

Lengthy discussion of serious concerns around “the devil is in the details” of implementing AOT

Important Considerations for Implementing Assisted Outpatient Treatment: A Collaborative Advocacy Agenda

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For my entire career a vicious debate has raged about involuntary outpatient treatment largely pitting parents and clinical professionals on the pro side against consumers and rehabilitation professionals on the con side. Like it or not, packaged as Assisted Outpatient Treatment (AOT), involuntary outpatient treatment is increasingly coming to a neighborhood near you. Los Angeles County is nearly ready to begin implementing AOT under Laura’s Law. The time for contentious advocacy aimed at stopping AOT has ended and the time for collaborative advocacy aimed at implementing AOT as well as possible is upon us. Whenever a major new initiative like this is launched, even in its pilot stages, there is the likelihood of more unintended consequences than intended consequences. This paper describes a series of important considerations for implementing AOT and some concrete recommendations for a collaborative advocacy agenda.

The cornerstone of the con position has always been that even if AOT is done with the best of intentions forcing someone to do something or to change in a way they don’t want to change is inherently an assaultive thing to do. There is a large risk the coerced person will react resentfully and even aggressively in response. There is also a large risk that the people exerting power coercively will be corrupted by their power and abuse it (This damaging effect on staff who forcibly treat people is why I personally wouldn’t want to be involved in it.).

- Robust grievance processes should be included to decrease the powerlessness and helplessness of the people being forced into treatment to hopefully decrease their resentment and aggression.
- Checks and balances should be included to limit the power of the people involved (including families, referral sources, legal agents, and treatment staff) including oversight to detect abuse.

The cornerstone of the pro position has always been that there are some people with mental illnesses who will not respond to any intervention besides force to do what’s good for them. This implies that other means of persuasion besides threats of punishment should be used before resorting to force. In general we have four levels of persuasion available to us:

1. Avoiding punishment
2. Seeking rewards
3. Internalizing rewards

4. Pursuing higher values or principles

Avoiding punishment is the lowest of these forms of persuasion.

- The criteria for implementing and discontinuing AOT should include the person's motivational level and the need to use the lowest form of persuasion.
- Outcomes for the legal process should include how often they brokered an agreement using a higher form of persuasion instead of either just granting or denying the petition for AOT. (Apparently the exemplary program in Nevada County has about 90% brokered agreements for services without granting the AOT petition.)
- Outcomes for the involuntary treatment process should include how often they achieve a voluntary engagement as a reason to terminate AOT, rather than people no longer meeting medical or legal criteria as a reason to terminate. (It seems to me that people who are released from involuntary treatment without being persuaded of its value and to continue in it are often harder to engage over the long run than people who were never treated involuntarily at all – an unintended negative consequence.)

A key argument has been effectively made by the proponents of AOT that it actually reduces the amount of coercion these people experience because without AOT they are hospitalized and jailed more frequently. It's tempting to include the amount of recent coercion someone has experienced as a criteria for inclusion in AOT to maximize this benefit (either directly or indirectly by limiting who can petition for AOT to coercive agencies like jails, prisons, and hospitals). Doing this would create another "fail first" system and lose the possibility of proactively diverting people from these traumatic and devastating settings. However, screening for and predicting future risk of coercion is likely to be an unreliable process, especially if the population being screened broadens. Diverting people who are certain to be heading to hospitals, jails, or prisons at their point of admission would be a compromise between prevention and "fail first". There is still the likelihood of people trying to get someone hospitalized or incarceration who they wouldn't otherwise because they're expecting AOT diversion.

- A rapid response, point of contact, diversion to AOT from hospital, jail, and prison admissions should be included.
- Referral criteria should overtly include an evaluation of the likelihood of reducing coercion overall by enrollment in AOT.

