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MENTAL HEALTH
COMMISSION
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Current (2020) Members of the Contra Costa County Mental Health Commission

Barbara Serwin, District II (Chair); Leslie May, District V(Vice Chair); Supervisor Diane Burgis, BOS Representative, District III; John Kincaid, District II; Joe Metro, District V; Douglas Dunn, District III; Graham Wiseman, District II; Geri Stern, District I; Gina Swirsding, District I;; Sam Yoshioka, District IV; Katie Lewis, District I; Kira Monterrey, District III; Alana Russaw, District IV; Laura Griffin, District V; Candace Andersen, Alternate BOS Representative for District II

Mental Health Commission (MHC)
Wednesday, August 5th, 2020 ◊ 4:30pm-6:30pm
VIA: Zoom Teleconference:

https://cchealth.zoom.us/j/6094136195
Meeting number: 609 413 6195
Join by phone:
1 646 518 9805 US
Access code: 609 413 6195

I. **Call to Order/Introductions**

II. **Public Comments**

III. **Commissioner Comments**

IV. **Chair Comments/Announcements**

V. **APPROVE July 1, 2020 Meeting Minutes**

VI. **RECEIVE Behavioral Health Services Director's Report, Dr. Suzanne Tavano**

VII. **DISCUSS Assisted Outpatient Treatment (AOT) program topics and events, including a report out of the July 24th AOT workgroup meeting, an Ohio 2019 AOT Symposium presentation, notice of a Treatment Advocacy Center and American Psychiatric Association White Paper, and notice of an upcoming Treatment Advocacy Center consultation with the Contra Costa County AOT program.**

(Agenda Continued on Page Two)

The Contra Costa County Mental Health Commission is appointed by the Board of Supervisors to advise them on all matters related to the county's mental health system, in accordance with mandates set forth in the California State Welfare & Institutions Code, Sections 5604 (a)(1)-5605.5. Any comments or recommendations made by the Mental Health Commission or its individual members do not represent the official position of the county or any of its officers. The Commission is pleased to make special accommodations, if needed, please call ahead at (925) 957-2619 to arrange.

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VIII. CONSIDER motions proposed by the MHC Justice Committee regarding police training and use of force as they relate to police response to mental health crisis calls, Commissioners Geri Stern and Douglas Dunn:

a. Request the Board of Supervisors to recommend to the County Sheriff's Department and the Contra Costa Police Chief's Association to ban outside training that actively encourages police officers to treat every citizen encounter as a threat to be handled by deadly force and to implement instead community-oriented, de-escalation training such as that offered by the Police Executive Research Forum (PERF).

b. Request the Board of Supervisors to recommend to the Sheriff's Department and the Contra Costa Police Chief's Association to establish Uniform Use of Force standards for all 5150 situations following crisis de-escalation training such as that offered by the Police Executive Research Forum (PERF).

IX. DISCUSS needs that people with a serious mental illness have for voting support.

X. Adjourn

The Contra Costa County Mental Health Commission is appointed by the Board of Supervisors to advise them on all matters related to the county's mental health system, in accordance with mandates set forth in the California State Welfare & Institutions Code, Sections 5604 (a)(1)-5605.5. Any comments or recommendations made by the Mental Health Commission or its individual members do not represent the official position of the county or any of its officers. The Commission is pleased to make special accommodations, if needed, please call ahead at (925) 957-2619 to arrange

Highlights from Justice Systems Committee Meeting July 28, 2020

- Calendarize discussion with County Supervisors of the role the Mental Health Commission will have on the following committees, as we should be representing constituents in each area:
  A) Racial Justice Oversight Body
  B) Office of Justice Equity
- Discussion with (?) of the Outpatient Social Services, of the lack of IT equipment with cameras to conduct Zoom meetings with clients/consumers
- Recommend to the Sheriff Department and the Contra Costa Police Chiefs Association:
  A) Ban treating citizen encounters as "the enemy" or a "threat to be handled by deadly force." Implement use of PERF training.
  B) Require the Sheriff Department and the Contra Costa Police Chief's Association to establish 5150 criteria and de-escalation training offered by PERF.
- Look at the White Paper from Teresa Pasquini so we can put it on the August agenda
- Douglas Dunn volunteered to attend Consultation meeting
- Contact the Registrar of Voters to speak to us at the August Executive Committee meeting regarding the loss of voting places; is there a way the severely mentally ill population and unhoused population will be able to receive voting materials and vote if there are address issues; and, can volunteers bring their ballots to the Martinez headquarters after they are completed by this population?
- Contact the Manager of the San Francisco Mobile Crisis Response Team, who work collaboratively with the San Francisco Police Department.

IMPLEMENTING ASSISTED OUTPATIENT TREATMENT: ESSENTIAL ELEMENTS, BUILDING BLOCKS AND TIPS FOR MAXIMIZING RESULTS

OCTOBER 2019

Treatment Advocacy Center:

Brian Stettin, JD, Policy Director
Amy Lukes, MSSA, Project Manager
John Snook, JD, Executive Director
Betsy Johnson, Policy Advisor

Northeast Ohio Medical University:

Mark R. Munetz, MD, Margaret Clark Morgan Endowed Chair of Psychiatry
Deb Hrouda, PhD, Director of Practice Implementation and Evaluation

GRANT STATEMENT
Funding for this initiative was made possible (in part) by Grant No. 1H79SM080818-01 from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

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Jeffrey Geller, MD, Professor of Psychiatry, U. Mass. School of Medicine, Worcester, MA
Hon. Oscar J. Kazen, JD, Probate Judge, Bexar County, TX
Melissa Knopp, JD, Project Manager, Stepping Up Ohio, Hudson, OH
Sgt. Kelly Kruger, Psychiatric Liaison Unit, Police Department, San Francisco, CA
Hon. Cynthia Lu, JD, District Judge, Family Division, Washoe County, NV
Nicholas Schrantz, MA, Probate Monitor, Butler County, OH
Eric Smith, AOT Participant, San Antonio, TX
Hon. Elinore Marsh Stormer, JD, Probate Judge, Summit County, OH

American Psychiatric Association Council on Psychiatry and Law:

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Elizabeth Sinclair, MPH, Director of Research and Public Affairs

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Executive Summary

Assisted Outpatient Treatment (AOT) is the practice of providing community-based mental health treatment under civil court commitment, as a means of: (1) motivating an adult with mental illness who struggles with voluntary treatment adherence to engage fully with their treatment plan; and (2) focusing the attention of treatment providers on the need to work diligently to keep the person engaged in effective treatment.

Studies demonstrate that when adequately funded and carefully implemented, AOT reduces system treatment costs[1] and improves participants' quality of life.[2] But while state laws authorizing AOT are widespread (covering all but three states at the time of this publication), the actual practice of AOT by mental health systems is not. The purpose of this paper is to serve as an informational starting point for those wishing to reap the benefits of AOT implementation in their own communities.

Essential Elements of AOT Programs

In particular, this paper offers guidance in the establishment and operation of formal AOT *programs* on the local level. An AOT program is defined herein by its "essential elements," as a systematic, organized effort to:

1. identify individuals within the service area who appear to be persistently non-adherent with needed treatment for their mental illness and meet criteria for AOT under state law;
2. ensure that whenever such individuals are identified, *the mental health system itself* takes the initiative to gather the required evidence and apply to the court for AOT, rather than rely on community members to do so (although community members should not be impeded from initiating an AOT petition or investigation where permitted by state law);
3. safeguard the due process rights of participants at all stages of AOT proceedings;
4. maintain clear lines of communication between the court and the treatment team, such that the court receives the clinical information it needs to exercise its authority appropriately and the treatment team is able to leverage the court's powers as needed;
5. provide evidence-based treatment services focused on engagement and helping the participant maintain stability and safety in the community;
6. continually evaluate the appropriateness of the participant's treatment plan throughout the AOT period, and make adjustments as warranted;
7. employ specific protocols to respond in the event that an AOT participant falters in maintaining treatment engagement;
8. evaluate each AOT participant at the end of the commitment period to determine whether it is appropriate to seek renewal of the commitment or allow the participant to transition to voluntary care;
9. ensure that upon transitioning out of the program, each participant remains connected to the treatment services they continue to need to maintain stability and safety.

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Setting Up for Success: The Building Blocks of a Sustainable AOT Program

An AOT program encompassing all nine of the "essential elements" takes planning and collaboration among a range of community stakeholders. To simplify this process, this paper identifies ten "Building Blocks" for establishing a new AOT program and maintaining it as a permanent fixture within a local mental health system:

Building Block 1: Secure buy-in from key leadership.

Building Block 2: Reach a shared understanding of the law and the funding landscape.

Building Block 3: Determine the appropriate level of judicial engagement.

Building Block 4: Establish a mechanism for oversight of participants.

Building Block 5: Create written policies, procedures and forms.

Building Block 6: Hold regular stakeholder meetings.

Building Block 7: Print materials to inform participants of rights and responsibilities.

Building Block 8: Educate stakeholders and the community at large.

Building Block 9: Track data for purposes of program evaluation and improvement.

Building Block 10: Mentor neighboring communities.

Maximizing Results: Tips from AOT Practitioners

The Building Blocks offer guidance in developing and sustaining an AOT program but say little about maximizing results in the day-to-day practice of AOT. This is an area sorely in need of study. Although a substantial body of research affirms the effectiveness of particular AOT programs, few of the studies to date have endeavored to measure the impacts of the various policy choices that AOT programs make.

