

# HOT TOPICS IN MENTAL HEALTH & LAW: ASSISTED OUTPATIENT TREATMENT

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## “AOT in the United States: History, Evidence, Implementation, and Future Directions”

Presented by Jeffrey W. Swanson, PhD

September 10, 2026



CENTER FOR MENTAL HEALTH, POLICY & THE LAW  
UNIVERSITY *of* WASHINGTON

# ABOUT THE CENTER FOR MENTAL HEALTH, POLICY & THE LAW

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The Center for Mental Health, Policy, and the Law (CMHPL) is housed within the University of Washington (UW) Department of Psychiatry and Behavioral Sciences in the UW School of Medicine.

The CMHPL's mission is to address the most urgent issues arising at the interface of mental health and the law, in order to help justice-involved people with mental illness lead full and productive lives.

**Learn more on our website:** <https://cmhpl.psychiatry.uw.edu/>

# HOT TOPICS IN MENTAL HEALTH & LAW: ASSISTED OUTPATIENT TREATMENT

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**September 10, 12:00–1:00 p.m. PT**

“AOT in the United States: History, Evidence, Implementation, and Future Directions”

*Jeffrey W. Swanson, PhD*

**October 15, 12:00–1:00 p.m. PT**

“AOT in Washington State”

*Diane Weiner, LMHC*

**November 19, 12:00–1:00 p.m. PT**

“AOT Graduate Experiences”

**December 10, 12:00–1:00 p.m. PT**

“AOT Research in the United States: Interpretation, Outcomes, and Future Directions”

*Kiersten Jeske, PhD*

**January 21, 12:00–1:00 p.m. PT**

Family perspectives: Assisted Outpatient Treatment  
Challenges in Practice

*Jerri Clark*

**February 11, 12:00–1:00 p.m. PT**

Team-based care for serious mental illness

*Maria Monroe-DeVita, PhD & Lorna Moser, PhD*

**March 11, 12:00–1:15 p.m. PT**

AOT in Practice: Perspectives From Pierce County

*Liz Biviano; Laura Fonda, SUDP; Joel Harte, JD; Marcus Miller, JD, Judge Matthew Thomas, JD*

**April 8, 12:00–1:00 p.m. PT**

“A Panel Discussion on the Assisted Outpatient Treatment Hot Topics Series”

*Jerri Clark; Laura Fonda, SUDP; Kiersten Jeske, PhD; Lorna Moser; Jeffrey W. Swanson, PhD; Bradley Tarr, Diane Weiner, LMHC; and more!*

# RECORDINGS & CONTINUING EDUCATION

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- > The recording and presentation slides will be made available on our website within 1 week. We will email attendees with the link.
- > Continuing Education:
  - UW faculty and staff ONLY: You received an email from cmhpl@uw.edu with instructions and will need to sign in via text by 2:00 p.m. PT.
  - For non-UW learners, we will track attendance via Zoom. You do not need to log in or update your name on Zoom, as attendance is tracked with your unique Zoom link.
  - Continuing education is only available for attendees who attend the live Zoom session.

# DISCLOSURES

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Today's speaker, Jeffrey W. Swanson, has no financial relationships with an ineligible company relevant to this presentation to disclose.

None of the planners have relevant financial relationship(s) to disclose with ineligible companies whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

# QUESTIONS

To submit a question, please click the Q&A icon on Zoom.



**Reminder:** The series will conclude with a panel discussion and Q&A on April 8. Submit your questions: [cmhpl@uw.edu](mailto:cmhpl@uw.edu)

# FINAL LOGISTICS

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# JEFFREY W. SWANSON, PHD

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Jeffrey W. Swanson, PhD, is Professor in Psychiatry and Behavioral Sciences at Duke University School of Medicine and a faculty affiliate of the Wilson Center for Science and Justice and the Center for Firearms Law at Duke University School of Law. Trained as a sociologist at Yale University, he is a social scientist whose research focuses on mental health policy, outpatient civil commitment, violence prevention, suicide prevention, and firearm-related injury. He has authored more than 250 scholarly publications and led some of the first empirical studies evaluating involuntary outpatient commitment, psychiatric advance directives, and risk-based firearm removal laws. Dr. Swanson is a recipient of the Isaac Ray Award from the American Psychiatric Association and the American Academy of Psychiatry and the Law, and the Carl Taube Award from the American Public Health Association.