The effectiveness of AOT appears to rely upon intensive treatment resources (and perhaps housing subsidies) – generally ACT / FSP level, about \$15000 per person. This level of resources is not available for everyone who needs them (except perhaps in New York). By way of contrast, in California the state parole department runs poorly funded, coercive outpatient services (POC) that appear to be ineffective (though to be honest, I don't know if their effectiveness has really been studied.) In any event, AOT advocates have not been advocating for a civil version of POC. They've been advocating for an

involuntary version of ACT / FSP. This lack of resources has been a major obstacle to implementing Laura's Law in California and it has only been through the diversion of MHSA funds that AOT can even begin in Los Angeles.

- AOT should authorize and triage to a system of care with different cost levels to help manage the costs of the services they are mandating. Just because someone needs involuntary outpatient treatment doesn't mean they need highly intense services (especially indefinitely).

The MHSA set aside a substantial portion of the new revenues from taxing millionaires for voluntary Full Service Partnerships (FSPs). These programs have largely been successful in engaging people in community based services who had been heavily homeless, jailed, hospitalized, and institutionalized and had been unserved or underserved by the existing services. Statewide they have demonstrated success in reducing homelessness, incarceration, and hospitalizations rivaling any AOT programs. They also cost a lot of money. At this point almost all FSP programs in Los Angeles are full almost all of the time and most people who want services are turned away back to the street, jails, and hospitals. An effort is underway to create flow within these programs, helping people "graduate" to lower levels of care to open up the opportunity for new people in need. This effort is quite difficult and often resisted by everyone concerned (including families, staff, consumers, and judiciary).

The success of FSP programs has not gone unnoticed. There are growing, passionate referral sources from chronic homelessness, jail diversion, incompetent to stand trial, hospitals and institutions, aging out of foster care, families, early prison release (AB109 step down), outpatient clinics, and even immigration detention centers. All are clamoring for access to FSP programs. Any one of them could likely fill the entire FSP capacity. Although touching family stories are often relied upon in the promotion stages of obtaining services, as time goes on those with more influence within the system tend to have more access.

The promoters of AOT joined those clamoring for access to FSPs. They emphasized that even with engagement efforts there are clearly people heavily in need of FSP services who do not agree to them voluntarily and would likely benefit from them involuntarily. They convinced the California legislature to remove the "voluntary services only" restriction on the usage of MHSA funds to allow access for these involuntary AOT people. There is a possibility that because of the legal authority attached to AOT people, they will be given higher priorities than these other competing FSP applicants and over time push them out. We could find ourselves in the situation where people would intentionally not agree to FSP services to be put on AOT to get access to FSP services. This situation has occurred over time with involuntary hospitalizations pushing out voluntary hospitalizations.

- An FSP access committee with substantial power should be established to negotiate between these competing applicants for FSP services. The AOT process would need to be made subservient to this committee, such that the AOT court can't mandate services beyond their allocation.

One of the key FSP resources that is very popular is housing subsidies. Social Security doesn't provide enough income to live in even the worst housing hardly anywhere in Los Angeles (or apparently any major real estate market in the country). HUD Section 8 subsidies are extremely limited and continually reduced. Applicants face multiple year waiting lists or closed waiting lists. Allocations for special mental health programs like Shelter-Plus certificates are rapidly filled too. One of the reasons it's sometimes hard to flow people beyond FSP is because they can't afford housing without it. The success of AOT people is likely to depend on their access to housing subsidies. Any existing resources are already oversubscribed.

- AOT should develop a funding stream for housing subsidies independent of existing mental health funds. This would likely add about \$5000 per year to the cost of each person.
- AOT should develop funding streams for housing that persist after AOT so people don't remain on AOT indefinitely just to access housing subsidies.

Gaining access to services and resources is not the only appeal of AOT. The coercive abilities are in themselves appealing. It is natural for people who are frustrated to want to "make them do it." The level of frustration in our society is enormous. There are strong desires to make people follow laws, make kids go to school, make people come to this country legally, make them take care of their children, make them lose weight, stop smoking, and take care of their health, make them stop using drugs, stop being homeless, and, of course, make them take their psychiatric medications. Many of these important issues have gotten legal coercive powers to help them. Over the years, forcing people with mental illnesses into treatment has received legal support. AOT is an expression of that support and an acknowledgment of that frustration.

