

November 3rd, 2015

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Delivered before the Oklahoma State Senate regarding Assisted Outpatient Treatment (AOT) and other strategies and tools to engage persons living with mental illness (Senate Interim Study 15-46).

Date: Tuesday, November 3, 2015
Time: 1:00 PM
Location: Room 419-C, State Capitol Building

Testimony

Good afternoon, and thank you for having me today. My name is Erik Vanderlip, and I am a practicing community psychiatrist, a family physician, an academician and health services researcher at the University of Oklahoma School of Community Medicine. Today, I come to you in my experience as a psychiatrist team-member intimately involved in the care of persons served by our University of Oklahoma Integrated Multidisciplinary Program of Assertive Community Treatment (OU IMPACT) – an advanced team of dedicated persons proactively serving some of the most complex individuals with mental illnesses in our community.

I came to this job through a basic desire to help persons less fortunate than I fundamentally feel better – to allow themselves to open up their potential for growth, health, meaningful relationships and contributions to society. Through my journey in seeing and working with thousands of persons over the years in three different states, and national work with the

American Psychiatric Association, I've witnessed first-hand the limitations of our healthcare services to engage populations in their health, who, at times by virtue of their intrinsic illness state, lack the capacity to make informed decisions in their own best interest. I've witnessed needless suffering, as evidence-based treatments that can restore the capacity for thought are neglected in the name of autonomy. Family members and service providers must stand helplessly by until their loved ones and patients begin to teeter on the edge of death or grave disability from isolation, self neglect, unfettered substance use and increasing levels of evidence for the potential of violence to self or others. Our current approach to treatment in these situations is akin to pulling them back over the edge when we finally have evidence that they are falling. This approach takes more effort, time and resources – taxing an already burdened system – and inevitably misses some.

This is particularly vexing given the data on Assisted Outpatient Treatment – AOT – one vital puzzle piece to proactive care and engagement, which has demonstrated returns on investment from cost savings, resources and lives saved. In one study of 331 adults from North Carolina with persistent severe mental illness randomly assigned to AOT vs. usual care, those able to stay with the program for greater than 90 days had nearly 60% reduction in hospitalizations and shorter overall length of hospitalizations (average: 20 days less) than those receiving usual care¹. Cost analyses of AOT programs in Ohio and New York have both yielded reductions of nearly 50% in total costs of care that were sustained even after civil commitment

¹ Swartz, M. S. et al. 2001. “A Randomized Controlled Trial of Outpatient Commitment in North Carolina.” *Psychiatric services (Washington, D.C.)* 52(3):325–29. Retrieved (<http://www.ncbi.nlm.nih.gov/pubmed/11239099>).

was removed, and most of this cost savings was achieved through reductions in hospitalization use². To quote from a large, comprehensive report generated earlier this year on AOT:

Assisted outpatient treatment refers to a program or collection of services in which community-based mental health treatment is delivered under a civil court order to an individual who meets criteria established by the state where the order is issued. Criteria differ by state but are universally limited to at-risk adults with severe mental illness who have a history of cycling through jails, prisons, emergency departments, or hospitals because of symptoms associated with repeated non-adherence to prescribed treatment. Psychosis, paranoia, or delusions typically are among the associated symptoms.

A number of studies have found that court-ordered outpatient treatment improves treatment adherence and engagement in the target population, reducing the incidence of psychiatric emergency/crisis service use, criminal justice involvement, and other consequences of non-treatment. Additionally, because AOT services are provided in home and community-based settings, they offer a less costly and less restrictive alternative to inpatient treatment for persons with severe mental illnesses. As a result, the costs incurred by the high utilization of public services in the eligible population drop significantly when costs are compared prior to, during, and after AOT. Cost savings have been found both in jurisdictions where AOT is administered with new funding in discrete programs and where it is integrated with and delivered through existing mental illness treatment and support services.²