# Assisted Outpatient Treatment in the United States: History, Evidence, Implementation, and Future Directions



Jeffrey W. Swanson, PhD

Professor in Psychiatry & Behavioral Sciences

Duke University School of Medicine

Faculty Affiliate, Wilson Center for Sciences and Justice

Duke University School of Law



Guest lecture: September 10, 2026 from 12:00 to 1:00 pm



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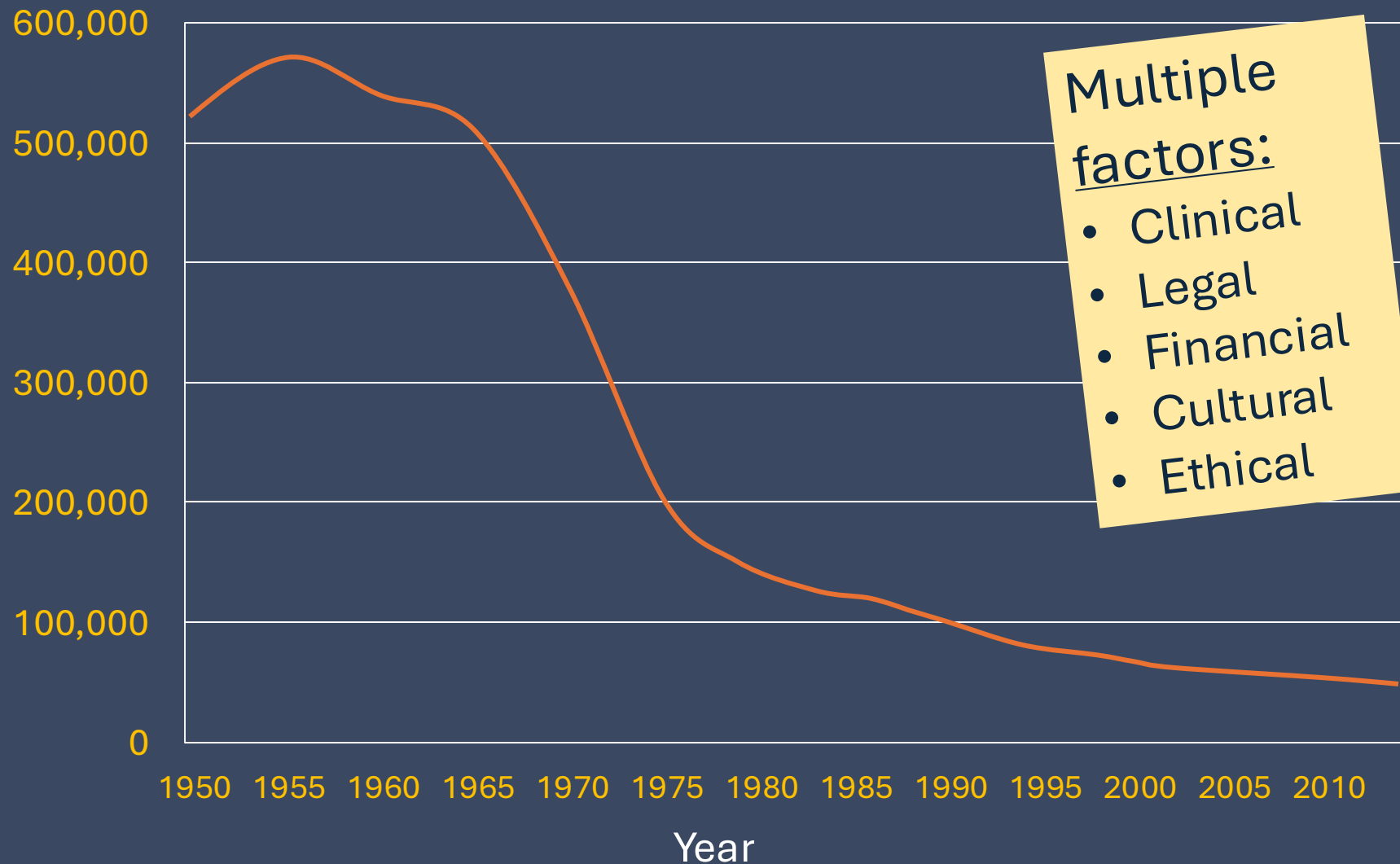
# Historical prelude to outpatient civil commitment

## Deinstitutionalization: The end of the state hospital era

- Outpatient commitment emerged in the context of one of the most dramatic institutional transformations in American mental health care.
- More than 550,000 patients resided in large public state-run psychiatric hospitals in the mid-1950s
- Fewer than 40,000 remain today.

