other approaches to promoting patient-centered practices included, for example, the use of a family advisory committee at Hinds County Mental Health Commission and the presence of clients at status hearings at Cook County Health and Hospital System, Doña Ana County, and ADAMHSBCC. Finally, the use of trauma-informed care was identified across multiple sites. Its use was seen as not only an important and effective clinical approach, but also as a central component to emphasizing both person-centered care and procedural justice.

### *ES.3.6. Innovation*

Several innovations, across a range of constructs and domains, including staffing, monitoring, and technology, were brought to bear on the development and ongoing-implementation of AOT programs. Innovations in facilitating AOT mainly focused on the creation of AOT-specific positions. For example, programs have established positions for linkage case managers, hospital, jail, and probate liaisons, and systems navigators to coordinate referrals, examinations, and hearings. Sites did, however, differ in whether or not these positions were designed to be a part of the treatment team, or independent of the treatment team. Another example of innovation includes the regular use of urine drug screens at Hinds County Mental Health Commission, Doña Ana County, and ODMHSAS to determine compliance with one's psychopharmacological medication regimen and to test for the presence of any illicit drugs or non-prescription medications. A Patient Report Card system is then used to record the results of the drug screen, in addition to other key health indicators (e.g., blood pressure, glucose levels) and is incorporated into the client's electronic health record. ODMHSAS sites had also incorporated a technological innovation such that iPads were being used for various functions, including as a means to input clinical information into a web-based treatment/tracking system, to facilitate communication between community mental health center staff and law enforcement officials to develop a response plan to crises, and to facilitate the provision of treatment wherein the AOT recipient can engage in a treatment session with their provider via the device.

### *ES.3.7. Evaluation Capacities*

Sites varied in their ability to collect primary and obtain secondary data necessary to evaluate the implementation and subsequent effectiveness of their programs, particularly with a focus on the effects of AOT. Generally, most sites possess sufficient prior evaluation experience, have existing or have newly developed data infrastructures, and substantial stakeholder partnerships, including through data sharing agreements or memoranda of understanding to meet the administrative, secondary data requirements that will be required for participation in the cross-site outcome evaluation. The main challenge will be sites' ability to obtain jail and hospital data, so that the outcome evaluation is not reliant on patient self-report only. A few sites will also experience challenges with obtaining all relevant Medicaid and non-Medicaid treatment services and cost data. At ADAMHSBCC, for example, the evaluation team is obtaining patient consent for use of Medicaid data, and all other secondary, administrative data, though program evaluations do not require such consent as they do not intend to create generalizable knowledge. Still, all sites recognize the importance of these data and are working to obtain them. While there are few concerns about being able to identify the service type and its frequency of delivery across sites, no site had proposed a plan to assess the adequacy and fidelity (i.e., quality) of non-ACT services, and only a few sites had planned on collecting ACT fidelity data. Some sites would benefit greatly from enhancing their data collection efforts related to the ongoing-implementation of AOT, including any changes that take place over time, AOT's effects separate and apart from ACT, and patients' and families' perceptions of AOT, including its effectiveness. All sites are attempting to have a non-primary treating clinician collect the survey data in an attempt to avoid undue influence when

assessing satisfaction with services and attempting to collect other social or behavioral outcomes that participants may not wish to report to their primary clinician. Five of the six sites (all but ADAMHSBCC) appear to have adequate staffing available to collect, clean, and process survey and administrative data in a valid and reliable manner. Plans to collect other outcome data across sites varied. For example, on one hand, both the Hinds County Mental Health Commission and Doña Ana County sites had, prior to the site visits, already incorporated additional outcome measures relevant to AOT. On the other hand, during the site visit, the independent evaluators associated with the ADAMHSBCC site presented no plans to collect any data other than what was required and with the National Outcome Measures (NOMS)/Government Performance and Results Act (GPRA) instrument. This latter approach would be severely limited in its ability to comment on the effectiveness of AOT. Finally, the feasibility of developing comparison groups/conditions, be they intra-community or inter-community, will remain one of the main challenges of the outcome evaluation.

## ES.4. Summary

We find that the development and ongoing-implementation of AOT programs under SAMHSA's 2016 grant program, at six sites, is proceeding consistent with SAMHSA's program expectations and based on empirically and theoretically-supported efforts, apart from minor, and to be expected challenges.

# 1. OVERVIEW OF ASSISTED OUTPATIENT TREATMENT

## 1.1. History and Current Implementation in the United States

Assisted outpatient treatment (AOT) is a civil court procedure by which a person with mental illness is placed on a court-ordered treatment plan in the community. Developed as a less restrictive and less costly alternative to involuntary hospitalization, AOT is meant to provide a remedy for the "revolving-door syndrome" whereby a patient's community tenure is interrupted multiple times by an arrest or inpatient hospitalization, often following disengagement from community care. AOT recipients, in an attempt to disrupt this costly cycle, are legally mandated, through a civil court process, to participate in community-based outpatient treatment, including routine outpatient services (e.g., case management), specialty, intensive services (e.g., Assertive Community Treatment [ACT]), and psychopharmacological services (e.g., medication management). When utilized, these services are effective in improving clinical, quality of life, social, and public safety outcomes among individuals with mental illness.

At present, AOT is authorized in 47 states and the District of Columbia; exceptions include Connecticut, Maryland, and Massachusetts. AOT mobilizes an array of community resources and costs are thus incurred through a variety of treatment systems (e.g., outpatient programs, hospitalizations, crisis services, transportation to treatment); the majority these costs, however, are covered by Medicaid. Some states with an AOT statute have invested specific funds in the program for both administration and intensive services (e.g., New York), whereas others have not (e.g., North Carolina).

## 1.2. Assisted Outpatient Treatment Statutory Characteristics

Statutory variation and variability in the scope and nature of treatment facilitated by AOT both within and across jurisdictions means that no two implementations of AOT in the United States look exactly alike. Namely, AOT statutes vary in their criteria of who may serve as petitioner; in most states, anyone (e.g., relative, mental health professional, physician, etc.) is permitted to file a petition for civil commitment, whereas in others only certain individuals can file the petition. For example, in Florida the petition may only be filed by the administrator of a receiving or treatment facility. Eligibility criteria for the AOT recipient also varies across state statutes; however, in general an individual must be 18 years of age or older, diagnosed with mental illness, assessed to be unlikely to be able to live safely in the community without supervision, have a history of treatment non-compliance resulting in psychiatric hospitalization or incarceration, or have committed serious acts or threats of violence to self or others. These latter two criteria are usually based on the patient's history in the past 2-3 years. Most statutes also require that the individual be unlikely to voluntarily participate in services and to need AOT to prevent relapse and subsequent violent or suicidal behavior.

Beyond statutory differences in eligibility criteria, programs may additionally differ in their treatment approach and associated target population. For example, AOT may utilize a step-up approach for people in the community who are non-compliant with efforts to get them engaged in enhanced voluntary services, or a step-down approach, essentially taking on the form of a conditional release for those in inpatient psychiatric care. Although all AOT orders are of limited duration, the typical length of time under the order differs across locations. The initial AOT order is most commonly 90 days prior to review (per the AOT statute in 17 states), followed by 180 days (in 15 states), 12 months (nine states), and 60 days (two states). The three remaining state statutes dictate initial order length of 45 days, 150 days, and 5 years.

## 1.3. AOT Research and Evaluation

Prior research has examined the implementation and effectiveness of AOT both domestically and internationally, and has generally shown reductions in subsequent arrests, hospital readmissions, and hospital length of stay. Domestic studies, including randomized controlled trials (RCTs) in New York and in North Carolina, along with non-controlled trials in New York, comprise the bulk of research on AOT.

These domestic studies have reported many improved outcomes associated with receipt of AOT and subsequent access to intensive community-based services, including reduced hospitalization and length of stay and increased receipt of medication--outcomes that persisted post-treatment. For example, the Duke Mental Health Study in North Carolina evaluated the effectiveness of AOT, combined with case management, compared to case management services alone. The AOT program reported reductions in rehospitalizations in some analyses but equivocal findings on other hospital outcomes, except for consumers who experienced longer court orders. When compared to those who underwent brief periods of AOT (i.e., 0-179 days), individuals with extended AOT (i.e., 180-365 days) had a reduced probability of arrest and fewer inpatient hospitalizations and improved treatment adherence outcomes, among others. However, these findings have been criticized methodologically by some, as length of court order was not randomized. In contrast, the Bellevue Study, an RCT of a pilot AOT program in New York, found no significant differences between experimental and control groups in hospital readmission rates and lengths of stay, though small sample size and a lack of enforcement of the court order in the case of non-compliance have been cited as limitations. However, a subsequent retrospective, quasi-experimental evaluation in New York was conducted following the enactment of a statewide AOT statute. This evaluation showed multiple improved outcomes for AOT recipients, including reduced hospitalizations and length of stay, and increased receipt of medicine and intensive case management services.

International evaluations of similar court-ordered treatment programs have typically reported less-favorable results. For example, the Oxford Community Treatment Order Evaluation Trial, an RCT of community treatment orders (CTOs) in England and Wales did not find any reduction in hospitalizations, nor significant changes in clinical and social outcomes. However, some have criticized these findings as lacking a true voluntary comparison group; the control condition was itself a form of conditional release from the hospital, and included legal leverage similar to that under the CTOs in the experimental condition (e.g., rehospitalization if deemed necessary by their clinician). Data from Australia similarly failed to report improved outcomes, save increased receipt of case management services. Because AOT is a complex community intervention whose effectiveness will likely vary by the contexts in which it is implemented, some observers have pointed out that RCTs may not adequately evaluate the potential effectiveness of AOT.

Equivocal findings across existing research highlight the need for a renewed focus on how AOT is developed and implemented. Indeed, both the North Carolina RCT and the evaluation of New York's AOT program via secondary, administrative data demonstrate how differences in program characteristics, such as duration of AOT, can affect important outcomes. Further considerations of variability in program implementation--both by statute (e.g., eligibility criteria, level of sanctions in the event of non-compliance) or by site (e.g., evidence-based treatment programs, stakeholder buy-in) may result in policy and practice advances through a better understanding of how AOT programs are in fact implemented in practice. Additionally, this implementation evaluation will provide the foundation for the subsequent outcome evaluation, which will examine what elements of AOT influence health and social outcomes for people under court orders, as well as the use of services, associated costs, and patient and family satisfaction.

# 2. OBJECTIVES AND METHODOLOGY OF THE IMPLEMENTATION EVALUATION

## 2.1. Case Study Site Selection

While the Substance Abuse and Mental Health Services Administration (SAMHSA) funded the implementation of 17 pilot AOT programs across the nation, this evaluation focuses on six of the 17 programs, as noted in ***Table 2-1***. These program sites were selected by the HHS AOT program advisory committee per several criteria, including but not limited to geographic diversity, AOT program type, AOT program size, data availability, and suitability for the subsequent outcome evaluation.

**TABLE 2-1. Grantee Information for Six Case Study Sites**

| Grantee | Implementing Location(s) | AOT Program Director | SAMHSA Project Officer |
|---|---|---|---|
| AltaPointe Health Systems Incorporated | Baldwin Co, AL | Cynthia Gipson | Fola Kayode |
| Cook County Health & Hospital System | Chicago, IL | Dan Lustig | Fola Kayode |
| Hinds County Mental Health Commission | Jackson, MS | Kathy Crockett | Fola Kayode |
| Doña Ana County | Las Cruces, NM | Jamie Michael | Mariam Chase |
| ADAMHSBCC | Cleveland, OH | John Garrity | Fola Kayode |
| ODMHSAS | Oklahoma City, Tulsa, and Rogers, Washington, Ottawa, and Delaware Counties, OK | Leslie Ross | Mariam Chase |

## 2.2. Characteristics of the Service Area

The selected AOT programs are being implemented in geographically and socioeconomically diverse locations, as demonstrated in ***Table 2-2***. Specifically, Cook County Health and Hospital System, Hinds County Mental Health Commission, and ADAMHSBCC serve primarily urban populations, whereas AltaPointe Health Systems is in a chiefly rural area. Doña Ana County serves both urban and rural populations. All five of these programs cover a single-county catchment area. In contrast, ODMHSAS serves six counties--two urban, four rural--and the six community mental health centers are strategically distributed across counties to provide the best coverage. Five of six community mental health centers are in urban counties with high population density, and the sixth center serves the four rural counties.

| TABLE 2-2. Program Site Population Characteristics | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Program | Geographic Location | Geographic Classification | # Site Counties | Combined State Population | % Female | % Non-White Racial/ Ethnic Status | % Poverty | Psychiatric Beds/ 100,000[a] |
| AltaPointe Health Systems | South | Rural | 1 | 204,000 | 51 | 13 | 13 | 7.9 |
| Cook County Health & Hospital System | Midwest | Urban | 1 | 2,700,000 | 52 | 35 | 17 | 9.3 |
| Hinds County Mental Health Commission | Southeast | Urban | 1 | 243,000 | 53 | 73 | 24 | 16.2 |
| Doña Ana County | West | Both | 1 | 214,000 | 51 | 71 | 28 | 11.0 |
| ADAMHSBCC | Midwest | Urban | 1 | 1,200,000 | 48 | 36 | 20 | 9.7 |
| ODMHSAS | South | Both | 6 | 1,573,000 | 51 | 27 | 16 | 11.0 |

a. Indicates state-level, not site-level.