Until such data is available, the Tips from AOT Practitioners offer advice drawn from a wide range of AOT experience. They reflect deeply held views of the practitioners consulted on the policies and practices that allow AOT programs to achieve optimal outcomes for participants.

Tip 1: Foster a culture of respect and compassion.

Tip 2: Deliver comprehensive evidence-based mental health services.

Tip 3: Incorporate a treatment plan into the court order.

Tip 4: Respond appropriately to treatment non-adherence.

Tip 5: Maintain a sufficient duration of commitment for each participant.

Tip 6: Make judicious use of law enforcement partners.

Tip 7: Ensure warm hand-offs upon treatment transitions.

Tip 8: Encourage family and friend engagement.

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Purpose of this document

In 2018, the American Psychiatric Association was awarded a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) to establish a training program to facilitate the national expansion of assisted outpatient treatment (AOT). This paper was developed as a baseline for the content of that training program. It aims to explain what AOT is and how it can benefit communities, provide a view into the variability of AOT programs, and identify practices considered promising for successful systematic implementation.

The contributors to this paper include AOT-involved consumers, practitioners, judges, law enforcement officers, and researchers from across the nation. The AOT programs they represent include those operating in rural, suburban and urban environments; both long-standing and newly implemented programs; and programs employing varying levels of judicial engagement.

Introduction

Adults with severe mental illness (SMI) comprise less than 4% of the United States population.[3] The great majority can be treated effectively with current medications, therapy and community supports. Yet on any given day, as many as half are not receiving treatment.[4] There are multiple reasons for this troubling state of affairs -- some related to a widespread lack of access to treatment services, and others reflecting the difficulty of keeping some people with SMI engaged with treatment. Access barriers are largely attributable to the need for services outweighing the funding available in the public mental health system[5] or from private insurers. Engagement challenges (i.e., the fact that some individuals with SMI are non-adherent to the medications and therapies made available to them) tend to be more complex. Reasons for treatment non-adherence include deficits in cognitive functioning, financial and transportation barriers, lack of community supports and prior negative experiences with medications. For some, an overriding reason for non-treatment is an inability to recognize and acknowledge their illness and/or need for treatment.[6] A persistent lack of awareness of illness is sometimes a manifestation of the illness itself –and is not fully understood clinically, but has been viewed by some as a symptom of brain dysfunction referenced in the neurology literature as "anosognosia."[7]

As represented in the graphic below (Figure 1), the typical pattern for those unable to adhere to treatment is to cycle repeatedly from tenuous stability to psychiatric crisis.

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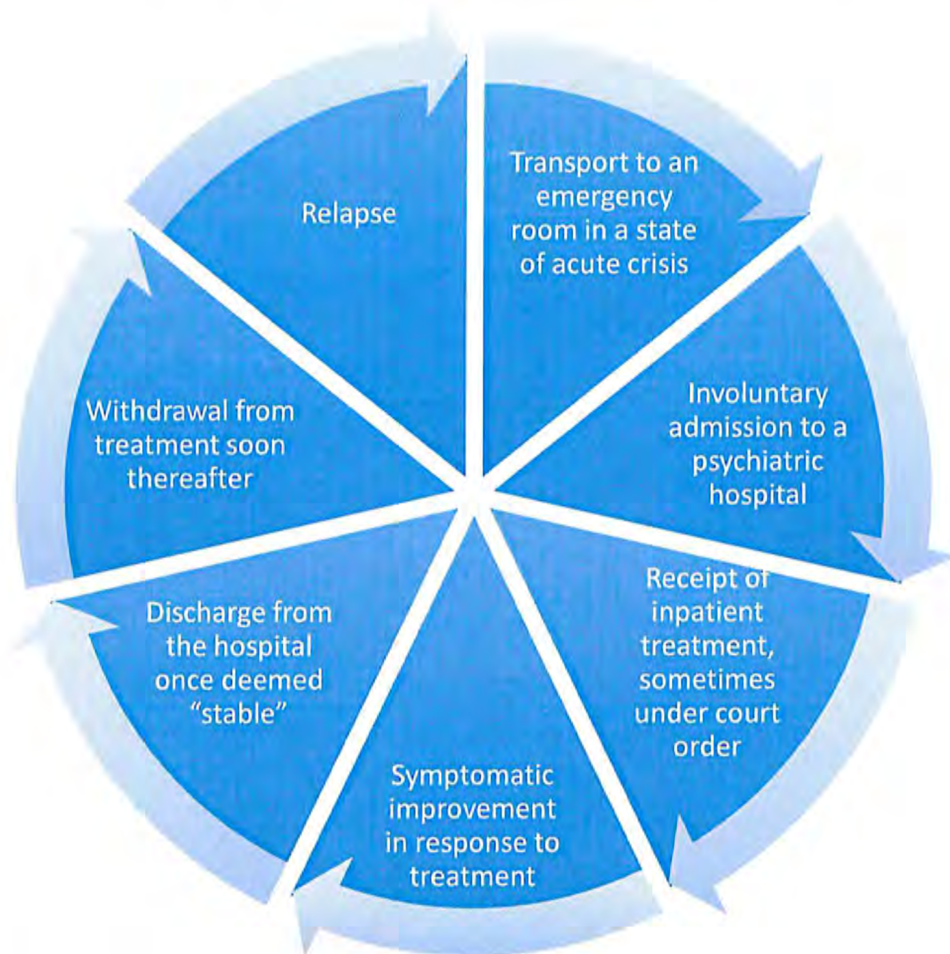
Figure 1. A problematic cycle for individuals unable to adhere to mental health treatment



It is this subset of the universe of people with SMI -- those caught in the mental health system's "revolving door" who are unwilling or unable to voluntarily engage with treatment -- for whom the clinical and legal mechanism of "assisted outpatient treatment" (AOT) has been designed. AOT is community-based mental health treatment provided under civil commitment, authorized by law in 47 states and the District of Columbia at the time of this publication.[i] It leverages the authority of the court to motivate the participant to maintain engagement with treatment providers. After extensive review, the American Psychiatric Association has concluded, with respect to people with SMI who are unlikely to seek or voluntarily adhere to needed treatment, that AOT programs "*have demonstrated their effectiveness when*

[i] The three states lacking AOT laws as of 2019 are Connecticut, Massachusetts and Maryland.

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systematically implemented, linked to intensive outpatient services and prescribed for extended periods of time." [8]

Although AOT is not a panacea for the many challenges currently facing public mental health, it is an essential tool for mental health systems struggling to meet the needs of their most difficult-to-serve patients. Research demonstrates that participation in AOT has a significant effect in preventing re-hospitalization and re-arrest for the limited population it serves, when compared with similar services provided without court involvement.[9]

Implementing AOT, however, is not simply a matter of a judge issuing court orders. Effective implementation requires a concerted collaborative effort by local mental health officials, community-based providers, the court (to varying degrees, depending on the program model), hospitals, consumer and family advocates, and law enforcement.

If all of these stakeholders are willing to make the necessary modest investments of time and resources, the process of establishing an AOT program need not be especially complex or difficult. The rewards may take many forms, including lives saved, recoveries achieved, suffering prevented, budget strain reduced, and access to services expanded.

What is AOT?

AOT -- known by a variety of other names from state to state, including "outpatient civil commitment" and "mandatory outpatient treatment" -- is the practice of providing community-based mental health treatment under civil court commitment, as a means of:

1. motivating an adult with mental illness who struggles with voluntary treatment adherence to engage fully with their treatment plan
2. focusing the attention of treatment providers on the need to work diligently to keep the person engaged in effective treatment.

It is intended to maximize the safety and well-being of both the participant and the public by averting, or at least diminishing, the consequences of treatment non-adherence.

Historically, patients involuntarily committed to hospitals were confined for long periods. In the modern era, civil hospital stays are short and patients are typically discharged when no longer deemed imminently dangerous to self or others. For some individuals with SMI, discharge happens too early in their recovery to allow them to appreciate the need to continue treatment. AOT initially evolved as a hospital discharge-planning tool, utilized with participants considered unlikely to engage with outpatient treatment if allowed complete autonomy.[10]

More recently, AOT has also emerged as a process initiated preventatively for an individual in the community who does not currently meet hospital commitment criteria, but appears to be decompensating due to treatment non-adherence. Some jurisdictions have also found AOT useful in transitioning individuals with mental illness from the criminal justice system to community-based treatment, to prevent both future hospitalization and criminal recidivism.[11]

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An often-overlooked essential feature of AOT is the intended mutuality of responsibility to the court. Just as the court commits the participant to engage with the treatment prescribed, the treatment system is increasingly engaged to provide the necessary services in a timely manner and at a high level of quality. In many states, this takes the form of a specific treatment plan incorporated into the court order, which both participant and providers develop and are expected to honor.

Unlike other legal proceedings involving a court order, AOT is not typically enforced by the threat of contempt of court. Many states explicitly prohibit holding a non-adherent AOT participant in contempt. Even where allowed by law, it is widely understood that punishing a participant for disengaging from treatment would be counter-therapeutic and counter-productive. Instead, the theory behind AOT is simply that a court order can help motivate the participant to regard treatment adherence as a matter of great importance.

However, the preclusion of punishment for a participant's failure to follow the AOT court order should not be confused with a preclusion of *consequence* in such circumstances. The section of this paper on "Maximizing Results" discusses how AOT programs appropriately respond to participant non-adherence.