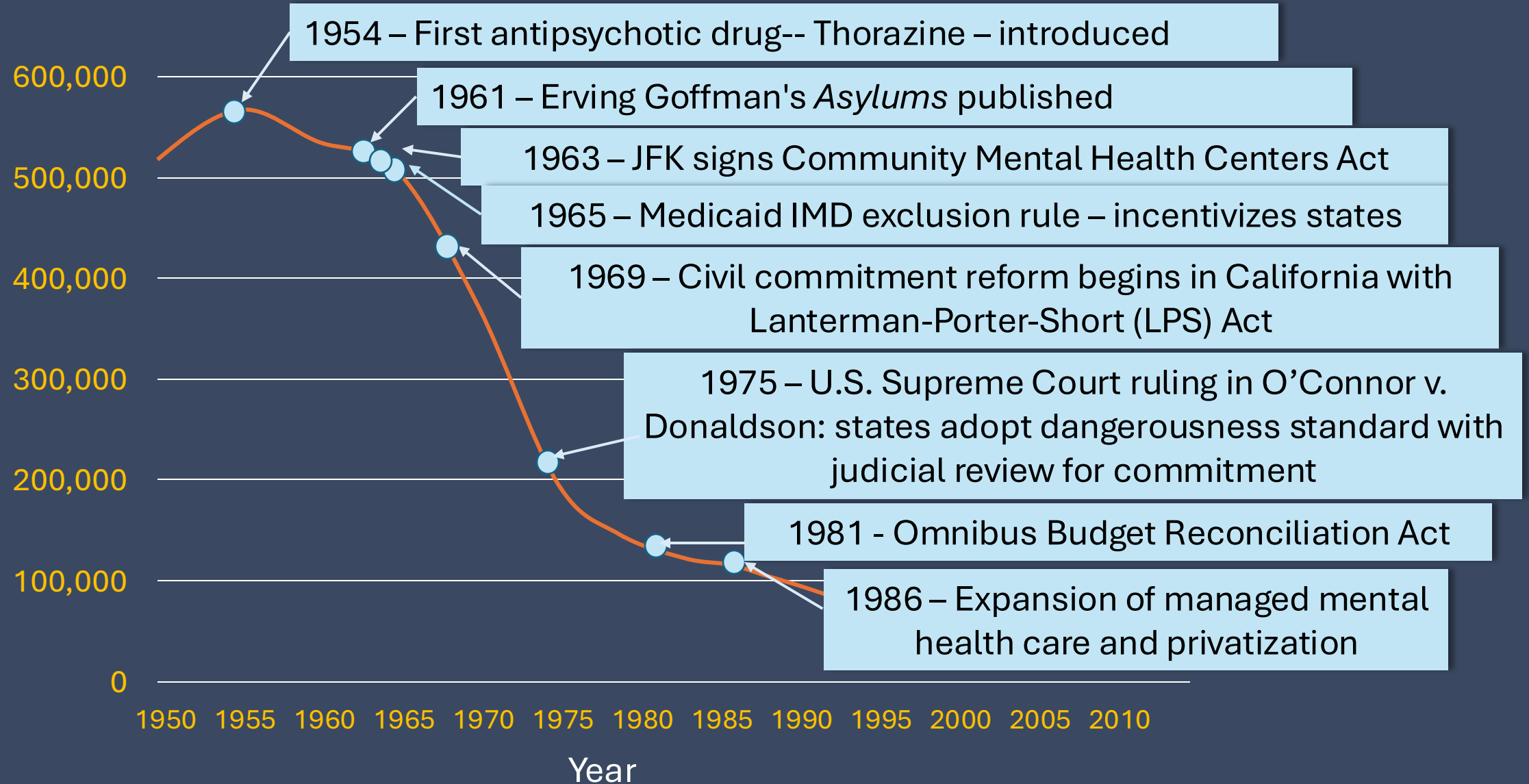
# Timeline of deinstitutionalization

Number of patients in state mental hospitals



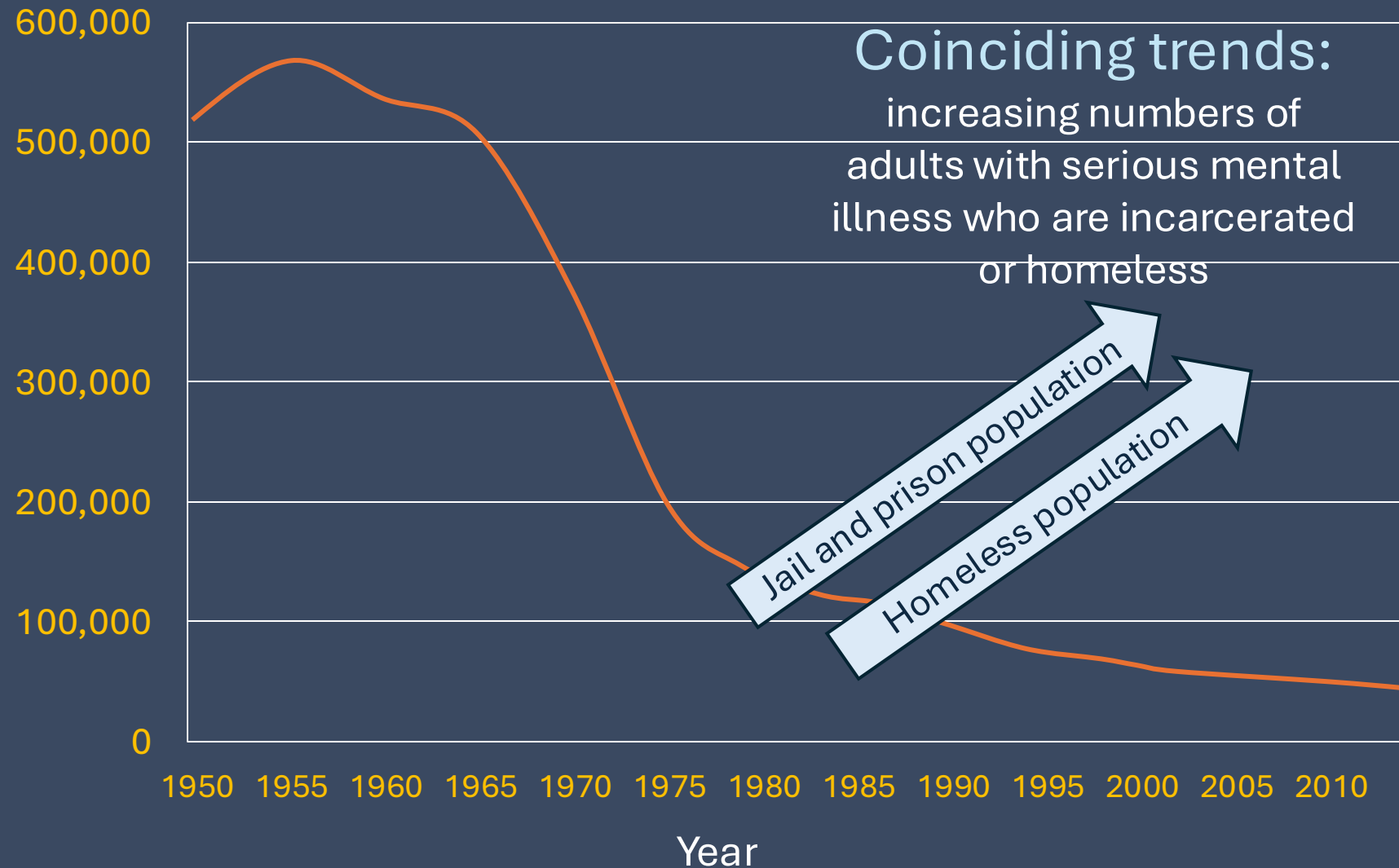
# Timeline of deinstitutionalization

## Number of patients in state mental hospitals



# Timeline of deinstitutionalization

Number of patients in state mental hospitals



# What replaced the state hospital as it had existed?

Not one system, but many:

- community mental health services
- Medicaid-funded treatment
- emergency departments
- homeless shelters
- jails and prisons
- families

# The post-deinstitutionalization “revolving door”



Outpatient civil commitment was developed as a legal tool to address this costly recurring cycle for a small subgroup of high-need SMI adults.

# Key elements of outpatient commitment, aka “assisted outpatient treatment” (AOT)

- Extends state’s civil commitment authority from the institutional setting into the community.
- Civil court order that requires certain individuals with a serious mental illness to comply with recommended outpatient treatment and receive services
  - Conceptually, also “commits the system” to the individual; creates accountability.
- “Treatment plan wrapped in a legal order”
  - Services under AOT can include Assertive Community Treatment (ACT) or Intensive Case Management (ICM), prescribed medication, psychosocial treatment, and access to subsidized housing
- Sanction for non-adherence: non-criminalizing police transport to a mental health facility for evaluation, hopeful persuasion, or involuntary hospitalization if needed
  - No forced medication in outpatient setting

# 48 states + DC authorize some form of outpatient civil commitment (OPC/AOT) in statute: several types

## Conditional release only

- Outpatient supervision available primarily as a condition of release from inpatient commitment.
- No direct court-ordered community commitment for persons living in the community.
- ~2-6 states

## High-threshold OPC

- Direct outpatient commitment permitted, but individual must currently meet inpatient commitment criteria (dangerousness, grave disability, etc.).
- Functions as a less restrictive alternative (LRA) or community diversion from hospitalization.
- ~20-25 states

## Preventive OPC

- Court may order treatment for a person who does not currently meet inpatient commitment standards, but whose history shows recurrent nonadherence, deterioration, hospitalization, violence risk, or similar adverse outcomes. Includes statutes modeled on Kendra's Law and related approaches.
- 23 states

Johnston EL. The Constitutionality of Assisted Outpatient Treatment. Ohio St. LJ. 2025;86:69.

Johnston EL, Klein A. Assisted Outpatient Treatment: A State-by-State Comparative Review. Clev. St. L. Rev.. 2024;73:723.