## 2.3. Research Questions

To better understand the development and implementation of AOT across the six case study sites, the following research questions were examined:

1. **AOT programs and civil court processes**: Are there differences across the pilot programs, their implementation, and the civil court procedures utilized?

2. **Target populations**: Who do the programs intend to serve and who do the programs actually serve?

3. **Service infrastructures and clinical approaches**: What existing and newly established service infrastructures are supporting AOT program participants?

4. **Stakeholder involvement**: What stakeholders were involved in the development and implementation of the AOT program and have their roles changed over time? What stakeholders are involved in the civil court process, and what are their roles?

5. **Person-centered practices and procedural justice**: To what extent do the programs retain due processes and choices for individuals vis-à-vis person-centered practices?

6. **Innovation**: What are some of the innovative practices and arrangements to implementing AOT programs that have emerged from the AOT pilot grants?

7. **Evaluation capacities**: What is the data collection capacity of the program sites? What supports will need to be in place to collect valid and complete data surrounding the nature, intensity, and quality of services and health and social outcomes if the site is also selected for the outcome evaluation?

## 2.4. Methodological Approach

In this report, we address these research questions using qualitative information gathered from six case study site visits, supplemental materials (e.g., policy and procedure manuals, relevant legal forms), and the original grant applications. The 2-day site visits consisted of interviews and observations conducted by three-person teams, and were led by Brian Case of PRA and Richard Van Dorn of RTI International, with additional support from Henry Steadman of PRA (Cook County Health and Hospital System and Oklahoma), Holly Stockdale of RTI

International (Doña Ana County and AltaPointe Health Systems), and Marvin Swartz of Duke University Medical Center (Hinds County Mental Health Commission and ADAMHSBCC).

Findings are synthesized and analyzed across sites using the i-PARIHS model, which attends to core constructs of facilitation, innovation, recipients, and context to capture the dynamic and multifaceted nature of implementation. Within this framework, facilitation is considered the active ingredient by which innovation is assessed and aligned with recipients, and in varied contexts. The system's outputs are thus derived from the relationship between the "what" (e.g., AOT program characteristics such as peer-involved outreach, patient-centered treatment planning), "who" (e.g., AOT coordinators who meet monthly, clinicians trained in trauma-informed care), and "where" (e.g., AOT site characteristics such as single point of access for petitions, geographic location). These factors were considered in interviews and observations and helped in the development of full site reports for the six programs.

In the chapters that follow, this implementation report first provides an overview of the legislative characteristics of AOT at each of the six sites (***Chapter 3***) before addressing each of the research questions above (***Chapters 4-8***)[1] and concluding with the summary and conclusions of the evaluation (***Chapter 9***).

[1] Findings on target populations (Research Question 2) are presented within ***Chapter 4*** (AOT Programs and Civil Court Processes). All other research questions are addressed in separate chapters.

# 3. ASSISTED OUTPATIENT TREATMENT IN LEGISATION AND IN PRACTICE

While most of this report attempts to synthesize, across sites, relevant aspects of AOT from initiation to renewal or termination of the order, this section provides a state-specific overview of each statute for the six case study sites. Moreover, each state in the case study with a civil commitment statute has a different history with outpatient commitment. This section reviews the characteristics of the AOT statutes in each state and local deviations from the statutes.

## 3.1. Characteristics of State Assisted Outpatient Treatment Statutes

### *3.1.1. Alabama*

Outpatient commitment was incorporated into the Code of Alabama in 1991. Two provisions within the statute address outpatient commitment, otherwise procedures follow the inpatient commitment statutes.

***Alabama Statute Key Features***

- *Criteria: Alabama uses preventive criteria for outpatient commitment.*
- *Order Types: There is only one type of order for AOT.*
- *Who Files: Any person may file a petition with the Probate Court.*
- *Cost to File: $700-2,000.*
- *Initial Order: An initial order is for up to 150 days.*

First, a respondent may be ordered to outpatient commitment by the Probate Court with the finding that the respondent is mentally ill, will "continue to suffer mental distress and will continue to experience deterioration of the ability to function independently" if untreated, and is "unable to make a rational and informed decision as to whether or not treatment for mental illness would be desirable," (Code Ala. 22-52-10.2). Second, the Code of Alabama Section 22-52.10.3 provides provisions for an order of outpatient commitment. At the involuntary commitment petition hearing, the Probate Court may order a respondent to outpatient commitment to be provided by a designated agency for a period of up to 150 days. The outpatient commitment cannot be ordered by the court unless the designated provider consents to treat the respondent. As with inpatient commitments, "any person may file a petition seeking the involuntary commitment of another person," (Code Ala. 22-52-1.2). The petition process is coordinated by the Probate Court clerk. Process is served by the Baldwin County Sheriff's Office. A Probate Court judge may compel a respondent's attendance at the examination and the hearings. Prior to the final hearing regarding the petition, a probable cause hearing may be held if temporary detention in a hospital is necessary (Code Ala. 22-52-8). Ineligible classes include chemical dependency, developmental disabilities, and physical disabilities.

At the hearing the respondent has access to legal counsel through a guardian ad litem.[2] Guardians ad litem are assigned on a rotational basis by the Probate Court judge. A private practice attorney receives support from the State of Alabama to serve as the petitioner's attorney. However, petitioners also have a right to secure private counsel. Hearings may take place in Probate Court in Bay Minette (the seat of Baldwin County), satellite court safe rooms in the towns of Fairhope or Foley, or at the Eastpointe Hospital in Daphne, Alabama. Petitioners receive a bill from the Probate Court for the costs of the outpatient commitment order, which includes costs covering attorney, guardian ad litem, and medical expert time spent on the case. The costs can range from $700-$2,000. For indigent petitioners, the costs may be submitted by the court to the state for reimbursement.

[2] Guardian ad litem is an attorney or mental health professional appointed by the court to represent the interests of the respondent. In the case of these six sites, guardians ad litem are attorneys.

The treatment provider must report "material non-compliance" to the Probate Court. Such non-compliance is grounds for revocation of the order. A revocation hearing will be held where the probate court may "enter an order for commitment to inpatient treatment" (Code Ala. 22-52.10.3).

### *3.1.2. Illinois*

In 2010, the Illinois General Assembly enacted legislation to create a specific standard for eligibility (entered into statute as 405 ILCS 5/1-119.1) and established Article VII-A "Admission on an Outpatient Basis by Court Order." Any adult may execute a petition for outpatient commitment. As defined in the Mental Health and Developmental Disabilities Code of the Illinois Compiled Statutes (405 ILCS 5), a person may be subject to involuntary admission on an outpatient basis under one of the following conditions:

1. If they would meet the criteria for involuntary inpatient commitment in the absence of outpatient treatment which "can only be reasonably ensured by a court order mandating such treatment," (405 ILCS 5/1-119.1(1)); or,

2. If left untreated would meet criteria for involuntary inpatient commitment and has refused "needed and appropriate mental health services in the community" on more than one occasion in the past (405 ILCS 4/1-119.1(2)).

***Illinois Statute Key Features***

- *Criteria: Illinois uses preventive criteria for outpatient commitment. However, the grant uses a narrower standard based on prior hospitalizations.*
- *Order Types: Three paths can be followed to outpatient commitment: an agreed-order, a contested order, or a combined order.*
- *Who Files: Any adult may file a petition with the Circuit Court.*
- *Cost to File: None.*
- *Duration of Initial Order: An initial order is for up to 180 days.*

People are excluded from eligibility due to chemical dependency, disability resulting from old age, developmental disabilities, or antisocial behavior.

The Illinois statutes provide for three pathways to an outpatient commitment order:

1. An agreed-order where the respondent agrees to enter into the order for outpatient commitment (405 ILCS 5/3-801.5).

2. A contested order where the respondent does not volunteer to participate in the outpatient commitment, culminating in adversarial hearing presided over by a judge of the Circuit Court.

3. A combined order where "a petition for involuntary admission on an outpatient basis may be combined with or accompanied by a petition for involuntary admission on an inpatient basis…" (405 ILCS 5/3-751(c)).

In all instances, the respondent is represented by a Guardianship and Advocacy Commission attorney and the state is represented by a State's Attorney. Except for Choate Mental Health Center, a state psychiatric hospital in southern Illinois, the application of AOT in Illinois has been sporadic. Prior to the AOT grant, Cook County Health and Hospital System had not invested in an infrastructure to implement and support outpatient commitment. For both contested and agreed-orders, the initial AOT order is for 180 days and can be renewed for an additional 180 days.

### *3.1.3. Mississippi*

Mississippi's civil commitment law permits "voluntary or court-ordered outpatient commitment for treatment with specific reference to a treatment regimen" as an alternative to inpatient commitment (§41-21-73) for an individual who, "based on treatment history and other applicable psychiatric indicia, is in need of treatment in order to prevent further disability or deterioration which would predictably result in dangerousness to himself or others when his current mental illness limits or negates his ability to make an informed decision to seek or comply with recommended treatment" (§41-21-61). Ineligible classes include those with chemical dependency, temporary intoxication, disabilities resulting from birth, disability resulting from old age, developmental disabilities, and physical disabilities. The affidavit for civil commitment may be filed by any interested person. A filing fee of $148 is collected by the Chancery from the petitioner. In Hinds County, the initial duration of the court order is 90 days, while in other Mississippi counties the initial order is for one year. This difference in initial duration is likely due to a lack of clarity in the statute: one section of the legislation states that "the initial commitment shall not exceed three (3) months" (§41-21-73(4)), whereas a later section dictates that "an outpatient shall not have or be charged for a recommitment process within a period of twelve (12) months of the initial outpatient order" (§41-21-74(4)). Prior to the AOT grant, there was no infrastructure in place for a "warm hand-off" or continuity of care for those on outpatient commitment.

***Mississippi Statute Key Features***

- *Criteria: Preventive and Non-Preventive.*
- *Order Types: Pathways consist of the Chancery Court or the Mississippi State Hospital.*
- *Who Files: Any interested person may file an affidavit with the Chancery Court.*
- *Cost to File: $148.*
- *Initial Order: An initial order is for 90 days by the Chancery Court or 12 months for state hospital step-downs.*

The court hearing is closed per Mississippi statute, so those in attendance are restricted to the petitioner; the individual being petitioned; the physician, psychiatrist, and psychologist retained by the Chancery; the public defender; and a special master (a private family practice attorney) assigned to preside over the hearing. The individual being petitioned will be picked up by two county deputies, one of whom is trained in CIT. After any testimony provided by the petitioner and the evaluation by the three professionals, the special master determines the appropriate level of care needed: outpatient commitment, inpatient commitment, or dismissal. The chancery judge then signs off on the decision of the special master. If the person being petitioned has been referred by the private hospital, the court will notify the hospital of the result of the hearing. If the person has been placed on AOT, the hospital will allow Hinds Behavioral Health Services to conduct an intake prior to discharge. Civil commitment hearings are held three times per week, and generally include 4-5 cases per hearing.

### *3.1.4. New Mexico*

In 2016 the New Mexico Legislature passed Senate Bill 113, the "Assisted Outpatient Treatment Act" (entered into statute as 43-1B). The statute permits a court to order outpatient commitment for an adult with a mental disorder who has demonstrated a lack of compliance with treatment, is unwilling or unlikely to participate in voluntary treatment, is in need of AOT as a least-restrictive alternative, and will benefit from AOT. Evidence of lack of compliance with treatment can be met in three ways:

1. Two hospitalizations or receipt of mental health services in correctional settings in the past 48 months.

***New Mexico Statute Key Features***

- *Criteria: Preventive.*
- *Order Types: There is only one type of order.*
- *Who Files: Petitioners are limited to an adult residing with the respondent, parent, spouse, adult sibling, adult child, hospital director, public/charitable organization director, a qualified professional, or a surrogate decision-maker.*
- *Cost to File: $132.*
- *Initial Orders: Initial orders are for up to 12 months.*

2. One or more acts of serious violent behavior toward self or others or threats or attempts at serious physical harm within the past 48 months.

3. Hospitalization, incarceration, or detention of six months or more and is to be released within the next 30 days or released within the last 60 days (NMSA 43-1B-3).

For the Doña Ana County AOT Program, an individual who meets these criteria may be referred to the program by filing a referral form with the program. By statute, petitioners can be an adult who resides with the respondent, the parent or spouse of the respondent, an adult sibling or child of the respondent, the director of hospital where the respondent is hospitalized; the director of a public or charitable organization where the respondent resides and receives mental health services; a qualified professional who supervises the treatment or treats the respondent for a mental disorder within the past 48 months; or a surrogate decision-maker (NMSA 43-1B-4).

If the program determines an individual to be eligible for AOT, the staff schedule an interdisciplinary team meeting to complete a written treatment plan. Case management services or ACT must be included in the treatment plan. Medication types, dosages, and administrations must be specified in the plan (NMSA 43-1B-7(C)). For respondents with co-occurring disorders, the treatment plan may include drug testing services. For the Doña Ana County AOT Program, La Clinica De Familia is the primary provider and ACT will be the primary service. The qualified professional must prepare, or in the case of the Doña Ana County AOT Program, sign off on the treatment plan prepared by the interdisciplinary team. The treatment team must provide the treatment plan to the District Court no later than the date of the hearing. The treatment plan must indicate all services to be received by the respondent and a provider to deliver each service. The development of the treatment plan must take into account any advance directive. In addition, development of the treatment plan must provide the respondent, current treatment provider(s), an individual "significant to the respondent," and any surrogate decision-maker with an opportunity to provide input into the treatment plan.