What Is An AOT *Program*? (The Essential Elements)

At its core, AOT is a legal procedure that may be employed in the case of a specific individual who meets statutory criteria. It would certainly be possible for a local mental health system to think of AOT strictly in these terms, i.e., as a tool to be utilized from time to time, perhaps initiated by a family member or caregiver, when traditional service delivery models have failed.

While this sort of transactional approach to AOT is an option, this paper is targeted to those interested in implementing AOT in a more comprehensive and systematic manner. Research and experience shows that communities can make the greatest possible use of their state AOT laws by establishing a local AOT *program, i.e.,* an organized effort encompassing these essential elements:

1. identify individuals within the service area who appear to be persistently non-adherent with needed treatment for their mental illness and meet criteria for AOT under state law;
2. ensure that whenever such individuals are identified, *the mental health system itself* takes the initiative to gather the required evidence and petition the court for AOT, rather than rely on community members to do so (although community members should not be impeded from initiating an AOT petition or investigation where permitted by state law);[ii]
3. safeguard the due process rights of participants at all stages of AOT proceedings;

[ii] Many states allow family members (and sometimes other private citizens) to petition the court for an AOT order. Having this as a legal option makes AOT possible in a particular case where no program exists in the jurisdiction, or as a fail-safe where an existing program declines or neglects to petition, but it would be impractical to base an AOT program on the expectation of private petitioning. Family members are often reluctant to assume an adversarial posture against their loved one in court, and/or ill-equipped to hire counsel and compile the required evidence. Family members may also have different views than the service providers about an individual's treatment needs.

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4. maintain clear lines of communication between the court and the treatment team, such that the court receives the clinical information it needs to exercise its authority appropriately and the treatment team is able to leverage the court's powers as needed;
5. provide evidence-based treatment services focused on engagement and helping the participant maintain stability and safety in the community;
6. continually evaluate the appropriateness of the participant's treatment plan throughout the AOT period, and make adjustments as warranted;
7. employ specific protocols to respond in the event that an AOT participant falters in maintaining treatment engagement;
8. evaluate each AOT participant at the end of the commitment period to determine whether it is appropriate to seek renewal of the commitment or allow the participant to transition to voluntary care;
9. ensure that upon transitioning out of the program, each participant remains connected to the treatment services they continue to need to maintain stability and safety.

This list of essential elements is intended only to identify the basic functions that together constitute an AOT program. An ostensible AOT program is fundamentally incomplete if it fails to include any of these functions, but that is not to suggest that a program which "checks all the boxes" will necessarily be successful. The "Maximizing Results" section of this paper identifies policies and practices that existing AOT programs have found allow them to perform these essential functions effectively.

Setting Up for Success: The Building Blocks of a Sustainable AOT Program

Through consultation and observation of many AOT programs, from conception to infancy to maturity, ten "Building Blocks" have been identified – the basic steps that community stakeholders can take to establish a new AOT program and maintain it as a permanent fixture within a local mental health system.

The Building Blocks are intended to guide local teams comprised of mental health authorities, providers of hospital and community-based care, and civil court judges in the establishment and day-to-day operation of AOT programs. They are not intended as a "cookie-cutter" guide to AOT implementation nor to suggest that any two counties should practice AOT in exactly the same way.

Accordingly, several of the Building Blocks reflect the need for a culture of collaboration to facilitate informed decision-making and tailoring of an AOT program to account for a particular jurisdiction's laws, population, resource limitations, and stakeholders. For example, New York City's extensively studied AOT program utilizes a limited level of court engagement, largely relying instead on the City Health Department's oversight of the participant's treatment adherence. By contrast, the AOT program in Bexar County, Texas was created at the impetus of the probate court and not surprisingly employs a more judge-centric model.

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The Building Blocks were identified through observation of commonalities (not necessarily universal) among existing AOT programs. Further study is needed to conclusively link these recommendations to improved participant outcomes.

Building Block 1: Secure buy-in from key leadership.

The launch of a new AOT program should begin with bringing together key leaders of the treatment system, the court, and the mental health advocacy community to form an "AOT implementation team" for the purposes of planning and conducting a needs-assessment. The planning process will benefit from these leaders' strong knowledge of the community and its existing resources and challenges. It is especially helpful if one strong leader assumes a primary role as the driving force for AOT implementation.[12] Each of these stakeholders represents a link in the chain of a well-functioning AOT program; failure to secure buy-in from any one could prove fatal to the entire venture.

While support of top organizational leadership is critical, some participants in the initial planning should be middle management staff more directly involved in the day-to-day functioning of the system. Although top leaders may know how things are *supposed* to work, those with direct supervisory roles know how things *actually* work, which is critical to inform the planning.

Ideally, participants include the leadership of:

Public mental health authority

> Most state statutes commit an AOT participant to the state, regional or county mental health authority, although commitment directly to a private provider is sometimes permitted. It is generally the responsibility of the authority to see that transitions between levels of care are effectively managed and that the clinical team is able to help the participant meet the requirements of the court order. This requires adequate staffing, services and program support, to provide regular review of the participants committed to its care.

Civil court judge and other court personnel

> The judge and other court officers are responsible for conducting the judicial proceeding outlined in the statute. They ensure that timelines for notice, hearings and rulings are met. In each case, the judge must determine whether the need for AOT has been established under state law according to the applicable standard of proof. If the participant has difficulty maintaining engagement with treatment, the judge may be called upon to order an emergency evaluation, and/or determine if the participant has come to require commitment to a more restrictive treatment setting.

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Beyond those essential functions, the role of the civil court judge in an AOT program can vary greatly depending on the community and the particular program's design. This is discussed in greater detail in Building Block 3.

Mental health professionals representing community-based, inpatient and psychiatric crisis services

The community-based clinical team's primary goal is to engage the participant, with the ultimate goal of having the participant accept needed treatment, including medication, voluntarily. Once the AOT order is in place, the clinician works with the participant to develop a treatment plan, detailing the services necessary for the participant to maintain stability and achieve their recovery goals while also ensuring accountability to the mental health authority for delivering needed services. At a minimum, these services must include case management and psychiatric care. In coordinating such care, program staff will need a comprehensive understanding of the underlying treatment funding processes in the state, and strong relationships to navigate eligibility and funding concerns.

Once the plan is in place, the treatment team monitors the participant and provides documentation to support any motions to the court that may become necessary to modify or discontinue the AOT order or seek emergency evaluation.

Most participants enter AOT upon hospital discharge.[13] Typically, a hospital psychiatrist provides necessary documentation so the attorney representing the mental health authority can file the affidavit or petition for inpatient treatment. The AOT order may or may not require an additional court hearing post-discharge. The hospital also has an important role in the enforcement of the AOT order. If participant non-adherence leads to deterioration to a point requiring hospitalization, the hospital should be open to receiving the participant back into care.

Crisis services are an important adjunct to the treatment team. Communication between the treatment team and crisis staff will ensure the sharing of clinical information relevant to the request for evaluation and the post-evaluation discharge plan. If the evaluation determines that the participant does not meet criteria for involuntary hospitalization, crisis services staff should nonetheless encourage the participant to accept medication. Without collaboration between crisis service providers and community-based AOT providers, it is difficult to address a participant's treatment non-adherence effectively and comprehensively.

Attorney representing petitioner

In any civil commitment proceeding, an attorney for the petitioner (the party seeking commitment) presents the evidence in support of the petition. Depending upon the practice of the jurisdiction, this function may be performed by an Assistant District Attorney (operating in a civil capacity), county counsel, agency counsel, hospital counsel,

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or an independent attorney under contract. The attorney is also responsible for filing motions, including requests for hearings, requests for evaluation for hospitalization, and motions to continue and discontinue court orders.

Attorney representing respondents

A person for whom civil commitment is sought is known in legal terminology as the "respondent" to the court petition.[iii] Most states require that such respondents receive legal representation. Although a few states permit representation in AOT cases by a non-attorney, this responsibility generally falls to the same legal services provider (such as a public defender's office or non-profit legal services corporation) or pool of private attorneys who represent patients in inpatient commitment proceedings in that jurisdiction.

Respondent's counsel must ensure that their client understands their legal rights and responsibilities before agreeing to participate in AOT. For respondents who exercise their right to contest the AOT petition, counsel must hold the petitioner to its burden of proof in establishing that the respondent meets the statutory AOT eligibility criteria (and in some states, that the proposed treatment plan meets statutory requirements). Respondent's counsel should also ensure their client has ample opportunity to participate in the design and coordination of their AOT treatment plan.

Sheriff and/or police agency

As the law enforcement arm of the court, the sheriff is generally responsible for serving subpoenas and executing "pick up" orders (authorizing an individual's transport to, and temporary detention in, a psychiatric facility for evaluation). In some jurisdictions, a police department may take on these responsibilities. Whoever executes the orders would do well to have specialized knowledge, training and experience in dealing with individuals with mental illness. Where available, Crisis Intervention Team (CIT) officers should be deployed. It has been shown that CIT officers generally have lower rates of use of force in the face of participant resistance than non-CIT trained officers.[14] Efforts to have mental health staff and police partner for such calls could also be helpful in reducing negative outcomes.

Peer mentors and consumer/family advocates

Experience from AOT programs points to the benefit of involving peer support specialists and consumer and family advocates in developing a program that is responsive to the needs of those it serves.

[iii] Throughout this paper we refer to an individual who has been court-ordered to receive AOT services as a "participant." It would be presumptuous to use this term in reference to an individual subject to an unadjudicated AOT petition. We instead refer to such an individual as a "respondent."