My experience in AOT is deep and personal. Through our IMPACT team, I've witnessed how it can be an essential mechanism of engagement and how the current understanding of the law limits its application. The OU IMPACT team has been in existence for over a decade, providing an evidence-based, cost-effective strategy to deliver community behavioral health services to adults afflicted with severe mental illnesses in the least restrictive settings possible – namely their homes and communities. OU IMPACT is an Assertive Community Treatment (ACT) team,

² Health Management Associates: *State and Community Considerations for Determining the Cost Effectiveness of AOT Services – Final Report*. February 2015.

one of over a dozen across the state. ACT teams are simply a hospital psychiatric treatment team with the ability to engage clients under the care of the team whenever and wherever they need. ACT represents the most intensive form of community-based services delivery anywhere in the healthcare system. The typical caseload of a primarily urban-based 10 person ACT team is around 100 clients – or a ratio of 10 clients to every staff member. ACT provides interdisciplinary behavioral health services, such as psychiatric care (an embedded 0.5 to 1.0 FTE psychiatrist), substance use treatment, counseling and psychiatric rehabilitation, case management and now, thanks to our statewide Health Home efforts, integrated primary care. Referral criteria to ACT teams requires that an individual suffer with a serious mental illness (schizophrenia, schizoaffective disorder, bipolar disorder or treatment resistant depression) *and* they demonstrate an inability to appropriately use existing community mental health services as evidenced by high inpatient psychiatric utilization. The majority of ACT services, in keeping with original models, are performed in the community – seeing clients in their homes or places of work – wherever it is most convenient for the clients. As a consequence of the intense and small caseload and the community-based proactive outreach, ACT teams excel at client engagement, follow-up and care coordination. In spite of this relative glut of resources and expertise, there are still limits to engagement frequently encountered with clients receiving ACT services.

I recall one case in particular. Earlier this year one of the IMPACT team clients began to suffer from a missed dose of a long-acting injectable medication for her psychosis. Active hallucinations, delusions of staff attempting to poison her food and clothing, and irritable mood clouded her mind and made personal interactions challenging. She refused to take any

medications – something she typically did not complain of when on medications – and deteriorated to the point of yelling and cursing staff at the housing complex in which she was staying, threatening to harm the staff of the team and the housing complex, and refusing to engage in care or treatment. This process unfolded over the course of 6 weeks, but without civil commitment to treatment we were forced to wait until we had evidence of imminent danger to hospitalize her and re-initiate medications. The team, having worked with this client for years, had seen this pattern before but was helpless to engage to avert hospitalization. Given that each successive relapse becomes more treatment resistant, she was hospitalized for 5 weeks until she could be safely released back to the community – even with the intensive treatment supports of the OU IMPACT team. Even more unfortunate was that this same pattern had happened approximately one year prior, and AOT was not pursued upon discharge from the hospital at that time (the decision to continue civil commitment is a treatment plan decision undertaken by the hospital team prior to discharge, often not in consultation with outpatient providers).

Recently I received an email regarding the status of another complicated team client in which our team leader explicitly reflected on the fact that the only mechanism of engagement around current treatment was this client’s civil commitment. It is my experience that often clients are grateful for the services of the team after their capacity for decision-making is restored.

In regards to HB 1697, the amendments contained would provide a new avenue to programmatic treatment that already exists but is fundamentally reactive and wasteful by current interpretation of the law. The amendments in HB 1697 would have allowed our team

to engage our client earlier or undergo court-ordered treatments that likely would have avoided a costly five-week hospitalization, significant agitation and further treatment resistance in addition to avoiding the threat of violence to staff at the housing complex and our team.

By allowing for more ability of loved ones and treatment providers to advocate on behalf of others requiring services, we can extend our tools of engagement and significantly impact the lives of persons suffering with mental illnesses who lack capacity to make informed decisions regarding their health and well-being. I very much appreciate the opportunity to share my perspective as a clinician on the benefits of Assisted Outpatient Treatment, and welcome any questions or discussion.

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