In addition to developing a treatment plan, the program must schedule an evaluation with a qualified professional (i.e., nurse practitioner, physician, psychiatrist, psychologist, or physician assistant) who can complete the Affidavit of Qualified Professional and inform the District Attorney's Office about an upcoming petition.

A petition for an order authorizing AOT is filed with the District Court, along with a filing fee for $132 unless waived by the court. The petition must address each criterion for AOT, provide facts to support each criterion, and state whether the respondent is present in the county where the petition is filed. The petition must be accompanied by an Affidavit of Qualified Professional stating that a qualified professional has examined the respondent no more than ten days prior to the filing of the petition and they would be willing to testify at the petition hearing (NMSA 43-1B-5). A Qualified Protective Order, which authorizes access to protected health information for the purposes of the proceeding (NMSA 43-1B-6), must accompany the petition for AOT.

A District Court hearing must be held no sooner than 3 days or later than 7 days from the date that process is served upon by the parties. Hearings can be held as late as 30 days if stipulated by the parties or upon a showing of good cause. If the respondent is hospitalized, the hearing must take place prior to discharge (NMSA 43-1B-6(A)(2)). The respondent is represented by counsel in all proceedings. For Doña Ana County, a respondent's attorney on contract with Doña Ana County represents respondents for inpatient and outpatient commitment proceedings. If the respondent fails to appear at the hearing, the hearing may be conducted so long as the respondent's attorney is present. In addition, if the respondent has refused to submit for an examination by a qualified professional, the court may issue a written order directing a peace officer trained in crisis intervention to detain and transport the respondent for examination.

During the hearing, the qualified professional must provide testimony that the respondent meets criteria and is in support of the written proposed treatment plan. A surrogate decision-maker has the right to testify. The hearing may take place at the District Court or at a local hospital, such as Memorial Medical Center or Mesilla Valley Hospital in Doña Ana County.

If the District Court orders AOT, the order will be for a period up to 12 months and will specify the treatment services to be received, including medications, and the provider to deliver services. The AOT order may not be in conflict with an advance directive or the testimony of a surrogate decision-maker. Respondents have the right to an expeditious appeal (NMSA 43-1B-9). Material changes to the orders must be approved by the court, excluding changes in medication or dosage that are subject to clinical judgement. Orders may be renewed for an additional 12 months.

In the event that a recipient's condition is "likely to result in serious harm to self or likely to result in serious harm to others," a qualified professional may certify the need for detention and transport for the recipient to emergency mental health evaluation and care (NMSA 43-1B-13(A)). However, failure to comply with the AOT order is not grounds for involuntary civil commitment (NMSA 43-1B-13(B)). The District Court will hold routine status hearings with the recipient and relevant parties during the 12-month order.

During the site visit of the Doña Ana County AOT Program, the District Court judge expressed the expectation that she will order treatment guardianship for any AOT recipient and that the treatment guardian will be expected to participate in any hearings related to the order and the status of the recipient. The duties of a treatment guardian are outlined in statute (NMSA 43-1-15 subsections (B) to (M)). For any individual "incapable of informed consent," subsequent to a petition the District Court may assign a person to serve as treatment guardian whose duties entail making treatment decisions on behalf of clients and advise providers on the course of treatment. At Doña Ana County, treatment guardianship is provided by the Forensic Intervention Consortium of Doña Ana County (FIC-DAC).

### *3.1.5. Ohio*

Ohio has two provisions for outpatient commitment. The first provision provides for a step-down from inpatient commitment for people initially committed by order of the Probate Court for a maximum of 90 days. In practice, court-ordered inpatients are routinely discharged from hospitalization prior to expiration of the 90-day order. Since the Probate Court commits the inpatient to the local Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board rather than to the state hospital, the Board retains the commitment if the inpatient is discharged from the hospital within 90 days. The Board may place the individual into outpatient commitment for the remainder of the 90-day order (sometimes referred to as a "split order" or "split-commitment") or terminate the order if "the respondent's treatment needs could be equally met in an available and appropriate less restrictive setting" (51 Ohio Revised Code 5122.15(F)). Under this provision, the initial 90-day commitment order may be renewed by the Probate Court for an additional 180 days. The second provision for outpatient commitment, known as the "Fifth Criterion" was established by the 130th General Assembly in 2014 (Ohio Senate Bill 43). The Fifth Criterion is limited to outpatient commitment due to a history of treatment non-adherence and to prevent "a relapse or deterioration that would be likely to result in substantial risk of serious harm to the person or others," (51 Ohio Revised Code 5122.01(B)(5)(iv)). Respondents committed under the

***Ohio Statute Key Features***

- *Criteria: Preventive and Non-Preventive.*
- *Order Types: Two paths to AOT: a split-commitment and a stand-alone outpatient commitment (Fifth Criterion).*
- *Who Files: Anyone may file an affidavit with the Probate Court.*
- *Cost to File: $25.*
- *Initial Orders: Initial orders are for 90 days. Renewals may be for up to 24 months, but recipients have a right to a new hearing every 180 days.*

Fifth Criterion are not subject to inpatient commitment. Fifth Criterion outpatient commitments are for an initial period of 90 days.

The first step for inpatient and outpatient commitment begins with the filing of the Affidavit of Mental Illness. The process is the same in every Probate Court in Ohio. In fact, the exact wording of the Affidavit of Mental Illness is included in the statute (O.R.C. 5122.111). At ADAMHSBCC, the psychiatric department of the Probate Court has two social workers on staff who assist individuals in filing an affidavit. By statute, the filing fee is $25. Anyone may file an affidavit. The affidavit must establish "facts being sufficient to indicate probable cause that the above said person is a mentally ill person subject to court order," (O.R.C. 5122.111). Upon finding of probable cause, the court may issue a temporary order of detention for up to 48 hours in a hospital or other designated facility or the respondent may be permitted to remain in the community.

Within 2 business days of the affidavit filing, an investigative screening must be completed by the ADAMHS Board or a provider designated by the Board. The investigator must determine whether the respondent is a "mentally ill person subject to court order" and, if so, the least-restrictive service delivery setting. A pre-hearing medical exam must also be carried out by a psychiatrist or by a psychologist with a physician. An initial hearing must be held within 5 days after the respondent is detained or the affidavit is filed, in a "physical setting not likely to have a harmful effect on the respondent," (O.R.C. 5122.141). The purpose of the initial hearing is to determine whether the respondent is a "mentally ill person subject to court order." A full hearing is held to determine whether a 90-day order of involuntary commitment should be issued by the court. An attorney from the ADAMHS Board must present in favor of the commitment and the respondent has access to court-appointed counsel if the respondent is not currently represented by counsel. The involuntary commitment may be for inpatient hospitalization or for outpatient commitment (i.e., the Fifth Criterion). The commitment is made to the ADAMHS Board, not the hospital, for inpatient commitments. A commitment may be continued for up to two years (O.R.C. 5122.15(H)), but recipients have a right to a new hearing every 180 days.

For people subjected to emergency hospitalization, an examination must take place within 24 hours of admission. If the examiner determines the patient is a "mentally ill person subject to court order," the hospital's chief clinical officer may detain the patient for up to 3 days so as to file an Affidavit of Mental Illness (O.R.C. 5122.10) and proceed to an initial hearing on probable cause.

If an outpatient commitment recipient, who was stepped-down from the hospital, is found to require a more restrictive setting, the ADAMHS Board may return the recipient to inpatient hospitalization without a hearing (unless requested by the recipient). For recipients committed under the Fifth Criterion, a full hearing for involuntary commitment is required by statute.

### *3.1.6. Oklahoma*

In 2016, the Oklahoma Legislature passed House Bill No. 1697, known as the "Labor Commissioner Mark Costello Act," amending Oklahoma Mental Health Law (43A O.S. 2011) to authorize "outpatient services which have been ordered to treat an assisted outpatient's mental illness and to assist the person in living and functioning in the community, or to attempt to prevent a relapse or deterioration that may reasonably be predicted to result in suicide or the need for hospitalization," (House Bill No. 1697, pp. 9). Named in honor of former Labor Commissioner Mark Costello, who was killed by his son with a mental disorder, the act took effect on November 1, 2016.

The Oklahoma statute includes preventive criteria (e.g., to prevent future relapse or deterioration) but does not specify an unwillingness to accept voluntary treatment as a justification for eligibility. Ineligible classes include those with disability resulting from old age, developmental disabilities, and physical disabilities.

Though the referral can be completed by anyone, with the new AOT law only a licensed mental health professional employed by ODMHSAS or employed by a Community Mental Health Center can file the petition (43 O.S. 2011, Section 5-410 Sub. A).

In the instance that a treatment plan was not filed with the petition, the court will issue an order for a treatment plan and a notice of continued hearing whereby the petitioner must provide a treatment plan as well as progress notes, medical records, nursing notes, and complete discharge plans in advance of the hearing. Any material changes to treatment plans over the course of an AOT order must be reviewed and approved by the court. Initial orders are for 12 months, at which time the order may be stayed, vacated, or modified. Renewal orders are for a term of 12 months. Non-compliance with the order is not grounds for involuntary inpatient commitment or a finding of contempt of court.

***Oklahoma Statute Key Features***

- *Criteria: Preventive and Non-preventive.*
- *Order Types: Two paths consisting of a preventive outpatient commitment and a conditional release.*
- *Who Files: Petitions can be filed by a mental health professional employed by ODMHSAS or a Community Mental Health Center.*
- *Cost to File: None.*
- *Initial Orders: Initial orders are for 12 months.*

Prior to the 2016 passage of the "Labor Commissioner Mark Costello Act," which established AOT, Oklahoma had a pre-existing "Alternatives to Hospitalization" provision in its Mental Health Law, Title 43A of the Oklahoma Statutes. The statutes provided the court with the authority to "order the individual to receive whatever treatment other than hospitalization is appropriate for a period set by the court" (43 O.S. 2011, Section 5-416 Sub. B) as well as for the court to modify an order of involuntary inpatient commitment and order alternative treatment (43 O.S. 2011, Section 5-419).

**TABLE 3-1. AOT Statute Characteristics by State**

| State | Year AOT Statute Established | Pre-existing OPC Statutes | AOT Eligibility Criteria | | | | |
|---|---|---|---|---|---|---|---|
| | | | Danger to Self/Others | Prevent Future Danger to Self/Others | Unable to Meet Basic Needs | Treatment to Prevent Deterioration | Unwilling to Accept Voluntary Treatment |
| Alabama | 1991 | No | – | – | – | √ | √ |
| Illinois | 2010 (Revision) | Revised in 2010 | √ | √ | √ | √ | √ |
| Mississippi | 1994 | No | √ | √ | √ | √ | √ |
| New Mexico | 2016 | No | √ | √ | √ | √ | √ |
| Ohio | 2014 | Yes, provisions for split-commitment | √ | √ | √ | √ | √ |
| Oklahoma | 2016 | Yes, but not utilized in the grant | √ | – | √ | √ | – |

## 3.2. LOCAL PROGRAM DEVIATIONS FROM STATE STATUTES

Several AOT grant sites have deviated from their state statute in implementing AOT. These deviations include the application of narrower standards of eligibility, the use of status hearings and meetings by the court, the use of AOT as a voluntary program, the implementation of dual-eligibility requirements, and the interface between guardianship requirements and AOT.

**More restrictive standard for eligibility**. Cook County Health and Hospital System uses a more restrictive standard for eligibility than the criteria in the Illinois Compiled Statutes, stating that respondents must have a minimum of two episodes of inpatient hospitalization in the past 12 months. In the statutes, a respondent

meets AOT criteria if in the absence of court-mandated outpatient commitment a person would meet inpatient criteria or if a person's condition would be expected to deteriorate to the point of requiring inpatient hospitalization and has, on more than one past occasion, refused community-based treatment. At Cook County Health and Hospital System, criteria emphasize a focus on stepping down people from inpatient hospitalization to outpatient commitment. However, it also raised a concern among treatment staff at the Chicago-Read Mental Health Center, a state hospital, about the eligibility of long-term inpatients for the program.

***Deviations***

- *Narrower standard of eligibility.*
- *Status hearings and meetings.*
- *Voluntariness of AOT.*
- *Dual requirements to meet AOT and ACT criteria.*
- *Blanket guardianship.*

**Status hearings and meetings**. Three of the six sites hold status hearings (not legal hearings), used to monitor recipients' progress over the course of the AOT order. At Doña Ana County, for example, status hearings with recipients will be held every 30 days. At ADAMHSBCC, status meetings are held with recipients on a periodic basis. At Cook County Health and Hospital System, review hearings may be held as frequently as every two weeks via video-conferencing. Unlike Doña Ana County and ADAMHSBCC, recipients at Cook County Health and Hospital System do not typically participate in the status hearings, though they have the right to do so.