# Criteria for preventive OPC in North Carolina (1983)

- Presence of a serious mental illness
- Capacity to survive in the community with available supports
- Clinical history indicating a need for treatment to prevent deterioration that would predictably result in dangerousness
- Mental status that limits or negates the individual's ability to make informed decisions to seek or comply voluntarily with recommended treatment

# OPC laws named for homicide victims



Kendra Webdale  
(1966 - 1999)

("Kendra's Law" - NY)



Laura Wilcox  
(1982 - 2001)

("Laura's Law" - CA)



Kevin Heisinger  
(1976 - 2000)

("Kevin's Law" - MI)

# Meldrum et al. 2016 survey of AOT implementation: 20 states with “active AOT programs”

- AOT programs varied considerably:
  - style of implementation
  - statutory criteria applied
  - agency responsible
  - use of a treatment plan
  - monitoring procedures
  - numbers of participants involved

# Meldrum et al. survey of AOT implementation: 20 states with “active AOT programs”

- Common problems
  - inadequate resources
  - lack of enforcement power
  - inconsistent monitoring
  - weakness of interagency collaboration
- Uneven implementation of AOT programs within and across states
  - ambivalence in the community among judicial officials and mental health clinicians about the role and scope of AOT and the difficulties of implementation under existing funding constraints and statutory limitations

# Prevalence and context of AOT: MacArthur Research Network study on prevalence of “leveraged” treatment

- 12% - 20% of a large, 5-site sample of outpatients with SMI in public systems of care reported experiencing outpatient commitment
  - 44-59% report receiving some form of “leveraged” outpatient treatment, with civil legal, criminal justice, or social welfare (money or housing) contingencies linked to treatment participation

Monahan J, Redlich AD, Swanson J, Robbins PC, Appelbaum PS, Pettila J, Steadman HJ, Swartz M, Angell B, McNiel DE. Use of leverage to improve adherence to psychiatric treatment in the community. *Psychiatric Services*. 2005 Jan;56(1):37-44.

# AOT = Statute + Program + Treatment Plan: Three models

| Component        | New York (Kendra's Law)                                                                                   | Los Angeles (Laura's Law)                                                                       | Houston (Texas Model)                                                                                                    |
|------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|
| Statute          | Preventive AOT statute; formal court order and treatment plan                                             | Court order available, but petition generally follows intensive outreach efforts                | Broad statutory authority, implementation largely determined locally                                                     |
| Program          | Statewide administrative infrastructure; judicial oversight; extensive monitoring                         | "Outreach-first" model emphasizing voluntary engagement before court intervention               | Cross-system coordination among courts, hospitals, behavioral health providers, housing services, and community agencies |
| Treatment Plan   | ACT, intensive case management, medication management, housing and support services linked to court order | Voluntary service enrollment often encouraged before formal order; intensive community services | Intensive case management, wraparound services, housing supports, care coordination                                      |
| Primary Emphasis | System accountability                                                                                     | Engagement and outreach                                                                         | Implementation and coordination                                                                                          |

# Research evidence for AOT effectiveness

- Randomized trials
  - Bellevue Study (Steadman et al., 2001)
  - Duke Mental Health Study (Swartz et al., 1999; 2001)
  - UK OCTET study (Burns, 2014)
- Large, quasi-experimental evaluations
  - New York AOT studies (Swartz et al., 2010; Swanson et al., 2013)
  - SAMHSA Multistate Evaluation (Johnston et al., 2025)
  - New York AOT evaluation 2 (Jones et al., 2026)
- Evidence reviews
  - RAND study (Ridgely et al. 2000)
  - UK report (Churchill et al., 2007)
  - Cochrane Collaborative report (Kisely et al., 2011)

# Key finding from 1990s Duke Study in NC (N=264)

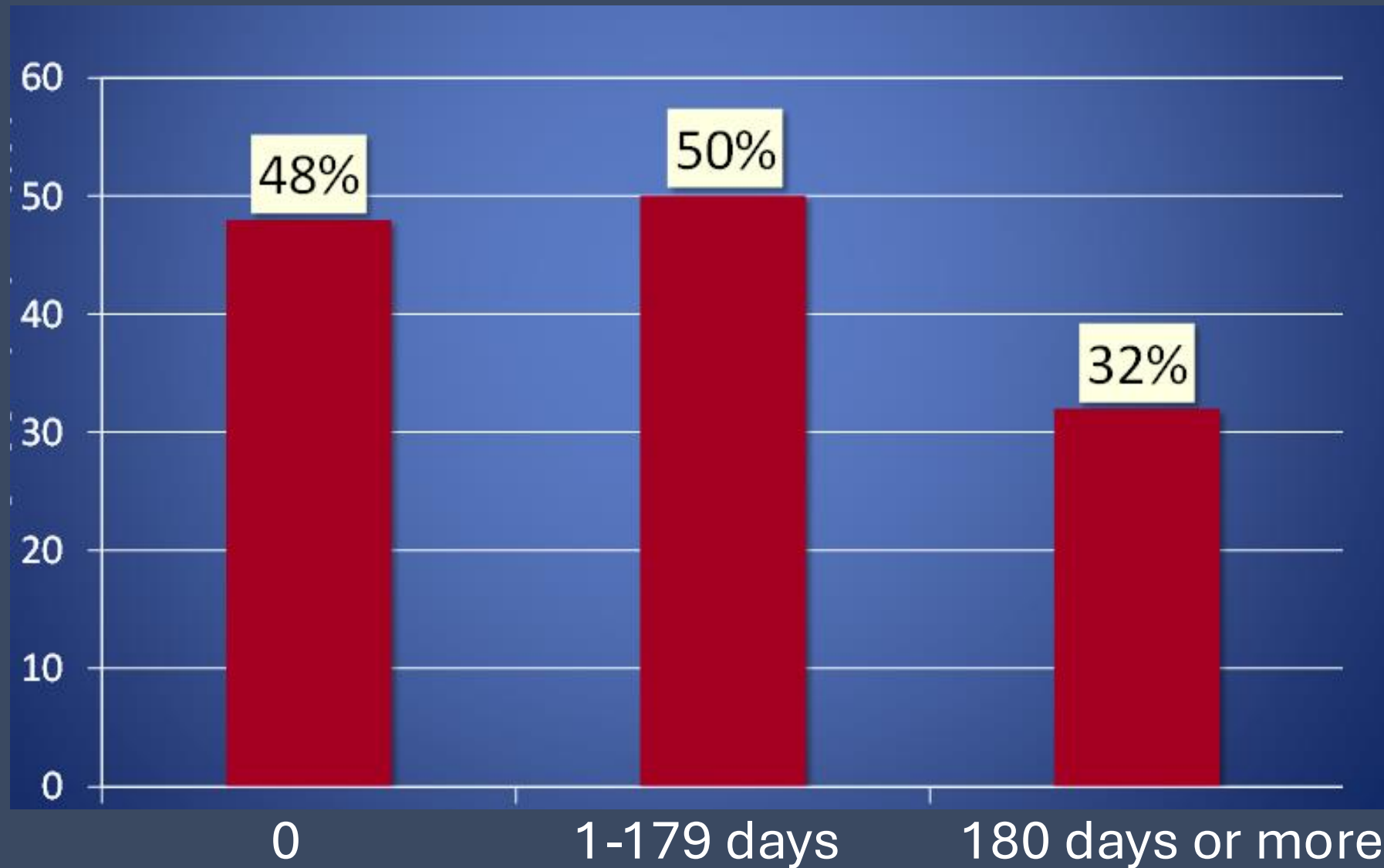
Odds ratio for hospital readmission during  
any given month of 1-year trial

