Mental Health
FACTS IN BRIEF

Assisted Outpatient Treatment (AOT) Community-Based Civil Commitment

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Assisted outpatient treatment (commonly abbreviated "AOT") is a form of civil commitment that authorizes the judicial system to commit eligible individuals with severe psychiatric disorders to mental health intervention in the community. Also known as "mandatory outpatient treatment/MOT," "outpatient civil commitment" and by other names, the purpose of court-ordered community treatment is to improve the health, safety and welfare of both the individuals under AOT and the public.

In all states, voluntary mental health services are the default model for treatment, with AOT becoming an option only when individuals do not engage with services voluntarily. AOT in some form is authorized by statute in 47 states and the District of Columbia but is unevenly practiced and not available everywhere it is allowed. (In 2019, the states without AOT statutes were Connecticut, Maryland and Massachusetts). Depending on location, AOT may be used independent of hospitalization or as a condition of hospital discharge.

Criteria for AOT vary among the states. In about half the states with AOT statutes, statutory criteria for inpatient and outpatient commitment are identical. The other half have specific provisions for AOT that are distinct from inpatient criteria in some way.

BRIEF HISTORY

Mental illness treatment in the United States was delivered primarily in state-operated mental hospitals from the mid-19th century until the mid-1950s. After political, social and other forces converged to produce widespread closure of those psychiatric beds, states began in the 1970s to enact legislation specifically authorizing civil commitment outside of hospitals for individuals who chronically struggled to succeed in the community because of untreated symptoms.

AOT has long attracted passionate proponents and opponents and was little used until the beginning of this century. As research has emerged indicating AOT can improve outcomes for specific at-risk populations, the model has been endorsed by a variety of public agencies and national organizations and become more widely implemented.

COMMUNITY POLICIES AND PRACTICES

The use of AOT in any given community is a function of multiple factors.

State law establishes the criteria respondents must meet to qualify. Local policy and priorities influence whether the mechanism is incorporated in a given jurisdiction's toolbox of mental illness interventions. The completeness of relevant community mental health resources defines and may limit the feasibility of implementation. Law enforcement, family members, consumers of mental health services and other stakeholders may make the local environment for use of outpatient commitment more or less favorable. Ultimately, clinical determinations of medical appropriateness and public funding also play a role in the availability of interventions, regardless of how desirable they may seem to the court, family members or others.

All these and additional variations make comparisons of outpatient commitment practices difficult, even within the same state where courts operate under the same statutes. That being said, the following characteristics are commonly found where AOT is used.

- The AOT case comes before a judge after a petition for outpatient commitment is filed with the court.
- The petitioner for the commitment order and the respondent typically are represented by counsel.
- The judge makes a finding whether the respondent meets statutory criteria for court-ordered civil commitment in the community.

- Respondents found to meet criteria for court-ordered community treatment are committed to the care of a specific provider, typically a state, regional or local mental health system or, more rarely, to a private provider.
- By requirement of state statute, at the preference of the court or by request from the service provider, a treatment plan containing specific clinical directives may be incorporated into the court order. The plan typically includes provision for a case manager and for the patient to take prescribed medications.
- Courts have discretion with regard to the role of the judge after the order is issued. In practice, the role varies from adjudication alone to a more hands-on follow-up.
- The duration of the first outpatient commitment period and provisions for renewal of the order or discharge from it vary according to governing state law and local practice.
- The court order is typically enforced through a clinical response focused on restoring the participant to treatment adherence. State statutes differ on the mechanics of enforcement, and a handful of states establish no procedures for responding to non-adherence to the court order. In most cases, however, the statute authorizes the court and/or the mental provider to initiate an involuntary psychiatric evaluation if an individual under an AOT order is not adherent and/or shows signs of mental health deterioration. Based on that evaluation, hospitalization may follow as part of the AOT order or independent of it. Hospitalization may require separate court action, depending on the statute.
- AOT laws may also have an express prohibition against using contempt authority for the respondent's failure to adhere to the AOT order.

The statutes do not mandate action by mental health systems, but the AOT order ideally acts as a catalyst for mental health providers to deliver services at the same time it commits patients to accept their services in the community.

SUPPORTING EVIDENCE

The Substance Abuse and Mental Health Administration, American Psychiatric Association and similar organizations have deemed assisted outpatient treatment to be an effective intervention for eligible individuals. Although national data have not been developed, a substantial body of research has reported positive outcomes from AOT for the target population in specific states and communities (e.g., New York, North Carolina and Ohio, among others). Despite differences in policy and practice among locations, these studies have consistently found lower rates of rehospitalization, arrest, re-arrest, incarceration, homelessness, violence and suicide for participating patients living in their communities under AOT orders for six months or longer.

More limited cost-effectiveness research and anecdotal evidence have further reported government cost savings from outpatient commitment compared with the consequences of individuals with untreated mental

illness cycling through jails or hospitals. Another area of emerging research focuses on the role of procedural justice in reducing patient perceptions of coercion from the court order.

Many characteristics and variables of outpatient commitment have not yet been sufficiently studied to validate or invalidate them. More research is needed, for example, to determine the role of assertive community treatment in fostering positive outcomes from AOT. How judicial involvement after the court order may affect AOT effectiveness is another area that requires further study. As relevant data are collected, analyzed and reported by more states and communities, answers to open questions such as these may lead to further refinement of outpatient commitment policies and procedures.

CONSIDERATIONS

What is the patient's current condition and history?
Specifically, does he or she have a history of non-adherence to treatment (e.g., not meeting with mental health providers, not taking prescribed medications)?

Does the individual acknowledge his/her need for treatment or lack insight into his/her condition?

Is there a record of repeated consequences of treatment non-adherence (e.g., repeated hospitalization, arrest, suicide attempts)?

What services does the mental health provider recommend to support the individual's adherence to treatment in the community?
Are those resources available?

Where are the recommended services located, and will the subject be able to access them?

What resources does the individual have in place to support and reinforce the court order to community treatment (e.g., family members, peer support, non-family caregivers)?

SUMMARY

Voluntary adherence to needed psychiatric care is always preferable to a court order. For individuals with serious mental illness who decline voluntary services and meet criteria, AOT petitions may come before the court. Familiarity with the history, policies and evidence for the practice of outpatient commitment can help judges adjudicate these cases.

RESOURCES

- Substance Abuse and Mental Health Services Administration. Civil commitment and the mental health care continuum: Historical trends and principles for law and practice. Rockville, MD: Substance Abuse and Mental Health Services Administration (2019). Retrieved from https://www.samhsa.gov/sites/default/files/civil-commitment-continuum-of-care_041919_508.pdf

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- Swartz M et al. Resource document on involuntary outpatient commitment and related programs of assisted outpatient treatment. Washington DC: American Psychiatric Association (2015). Retrieved from https://smiadviser.org/wp-content/uploads/2019/07/Resource-document-on-Involuntary-outpatient-commitment-2015-10-20.pdf

ABOUT THE AUTHORS

Doris A. Fuller, MFA, is a personal and professional mental health advocate and researcher whose work has been published on three continents and widely reported by general media. At the nonprofit Treatment Advocacy Center, Fuller authored groundbreaking studies about the role of serious mental illness in the criminal justice system and produced the judicial education documentary video *Mental Illness on Trial*.

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SJI State Justice Institute

NCSC National Center for State Courts

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