**Voluntariness of AOT**. Some of the sites have incorporated voluntary elements into AOT, though it is important to note that individuals who are already actively engaged in treatment are not eligible for AOT. Similarly, the response to non-compliance does not differ between those who voluntarily agree to participate in AOT and those who do not. In three of the sites, however, it is encouraged or preferred that the individual going on AOT voluntarily agrees to the AOT order. At Doña Ana County, for example, the judge expressed a reluctance to compel a respondent to participate in the AOT program and stated that she would not order AOT unless the respondent voluntarily agreed to participate. Hospital treatment teams with AltaPointe Health Systems recommend patients for AOT who were agreeable to outpatient commitment based on the expectation that it will reduce non-compliance with the court order, though clinical need is prioritized over a respondent's potential refusal with being placed on outpatient commitment, and the civil process remains the same regardless of the respondent's willingness, or not, to participate. However, not all voluntariness is a deviation. Illinois statutes specify an "agreed-order" pathway to outpatient commitment where the respondent agrees to the order. At Cook County Health and Hospital System, the agreed-order is the primary pathway to outpatient commitment. Though the AOT program is open to both agreed-order and contested order recipients, it is likely that contested orders will be uncommon due to two factors: (1) the aggressive defense that will be offered by the GAC attorney; and (2) psychiatrists' likely unwillingness to recommend a contested order given the burden associated with an adversarial hearing, which could require days of preparation and a longer court-attendance requirement.

**Dual-eligibility requirements**. For ADAMHSBCC, where the dedicated service is ACT, respondents must meet ACT criteria in addition to outpatient commitment criteria in order to receive services. Respondents who do not meet clinical criteria for ACT are not served by the AOT program.

**Blanket guardianship**. In three of the programs, guardianship[3] may interface with outpatient commitment. For ADAMHSBCC and Cook County Health and Hospital System, however, guardianship is set forth in statute and thus its application is not a deviation. Specifically, guardianship is a separate statute in Ohio and only interfaces with outpatient commitment as a happenstance. For example, an individual may be placed on an AOT order who, under separate circumstances, has been placed under guardianship with a family member. For Cook

[3] Guardianship is a legal provision by which a designated individual makes decisions on behalf of a person with mental illness in matters related to medical, financial, and other personal care decisions.

County Health and Hospital System, custodians are defined in the outpatient commitment statute as required parties to the order and have specified duties.

In contrast, the use of blanket guardianship applies to only the Doña Ana County site. Guardianship is a separate statute in New Mexico that pre-exists the AOT statute. A treatment guardianship organization makes this service available at Doña Ana County. The judge stated that guardianship by treatment guardians, which is authorized in a separate statute from outpatient commitment, would be ordered for all AOT recipients.

# 4. ASSISTED OUTPATIENT TREATMENT PROGRAMS AND CIVIL COURT PROCESSES

## 4.1. Assisted Outpatient Treatment Initiation Across Sites

Across programs, there is great variability in the judicial process and the AOT program's involvement. This section reviews initiation processes across the six sites, from the filing of the petition to the petition hearing where a judge or other court officer (e.g., magistrate in Cuyahoga County for ADAMHSBCC; special master at Hinds County Mental Health Commission) determines whether AOT is the least-restrictive setting.

***Time from Petition to Commitment***

- *AltaPointe Health Systems: 1 court day.*
- *Cook County Health and Hospital System: A month or more due to logistical delays; court process could take a few days.*
- *Hinds County Mental Health Commission: 2-3 court days.*
- *Doña Ana County: 13 days based on statute provisions of no more than 10 days from time of examination to filing of petition and no less than 3 days following the service of process for the hearing to take place, unless good cause is shown.*
- *ADAMHSBCC: 2-3 days, although split-commitment cases do not require a new hearing.*
- *ODMHSAS: 1 week at most.*

### *4.1.1. Petition*

In each site, statute defines who can file a petition for an individual to be considered for AOT. In addition, there is substantial variability in filing fees. At ODMHSAS, for example, there is a single point of access such that all petitions for AOT go through the relevant community mental health center before proceeding to civil court. In all other programs, the petition is filed directly with the court. The other five states permit a broader array of petitioners, with AOT programs including AltaPointe Health Systems, Cook County Health and Hospital System, and ADAMHSBCC permitting any person to file an affidavit. Hinds County Mental Health Commission and Doña Ana County have a designated list of petitioners. In practice, at Hinds County Mental Health Commission the behavioral health agency prefers that the petition is filed by a family member for step-up commitments. Beyond the pre-screening evaluation (attended by the AOT systems navigator), the agency is uninvolved in the judicial process and is only notified of the court order after the hearing has concluded. For Doña Ana County, ODMHSAS, and Cook County Health and Hospital System, the expectation of the court is that the examination of the respondent will take place prior to the filing of the petition.

### *4.1.2. Examination*

The examination of the respondent may be conducted by a panel, as at Hinds County Mental Health Commission where a psychiatrist, other physician, and psychologist examine the respondent. At Cook County Health and Hospital System, two examination certificates must accompany the petition. The examinations can be completed by a psychiatrist, other physician, qualified examiner, or clinical psychologist. In practice, the petitions submitted to the Cook County Circuit Court at the time of the site visit had been completed by hospital psychiatrists. At AltaPointe Health Systems, the respondent may be examined by both a hospital psychiatrist and the AltaPointe Probate Liaison in the case of step-downs, or just the Probate Liaison in the case of step-ups from the community. At Doña Ana County, the designated qualified professional may be a physician, licensed psychologist, prescribing psychologist, certified nurse practitioner or clinical nurse specialist with a specialty in mental health, or a physician assistant with a specialty in mental health.

### *4.1.3. Judicial Review of Treatment Plan*

For three of the programs--AltaPointe Health Systems, Hinds County Mental Health Commission, and ADAMHSBCC--a treatment plan is not reviewed by the judge at the time of the hearing. The AltaPointe Probate Liaison conducts a pre-hearing assessment with the respondent that includes a treatment planning phase. However, the treatment plan is presented to the judge during the course of the hearing or reviewed as an attachment to the petition. At Hinds County Mental Health Commission, the Hinds Behavioral Health Services

may not be aware that a respondent has been placed on an outpatient commitment order by the Chancery Court until after the petitioner hearing.

**TABLE 4-1. Characteristics of AOT Initiation by Program Site**

| Program | Examination | Judicial Review of Treatment Plan | Legal Representation | Examiner Testimony | Respondent Can Be Compelled to Hearing |
|---|---|---|---|---|---|
| AltaPointe Health Systems | Licensed medical doctor or qualified mental health professional | No | Yes, guardian ad litem | Yes | Yes, ordered by judge and carried out by sheriff's deputies |
| Cook County Health & Hospital System | 2 certificates required from a psychiatrist, other physician, qualified examiner, or clinical psychologist | Yes, developed as part of the order | Yes, Guardianship and Advocacy Commission attorney | Yes, only 1 certifying examiner required to offer information | Yes, the judge may order a peace officer or "another person" to compel attendance.[a] |
| Hinds County Mental Health Commission | Psychiatrist, other physician, and psychologist | No | Yes, public defender | Yes, all 3 examiners | Yes, the Chancery may order a sheriff's deputy to compel attendance |
| Doña Ana County | Qualified professional defined as physician, licensed/prescribing psychologist, certified nurse practitioner or clinical nurse specialist with mental health specialty, or a physician assistant with a specialty in mental health | Yes, must be approved by qualified professional before court submission. Additional criterion for including medication in treatment. | Yes, contract attorney | Yes | No, court may compel a respondent to participate in examination but not hearing. The hearing can take place without respondent, but is unlikely given judge's emphasis on voluntary participation. |
| ADAMHSBCC | Psychiatrist or a clinical psychologist and a non-psychiatrist physician | No | Yes, guardian ad litem | Yes, but on a split-commitment a separate outpatient hearing is not held by the court. | No, the respondent can waive the right to attend. However, the court may issue a temporary order of detention upon the finding of a probable cause hearing that the respondent is a "mentally ill person subject to court order." |
| ODMHSAS | Clinician/Prescriber | Yes, detailed treatment plan must accompany the petition. | Yes, public defender | Yes | No |

a. Although 405 ILCS 5/3-756 provides the court with this authority, it is unlikely to occur for Cook County Health and Hospital System. First, the court also has the authority to waive the respondent's attendance at the hearing under a separate statute. Second, given the program's focus on the agreed-order pathway, the court is unlikely to compel a respondent who is voluntarily participating in AOT.

At Cook County Health and Hospital System, the treatment plan is developed as part of the order. Assuming that an agreed-order is under review, the respondent's attorney from the Illinois Guardianship and Advocacy Commission will offer greater scrutiny of the proposed treatment plan with the agree-order established by the parties than the Circuit Court judge. In contrast, judges conduct a detailed review of the treatment plan at ODMHSAS. If a treatment plan is not attached to the petition, a separate hearing must be held to establish a

treatment plan which includes releases of clinical notes and treatment records for court review. At Doña Ana County, the treatment plan must be developed collaboratively with the respondent, treatment provider, respondent's designated family or friend, and a surrogate decision-maker (e.g., treatment guardian), if applicable. The plan must be approved by the examiner and reviewed by the court, including special detail on substance use treatment needs and psychotropic medications.

#### *4.1.4. Legal Representation*

Respondents have legal representation provided in every site. At Hinds County Mental Health Commission and ODMHSAS, respondents are represented by a public defender. At ADAMHSBCC and AltaPointe Health Systems, private practice guardians ad litem are appointed by the court to offer counsel for respondents. Guardians ad litem are selected from a pool to represent respondents in response to the current legal action. At Doña Ana County, the Doña Ana County Health and Human Services contracts with an attorney to represent all civil commitment cases. At Cook County Health and Hospital System, the Illinois Guardianship and Advocacy Commission provides legal representation to respondents.

Respondents' level of access to their legal representation varies by site. At AltaPointe Health Systems, a respondent may not meet their guardian ad litem until immediately prior to a hearing. On the other the hand, at Cook County Health and Hospital System the Guardianship and Advocacy Commission attorneys are part of the development of the agreed-order process and routinely meet with their clients on the state hospital units.

#### *4.1.5. Examiner Testimony*

The examiner provides testimony at the petition hearing in every site. At Cook County Health and Hospital System, Illinois statute only requires that one of the certifying examiners offers information regarding why AOT is in the best interest of the respondent. At Hinds County Mental Health Commission, all three examiners offer testimony to the special master. At ADAMHSBCC, if the case involves a split-commitment where the recipient was initially subject to a 90-day involuntary inpatient commitment, the ADAMHS Board may retain the commitment on an outpatient basis for the duration of the order without a court hearing. Rather, the ADAMHS Board must notify the Probate Court of the intention to step-down the recipient to outpatient commitment as the least-restrictive setting.

#### *4.1.6. Respondent Attendance*

In three programs, the court has the authority to compel a respondent's attendance at the petition hearing: AltaPointe Health Systems, Cook County Health and Hospital System, and Hinds County Mental Health Commission. At AltaPointe Health Systems and Hinds County Mental Health Commission, the judge may order sheriff's deputies to compel the respondent's presence in court. With Cook County Health and Hospital System, a peace officer or "another person" can compel a respondent's attendance although this is unlikely to occur in the Cook County Health and Hospital System AOT Program for practical reasons: first, the court may compel attendance but it also may waive attendance by the respondent so long as their attorney is present. Second, Cook County Health and Hospital System emphasizes the agreed-order pathway to AOT where the respondent establishes a voluntary agreement with the court, the provider, and a custodian.

At Doña Ana County, the court may compel a respondent's attendance at the examination but not at the court hearing. The hearing may take place without respondent attendance, but such an event is unlikely given the judge's emphasis on using AOT as a voluntary program. At ADAMHSBCC, respondents may waiver their right to attend the hearing. If the respondent's condition merits hospitalization, the court can issue a temporary order of detention to a hospital. The Probate Court may hold the petition hearing at the hospital. At ODMHSAS, the court does not have the authority to compel attendance at the examination or at the hearing.

## 4.2. Target Populations

In general, AOT is intended for persons with mental illness who have demonstrated difficulty engaging in outpatient services, which they need to prevent their conditions from deteriorating to the point that they require hospitalization. However, the constitution of AOT recipients--including the severity of and current insight into their mental illness, as well as their related likelihood of treatment success--may differ in meaningful ways as a function of several state-specific and site-specific factors.

As described in ***Section 3*** (AOT in Legislation and in Practice), eligibility criteria and ineligible classes are set forth in each state statute. All states include eligibility criteria which are preventive in nature and thus permit cases in which decompensation has not yet occurred, but is likely. Ineligible classes are specified by statutes in Alabama, Illinois, Mississippi, and Oklahoma, and exclude individuals with co-occurring disabilities (e.g., developmental) or dependencies (e.g., chemical). Beyond the state statute, however, the program site also has some say in determining which individuals are fit for AOT. Some of these site-level determinations are mentioned in ***Section 3.2*** (Local Program Deviations from State Statutes)--namely, the narrower standard of eligibility at Cook County Health and Hospital System and the dual-eligibility criteria for both AOT and ACT at ADAMHSBCC, and the emphasis of voluntariness at AltaPointe Health Systems, Cook County Health and Hospital System, and Doña Ana County.