With regularity, other frustrated people have attempted to use mental health laws to promote their own agendas. Once legal support is obtained, the legal process has routinely imposed its own standards and prioritized its own frustrations. (I heard of a mental health court in New Mexico that mandated the local clinic to serve drunk drivers and wife beaters, two populations that frustrated the courts the most but who the clinics had been rationing out to use their limited resources elsewhere.) Everyone's assumption is that once AOT is established it will be used to address their particular frustrations, often unaware of how many competing frustrations there are.

The legal system is also notorious for ignoring budgetary realities. Criminal court judges sentence people to prison without regard to how much prison capacity exists, to how sending more people hopelessly degrades the program, or to how other valuable public services (like education) will need to be cut to pay for their orders. Special education hearings mandate services far above the ability of the school district to provide them and as a result we now have about 1/3 of our "normal" students' funds diverted to special education students. Given the present level of rationing mental health funds, including a financially irresponsible legal partner is highly risky. (For example, it's estimated that treating in psychiatric hospitals all the people currently in jail found incompetent to stand trial would use about

1/3 of our entire mental health budget. These people are very frustrating to the legal system and could be mandated AOT services, massively reducing everyone else's services.)

- The AOT process should have a transparent budget and be required to make responsible rationing decisions to remain within the budget – including the judges.

Depending on whose frustrations are driving the petition process, the people in AOT may need a diversity of services. There is a perception that the most important obstacle to mental health and community living is refusal to take needed medications. This is only true for a subset of frustrating people. In our FSP program other common obstacles include – ongoing substance abuse, inability to control anger often from childhood trauma, immediate gratification craving and low frustration tolerance, impaired cognitive abilities (developmentally, brain damage, or substance abuse), severe poverty and poor money management skills, physical illnesses (especially chronic pain), learned helplessness and hopelessness, stealing, and an inability to tolerate being around other people. We need to make highly individualized assessments and recovery plans using a whole team of people with different skills and life experiences to help them engage in our program, overcome these obstacles, and become more self responsible and self reliant. In contrast most court ordered treatment orders are stereotyped, cookie cutter, and include an almost magical belief in the power and infallibility of psychiatric medications.

- AOT orders should be carefully developed including people with relationships with the person who know them well and the person themselves (incorporating their perspectives), be highly individualized, regularly reviewed and revised, and go beyond medication compliance. At a minimum, substance abuse and trauma should be included alongside mental illness concerns.

Our court system is amazingly overburdened. The criminal justice system has almost entirely replaced a system of hearings and judicial decision with a system of plea bargaining negotiations. Model mental health courts and drug courts have found a need to diverge substantially from prevailing court procedures to be effective. Some exemplary court practice include: More time per case is allocated. Judges become actively involved, interacting directly with the clients and even forming relationships with them and directly negotiating with them instead of lawyers negotiating with each other. Resource providers are available at the court and their input and agreement is incorporated into the judgments and plans. There are ongoing frequent judicial progress reviews, not just of ongoing eligibility but of progress and need for plan changes. It's been estimated that AOT requires \$3000 per year of legal services per person.

- The court participating in AOT should be well funded and proactively alter its roles and procedures to facilitate AOT in the ways model mental health courts and drug courts have.
- There should be an ongoing review of and improvement of the legal services involved in the AOT program.

In putting together analysis and recommendations our advocacy goal should not be to make it seem impossible to implement AOT successfully or to over-regulate it or include “poison pills” to sabotage it. We need to collaborate in an honest attempt to address a variety of serious concerns as we move forwards in implementing AOT. I hope that the people who have been promoting AOT have already incorporating many of these considerations and ones like them into their plans.