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Peer mentors live with mental illness and may prove invaluable in the engagement of participants. Research indicates that using peer mentors can decrease hospitalization for patients hospitalized frequently.[15] They may themselves have experienced AOT and found that it contributed to their recovery.

Consumer advocates can also help energize AOT programs and community education activities and hold programs accountable for the quality of services provided to participants.

Family advocates can educate the community, including other family members, about the availability of AOT and will often help identify gaps in effective implementation.

Building Block 2: Reach a shared understanding of the law and the funding landscape.

Once organized, the AOT stakeholder implementation team should begin its work by thoroughly reviewing the civil commitment laws and regulations in their state to determine the availability of AOT, the legal standards for qualifying an individual to participate, the procedures outlined for obtaining an AOT order, and other guidelines. Before moving ahead, the implementation team must achieve a shared understanding of the law.

An understanding of potential funding streams and the role of managed care, Medicaid and other insurance programs is also critical. The mental health services provided to AOT participants typically rely on funding that the participant is already eligible for, such as Medicaid and/or state or county funds. In cases involving any third-party payer, pre-approval of the components of the AOT treatment plan may also be required. Approval may require additional findings by the clinicians providing the services, such as a finding that the services are medically necessary. In designing the AOT program, the implementation team must be mindful of the underlying treatment funding processes in the state. For AOT participants who are not in the public mental health system, there also may be issues to be considered at the outset as to where and with whom they will receive services and how services will be funded.

Building Block 3: Determine the appropriate level of judicial engagement

The most extensively studied AOT programs, in New York and North Carolina, limit the role of the court to the performance of essential judicial functions. In these programs, judges tend to take their statutory duties seriously (ensuring that procedures are followed and evidentiary burdens are met), but are not relied upon to personally inspire participants to follow their treatment plans. Nationally, other AOT programs place far greater emphasis on the judge as a source of motivation, often utilizing practices that have migrated from problem-solving criminal courts, including mental health courts.[16] This divergence in approach – between programs that

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look to the court strictly for the order itself and those in which active courts collaborate with treatment providers to engage program participants – has been driven by basic differences in how program planners have conceived AOT across jurisdictions. Which path to follow, or whether to choose one in between, is a fundamental question an implementation team must grapple with at an early stage of the planning process.

Under the "active court" model, the judge endeavors at the initial AOT hearing to forge a personal connection with the participant, and sets out expectations for both participant and the treatment team. The court also conducts regular status hearings, or reviews, with the parties during the period of the order.

An AOT program of this type has not yet been the subject of published research, and studies of mental health or drug courts may be inapplicable due to the inherent differences between civil and criminal courts (such as the use of sanctions and rewards in criminal treatment courts) and the nature of the populations served. The ample data currently supporting AOT as an evidence-based practice under certain conditions has been collected entirely from programs that employ a more limited role for the judge.

Active court AOT programs seek to leverage what has come to be known as the "black robe effect." This is the proposition that an AOT participant's respect for the authority of the court, and sense of accountability to the court developed through personal interaction, will provide additional motivation for treatment engagement.

Those who question the efficacy of the active court model suggest that participants may benefit more from additional time spent in treatment services than at status hearings, and believe that over-emphasizing the "black robe effect" is not person-centered and places more valence on the positive impact of the judge over the treatment system than current research supports. It has also been noted that an active court model may be more challenging to implement in jurisdictions where court systems are already overburdened, and may prove more difficult to sustain over time, as particular judges come and go, in that it requires a judge who is empathetic, personally invested in the effort, and skilled in motivating participants.

On the other hand, many stakeholders involved in active-court AOT programs believe strongly that the enhanced role of the judge adds significant value. The impact of an active court on program outcomes is a question in need of empirical study.

In any event, the choice of model for an implementation team need not be binary. For example, in some AOT programs, judges attempt to engage personally with participants at their initial AOT hearings, but do not conduct status hearings during the period of the order. Other programs conduct status hearings with participants who are thought to need such additional oversight, but not with others.

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Building Block 4: Establish a mechanism for oversight of participants.

The public mental health authority is generally responsible for monitoring the status of AOT participants. How exactly this is achieved varies widely among programs.

In New York City, where there are typically more than 1,000 AOT participants citywide on a given day, monitoring is accomplished through four teams (one for each borough, with Brooklyn and Staten Island combined) staffed by the City's Department of Health and Mental Hygiene (DHMH). These teams do not themselves provide services to AOT participants, but communicate regularly with the treatment teams and keep careful track of the progress of each participant.

Like other AOT programs across New York State, the New York City program also receives oversight support from the state's Office of Mental Health (OMH). AOT programs statewide report regularly to their assigned OMH AOT Regional Coordinator on adverse incidents and outreach to participants who cannot be located. All information is captured in a statewide database. This level of oversight likely adds to the documented success of the New York model.

By contrast, in the much smaller jurisdiction of Butler County, Ohio, (pop. 383,000), the role of oversight is delegated to an "AOT monitor" – a single person integral to the AOT program's ability to coordinate participant care, maintain the progress of each participant through the court system, and track outcomes. As in New York City, the Butler County AOT monitor stands apart from both the treatment team and the court. (In other jurisdictions, the monitor's function may be assigned to a treatment team member.) But unlike New York City, Butler County employs an active court AOT program model, which requires the monitor to function as a liaison between the court and the treatment team -- maintaining communication between them and serving as a point of contact for each.

The Butler County AOT monitor's regular duties include tracking all directives from the court, ensuring that needed resources are available to each participant, addressing barriers to service access that participants may encounter, ensuring timely participant evaluations, and generally monitoring whether the services provided are aligned with each participant's needs.

The use of a single monitor is common in Ohio AOT programs, but there is considerable variety in how the position is staffed, depending on available funding and size of the jurisdiction. Some county mental health boards combine AOT oversight with their forensic monitoring role; others contract with outside agencies to provide the service. As AOT implementation expands in Ohio, a statewide AOT monitors group has formed to share best practices and standardize data collection.

Another model to consider is Arizona, where the state's Medicaid program, known as the Arizona Health Care Cost Containment System (AHCCCS), provides oversight and monitoring of

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the entire mental health system, including AOT, to ensure cost containment and effective use of funds. This allows for AOT data collection and oversight without the creation of a separate AOT monitoring structure.

In the end, those seeking to implement AOT on a local level may find that state government support for the monitoring of AOT participants is not available in their own state. In this circumstance, the implementation team must address the need for an adequate oversight function in their program design and budget.

Building Block 5: Create written policies, procedures and forms.

Prior to program launch, implementation team work groups should finalize basic policies and procedures. These may include task flow diagrams, job descriptions, organizational charts, contact lists, sample educational materials, and any anticipated pathways of care, written in a manner understandable to all involved. Locally tailored documents should set forth criteria for AOT as well as processes for involuntary commitment and continuity of treatment during transitions between levels of care and providers or to another jurisdiction.

Forms for participant tracking, assessment and monitoring progress are also vital to successful AOT programs. Similar to a patient record, documentation regarding a participant's progress can tell a story and assist with planning. A well-developed tracking system facilitates routine data collection at critical junctures in time for each participant.[17]

Building Block 6: Hold regular stakeholder meetings.

Once an AOT program is launched, a group representing each of the stakeholders listed in Building Block 1 (but not necessarily the same top leaders who comprised the implementation team) should continue to meet periodically for purposes of program improvement and evaluation. Each meeting agenda should focus on assessing the program's current impact on participant outcomes, ensuring that appropriate individuals are being referred to AOT, and identifying gaps in services. Meetings should be held at least quarterly; greater frequency may be required in the initial years of the program, or to accommodate interest in engagement from community members.

Building Block 7: Print materials to inform participants of rights and responsibilities.

Participants are sometimes committed to AOT during a psychiatric crisis or with great anxiety and confusion about their rights and responsibilities. Some AOT programs have found it helpful to provide participants with a standardized pamphlet or handbook when they join the program. The materials should:

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- be written simply;
- be offered in all languages commonly spoken in the jurisdiction;
- provide a basic explanation of the program and the legal implications of the court order;
- assure participants of their rights to due process and high-quality treatment in conjunction with their responsibilities to adhere, and provide guidance on how to seek redress for perceived rights violations;
- list contact information for key members of the program team.

Building Block 8: Educate stakeholders and the community at large.

Community engagement regarding the potential benefits and the process of AOT should be initiated prior to program launch and repeated periodically. This will deepen stakeholder investment in the success of the program and facilitate identification of proper AOT candidates from all referral sources. Target audiences include:

- Staff at health care facilities and agencies serving potential AOT participants
- Family, caregivers
- National Alliance on Mental Illness (NAMI) affiliates and other advocacy groups
- Law enforcement
- Peer-support services
- Psychiatrists in private practice

Building Block 9: Track data for purposes of program evaluation and improvement.

Tracking tools can assist with measuring success, identifying opportunities for improvement, and performing program cost/benefit analysis. Teams should consider data tracking capacity during the planning stages. It is recommended that participant data continue to be tracked after AOT graduation to measure the sustainability of gains achieved under the program. Key data include:

- Hospitalizations and emergency room / crisis center visits (psychiatric and otherwise)
- Civil commitments
- Criminal justice interactions
- Housing maintenance
- Employment
- Treatment costs

Evaluation of participant and family satisfaction is also important in sustaining the program in the long term. A neutral third party should be engaged to conduct an analysis of program feedback. Areas of evaluation may include:

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- Interactions during court proceedings
- Interactions during treatment team meetings
- Quality of information about the program provided to participants
- Perceptions as to whether the program upheld standards of participant dignity/privacy
- Perceptions of coercion
- Perceived benefits of participation
- Suggestions for improvement

Another critical source of information is program staff. A process should be developed for the regular reporting to the stakeholder group of the staff's unvarnished (and potentially anonymous) opinions and observations.