Another site-level determination that directly affects the program's target population is the utilization of a preventive or non-preventive step-up, step-down, or a mixed approach to AOT. Prior to implementation, AltaPointe Health Systems, Hinds County Mental Health Commission, Doña Ana County, and ODMHSAS anticipated using a mixed approach. Thus far, most AOT recipients at Hinds County Mental Health Commission and ODMHSAS have been stepped up from the community, whereas the majority have been stepped down from the hospital at AltaPointe Health Systems. Similarly, Doña Ana County anticipates that most recipients will be stepped down from area hospitals. Cook County Health and Hospital System and ADAMHSBCC originally planned to adopt a step-down approach. This continues to be the case at Cook County Health and Hospital System, where they have initiated processes for stepping individuals down from two state hospitals or from the jail. At ADAMHSBCC, most referrals have come from area hospitals and the state hospital, but they have also stepped some individuals up from the community. Across sites implementing both step-up and step-down models, initiating AOT via step-down is largely regarded as the easier procedure. At Hinds County Mental Health Commission, for example, stepping an individual down from the state hospital does not require a hearing and the initial duration of the court order is 12 months (in contrast to a step-up order, which has an initial duration of 90 days).

***AOT Models***

- *Step-up AOT targets individuals in the community who are non-compliant with needed treatment.*
- *Preventive criteria deem that AOT is needed to prevent future relapse or deterioration.*
- *Non-preventive criteria determine that an individual poses a threat to themselves or others.*
- *Step-down AOT targets individuals transitioning from inpatient hospitalization or a jail stay.*
- *Mixed AOT has a wider target population, utilizing both step-up and step-down processes.*

In addition, programs differ in their inclusion or exclusion of criminal justice-involved recipients. At ADAMHSBCC, Doña Ana County, and Hinds County Mental Health Commission, individuals may not have any pending criminal charges, though at Hinds County Mental Health Commission the district attorney may remand, or revoke, charges on the condition that the individual seeks civil commitment. At AltaPointe Health Systems, Cook County Health and Hospital System, and ODMHSAS, AOT recipients may have ongoing minor criminal charges, which may prompt significant differences in court orders, monitoring, and sanctions between justice-involved and non-justice-involved AOT recipients. For example, at ODMHSAS the sanctions to non-

compliance are minimal for those who are not justice-involved, whereas the response to non-compliance for those who are justice-involved is left at the discretion of the local probation and parole office.

Finally, utilization of pre-existing authorization for court-ordered outpatient treatment in the service area may affect the population served by AOT. Unlike other counties in Oklahoma, Tulsa County has used a pre-existing authorization within its involuntary commitment statute to provide court-ordered outpatient treatment as a step-down from involuntary inpatient hospitalization. This court-committed outpatient program (CCOP) has different procedures that permit enforcement of the treatment order due to non-compliance, including involuntary pick-ups resulting in immediate admission to inpatient hospitalization, and more frequent review hearings. This may affect the constitution of AOT recipients in Tulsa County relative to other Oklahoma jurisdictions (e.g., reducing the number of step-downs from inpatient hospitalization since CCOP provides the court with greater enforcement authority).

**TABLE 4-2. Characteristics of Target Population by Program Site**

| Program | AOT Model | Ineligible Classes | Criminal Justice Involvement | Total Target N |
|---|---|---|---|---|
| AltaPointe Health Systems | Mixed | • Chemical dependency<br>• Developmental disabilities<br>• Physical disabilities | • Pending and ongoing low-level criminal cases or supervision are acceptable<br>• Officers may refer individuals for consideration<br>• Criminal charges will not be tied to the petition for respondents identified by law enforcement | 380 |
| Cook County Health & Hospital System | Step-down | • Chemical dependency<br>• Disability resulting from old age<br>• Developmental disabilities<br>• Antisocial behavior | • Inmates with mental disorders receiving health care from Cermak Health Services and with low-level charges are eligible for AOT | 400 |
| Hinds County Mental Health Commission | Mixed | • Chemical dependency<br>• Temporary intoxication<br>• Disability resulting from birth<br>• Disability resulting from old age<br>• Developmental disabilities<br>• Physical disabilities | • No pending criminal charges<br>• District Attorney may remand, or revoke, charges on condition that a respondent seeks civil commitment | 300 |
| Doña Ana County | Mixed | None | • No pending criminal charges | 150 |
| ADAMHSBCC | Mixed | None | • No pending criminal charges | 400 |
| ODMHSAS | Mixed | None | • Pending and ongoing low-level criminal cases are acceptable | 375 |

## 4.3. Post-Initiation Procedures and Clinical Determinations

At the time of the site visits, five of the six sites had recipients under court order. Doña Ana County was the only site without any recipients, though they now have one recipient. The number of current AOT recipients ranges from one to 13 across sites. Most individuals petitioned to AOT have been placed under a court order. At Cook County Health and Hospital System, however, many petitions have been filed without subsequent AOT enrollment, suggesting that there are some obstacles to an efficient initiation procedure. Specifically, the two state psychiatric hospitals have referred 37 patients to AOT, but only two patients were successfully placed and kept on an AOT court order.

| TABLE 4-3. Characteristics of AOT Post-Initiation by Program Site | | | | | | | |
|---|---|---|---|---|---|---|---|
| Program | Judicial Status Hearings | Material Changes to Treatment Plan Reviewed by Judge | Guardianship | Response to Non-compliance | Pick-up Orders Allowed | Destination of Pick-up Order | Renewals |
| AltaPointe Health Systems | No | No | No | Notification to court for revocation hearing. | Yes | Court | 150 days |
| Cook County Health & Hospital System | Yes | Yes, for medication if the changes are not agreed to by both recipient & provider | Yes, a custodian is assigned to all recipients by statute[a] | Voluntary inpatient admission by court or custodian. | Yes, may be ordered by court or custodian | State hospital | 180 days; An agreed renewal may be established by stipulation by the parties |
| Hinds County Mental Health Commission | No | No | No | Notification to court for commitment hearing. | Yes | Court or hospital | New commitment hearing for 90 days |
| Doña Ana County | Yes | Yes, but medication changes are subject to clinical judgment | Yes, a treatment guardian may be ordered through a parallel procedure | Court has no recourse. Qualified professional may order emergency evaluation. | No | N/A | 12 months |
| ADAMHSBCC | Yes | No | Yes, a guardian may be ordered through a parallel procedure | Split-commitment may be returned to hospital without hearing. Outpatient commitments require a new hearing. | Yes, for split-commitments | Hospital | Recommitment hearings; commitments may continue for up to 24 months with new hearings every 180 days |
| ODMHSAS | No | Yes, all material changes require a hearing | No | Court has no recourse. | No | N/A | Recommitment hearing for 12 months |

a. Custodians (at Cook County Health and Hospital System) are not legal agents, and therefore do not have the equivalent standing as guardians at Doña Ana County and ADAMHSBCC.

Most issued court orders for AOT were still in effect across sites. One AOT recipient was stepped down to traditional treatment services following the completion of the 90-day order; one was stepped up to inpatient treatment per their own wishes. At Cook County Health and Hospital System, two individuals were enrolled but then discharged from the hospital into residential treatment, a level of care not supported by the AOT program. Some AOT recipients have been revocated and returned to an inpatient commitment, which was the case at AltaPointe Health Systems.

### *4.3.1. Judicial Status Hearings*

Periodic status hearings are conducted by three of the programs: Cook County Health and Hospital System, Doña Ana County, and ADAMHSBCC. At Doña Ana County, the judge has set aside 3 hours each week for conducting review hearings with the expectation that recipients will have review hearings every 30 days.

At Cook County Health and Hospital System, the status hearings are conducted via video-conferencing and the recipients are not expected to participate. Status hearings begin on a 2-week schedule and are adjusted based on a recipient's compliance with the order. At ADAMHSBCC, status meetings are held every week on Wednesday afternoons. They generally see AOT recipients the same week as the start of the order and then biweekly. The period between hearings may be extended in cases where the recipient is doing well on the program. Status meetings are not legal hearings, so the content of the meetings are recorded in the judge's or magistrate's personal case notes rather than into the court record.

> *"Some [recipients] are going to be more seamless than others. Maybe Mr. Smith, his status could be kicked out for 60 days. But Ms. Smith is having some difficulty and we need to set it [the hearing] out for two weeks. It's going to really be on a case-by-case basis."*

At AltaPointe Health Systems, Hinds County Mental Health Commission, and ODMHSAS, there are no status hearings built into the program and the court is not involved until the court order is up for possible renewal, unless a request is made by the treatment provider. Such requests may include material changes to the treatment plan or reports of material non-compliance as grounds for revocation of the order.

#### *4.3.2. Material Changes to Treatment Plan Reviewed by Judge*

Material changes to the treatment plan must be reviewed by the judge in three programs: Cook County Health and Hospital System and Doña Ana County, and ODMHSAS. At ODMHSAS, material changes to the treatment plan, including any terms relating to psychotropic medication (i.e., changes in medication, dosage, or administration), must be reviewed in a hearing by the District Court. Material changes at Doña Ana County are construed more narrowly, such that only additions or deletions of categories of treatment must be approved by the court. Changes in medication are subject to clinical judgement of the provider. At Cook County Health and Hospital System, an additional safeguard finding is required by the court to include medications in the AOT order. Any contested changes, where the prescriber and the recipient are not in agreement is subject to formal approval by the court. However, if the prescriber and recipient are in agreement that a medication is not working, they do not need to go to court. In the same three jurisdictions, treatment plans must be approved by the court as part of the initial order for AOT.

#### *4.3.3. Guardianship*

Guardians, or surrogate decision-makers, and custodians, which are not legal agents, have a role in three of the six programs: Cook County Health and Hospital System, Doña Ana County, and ADAMHSBCC. Guardians, which are defined in separate statutes for Doña Ana County and ADAMHSBCC, have a role as surrogate decision-makers for AOT recipients. At ADAMHSBCC, guardians are often family members and are court-mandated by the Probate Court. Approximately 30 adults with severe mental disorders were on the guardianship roster at the time of the site visit. For the Cuyahoga County Probate Court, AOT recipients with guardians was a coincidence and not encouraged or discouraged by the court although guardians could file an Affidavit of Mental Illness with the court to initiate commitment proceedings. At Doña Ana County, professional treatment guardians from the Forensic Intervention Consortium of Doña Ana County will be ordered as guardians to any AOT recipients. This would require two orders from the Third Judicial District Court, an order for AOT and an order for treatment guardianship. Treatment guardianship terms can be for up to 12 months, the same term as an AOT order. At Doña Ana County, the treatment guardians have an enforcement authority that the AOT statute does not provide to the court, including the ability to petition the court for an enforcement order. This authority is appreciated by treatment providers, who voiced a desire for even more treatment guardians.

> *"In the orders that I have had, it's in the order that the respondent and the custodian both understand that if there's non-compliance with the order [then] the custodian may have the respondent brought back to the hospital as a voluntary [admission]."*

At Cook County Health and Hospital System, an outpatient commitment order requires the designation of a custodian, who is often a family member. The custodian has obligations under the order and is the point of contact for the Guardianship and Advocacy Commission attorney while the recipient is on the AOT order. The custodian has the authority to request that the court send a peace officer to place the recipient into a hospital for up to 24 hours. Use of court-intensive programs seem to follow the model of criminal specialty courts such as mental health courts and appear to be new variations on AOT practice.

#### *4.3.4. Response to Non-compliance*

Response to non-compliance, often referred to as the "teeth" of AOT, varies considerably across sites. Notification to the court regarding recipient non-compliance could represent a strong sanction, as it is likely to result in revocation of the AOT order. At Hinds County Mental Health Commission, the AOT team members verbally address resistance to treatment expressed by recipients and which may be followed up by a verbal warning to the AOT Team Leader if a recipient is routinely non-compliant with treatment. For recipients who avoid the AOT Team, the team members will increase unscheduled visits or check-in at other known locations. As a final response, the AOT Team Leader will send a notification letter to the Hinds County Chancery Court of material non-compliance and the court will consider the appropriate placement for the recipient. Similar to Hinds County Mental Health Commission, the AOT Team at AltaPointe Health Systems must send notice of material non-compliance to the Probate Court. However, the AOT program prefers to keep recipients in the community, including a meeting with the Probate Judge to reiterate the court order, when feasible, before revoking the order. At a hearing the Probate Court will consider the least-restrictive setting.

At Cook County Health and Hospital System, the custodian may have the recipient hospitalized on a voluntary basis for up to 24 hours, through application to the court. The Circuit Court may order 24-hour voluntary hospitalization if it finds that a modification of the AOT order is not adequate.

At Doña Ana County and ODMHSAS, the courts lack authority to respond to non-compliance by recipients. At Doña Ana County, a qualified professional may order emergency hospitalization for evaluation if the individual deteriorates. At ODMHSAS, non-compliance with the treatment plan is not grounds for involuntary admission *sua sponte*. Similarly, at ADAMHSBCC for AOT recipients under the Fifth Criterion, the Probate Court has not addressed potential provisions for recipients who are non-compliant with treatment. The Probate Court is not able to hospitalize Fifth Criterion recipients without undergoing the full process for inpatient commitment. Some ADAMHSBCC stakeholders referred to the "black robe effect" as a general putative mechanism to reduce non-compliance, but have not formulated more specific responses.