|                 | Odds Ratio | 95% CI        | p value |
|-----------------|------------|---------------|---------|
| Control (n=135) | [1.00]     |               |         |
| OPC (n=129)     | 0.64       | (0.46 – 0.88) | p<0.01  |

Swartz MS, Swanson JW, Wagner HR, Burns BJ, Hiday VA, Borum WR (1999). Can involuntary outpatient commitment reduce hospital recidivism? Findings from a randomized trial in severely mentally ill individuals. *American Journal of Psychiatry*, 156(12), 1968-1975

# Duke Mental Health Study subgroup analysis: Percent of participants rehospitalized in 12 months by days of outpatient commitment received

Percent  
hospitalized



# Important context from the Duke study

- Participating treatment teams agreed to systematically review expiring OPC orders using common renewal criteria.
- Participating hospitals agreed to renew OPC orders for study participants readmitted from the experimental group.
- Renewal decisions were therefore not solely ad hoc judgments about who was "doing well."
- Participants whose OPC orders were renewed had significantly poorer baseline insight into illness and treatment (ITAQ scores) than participants whose orders were not renewed.

## Reference

- Swartz MS, Swanson JW, Wagner HR, Burns BJ, Hiday VA, Borum R. *A randomized controlled trial of outpatient commitment in North Carolina*. Psychiatric Services. 2001;52:325-329.

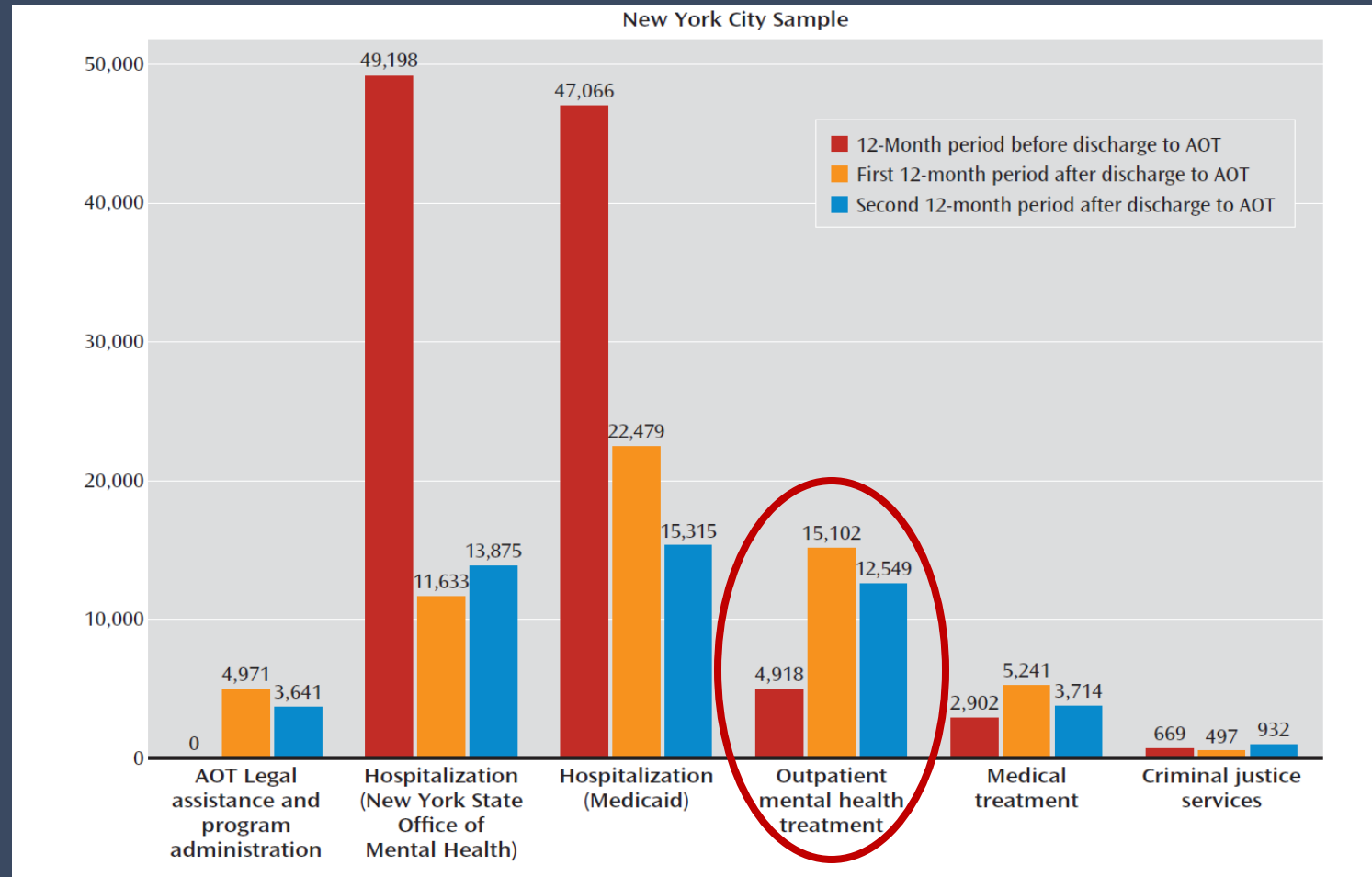
# New York State Assisted Outpatient Treatment (AOT) Evaluation Study