New York's AOT statute requires robust data collection from each program to the state OMH; the agency makes the latest collected data available on its website. This data measures the effectiveness of AOT and collects demographics of participants. The cost of the reporting infrastructure and data analysis is borne by the state.

California's AOT statute also requires data collection, but has been criticized for not also providing a mechanism for reporting. Roughly 50% of AOT programs in California are collecting data.[18] New Jersey's Department of Human Services collects data on county-level programs throughout the state. The Ohio Department of Mental Health and Addiction Services has developed a data portal in an effort to facilitate and standardize county AOT programs' data collection.

AOT programs must not only collect information, but also *use it*. The tracking and surveys called for above should be utilized to identify deficiencies in the program and should lead to the development and execution of improvements. Developing improvement strategies is a primary purpose of regular stakeholder meetings.

Participant and community needs change over time. Programs must expect to adapt continually to maintain good outcomes.

Building Block 10: Mentor neighboring communities.

Given that AOT requires considerable effort to initiate at the program level, successful AOT programs should assist their neighboring communities in developing their own AOT programs. The incentive for becoming an AOT knowledge resource for others includes a significant element of self-interest. Like everyone else, people under AOT often relocate across county and state lines. If a participant relocates to a nearby county without AOT, the court order cannot be meaningfully transferred and so the leverage of court-ordered treatment would be lost. If a particular AOT program operates as an island, participants who are less willing to engage in

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treatment may move to the neighboring county, which can effectively negate the court order. The goal of maximizing treatment engagement for individuals in need of ongoing supports should be pursued even across geographical boundaries, for the benefit of all.

Establishing a network of operational AOT programs in a region makes each local program that much better equipped to maintain continuity of care. This can only happen over time, as successful early adopters help and serve as models to their nearby counterparts. However, it must be re-emphasized that one community's AOT program might look different from another's. For participants who relocate and transition between AOT programs, the important constant is for court-ordered care to yield maximum treatment engagement.

An AOT program's support for expanded implementation in its region might include:

- Presentations to stakeholder groups in neighboring counties;
- Inviting teams from neighboring counties to visit and observe the program in action;
- Publishing reports touting the program's clinical and fiscal successes;
- Seeking local media coverage of the AOT program;
- Freely sharing court forms, policy documents, budgets, staffing models, etc.

Maximizing Results: Tips from AOT Practitioners

The Building Blocks presented above offer guidance in developing an AOT program and sustaining it over time. They say little, however, about the day-to-day *practice* of AOT – that is, how treatment professionals and courts interact with participants and one another to make the program successful in improving treatment engagement and averting psychiatric crisis, hospitalization and criminalization. This section focuses on policies and practices associated with a wide variety of AOT programs, identified by practitioners (judges, psychiatrists, program directors and staff, et. al.) as critical to improving outcomes for AOT participants.

Caveat to Consider

Much of what is advocated in this section has a basis in research conducted outside the context of an AOT program. Although there is a substantial body of research demonstrating the effectiveness of AOT under certain conditions, studies published to date have generally not endeavored to identify the impact on results of the specific practices followed or policy choices made by AOT programs. In the absence of such data, some of the tips provided herein instead spring from anecdotal views of those with extensive experience in the practice and observation of AOT.[iv]

[iv] Current and former AOT practitioners and stakeholders consulted in the drafting of this paper include: Jennifer Bayer, Director of Continuity of Care, MHMR of Tarrant County, TX.; Latricia Coffey, MD, Psychiatrist, Las Vegas, NV; Robert Davison, LPC, Chief Executive Officer, MHA of Essex and Morris Counties, NJ; Hon. Oscar J. Kazen, JD, Probate Judge, Bexar County, TX.; Melissa Knopp, JD, Project Manager, Stepping Up Ohio; Sgt. Kelly Kruger,

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Tip 1: Foster a culture of respect and compassion.

By far, the most essential practice of any AOT program is to treat participants at all times with respect and compassion. Many participants are ordered to AOT at a time when they do not want to be, after years of negative experience with courts and psychiatric treatment. Quite understandably, they may associate going to court with being "in trouble" and regard treatment as unnecessary and burdensome. Successful AOT programs strive from day one to dispel such associations. They want participants to *welcome* the involvement of the treatment team (and the judge in programs utilizing active courts) in their lives -- to view AOT as a vehicle to a better life.

The obligations of respect and compassion extend to all members of the AOT team who interact with the participant. It begins with the clinical team members who work with the participant to develop the treatment plan. To the greatest extent possible, the plan should reflect the participant's own views of what treatments are most effective, and be oriented towards helping the participant achieve their own personal life goals. Practices such as shared and supported decision-making and motivational interviewing promote participant engagement by affirming the participant's choices in treatment.[19] The enhanced relationship between participant and provider is instrumental in achieving treatment adherence both while AOT is in effect and after it ends.

It is equally critical that participants receive compassion and respect from the court. This is especially true for programs that employ an active court model, relying on the judge or other court official meeting repeatedly with the participant over a series of status conferences. Participants are well-served by judges who take time to get to know and establish rapport with them, convey a strong and sincere concern for their quality of care and quality of life, take joy in and congratulate them for their success, know their life goals and support their pursuit of them, and take their complaints and concerns seriously.

For both the treatment team and the court, the principles of "therapeutic jurisprudence" are key to forging the bonds of trust with the AOT participant that motivate treatment engagement. Therapeutic jurisprudence is a legal movement rooted in the view that the law should be used to promote the mental and physical well-being of the people it affects. Research on AOT has found a strong connection between the practice of therapeutic jurisprudence and participant satisfaction.[20]

This echoes broader mental health research finding that levels of perceived coercion do not necessarily correlate with being court-ordered to care.[21] An individual who is ostensibly receiving care voluntarily may nonetheless feel high levels of coercion if they feel the system is unfair or has ignored their wants and needs; conversely, an individual under civil commitment

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Psychiatric Liaison Unit, San Francisco Police Department; Hon. Cynthia Lu, JD, Probate Judge, Washoe County, NV.; Nicholas Schrantz, MA, Probate Monitor, Butler County, OH; Eric Smith, Former AOT Participant, Bexar County TX; Hon. Elinore Marsh Stormer, JD, Probate Judge, Summit County, OH.

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may perceive no coercion if they believe they have been treated with dignity and respect by caregivers throughout the commitment process.

Tip 2: Deliver comprehensive evidence-based mental health services.

It should come as no revelation that quality treatment is essential to effective AOT. Every AOT treatment plan must be tailored to the specific individual needs of the participant, which may vary greatly in intensity.

A common misconception is that every AOT participant requires service under the comprehensive model known as "Assertive Community Treatment" (ACT). The severity of clinical need of many AOT participants may make them candidates for ACT, but there is no research to suggest that such services are always necessary for those who meet AOT criteria. There is, however, research to support the efficacy of AOT with varying levels of service intensity, including other forms of case management such as Intensive Case Management (ICM).[22, 23] Determinations of level of care should be made case-by-case, based on clinical needs, exactly as they would be in the absence of AOT.

AOT case managers must carry caseloads small enough to allow significant, frequent contact with each participant. The case manager, working with the treating psychiatrist and other appropriate team members, must monitor the participant's adherence to treatment and observe for behavior changes similar to previous behavior that preceded a psychiatric crisis. An AOT program must maintain a clear understanding as to who is responsible for monitoring each AOT participant, and when and how to take action if warranted.

While medications and case management are at the heart of most AOT treatment plans, participants will ideally have access to other evidence-based treatments such as Individual Placement and Support (IPS), Integrated Dual Disorder Treatment (IDDT) and Cognitive Behavioral Therapy for Psychosis (CBT-p), to name a few.

This is not to say that a mental health system must have all these services in place before implementing AOT. The research associating AOT with improved treatment outcomes has examined programs with relatively robust treatment services in place, but does not identify any particular treatment service as essential to such outcomes. Until such data emerges from future study, it is reasonable to assume that at a minimum, a typical treatment plan should include case management, medication management and psychiatry.[24]

Tip 3: Incorporate a treatment plan into the court order.

Some state AOT laws require a treatment plan to be presented to the court and incorporated into the AOT order, such that the order becomes not just a general directive to adhere to prescribed treatment, but a *specific* directive to adhere to the particular set of treatment services that have been identified as necessary to allow the participant to live safely in the community. Even in states that do not require this under law, there is no barrier to the treatment team presenting a treatment plan to the court and requesting its incorporation into the order. Many

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programs find this process helpful as a means of defining expectations among the participant, providers and the court.

The treatment plan should be a basic outline of services to be provided, the provider responsible for each such service and the participant's responsibilities for adherence. It should be written so that minor changes recommended by the treatment team will not require court approval. For example, if the plan includes medication, specific brands or dosages should not be listed, as these frequently require changes over the course of a participant's treatment.