#### *4.3.5. Use of Pick-up Orders for Non-compliance*

Four of the six sites have state statutes that permit the use of pick-up orders in response to recipient non-compliance. At AltaPointe Health Systems and Hinds County Mental Health Commission, pick-up orders are issued by the court following notice of material non-compliance that will result in a revocation hearing and recommitment based on the least-restrictive setting. At Cook County Health and Hospital System, the court or the custodian may initiate a pick-up order for the transport of the recipient to a 24-hour voluntary admission to a state hospital. At ADAMHSBCC the recipient may be returned to inpatient hospitalization without a hearing if they are on a 90-day split-commitment. Otherwise, a new petition must be filed for commitment to an inpatient setting. At Doña Ana County and ODMHSAS the courts do not have recourse to use pick-up orders for non-compliance. If the recipient's mental status deteriorates a qualified professional may commit the recipient for an emergency evaluation at Doña Ana County.

However, not all sites with the statutory authority to issue pick-up orders are comfortable with using them. For example, at ADAMHSBCC the court representatives emphasized that they did not want to criminalize mental

illness by using pick-up orders. As reluctant as stakeholders may be to use sanctions for non-compliance, lack of clearly formulated responses will likely erode the long-term utility of AOT, particularly if clinicians feel it has no "teeth."

#### *4.3.6. Renewals*

The process for renewing or terminating the AOT order, including the clinical determination involved, appears to vary across sites. Generally, the treatment provider (e.g., AOT team delivering ACT and any additional evidence-based practices or EBPs) notes the recipient's progress, cooperation with treatment, and insight into their mental illness on an ongoing basis. At Hinds County Mental Health Commission, the AOT Team must petition the Chancery Court for a full hearing using the same process as is required for a new commitment to inpatient or outpatient treatment. On the other hand, for renewal of an agreed-order with Cook County Health and Hospital System, the parties may be established by stipulation of the parties.

> *"Maybe we can solve this problem of 'revolving-door' if we have more outpatient [commitment]. Because an outpatient order is twice as long as an inpatient order; It can be 180 days and it can be extended by agreement for another 180 days. You're looking at a year."*

For some of the programs, such as ADAMHSBCC and Doña Ana County, recipients are not mandated to attend the hearings on the initial order or the renewal order. Attendance may be waived by the court so long as the respondent's legal representative is present at the hearing. However, given these sites' emphasis on the voluntariness of AOT, it is unlikely that orders will be renewed without attendance by the recipient at the renewal hearing.

# 5. SERVICE INFRASTRUCTURES AND CLINICAL APPROACHES

## 5.1. Evidence-Based Practices

Services and interventions being provided to AOT participants match what was proposed in each site's SAMHSA grant application. ACT is being implemented as part of treatment services under the AOT court order at all six case study sites. Indeed, ACT is commonly paired with AOT court orders, as ACT services are tailored to the specific needs of the AOT recipient to provide intensive and multifaceted treatment in the community. Additionally, each of the six sites participating in the implementation evaluation were using ACT or "ACT-like" services as their main community-based service for AOT clients.

***ACT***

- *Services are adapted to the needs of the AOT recipient to address issues related to treatment (e.g., medication adherence, psychiatric symptoms), rehabilitation (e.g., housing, employment), substance abuse, and day-to-day living.*
- *ACT teams are typically comprised of mental health professionals from different disciplines, including psychiatry, nursing, social work, case management, and peer support.*
- *Team members share caseloads and meet regularly to discuss clients and make treatment decisions.*
- *ACT teams provide 24-hour coverage and engage in assertive outreach. Most service contacts are thus conducted at the recipient's home or a community setting to facilitate adherence with treatment.*

The characteristics of AOT teams by site are presented in ***Table 5-1***. In general, sites have demonstrated high fidelity to ACT with regard to team members, frequency of contact with AOT recipients, and inclusion of substance use treatment. Some deviations from traditional ACT standards are present at AltaPointe Health Systems and Hinds County Mental Health Commission; neither program has a full-time psychiatrist on the AOT team. Furthermore, at AltaPointe Health Systems the AOT team has limited capacity to provide substance use treatment services, despite many of the early recipients having severe substance use disorders.

Notably, AltaPointe Health Systems, Hinds County Mental Health Commission, Doña Ana County, and ADAMHSBCC have created treatment teams specifically for AOT recipients. In contrast, Cook County Health and Hospital System and ODMHSAS are using pre-existing ACT teams for AOT recipients. Utilization of a stand-alone AOT team versus a combined AOT/ACT has implications for post-AOT, such that a step-down to ACT alone at the end of the order may result in transferring to a new ACT team unless the AOT team decides to keep the individual even without the order.

**TABLE 5-1. ACT Components by Program Site**

| State | ACT/AOT Stand-alone vs. Pre-existing ACT | Team Members | Frequency of Contact | Substance Use Treatment Capacity | Physical Health Treatment Capacity | Transportation | Supporting EBPs |
|---|---|---|---|---|---|---|---|
| AltaPointe Health Systems | ACT/AOT | Medium fidelity | High fidelity | Low fidelity | Yes | Yes | IMR, CBT |
| Cook County Health & Hospital System | Pre-existing | High fidelity | High fidelity | High fidelity | Yes | Limited | MI |
| Hinds County Mental Health Commission | ACT/AOT | Medium fidelity | High fidelity | High fidelity | Yes | Yes | None |
| Doña Ana County | ACT/AOT | High fidelity | High fidelity | High fidelity | Yes | Yes | None |
| ADAMHSBCC | ACT/AOT | High fidelity | High fidelity | High fidelity | Yes | Yes | IDDT, MI |
| ODMHSAS | Pre-existing | High fidelity | High fidelity | High fidelity | Yes | Limited | IMR, IPS, Housing First, MI |

The only service area that does not have ACT available to AOT recipients is in ODMHSAS' four rural counties; instead, community outreach teams are used to provide services including Illness Management and Recovery (IMR) and Motivational Interviewing (MI). These EBPs are used at other sites to supplement ACT services, as are cognitive behavioral therapy (CBT), integrated dual diagnosis treatment (IDDT), Housing First, and IPS. In general, all sites espouse integrating trauma-informed care into treatment services, though across sites there is lack of specificity about what constitutes trauma-informed care and how it is delivered.

## 5.2. Housing and Transportation Infrastructures

Housing and transportation are critical elements for the effectiveness of the AOT civil court process and the treatment services made available under any AOT order. For example, in some states preferred access to housing has been a critical element of AOT's success.

Homelessness and a lack of appropriate housing options for AOT recipients are salient concerns at Cook County Health and Hospital System, particularly in south Chicago and for temporary transitional housing, particularly when benefits have not been approved. Case managers at the state hospitals were previously under the impression that housing would be available to AOT recipients, and when they realized that was not the case they became more reluctant to refer potential AOT recipients. At ODMHSAS, homelessness is an obstacle to AOT as well. Due to a shortage of affordable residential units, Tulsa County and Oklahoma County will be working toward a goal of Housing First for all people on AOT orders, though they acknowledge that the goal is not necessarily achievable. Issues with housing availability in the rural counties were deemed "a whole other beast." Lack of housing for clients, particularly in rural areas, poses issues to implementation including the safety of providers who participate in outreach, as they have to identify a neutral location for meetings with recipients.

***Supporting EBPs***

- *IMR: Structured, recovery-oriented psychosocial intervention with an emphasis on mental illness education.*
- *Motivational Interviewing: Counseling approach to harness intrinsic motivation to change maladaptive behaviors.*
- *CBT: Structured psychosocial intervention to develop positive coping strategies and emotional regulation.*
- *Integrated Dual Diagnosis Treatment: Multidisciplinary model to treat mental illness and co-occurring substance use.*
- *Housing First: Approach to secure housing for individuals and families experiencing homelessness.*
- *IPS: Approach to supported employment for individuals with mental illness.*

Moreover, lack of transportation is an issue present in all Oklahoma counties. Although AOT teams and peer specialists can provide transportation for recipients, many people who take the bus must set aside several hours each way for transit to and from the community mental health center for services. At ADAMHSBCC, in contrast, access to housing for AOT recipients is not an obstacle, either due to the recipient's Social Security Disability Income or the State of Ohio's Recovery Support Services fund. In addition, most recipients have the option to live with family members.

## 5.3. Surveillance Infrastructure

### *5.3.1. Compliance with the Court Order*

Monitoring of treatment engagement occurs via formal and informal mechanisms across sites. Generally, as part of ACT treatment services, the AOT team has regularly scheduled meetings to discuss AOT-related matters, including treatment and medication compliance of AOT recipients. Other practices implemented at sites to monitor compliance with AOT include "no-show" codes to be entered by the treatment provider into paper or electronic health records, as well as drug screening to assess medication compliance. Urine drug testing is available at Hinds County Mental Health Commission, Doña Ana County, and ODMHSAS, and blood testing is permitted at Doña Ana County's AOT statute as well. ODMHSAS has developed a Patient Report Card

system to record results of urine drug screenings, including medication compliance and use of non-prescription medications, as well as other key health indicators (e.g., blood pressure, glucose levels). The Patient Report Card is used by the AOT program as a measure of compliance; a redacted version of the report (without illicit drug use results) can be used by justice agencies.

At some program sites, surveillance responsibilities are shared by the court. As described in ***Section 4.3*** (Post-Initiation Procedures and Clinical Determinations), status updates and hearings are routinely implemented at Cook County Health and Hospital System, Doña Ana County, and ADAMHSBCC. Moreover, custodians with Cook County Health and Hospital System and guardians with Doña Ana County and ADAMHSBCC can serve as a means for the court to ensure adequate services are provided to a recipient.

### *5.3.2. Performance Assessment and Quality Improvement*

Across sites, various teams lead the evaluation of performance assessment and quality improvement processes via meetings and reports. For example, the Performance Improvement department at AltaPointe Health Systems is continuously involved in making changes to the electronic health record so that all aspects of service are captured. The site also prepares quarterly and annual reports on outcomes, barriers, successes, adherence to treatment plans, and recommendations for improvement. Cook County Health and Hospital System coordinates written and verbal communication between the AOT steering committee and treatment providers to monitor performance and create monthly reports. At Hinds County Mental Health Commission, the evaluation team generates a monthly data report, which provides an overview of individuals currently receiving AOT, including some NOMS information (e.g., breakdowns of perceptions of social connectedness and health, trauma and violence data, and alcohol and drug use). A quarterly evaluation report summarizes overall progress in program objectives (e.g., hiring updates, trainings, data collection, data entry, and data reporting). At Doña Ana County, two teams provide oversight of the AOT Program. The first team, the Monthly Treatment Team, reviews complex cases and identifies strategies to improve services for AOT recipients. The Doña Ana County Health and Human Services Department and staff from La Clinica de Familia serve on this team. The second team, the AOT Project Team, provides general oversight of project implementation and reviews performance and evaluation data points. The Doña Ana County Health and Human Services Department, the National Alliance on Mental Illness (NAMI), La Clinica de Familia, the Third Judicial District Court, and the local evaluators participate in this team. ADAMHSBCC holds quarterly AOT steering committee meetings, supplemented by monthly project workgroup meetings to evaluate data and identify any pressing issues. At ODMHSAS, the evaluation team, project director, AOT coordinators, and community and law enforcement stakeholders meet bimonthly to review progress; a subsequent report summarizes process and outcome measures and current AOT recipients.

In addition to reports and meetings, sites have conducted various trainings for staff and stakeholders prior to and during the implementation of AOT to facilitate processes and operations, including filing of petitions, SSI/SSDI Outreach, Access, and Recovery, cultural competency, crisis intervention training, and Mental Health First Aid CIT, as well as trainings to improve fidelity to ACT and other EBPs. Moreover, the development of a comprehensive policy and procedures manual at Hinds County Mental Health Commission has served as a reference guide for the implementation. Similarly, ADAMHSBCC provides judges with a reference guide outlining the steps and requirements of AOT.

## 6. STAKEHOLDER INVOLVEMENT

Sites generally viewed stakeholder involvement as necessary across two stages of the AOT program: (1) during the pre-implementation period, which included developing a specific AOT model (i.e., prior to submitting the grant proposal to SAMHSA); and (2) ongoing-implementation and modification (i.e., after being awarded the pilot grant funding). All sites reported strong judicial involvement, including from judges and magistrates and also from those providing legal representation during the civil process. The roles of certain parties varied across sites, however. For example, at Doña Ana County the AOT program established a formal memorandum of understanding with the Third Judicial District Court. All sites also had pre-implementation and ongoing-implementation involvement from both outpatient and inpatient treatment providers. Stakeholder involvement from law enforcement, NAMI or peer advisory groups, and local Housing Authorities was less consistent across sites, often to the detriment of the implementation, per stakeholders who addressed the issue during the site visits. Unlike past implementations of AOT, there appeared to be little opposition to its implementation across sites, particularly from professional advocacy groups.

**AOT Steering Committee/Board of Supervisors**. In four sites, a major stakeholder is an AOT Steering Committee/Board of Supervisors. In some cases, this agency is the lead stakeholder, as with the Health and Human Services Department at Doña Ana County and the Hinds County Mental Health Commission, and may have a role limited to project leadership (e.g., ADAMHSBCC) or offer project leadership and service delivery (e.g., Hinds County Mental Health Commission).

**Outpatient Treatment Providers**. The roles of the outpatient treatment providers have been to establish ACT services, in the case of newly-formed teams, or to establish protocols for integrating recipients into pre-existing ACT services. In addition, protocols needed to be established as part of the planning and early implementation of the projects regarding communication between the courts and outpatient treatment providers regarding screening and assessment, treatment plan development, or other responsibilities that outpatient treatment providers may have as part of the eligibility determination process for respondents. Such responsibilities vary by site.