- Legislatively-mandated statewide assessment of “Kendra’s Law” using administrative data and case manager reports (Swartz et al., 2010)
  - Study period: 1999-2007
- Design: Observational study with multivariable analysis of time series data
  - Participants: 3,576 AOT placements who had Medicaid
  - Outcomes: Hospital use, medications, receiving intensive outpatient treatment with case management

# New York State Assisted Outpatient Treatment (AOT) Evaluation Study

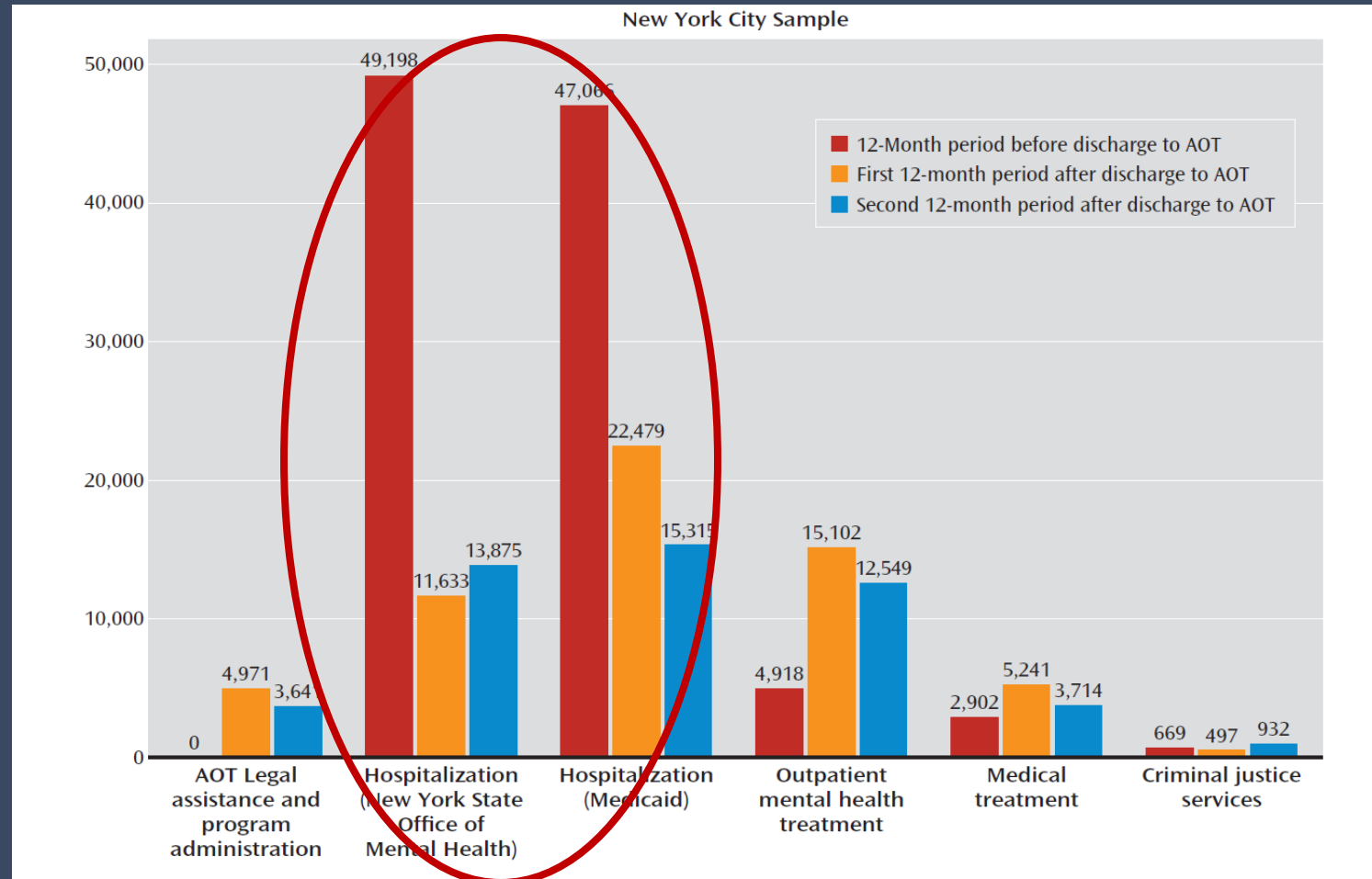
- Case manager data showing reduced hospitalization effect of adding AOT to ACT/ICM:
  - Monthly probability of hospitalization reduced 43% to 57% for participants receiving AOT plus intensive services compared to participants receiving ACT or ICM alone

# Summary costs by category, Assisted Outpatient Treatment (AOT) Period, and Sample



Swanson JW, Swartz MS, Van Dorn RA, Robbins PC, Steadman HJ, McGuire TG, Monahan J (2013). The cost of Assisted Outpatient Commitment: Can it save states money? *American Journal of Psychiatry*, 170:1423-1432.

# Summary costs by category, Assisted Outpatient Treatment (AOT) Period, and Sample



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# SAMHSA Multisite Evaluation: Community and System Outcomes (2025)



6 AOT Programs



392 Participants



Multisite Evaluation

| SOCIAL AND SYSTEM OUTCOMES                                                         |                                  | CHANGE       |
|------------------------------------------------------------------------------------|----------------------------------|--------------|
|   | Psychiatric inpatient episodes   | -41% to -47% |
|   | Psychiatric inpatient nights     | -9 nights    |
|   | Arrests                          | -19% to -24% |
|   | Illicit drug use                 | -14% to -20% |
|  | Homelessness (6-month follow-up) | -12%         |

## AOT BETTER OUTCOMES ASSOCIATED WITH

- Improved appointment adherence
- Improved medication adherence
- Improved psychiatric symptoms



### KEY TAKEAWAY

Consistent with earlier North Carolina and New York findings, duration of the court order and sustained engagement in services were associated with better outcomes.



AOT works best when law, services, and implementation work together.