As a routine, standardized practice, the treatment plan should be developed in collaboration with the AOT participant. As stated in American Psychiatric Association guidelines, "patients and their families should be consulted about their treatment preferences and should be provided with a copy of the involuntary outpatient commitment plan, so that they will be aware of the conditions to which the patient will be expected to adhere."[25] This is essential to maximize the participant's sense of self-direction and personal investment in the plan.

Of course, it will not always be possible to submit a plan to the court which the participant fully agrees with. A participant's challenge to the appropriateness or necessity of a particular aspect of the treatment plan must be taken seriously (and in some states will require court consideration if presented as a motion to modify the order), but the court should maintain a general reluctance to interfere with clinical determinations of the participant's needs.

Tip 4: Respond appropriately to treatment non-adherence.

It is not unusual or alarming for an AOT participant to miss one or more scheduled appointments, or even to stop taking prescribed medication. This alone is not reason to revoke outpatient status. However, if such non-adherence results in a change in behavior and if that behavior change is consistent with an established pattern of psychiatric deterioration which has historically led to re-hospitalization, the treatment team should never wait for a full decompensation to occur.

Before requesting that law enforcement detain the participant for evaluation to address detected non-adherence (as AOT court orders typically permit), the treatment team should endeavor to assess the participant, either in person in the community, and/or through any collateral information available. If the participant is not clearly demonstrating changes in behavior consistent with previous signs or symptoms of decompensation, the team should review the case to determine new engagement strategies and modify the treatment plan accordingly.

However, if the treatment team concludes that a more restrictive level of care must be considered, it should not hesitate to take action. The absence of sanctions in the AOT model should not be mistaken for an absence of consequence. In one study that found an AOT program ineffective, a primary explanation proffered by the authors was that the program had failed to establish a mechanism to respond meaningfully to substantial non-adherence.[26]

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AOT programs tend to have similar legal mechanisms available under state law to address non-adherence. Typically, after good faith efforts to solicit adherence have failed and the treatment team has become concerned that the participant may be in need of hospital care or other intervention, the treatment team notifies the court and requests an ex parte order for emergency evaluation. In some states, a judicial pick-up order is not necessary because state law authorizes a clinician to order the pick-up. Regardless of the outcome of this evaluation, if status hearings are a part of the AOT program model, the participant should be brought back to court for a status hearing to stress the importance of adherence to the court order.

Many AOT participants with histories of medication non-adherence are prescribed long-acting injectable antipsychotics (LAIs) when clinically appropriate. If the participant is late or has missed one or more doses of an LAI, they may be willing to resume such medication. The evaluating physician will need to determine if this is a safe and acceptable option. In most states the AOT order does not authorize the physical holding of a patient to administer an injection; state laws authorizing restraint and the involuntary administration of medication under certain circumstances must not be conflated with AOT laws.

Ultimately, an AOT participant cannot be committed to hospital care unless found to meet the state's ordinary criteria for inpatient commitment. In many cases of AOT non-adherence, this standard will not have been reached and the participant will have a right to return to the community. However, many AOT programs have found in these situations that the short-term hold followed swiftly by a court appearance, and the opportunity it affords to reconnect the participant with the treatment team and court, is usually effective in getting the participant re-engaged with treatment.

Tip 5: Maintain a sufficient duration of commitment for each participant.

The length of time that a participant spends on AOT is a policy matter for which research informs best practices. In North Carolina, a randomized controlled trial found that AOT was effective in achieving its intended outcomes only if continued for a period of 6 months or more.[27] In New York, a study examining the sustainability of the gains participants had achieved while under AOT, one year after graduation, yielded an unexpected finding. For participants who had received AOT for only the six months of the initial order period, the sustainability of clinical gains a year after graduation was found to depend on whether the participant had remained enrolled in ACT after leaving AOT: those who continued in ACT tended to sustain their gains, while those who did not receive ACT tended to fall back.[v] However, participants whose court orders had been renewed and kept in effect beyond the initial six months were found to have largely sustained their clinical gains, *regardless of whether they had continued in ACT.*[28]

[v] This study did not compare ACT with other intensive services, so should not be taken to indicate that ACT itself is the proper level of care at the end of an AOT period of six months or less.

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More research is needed on the question of the optimal period of an AOT order given the variations across regions. That said, for most AOT participants, it seems clear from current data that the length of time in the program matters. This should not be surprising. The goal of AOT is to help a participant engage with the treatment team, develop therapeutic relationships and come to recognize the improvements to their quality of life. For a participant with a long history of disengagement, the process of gaining trust in the treatment system and finding value in treatment requires sufficient time to take root.

As a guideline, AOT programs should seek to keep each participant under AOT for more than six months. The maximum length of each court order is a matter of state law and varies widely. Some states only permit an AOT order of 90 days or less. However, in nearly all states, AOT orders may be renewed an indefinite number of times, so long as the participant continues to meet statutory criteria. Clinical findings as to readiness, not the maximum court order length under state law, should drive a decision on whether to allow the AOT period to lapse (or to discharge someone from AOT prior to the expiration of the court order, which is also permissible in some states).

The court order should not be allowed to lapse if the evaluating clinician lacks confidence that the participant has come to understand the benefits of maintaining consistent treatment engagement and is equipped to keep it going without the court's involvement. A program will inevitably encounter participants who succeed under AOT in avoiding negative outcomes, but whose baseline conditions prevent progress in recognizing their need for treatment. In these cases, to stop AOT prematurely might consign the participant to fall back into a pattern of non-engagement. It is quite appropriate, and should not be regarded as a system failure, to keep such a participant in AOT as long as necessary through a series of court order renewals. Every effort, however, should be made to improve the participant's functioning and voluntary engagement in order to facilitate discharge from AOT. As with involuntary hospital commitments, the goal should be to return the participant to maximum level of autonomy appropriate for their abilities.

Tip 6: Make judicious use of law enforcement partners.

The American Psychiatric Association (APA) recommends that AOT court orders include language to explicitly authorize a clinician to direct a law enforcement officer to pick up a participant who may be decompensating and transport them to a facility for evaluation.[29] This facilitates rapid response to non-adherence, which is essential to effective practice of AOT. New York's AOT statute grants this authority directly to physicians, allowing the treatment team to effectuate a pick-up when deemed clinically necessary without having to obtain a new court order.

It is also true that every encounter between an armed officer and a vulnerable person with mental illness carries a risk of exacerbating the person's distress or an even more tragic result. For this reason, AOT programs should avoid overreliance on law enforcement partners. When

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participants begin to show behavior changes that raise concerns of a relapse, a program should do everything it can to address the situation with increased clinical supports. Involuntary evaluation requiring law enforcement transportation should be the last resort.

There are other opportunities for law enforcement partners to add value to AOT programs, particularly in jurisdictions where police or sheriffs deploy Crisis Intervention Team (CIT) officers. These are officers who have been trained to have special sensitivity to the needs and behaviors of people with mental illness, who make it their business to know those in the community who struggle and help them avoid criminalization. It is particularly important for CIT officers to be aware that a known individual is participating in AOT, so that they may alert the treatment team if they observe behaviors suggesting treatment disengagement.

Accordingly, AOT programs and courts should consider developing mechanisms to report active AOT orders to law enforcement partners. Some stakeholders may be uncomfortable with a practice of routine reporting out of concern that it runs afoul of the "Privacy Rule" of the federal Health Insurance Portability and Accountability Act (HIPAA), which generally bars disclosure of protected health information without a patient's consent. This may be of less concern in states where civil commitment proceedings are conducted in open court and considered a matter of open record.

In states where civil commitment is considered a confidential proceeding, a program should consider whether HIPAA concerns may be allayed by having the court specifically call for the disclosure to a particular law enforcement officer in the body of the AOT court order. A regulation promulgated by the U.S. Department of Health and Human Services establishes an explicit exception to the Privacy Rule, permitting disclosure of protected health information "for a law enforcement purpose to a law enforcement official ... in compliance with and as limited by the relevant requirements of ... a court order[.]" [30]

An important caveat here is that many states have medical privacy laws of their own, which may go beyond HIPAA in restricting access to health information. An AOT program should consult counsel before setting policy on disclosures to law enforcement.

Tip 7: Ensure warm hand-offs upon treatment transitions.

AOT participants commonly transition between levels of care or even institutions during the period of commitment. It is incumbent upon the treatment team to ensure that when these changes happen, new providers are well informed of the participant's treatment plan, especially the medications and any issues pertaining to risk of harm to self or others. If the participant is hospitalized, the outpatient treatment team should play an integral role in discharge planning. Visits to the hospital may provide opportunities for engagement as the case manager and participant align towards the goal of discharge.

If the participant ends up arrested and jailed for a criminal matter, the case manager should contact the jail's healthcare staff to see if the jail will be able to offer medications prescribed in

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the community and if the participant is willing to accept them. Continuation of medication should be a top priority. Communication with the jail and possibly the participant's criminal defense attorney is especially critical if the offense is a misdemeanor, since the participant's release might occur at any time. As soon as possible after release, the treatment team should establish contact to evaluate the participant and see that medication is continued immediately.

The ultimate treatment transition occurs when the participant is ready to leave AOT and engage in voluntary treatment. If this requires transition to a new provider, a joint meeting among the participant, the case manager and the new provider is beneficial to maintain continuity of care.

A participant's decision to relocate outside the jurisdiction of the AOT program is always a potential contingency. If the participant moves to another state, or to a county within the same state that does not have an AOT program, the court should consider terminating the order once the participant's relocation has been verified. However, if the participant moves to another county within the same state that *does* practice AOT, it will usually be possible to transfer the court order to the new county of residence and arrange for the program in the new county to assume responsibility for treatment provision.