**Inpatient Treatment Providers**. During the planning period, the core set of stakeholders consisted of the lead agency, the courts, and outpatient and inpatient treatment providers. With implementation, the sites were identifying additional stakeholders that required additional development and training in order to improve the efficiency of the program. All sites also had pre-implementation and ongoing-implementation involvement from both outpatient and inpatient treatment providers; however, the level of involvement varied and at times information was misconstrued or communicated incorrectly between parties, which has led to increasing frustration as the program continues to be implemented. Developing relationships with hospitals posed an issue in three of the six sites: Cook County Health and Hospitals System, Doña Ana County, and ADAMHSBCC.

**Judicial**. The judiciary is a core stakeholder in retaining the legal authority to order respondents to AOT. Members of the judiciary in each site participated in stakeholder meetings and provided leadership in developing procedures for determining eligibility, placing an individual on an AOT order, and monitoring recipients' progress.

**Law enforcement**. Law enforcement agencies are stakeholders in three of the sites: AltaPointe Health Systems, Hinds County Mental Health Commission, and ODMHSAS. In ODMHSAS, law enforcement officers receiving special training as part of the Community Response Teams formed for the AOT grant.

**NAMI/Peer Advisory Groups**. NAMI/Peer advisory groups are stakeholders in three of the sites: Hinds County Mental Health Commission, Doña Ana County, and ADAMHSBCC. The groups serve in advisory positions on stakeholder advisory groups. At Doña Ana County, the NAMI provides training on peer support as well.

**Housing Authorities**. The need for safe, low-cost housing or supported housing as an alternative to shelters, if available, was a reason that housing authorities participated as stakeholders in the Hinds County Mental Health Commission and Doña Ana County sites.

**TABLE 6-1. Key Stakeholders Involved in Developing and Implementing AOT**

| State | AOT Terring Committee/ Board of Supervisors | Outpatient Treatment Providers | Inpatient Treatment Providers | Judicial | Law Enforcement | NAMI/Peer Advisory Group | Housing Authority |
|---|---|---|---|---|---|---|---|
| AltaPointe Health Systems | | √ | √ | √ | √ | | |
| Cook County Health & Hospital System | √ | √ | √ | √ | | | |
| Hinds County Mental Health Commission | √ | √ | √ | √ | √ | √ | √ |
| Doña Ana County | √ | √ | √ | √ | | √ | √ |
| ADAMHSBCC | √ | √ | | √ | | √ | |
| ODMHSAS | | √ | √ | √ | √ | | |

## 7. PERSON-CENTERED PRACTICES AND PROCEDURAL JUSTICE

Acknowledging that AOT is one of the most divisive contemporary issues in mental health policy, nearly all of the evaluated AOT sites have made concerted efforts to address a range of stakeholders' perspectives related to their programs' fairness and effectiveness. Most programs identified person-centeredness and positive family engagement as priorities, though the specific way they are enacting these elements varies from site to site.

**Recipient Involvement in the Treatment Plan**. The one person-centered practice implemented across all AOT programs is the involvement of the AOT recipient in the creation or modification of the treatment plan. For example, at AltaPointe Health Systems that involvement begins upon intake (and prior to the hearing), when the probate liaison meets with the AOT candidate to discuss treatment priorities and preferences, including discussion of medications (e.g., preference for depot versus oral medications). Treatment plans may be modified with input from the recipient, are written in plain language, and focus on attainable goals. Similarly, at Cook County Health and Hospital System, candidates at the state hospital meet with the AOT linkage case managers and AOT team prior to the initial hearing, at which point they contribute to the development of the treatment plan. At Hinds County Mental Health Commission, the peer support specialists are central to efforts to identify the individual's goals. At Doña Ana County, the law stipulates that when developing the treatment plan, the qualified professional is required to provide the recipient, all current treating providers, relatives or friends (at the request of the recipient), or surrogate decision-maker (e.g., treatment guardian) the opportunity to participate in the development of the plan. The AOT program in Doña Ana County additionally involves a NAMI peer specialist and the respondent's attorney at the request of the recipient. At ADAMHSBCC, recipient involvement in their treatment plan is primarily carried out by the FrontLine Services ACT team and routine status meetings, in which goals and treatment progress are discussed. Of note, these person-centered practices are dictated by the external treatment provider and the Ohio court system, not by the AOT program itself. In Oklahoma, AOT law dictates that the staff who develop the written treatment plan must provide the respondent, a treatment advocate (if any), and a relative or friend an opportunity for active involvement in the plan's development. Beyond the letter of the law, AOT staff at ODMHSAS are enthusiastic about recipients having a voice in creating and modifying their treatment plan.

**Status Hearings**. Other efforts to emphasize person-centeredness include the AOT recipient's participation in status hearings at ADAMHSBCC and Doña Ana County. At ADAMHSBCC, the status meetings are held in a closed court room, so that other recipients are not present, and the recipient is permitted to bring a family member or friend for support. The meetings are not legal hearings, so no public records are entered as a result of the meeting. Notably, though Cook County Health and Hospital System also holds routine status hearings to review a recipient's progress under the order, the recipients typically do not participate in the hearings themselves.

> ***PAD***
> *A legal document, prepared at a time when the individual is of sound mind, describing mental health treatment preferences or naming a person to make treatment decisions in the event that the individual decompensates and is thus unable to make competent decisions.*

**Psychiatric Advance Directives**. At the time of the site visits, no AOT program had engaged with recipients around the development of a psychiatric advance directive (PAD). However, there is potential for future utilization of PADs in across all counties. At ADAMHSBCC, for example, the treatment provider includes the potential for creating a PAD as part of the general intake process for all new clients; however, this has not been incorporated as part of AOT. As another example, across ODMHSAS, PADs are the focus of an upcoming training and clinicians hope that they can learn how best to encourage recipients to use them. At Doña Ana County, PADs are not required but are part of information packets distributed by NAMI.

**Family Involvement**. Family involvement is encouraged across all sites, though many emphasized the need for caution in determining if it is appropriate on a recipient-by-recipient basis. Specifically, AltaPointe Hospital Systems, Inc., Hinds County Mental Health Commission, and ODMHSAS require willingness on the part of the recipient, as well as a clinical judgment that the family member will be helpful in the process. At Hinds County Mental Health Commission and ODMHSAS, family members are also invited to participate in committees to provide input. ADAMHSBCC involves family members only when the recipient has granted them permission to do so, with the exception of family members who are assigned as guardians by the court. Additionally, NAMI at Doña Ana County plays an active role in educating and engaging families about mental illness in New Mexico and how families can assist their loved ones in accessing appropriate treatment. As a partner in the AOT program, NAMI is training 25 peer support specialists to help patients and their families navigate the AOT process and connect them to local resources. One objective of the AOT program is to have a peer specialist visit each patient prior to their release from the hospital.

## 8. INNOVATION

One of the core constructs in the i-PARIHS model, innovation offers an important lens through which to consider how differences in practices, arrangements, and service delivery may affect implementation of AOT, as well as subsequent programmatic outcomes. Across the AOT programs included in the evaluation, innovations were observed across domains of staffing, monitoring, and technology. Innovations in staffing primarily exist in the form of positions created for the AOT program. For example, programs have established positions for linkage case managers, hospital and probate liaisons, and systems navigators to coordinate referrals, examinations, and hearings; of note, these positions may not be financially sustainable at the sites following the completion of the grant. Hinds County Mental Health Commission has also created a family advisory committee to provide a forum in which AOT recipients, peers, and family members of recipients can discuss treatment services. Finally, at Hinds County Mental Health Commission the court has standing arrangements for three medical professionals (a physician, psychiatrist, and psychologist) to participate in all commitment hearings.

Innovations in technology include video-conferencing as a mechanism through which to hold status hearings. At Cook County Health and Hospital System, this facilitates participation by individuals who otherwise might not be able to attend in person, including the judge, Guardianship and Advocacy Commission attorney, Assistant State's Attorney, community-based provider representative, and AOT linkage case manager. In the rural service areas of ODMHSAS, law enforcement officers use an iPad system to input information into a web-based system, communicate with community mental health center staff to develop a response plan, and even facilitate the provision of treatment; the AOT recipient can engage in an hour-long session with a therapist via the device.

Innovations in monitoring include judicial status updates via written reports or hearings, long-acting injectable medications for some AOT clients, and the implementation of regular urine drug screening. Some programs additionally have guardians or custodians that may be appointed in the case of mental illness; of the six states included in the cross-site evaluation, guardianship services are available at ADAMHSBCC and Doña Ana County. Cook County Health and Hospital System can provide custodians, who are not legal agents and therefore do not have the equivalent standing as guardians; however, they serve a role in facilitating compliance on the part of the recipient, as well as providing needed assistance, such as transportation to and from appointments.

# 9. SUMMARY AND CONCLUSIONS

To address the seven areas of investigation in the HHS Office of the Assistant Secretary for Planning and Evaluation RFPs, we conducted visits to six pilot AOT programs funded under SAMHSA's 2016 grant program, entitled "Assisted Outpatient Treatment Grant Program for Individuals with Serious Mental Illness." Sites were selected by the HHS AOT Advisory Committee per several criteria, including but not limited to geographic diversity, AOT program type, AOT program size, data availability, and suitability for the subsequent outcome evaluation. Prior to the site visits, we reviewed each of the 17 site's SAMHSA grant proposals and then conducted telephone consultations with each SAMHSA-funded AOT site to confirm information from their grant application and to clarify any early implementation issues. At the site visits, we observed multiple AOT processes, including treatment team meetings, AOT clinical evaluations, and AOT civil court petition hearings, conducted in-person interviews with multiple key treatment, legal, advocacy, and evaluation stakeholders, and collected all relevant site-specific AOT supplemental materials to gain insight into the development, implementation, and early operation of the AOT Program.

## 9.1. Limitations

While this observation- and interview-based implementation evaluation approach has substantial strengths because of its reliance on a well-specified implementation model (i.e., i-PARIHS model), and the involvement of multiple stakeholders and multiple written sources of information, there are still limitations associated with the AOT evaluation. First, all site visits were conducted very early in the implementation process. Because of this we were unable to observe the entire AOT process (e.g., petition to renewal or discontinuation of an AOT court order), or have all stakeholders comment on all aspects of the process from actual experience with the program, including relevant outcome evaluation components or data access issues. Second, due to between-site jurisdictional variation, or in some cases, judge's preferences we were not able to directly observe legal proceedings across all sites. Third, we are unable to use the data gathered during the implementation site visits to predict how sustainable each of the six AOT programs will be. That would require a subsequent site visit to assess that specific implementation outcome. Fourth, and finally, the six sites visited are not meant to generalize to all the SAMHSA-funded AOT sites specifically or other sites implementing AOT generally. We summarize findings and conclusions from each area of investigation below, and conclude with a brief overview of 'Other Issues to Consider' and a synthesis of the overall implementation of AOT across these six sites.

## 9.2. Assisted Outpatient Treatment Programs and Civil Court Processes

The six sites included in the evaluation developed and implemented a range of AOT programming, including preventive and non-preventive step-up (i.e., from the community to an AOT order), step-down (i.e., from an inpatient setting to an AOT order), and mixed approaches (i.e., a combination of both step-up and step-down approaches), in addition to varying pre-AOT and post-AOT civil court processes. All site visit states included eligibility criteria that were preventive in nature, thus allowing for an AOT order in situations where decompensation has not yet occurred, but is likely. Five of the six programs--all but the Cook County Health and Hospital System site in Illinois--are using a mixed approach to AOT; yet within this mixed approach sites are differentially emphasizing step-up and step-down approaches.

*"We've been waiting on something like this for years… so if we just make that effort [for those in the community to buy into AOT] it could be one of the most successful [programs] in the country because the need is here."*

Variation in civil court procedures was common as expected due to statutory variation, including AOT initiation (i.e., length of time from petition to commitment, requirements for who is allowed to examine the respondent and whether or not that individual is required to testify, whether judicial reviews of the treatment plan are required, and whether or not the respondent can waive their right to appear) and post-initiation processes (i.e., use of judicial status hearings and judicial reviews of changes to treatment plans, responses to non-

compliance via the use of pick-up orders or sanctions, and AOT renewals). One constant AOT initiation process was that respondents were statutorily guaranteed access to legal representation. Still, respondents' access to legal representation did vary across sites. At AltaPointe Health Systems, for example, a respondent might not meet their guardian ad litem until immediately prior to a hearing. At Cook County Health and Hospital System, for example, the Guardianship and Advocacy Commission attorneys are part of the development of the agreed-order process and routinely meet with their clients on the state hospital units.

## 9.3. Target Populations

Individuals under an outpatient civil commitment order generally matched each state's AOT statute. However, there were instances where implementing sites utilized additional AOT criteria that were not statutorily required or implemented other clinical or judicial criteria that has the potential to narrow the population of those eligible for AOT. For example, Cook County Health and Hospital System uses a more restrictive standard for eligibility, where candidates must have a minimum of two inpatient hospitalizations in the past 12 months, as they believe this is an indication of a lack of success in treatment. As another example, for ADAMHSBCC, where the dedicated service to be delivered under an AOT order is ACT, respondents must meet dual-eligibility requirements--both ACT and AOT--in order to receive services. Another example of how a site is implementing changes to the AOT process, not specified in the state's statute, that might affect the subsequent patient population, relates to the use of AOT at Doña Ana County as a voluntary agreement to participate in community-based outpatient treatment. Hospital treatment teams with AltaPointe Health Systems ask for the respondent to agree to outpatient commitment to speed up discharge from the hospital, but clinical need is prioritized over a respondent's potential refusal with being placed on outpatient commitment. Finally, ineligible classes are specified by statutes in Alabama, Illinois, Mississippi, and Oklahoma, and exclude individuals with co-occurring disabilities (e.g., developmental) or dependencies (e.g., chemical).