Johnson KL, Parish WJ, Theis E, Van Dorn RA, Callahan L, Swanson JW, Swartz MS.  
Clinical and Social Functioning Outcomes of Assisted Outpatient Treatment: Results From a Multisite Evaluation.  
*Psychiatric Research and Clinical Practice*. 2025;7:174-181.

# What do AOT recipients themselves think of AOT?

## Subjective quality of life

- Swanson JW, Swartz MS, Elbogen E, Wagner HR, Burns BJ (2003). Effects of involuntary outpatient commitment on subjective quality of life in persons with severe mental illness. *Behavioral Sciences and the Law*, 21, 473-491

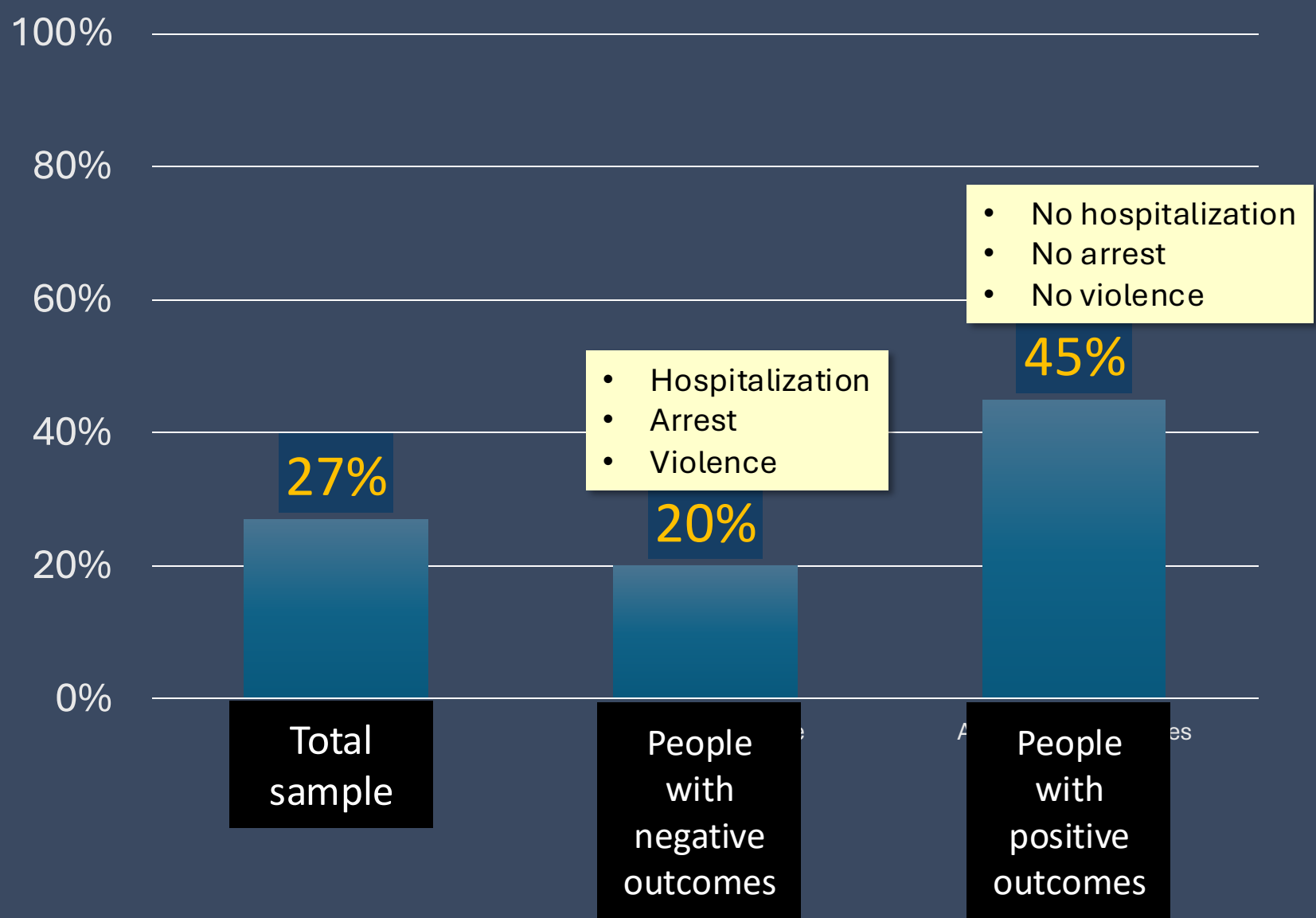
## Endorsement of personal benefit

- Swartz MS, Swanson JW, Monahan J (2003). Endorsement of personal benefit of outpatient commitment among persons with severe mental illness. *Psychology, Public Policy and Law*, 9:1, 70-93