Regardless of whether AOT will continue in the new jurisdiction of residence, the treating agency should work with the participant to arrange for continued care. Whenever possible, this should include a "warm hand-off" with intake appointments and seamless continuation of medication.

Tip 8: Encourage family and friend engagement.

With the participant's consent, including a family member or friend in the AOT process can promote positive outcomes.[31] Families and other members of the participant's support network can help explain the AOT program and emphasize the importance of treatment adherence. Having a supportive person in the courtroom can also help ease the participant's anxiety about appearing before a judge. And in programs employing an active court model, it provides the judge with another important perspective on whether the participant is making real progress towards their life goals.

Family members and friends can be helpful contacts for the treatment team because they are often the first to notice signs of psychiatric deterioration and can bring concerns to the attention of the case manager before the situation becomes a crisis. Just as importantly, they tend to notice and appreciate a participant's improvements and can provide positive reinforcement.

An added bonus of including family members and friends in the AOT process is that they can become some of the best advocates for the AOT program itself. Grateful family members often want to give back by sharing their experience with others and raising awareness of the program. It also provides program leaders with valuable feedback that can lead to program improvements.

The participant must be permitted to choose the family member(s) or friend(s) they find most helpful. Some might in fact undermine treatment adherence if their goals do not align with the

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participant's or if they are not convinced of medication's effectiveness in treating mental illness.[32] If the influence of such a family member or friend seems unavoidable, the treatment team should consider whether outreach to them would be a worthwhile intervention.

Conclusion

In its optimal form, AOT is practiced through a carefully planned program requiring close collaboration between the mental health system and the civil court. An AOT program can have positive impacts on both the people it serves and the greater community. Increased treatment adherence resulting from AOT translates to reduced use of hospitals, crisis services and jails; improved quality of life for individuals with SMI; increased public and participant safety; and overall reduced costs to society. AOT should be one of the tools available in every community to meet the needs of the small subset of individuals with mental illness who demonstrate difficulty with voluntary treatment adherence.

As noted repeatedly above, the research on specific practices in AOT implementation is lacking. It is recommended that further research attempt to answer important questions such as:

- Does a participant's personal interaction with the judge at the initial hearing and/or subsequent status conferences improve AOT outcomes if all other treatment interventions are equal?
- Which services are essential to AOT?
- What guidance can be offered to community mental health to maximize treatment engagement and limit the need for AOT orders, and what guidance can be given to AOT programs in transitioning participants to voluntary services?
- What role may AOT play for criminal justice-involved individuals?
- What are the most effective implementation approaches to AOT?
- How do funding and management of funding sources affect the operations of AOT programs?

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Voting by People with Mental Illness

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While voting laws trend toward universal suffrage, there are still some who encounter barriers in exercising the right to vote. Citizens with mental illness or cognitive and emotional impairments are especially vulnerable to exclusion from the political process, contributing to disenfranchisement. Facilitating the process for hospitalized patients to vote can increase their agency and amplify their voices and concerns. Through exercising their civic responsibility, psychiatric patients can have a hand in shaping a community in which they feel valued. In this article we will review the literature about voting, the current voting laws, and our lessons learned facilitating voting by proxy at Cambridge Hospital in the 2016 U.S. Presidential election, as well as the obstacles encountered. We will also propose methods to improve implementation of voting by hospitalized psychiatric patients for upcoming elections.

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Voting is a defining virtue of American society. For citizens, voting is a fundamental right and part of the foundation of our democracy.[1] The right to freely elect government representation affirms the importance of each individual's contribution to the social fabric and order of our society. While the U.S. Constitution protects this virtue, the right to vote has often conflicted with the eligibility to vote, an authority defined by each state. These conflicts have resulted in four constitutional amendments, the 15th, 19th, 24th, and 26th, which affirm that no citizen should be denied the right to vote on the basis of race, gender, ability to pay poll taxes, or age, respectively. While these amendments have progressively expanded access to the polls, they do not specifically grant the right to vote to those with mental illness or cognitive and emotional impairments. Misunderstanding and ignorance of voting laws can put this population at risk of being barred from fully joining the fabric of our society by being excluded from the democratic process. In other words, these citizens are excluded from the full rights of citizenship. Citizenship refers to the civil, political, and social rights and responsibilities each citizen has in a democratic society.[2] People living with mental illness are often stigmatized and stripped of the benefits of full citizenship due to the perception of mental incompetence.[2] "Citizenship-oriented care" is a new concept in mental health that goes beyond clinical and personal models of recovery to recognize the impact of discrimination and disenfranchisement in populations with mental illness.[3] It also promotes social inclusion by placing an "emphasis on the person's rightful place in society" (Ref. 3, p 20). A citizenship-oriented approach to recovery is rooted in activism and social justice. It calls for "socioeconomic and political efforts and a reaching across boundaries of disability and other barriers... to recover [the] right to full and valued participation in society" (Ref. 3, p 20).

Federal Law

States have the authority to establish voting qualifications, as long as these qualifications are in line with federal regulations.[4] Qualifications may be related to residency,[5] citizenship,[6] criminal record,[7] or mental capacity.[8] In the past, states have used this power to prevent "undesirable" groups from voting by enact-

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ing laws that established additional barriers to casting ballots, which in reaction prompted the enactment of federal laws. These federal laws include the Voting Rights Act, the National Voter Registration Act, the Americans with Disabilities Act, and the Help America Vote Act.

The Voting Rights Act (VRA) of 1965, which was enacted to address the obstacles that undermined the right of African-Americans to vote, was later expanded to require voters with disabilities to be allowed to receive assistance from a person of their choice.[9] It also prohibits conditioning the right to vote on passing a test.[10] The first provision of the act ensures that individuals with disabilities can appoint someone to assist them with voting, but does not clearly define what is meant by assistance. The second provision protects people with mental disabilities from unjust discrimination based on the ability to complete a test that is not required of all voters.[10]

The National Voter Registration Act (NVRA) of 1993 requires voter registration materials to be available in all state offices that offer services to people with disabilities.[11] These offices must also provide assistance in filling out and submitting the forms.[12] As mentioned above, the VRA requires voting standards to be applied equally to all voters. While the NVRA allows states to remove registered voters based on "mental incapacity," the basis for removal must be in line with the VRA, which prevents states from treating individuals with mental disabilities differently from the general voting population.[13] It is important to keep in mind that mental illness and mental disability are not the same as mental incapacity, as the latter is a legal determination made by a judge. For example, a person with a mental illness may have a sudden head injury that results in an inability to perform the minimum requirements of voting, and could be determined "mentally incapacitated" to vote. However, in this case the person is not "mentally incapacitated" due to a mental illness, and can regain the capacity to vote if the head injury sequelae resolve.

The Americans with Disabilities Act (ADA) provides the most robust protection for people with disabilities.[14] The Act defines disability as "[a] physical or mental impairment that substantially limits one or more major life activities" (Ref. 14, section 3). The ADA bars discrimination on the basis of disability in all services, programs, and activities provided to the public by state and local governments. In terms of voting rights, Title II of the ADA requires that both state and public governments ensure that people with disabilities, including those under guardianship,[15] have an equal opportunity to vote.[14] Title III of the of the ADA prohibits the establishment of practices that would prevent individuals from voting based on residence in a hospital, group home, or developmental disabilities center.[14] The U.S. Department of Justice further stated that the ADA "provisions apply to all aspects of voting, including voter registration, site selection, and the casting of ballots, whether on Election Day or during an early voting process" (Ref. 16, p 1).

The Help America Vote Act of 2002 (HAVA), which was passed after the 2000 Presidential election in wake of the controversy surrounding numerous disqualified ballots, made significant reforms in the voting process, including improving access to voting for the disabled.[17] HAVA includes a nonspecific accessibility mandate that states "[voting systems] shall be accessible for individuals with disabilities" (Ref. 17, section 271). This has been interpreted to include people with mental disabilities with the capacity to vote.[18] The HAVA included provisions to ensure that voters, including those with disabilities, had access to a secret and independent ballot, meaning that they could submit their vote in private.[17] Therefore, this law ensures that individuals with mental disabilities have equal access to registration and voting and prevents states from implementing overly stringent voter competency standards.