> *"I'm picturing [AOT] being most successful with those people who are kind of on their last strike. They may have some family support, but it's kind of on its last legs. Like, 'I don't want you to be homeless, so you can come to live here, but you're doing this!' It will be most helpful for that population and those people will make sure they get back to court."*

## 9.4. Service Infrastructures and Clinical Approaches

The primary evidence-based service being delivered at all six implementing sites studied for this report was ACT. ACT fidelity, in addition to the availability of other evidence-based services, including the presence of other intensive and evidence-based step-down services varied, however, across the sites. All sites appeared to be demonstrating high ACT fidelity with regards to frequency of clinical contact; however, there was less fidelity with regards to requirements for team members and substance use treatment capacity. For example, two programs (AltaPointe Health Systems and Hinds County Mental Health Commission) did not have a full-time psychiatrist assigned to their treatment teams providing ACT services to AOT recipients and AltaPointe Health Systems also was not utilizing an IDDT approach to address the co-occurring nature of substance use and mental health problems. Another difference between sites was the bundling of ACT and AOT as a single treatment modality, as opposed to the more traditional use of AOT as a court order, separate from treatment. In sites that have created or utilize a single treatment team there is a danger that the AOT and ACT needs of recipients will be conflated. Moreover, for sites that bundled ACT and AOT there is the potential that post-AOT step-downs to ACT alone may result in transferring

> *"We didn't anticipate, or anticipated and didn't plan for this population [to be] largely homeless. We are partnering with Heartland Alliance to help us with finding Safe Shelters until we can get people housed. But, under the L is a homeless shelter for our people; I see them there on my way to work every day…It's not fair to put that person on AOT and expect them to succeed; it's just a band-aid. They need their basic needs. While treatment is important it's not as important as eating and surviving."*

the client to a new ACT team unless the AOT team delivering ACT services decides to keep the individual without a court order, or exert some pressure to keep an AOT order so as to not disrupt service continuity. If this is the case, however, AOT teams may eventually run into capacity issues as the AOT caseload grows. Finally, examples of other evidence-based services available under AOT orders, or available as a step-down from an AOT order include Illness Management Recovery, CBT, Motivational Interviewing, IDDT, IPS, and Housing First. Lack of housing and transportation options in some counties pose an obstacle for the successful implementation of AOT.

## 9.5. Stakeholder Involvement

Across sites, a variety of stakeholders participated in both the development and implementation of AOT programs and were seen as crucial across two stages of the AOT program, during the pre-implementation period and during the ongoing-implementation and modification of the AOT program. All sites reported strong judicial involvement, including from judges and magistrates and also from those providing legal representation during the civil process. All sites also had pre-implementation and ongoing-implementation involvement from both outpatient and inpatient treatment providers. Stakeholder involvement from law enforcement, NAMI or peer advisory groups, and local Housing Authorities was less consistent across sites, often to the detriment of the implementation, per stakeholders who addressed the issue during the site visits. Unlike past implementations of AOT, there appeared to be little opposition to its implementation across sites, particularly from professional advocacy groups.

> *"This is a chance to see what we can do collectively and collaboratively to improve outcomes."*

## 9.6. Person-Centered Practices and Procedural Justice

Acknowledging that AOT is one of the most divisive contemporary issues in mental health policy, ranging from its effectiveness to its probity on legal and ethical grounds, most of the evaluated AOT sites made a concerted effort to address a range of stakeholders' perspectives related to their programs' fairness and effectiveness, while also attempting to minimize the perception that AOT and its judicial process more generally was an attempt to criminalize client's behavior. All sites incorporated patient involvement in creating and modifying the treatment plan (though ADAMHSBCC was an exception, as patient involvement was carried out by the external treatment provider and court system and not the AOT program itself) and some sites stressed the importance of allowing patients the opportunity to create and then incorporate a PAD into their court-ordered treatment plan. According to sites, other approaches to promoting patient-centered practices included, for example, the use of a family advisory committee at Hinds County Mental Health Commission and the presence of clients at status hearings at Cook County Health and Hospital System, Doña Ana County, and ADAMHSBCC. Finally, the use of trauma-informed care was identified across multiple sites. Its use was seen as not only an important and effective clinical approach, but also as a central component to emphasizing both person-centered care and procedural justice.

> *"[Peer specialists] can just present it in a different way. You know, 'You're right, it does feel bad being told what to do' and it's just easier for clients to talk to the peers, even about their grievances and all of this is more important when people are discharged without supports."*

## 9.7. Innovation

Several innovations, across a range of constructs and domains, including staffing, monitoring, and technology, were brought to bear on the development and ongoing-implementation of AOT programs. Innovations in facilitating AOT mainly focused on the creation of AOT-specific positions. For example, programs have established positions for linkage case managers, hospital, jail, and probate liaisons, and systems navigators to coordinate referrals, examinations, and hearings. Sites did, however, differ in whether or not these positions

were designed to be a part of the treatment team, or independent of the treatment team. Another example of innovation includes the regular use of urine drug screens by the Hinds County Mental Health Commission, Doña Ana County, and ODMHSAS to determine compliance with one's psychopharmacological medication regimen and to test for the presence of any illicit drugs or non-prescription medications. A Patient Report Card system is then used to record the results of the drug screen, in addition to other key health indicators (e.g., blood pressure, glucose levels) and is incorporated into the client's electronic health record. ODMHSAS sites had also incorporated a technological innovation such that iPads were being used for various functions, including as a means to input clinical information into a web-based treatment/tracking system, to facilitate communication between community mental health center staff and law enforcement officials to develop a response plan to crises, and to facilitate the provision of treatment wherein the AOT recipient can engage in a treatment session with their provider via the device.

## 9.8. Evaluation Capacities

Sites varied in their ability to collect primary and obtain secondary data necessary to evaluate the implementation and subsequent effectiveness of their programs, particularly with a focus on the effects of AOT. Generally, most sites possess sufficient prior evaluation experience, have existing or have newly developed data infrastructures, and substantial stakeholder partnerships, including through data sharing agreements or memoranda of understanding to meet the administrative, secondary data requirements that will be required for participation in the cross-site outcome evaluation. The main challenge will be sites' ability to obtain jail and hospital data, so that the outcome evaluation is not reliant on patient self-report only. At ADAMHSBCC, for example, the evaluation team is obtaining patient consent for use of Medicaid data, and all other secondary, administrative data, though program evaluations do not require such consent as they do not intend to create generalizable knowledge. Still, all sites recognize the importance of these data and are working to obtain them. While there are few concerns about being able to identify the service type and its frequency of delivery across sites, no site had proposed a plan to assess the adequacy and fidelity (i.e., quality) of non-ACT services, and only a few sites had planned on collecting ACT fidelity data. Some sites would benefit greatly from enhancing their data collection efforts related to the ongoing-implementation of AOT, including any changes that take place over time, AOT's effects separate and apart from ACT, and patients and families perceptions of AOT, including its effectiveness. All sites are attempting to have a non-primary treating clinician collect the survey data in an attempt to avoid undue influence when assessing satisfaction with services and attempting to collect other social or behavioral outcomes that participants may not wish to report to their primary clinician. Five of the six sites (all but ADAMHSBCC) appear to have adequate staffing available to collect, clean, and process survey and administrative data in a valid and reliable manner. Plans to collect other outcome data across sites varied. For example, on one hand, both the Hinds County Mental Health Commission and Doña Ana County sites had, prior to the site visits, already incorporated additional outcome measures relevant to AOT. On the other hand, during the site visit, the independent evaluators associated with the ADAMHSBCC site presented no plans to collect any data other than what was required and with the NOMS/GPRA instrument. This latter approach would be severely limited in its ability to comment on the effectiveness of AOT. Finally, the feasibility of developing comparison groups/conditions, be they intra-community or inter-community, will remain one of the main challenges of the outcome evaluation.

## 9.9. Other Issues to Consider

Additional issues observed during the site visits, either by the RTI/PRA team or identified by the sites themselves, are below. These include a mix of issues that may pose a challenge during the upcoming outcome evaluation and beyond, once the grant program ends.

- Across jurisdictions, court procedures are varied. Some allow greater leeway in stipulations, some hearings are waived, and occasionally physicians/examiners are not required to testify in person.
    - In court-intensive programs, there is risk of non-sustainability due to the amount of time and effort spent by AOT teams and the court.
    - Standardization could be used to streamline court procedures and reduce court expenses.

- Three of the six program sites have adopted elements by which AOT borders on becoming a "voluntary" program, which is necessarily in conflict with the underlying intent of AOT to provide treatment services, via court order, to those who otherwise would not willingly engage in those services.

- Assessment of the extent of court involvement across sites will be important to inform the potential role of the "Black Robe Effect" in AOT outcomes. This may include sites adding an adapted interview for judges, as well as adding "judge/magistrate" and "attorney" options to the Client Survey (e.g., adding specific references to these positions in L2 and L5), and either adding legal staff to Q20 or specific questions for legal staff (i.e., independent of "mental health workers").

- Finding a balance between the most effective length of initial and renewal orders is a difficult task, and is subject to treatment and judicial factors.
    - Short AOT orders (e.g., 90 days) may limit the amount of treatment services that can be provided in that timeframe or the effectiveness of the services.
    - Long AOT orders (e.g., 12 months) limit opportunity for the order to be driven by treatment needs and can limit the authority/presence of the court without ongoing judicial "status checks".

- Some of the "system" liaison positions (e.g., hospital, jail) that have been established by AOT programs call to question how they will be paid for in the future, particularly if the position is bundled with the ACT program and it remains a non-ACT reimbursable service.

- Filing fees across jurisdictions may limit or restrict AOT use without money set aside for indigent filings.

- Several AOT sites cited lack of Medicaid/health care coverage, housing options, and transportation options for AOT recipients as primary concerns related to AOT implementation.

- All sites evaluated in the case study herein included an ACT (or "ACT-like") program, which means that will likely be the first-line community treatment provided to AOT clients; however, ACT is not always clinically-indicated for AOT clients.
    - A broader array of community-based intensive services should be made available for first-line service delivery and step-down services.

- AOT program sites have varied quality assurance procedures in place. In addition to quantifying the fidelity and quality of services delivered to a given client, it will be important in the outcome evaluation to separately consider and document site-level quality assurance procedures (e.g., training offered, frequency/quality of supervision).

- While most sites, the exception being the ADAMHSBCC site at the time of the site visits, appear capable of collecting valid and reliable outcome and predictor data, and obtaining secondary, administrative data that can be used to inform the effectiveness of AOT, the timing of proposed primary data collection (e.g., every 6 months) will make evaluating some hypothesized relationships

difficult. For example, assessing the relationship between AOT and psychiatric symptoms, the latter of which are dynamic and fluid and are difficult to capture validly once every 6 months, will be difficult.

- Some hospital physicians were reluctant to file affidavits, often due to unfamiliarity with the process (e.g., lack of training) or logistical reasons (e.g., requiring too much time).

## 9.10. Overall Summary and Conclusions

We find that the development and ongoing-implementation of AOT programs under SAMHSA's 2016 grant program, at six sites, is largely proceeding in a fashion consistent with SAMHSA's objectives and based on empirically and theoretically-supported efforts.

## ACRONYM

| | |
|---|---|
| ACT | Assertive Community Treatment |
| ADAMHS | Ohio Alcohol, Drug Addiction and Mental Health Services |
| ADAMHSBCC | Alcohol, Drug Addiction and Mental Health Services Board of Cuyahoga County |
| AOT | Assisted Outpatient Treatment |
| CBT | Cognitive Behavioral Therapy |
| CCOP | Court-Committed Outpatient Program |
| CIT | Crisis Intervention Team |
| CTO | Community Treatment Order |
| EBP | Evidence-Based Practice |
| FIC-DAC | Forensic Intervention Consortium of Doña Ana County |
| GPO | Government Project Officer |
| GPRA | Government Performance and Results Act |
| HHS | U.S. Department of Health and Human Services |
| i-PARIHS | integrated-Promoting Action of Research Implementation in Health Services |
| IDDT | Integrated Dual Disorder Treatment |
| IMR | Illness Management and Recovery |
| IPS | Individual Placement and Support |
| MI | Motivational Interviewing |
| NAMI | National Alliance on Mental Illness |
| NOMS | National Outcome Measures |
| ODMHSAS | Oklahoma Department of Mental Health and Substance Abuse Services |
| OPC | Outpatient Commitment |
| PAD | Psychiatric Advance Directive |
| PRA | Policy Research Associates, Inc. |
| RCT | Randomized Controlled Trial |
| RFP | Request for Proposal |
| SAMHSA | HHS Substance Abuse and Mental Health Services Administration |
| SSDI | Social Security Disability Insurance |
| SSI | Supplemental Security Income |

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