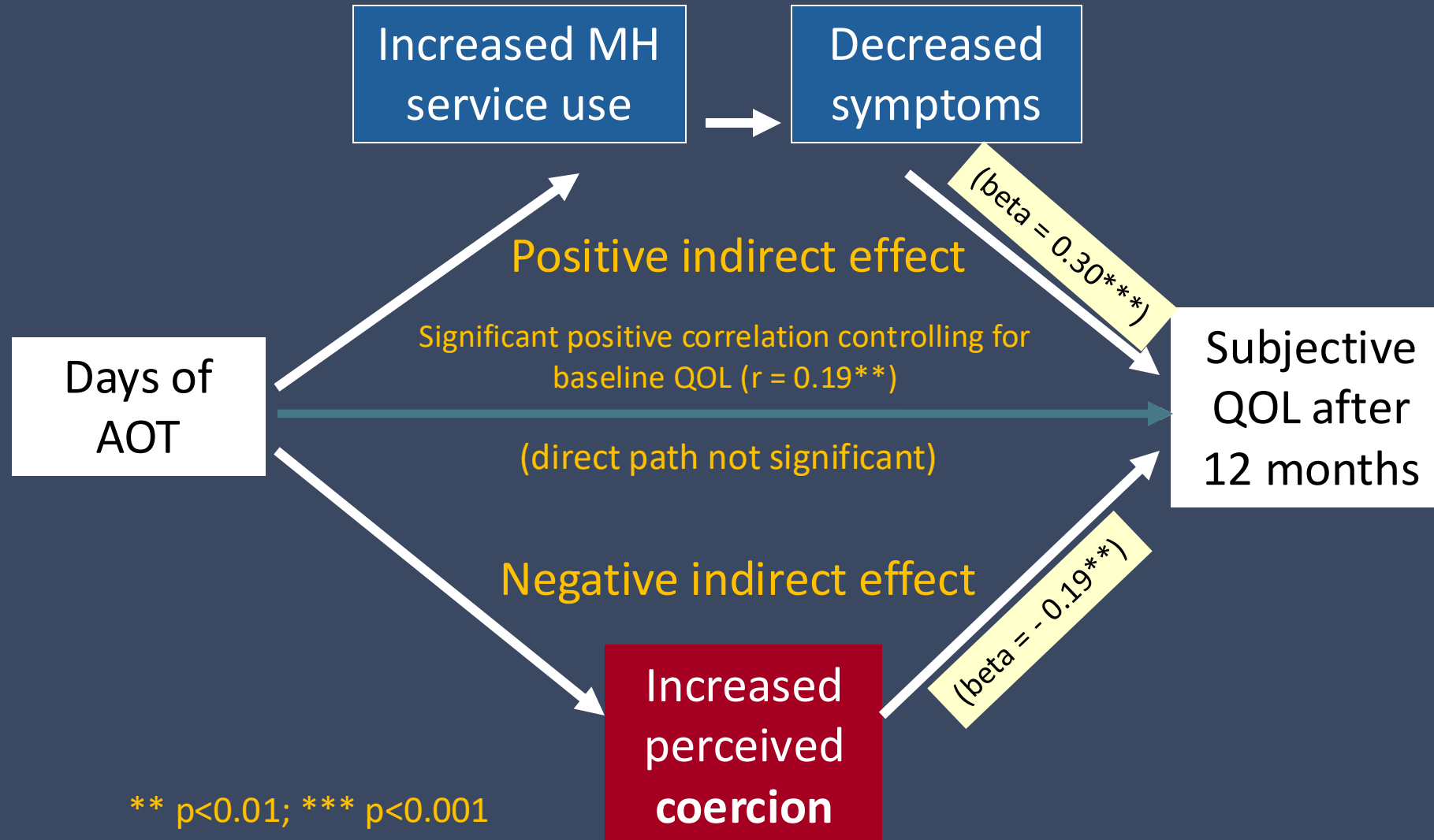
## Formal preference assessments

- Swartz MS, Swanson JW, Hannon MJ, Wagner HR, Burns BJ, Shumway M (2003.) Preference assessments of outpatient commitment for persons with schizophrenia: Views of four stakeholder groups. *American Journal of Psychiatry*, 160, 1139-1146

# Percent of participants endorsing personal benefit of AOT after 12 months



# Direct and indirect effects of AOT on quality of life



Source: Swanson JW, Swartz MS, Elbogen E, Wagner HR, Burns BJ (2003). Effects of involuntary outpatient commitment on subjective quality of life in persons with severe mental illness. *Behavioral Sciences and the Law*, 21, 473-491.

# Is AOT fair?

## Racial disparities in AOT

- Swanson, J., Swartz, M., Van Dorn, R., Monahan, J., McGuire, T., Steadman, H., and Robbins, P. (2009). Racial disparities in involuntary outpatient commitment: Are they real? *Health Affairs*, 28, 816-826.

## “Queue-jumping” in AOT

- Swanson JW, Van Dorn RA, Swartz MS, Cislo AM, Wilder CM, Moser LL, Gilbert AR, McGuire TG (2010). Robbing Peter to pay Paul: Did New York State's outpatient commitment program crowd out voluntary service recipients? *Psychiatric Services* 61, 988-95.



# New York's 2026 independent AOT evaluation

## Headline findings

- AOT participants improved significantly on most measured outcomes.
- Voluntary ACT participants also improved significantly.
- Voluntary ACT participants showed better outcomes on arrest measures.
- Several outcomes showed no significant difference.

## Bottom line

- The study confirms substantial improvement among people receiving intensive services under AOT, but raises new questions about the relative contribution of the court order itself versus their services that accompany it.

# New York's 2026 independent AOT evaluation

## Why the interpretation became controversial

### Authors' interpretation:

- Positive outcomes appear primarily driven by access to intensive services.
- Many participants reported they would have accepted services voluntarily.
- Expanded voluntary pathways might achieve similar outcomes while reducing coercion and procedural harms.

### OMH and AOT supporters:

- Participants under AOT improved substantially.
- AOT often outperformed comparison groups on key outcomes.
- Findings support the continued value of Kendra's Law. [

# New York's 2026 independent AOT evaluation

The real disagreement

Not: "Does AOT work?"

But: "What part of AOT works?"

- the legal order?
- the intensive services?
- both together?
- for whom?

# Ethical disagreement over AOT: Two opposing views of mandating treatment in the community

- “Mandatory treatment for those too ill to recognize they need help is far more humane than our present mandatory non-treatment.”  
-- E. Fuller Torrey
- “Failure to engage people with serious mental illnesses is a service problem, not a legal problem. Outpatient commitment is not a quick-fix that can overcome the inadequacies of under-resourced and under-performing mental health systems. Coercion, even with judicial sanction, is not a substitute for quality services.”  
-- Bazelon Center for Mental Health Law

# APA Position Statement : Key Statements

- Involuntary outpatient commitment, if systematically implemented and resourced, can be a useful tool to promote recovery through a program of intensive outpatient services
  - designed to improve treatment adherence,
  - reduce relapse and re-hospitalization,
  - and decrease the likelihood of dangerous behavior or severe deterioration
  - among a sub-population of patients with severe mental illness.

## APA Position Statement: Key Statements (cont.)

- Studies have shown that involuntary outpatient commitment is most effective:
  - when it includes a range of medication management and psychosocial services equivalent in intensity to those provided in assertive community treatment or intensive case management programs.
- States adopting involuntary outpatient commitment statutes should assure that adequate resources are available to provide such intensive treatment to those under commitment.

# ASSISTED OUTPATIENT TREATMENT IN WASHINGTON STATE

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**October 15, 12:00–1:00 p.m. PT**

**Diane Weiner, LMHC**, will discuss the reasons AOT was implemented in Washington state, the current progress of AOT implementation, and implementation barriers and challenges.



# FEEDBACK

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Post-event surveys are critical, and your feedback helps us to improve and develop future events.