These four acts work together on the federal level to ensure that individuals with mental disabilities have equal opportunity and access to vote with necessary assistance, without being discriminated against by the enactment of regulations that do not apply to the entire voter population. While each state establishes its own voting qualifications, their rules and regulations must abide by these federal laws.[4]

State Law Overview

Most states have mental health–related restrictions on the right to vote, with difficult-to-interpret restrictions that vary from state to state.[19] For example, half of the states disenfranchise those with court-determined incapacity.[19] Eleven states have laws with unclear terms such as "idiots," "insane persons," and "*non compos mentis*," which Appelbaum argued "lead to a profound, and arguably unconstitutional, vagueness about whom they are intended to exclude"

(Ref. 20, p 849). Ten states, including Massachusetts, have laws that bar voting by individuals who are "under guardianship" and have been found by a court to lack the capacity to vote.[19]

International Considerations

The right of citizens to vote in public elections and the duty of states to protect these rights are defined by numerous international treaties, but the laws that uphold these rights vary across countries. The United Nations' International Covenant on Civil and Political Rights has 169 cosignatory parties and protects the right of every citizen to vote "without unreasonable restrictions" (Ref. 21, p 179). Of United Nations Member States with laws or constitutional provisions related to the right to vote for individuals with mental illness, Bhugra found that over one third denied the right to vote to anyone with a mental health disorder, without qualifier.[22] Only 21 Member States placed no restriction on the right to vote for citizens with a mental health diagnosis. The remainder placed some restrictions on voting rights for persons with mental health impairments, leading to variable degrees of disenfranchisement around the globe. For example, the New Zealand Electoral Act of 1993 protects the voting rights for hospitalized patients with mental health disorders or intellectual disabilities, with few exceptions.[23] Australian laws, conversely, do not clearly protect the rights of psychiatric hospital patients, leading to variable application of federal provisions.[24] In Western Australia, psychiatrists can advocate to suspend the voting rights of patients they deem incapable of voting.[25] The United Kingdom allows for citizens to elect a proxy to deliver their vote if they are unable to go to the polls, but they can lose their right to vote if deemed to lack mental capacity by a health care provider.[26]

Capacity and Voting

A person's capacity for a task is generally defined as whether the person possesses the necessary abilities to complete the task.[27] How a specific symptom would functionally impact a specific capacity should be considered.[27] In evaluation of specific capacities, critical factors often include factually understanding the task and the likely consequences of a decision, rationally manipulating information, and communication of a choice that is maintained long enough to implement that choice.[27] A high level of understanding is not necessary; for example, for capacity to make medical decisions, the amount of information that needs to be understood is only what one requires to make a reasonable decision. With regard to voting, knowledge about politics varies greatly across society. In *Dunn v. Blumstein*,[28] the Supreme Court held that, under the Equal Protection Clause of the 14th Amendment, Tennessee could not have a yearlong residency requirement to register to vote because the durational requirement was not necessary to have knowledgeable voters or to ensure the ballot box's purity.

Voting should require a lower level of understanding and decision-making than does making a will (distributing one's assets), and a much lower level than the capacity to enter a contract (which has competing interests) or medical decision-making (which can have severe consequences). In balancing the risks of not allowing someone to vote who is competent versus allowing someone who is not competent to vote, the harms are quite limited if a marginally competent person were to vote, versus the large harms of disenfranchising voters.[29] Appelbaum noted that a 1982 American Bar Association project suggested that, to be allowed to vote, one must be able to provide the information required to register to vote.[20] This suggested quite a low bar (i.e., providing one's name, address, age, citizenship information), which likely only persons with severe dementia, intellectual disability, or psychosis would not be able to meet.[30]

In general, adults are presumed competent for tasks unless they are otherwise adjudicated. Guardianship is granted when an adult is incapacitated, and this limits the individual's rights significantly.[27] A person under guardianship may have difficulties specifically with managing their finances or self-care without assistance, which is not necessarily related to the capacity to vote.[20,29] Though it varies by jurisdiction, those who have guardians are often interpreted as being legally unable to vote.[31] In 2001, a federal district court in Maine ruled in *Doe v. Rowe* that the automatic exclusion of three people from casting ballots on the basis of them being under guardianship for reasons of mental illness violated their rights to procedural due process and equal protection from discrimination under the ADA and the 14th Amendment.[32]

Early research demonstrated that persons with mental illness demonstrate voting patterns common

to their geographic area.[33] In Canada, Valentine and Turner found that the voting patterns of institutionalized psychiatric patients reflected the voting patterns of the surrounding community.[34] Another Canadian survey of hospitalized psychiatric patients revealed a high level of political knowledge among the patients and concluded that previous laws restricting the voting rights of psychiatric patients were unnecessarily restrictive.[35] Similarly, in Israel, Melamed and colleagues concluded that facilitating the right of hospitalized psychiatric patients to vote "contributes to their feeling of being a participating member of the community... rather than a rejected minority with no rights" (Ref. 36, p 72).

These studies demonstrate that patients do not vote in a psychotic or confused manner, and that voting fosters a sense of order and belonging. In the *Doe v. Rowe*[32] decision, criteria for voting capacity were offered based on the person understanding the nature and effect of voting. This standard was meant to protect the integrity of voting, ensuring that those who vote have a basic understanding of the voting process, while not depriving those who wish to vote of their right to do so.[37] The assessment of decision-making ability should focus on specific functional capacities rather than diagnosis or history alone.[38] For example, one study suggested that individuals with mild Alzheimer's disease likely maintained capacity to vote, while individuals with severe Alzheimer's disease were likely not competent.[39] The Competency Assessment Tool for Voting (CAT-V) was developed based on *Doe* criteria, and it includes queries about understanding, appreciation, reasoning, and choosing.[37] Findings suggested that, in general, people with serious mental illness living in the community have the necessary capacities to vote.

Just as there is a risk of undue influence when writing a will, there is the possibility of undue influence on voters. For example, it has been alleged by proponents of voting restrictions that persons with mental illness can be taken advantage of and exploited.[40] States have a compelling interest in preventing fraudulent behavior and undue influence in voting.[30] In intellectual disability, concerns may relate to the person's desire to please others.[30] Hallmarks of undue influence in will cases include the abuse of a position of trust or power by a beneficiary, such that the testator lacks free will.[27] Isolation, medications that cloud cognition, and manipulation by controlling access to substances are also factors considered in undue influence cases. Consider the hospitalized patient who overhears well-meaning staff members discussing their political opinions at work. If these same staff members are facilitating the voting process, this conversation may unduly influence the voter's choice. Staff should be cognizant of this and help guard against swaying patients' decision-making, no matter how contentious an election. Schriner and colleagues note that, because ballots are cast in secrecy, this can help prevent pressure or threats.[30]

Field Notes

Recognizing that there was no existing system to facilitate voting by hospitalized patients and that hospitalization is often a barrier to full participation in citizenship, the Social Justice Coalition (an interprofessional organization at the Cambridge Hospital in Cambridge, MA) aimed to expand the hospital's patients' access to the polls. The organization is focused on promoting equity and improving the social, cultural, economic, environmental, and political health of the communities served. As such, patients who were hospitalized near Election Day 2016 were offered the opportunity to vote. While all hospitalized patients were extended an invitation, the resident psychiatrists spearheading this initiative (J.A.O., J.B.M.) took a special interest in the legal questions raised in trying to help psychiatric inpatients exercise the right to vote.

According to the Massachusetts Official Absentee Ballot Application, registered voters who have entered into a hospital or health care facility within five days of a primary or election day can have a ballot mailed to them or elect a proxy to hand-deliver their ballot.[41] Given this provision in the law, psychiatry resident volunteers consulted with the Massachusetts Election Commission, who advised that these absentee ballot applications and the ballots themselves should be hand-delivered to the voters' local election office.

With the support of the Cambridge Hospital's legal team, volunteer resident physicians created educational material to explain this last-minute absentee voting procedure, promote awareness among hospital staff, and provide copies of the absentee ballot application to patients. Patients were encouraged to designate a family member or friend as their voting proxy, and for those without someone to serve as proxy, hospital volunteers were made available. On November 3, 2016, five days before the election, this

material was distributed through email and physical copies were delivered to each hospital unit, where volunteers were also able to educate staff about this opportunity. Patients admitted to the hospital after noon on that day were identified as being potentially eligible for this opportunity to vote and were approached by clinical staff and volunteers to facilitate this process, if they were interested. Once absentee ballot applications designated a proxy, the applications were hand-delivered to the patient's local election office in exchange for the absentee ballot. This ballot was then hand-delivered to the hospitalized patient, and they voted in private and sealed the ballot. Then the completed ballot was returned in-person to the local election office.

In the development and execution of this program, there were a number of obstacles, the first of which was a lack of awareness of these laws and obligations that health care facilities have to assist patients who are unable to get to the polls. Federal statutes dictate that people with disabilities should not be subject to discrimination by any private[42,43] or public facility[44,45] or any facilities receiving federal financial assistance.[46] As such, service providers must make reasonable modifications to their policies and practices to ensure that patients who need help with the voting process receive it.[19] At the time of this project, volunteer resident physicians were unaware of this mandate and did not seek wider institutional support. As such, this effort was predominantly supported by the time and financial resources of the two resident physician volunteers who served as voting proxies. This dearth of financial and administrative resources likely limited the scope of impact that the program could make, given that the majority of eligible patients requested hospital proxies to submit their ballots. Depending on where patients were registered to vote, volunteers were required to drive significant distances to submit the ballot. In the case of psychiatric patients, there was uncertainty among hospital staff and patients themselves about their right to vote while admitted to an inpatient psychiatric unit.

Additional obstacles encountered while enacting this program included patients not knowing whether they were registered, or in what town. In those cases, resident volunteers needed to call local election offices to confirm registration prior to completing the absentee ballot application. During these phone calls, the resident volunteers encountered election officials who were equally uninformed or provided incorrect information about proxy voting for hospitalized patients, unearthing another potential barrier to voting for marginalized patients.

One resident facilitator (J.A.O.) wrote an article about this effort,[47] and the story was picked up by a number of other media outlets including *Boston Magazine*,[48] ABC News,[49] and Marketplace.[50] This prompted hospitalized patients and providers from other health care systems to seek advice on the procedures used at the Cambridge Hospital due to the obstacles they encountered when trying to implement similar programs.

Additional Barriers to Voting

The stigma of mental illness is just one barrier to the voting rights of psychiatric patients. Additional obstacles include the logistics of gaining entry into forensic or secure facilities where patients are housed. As discussed previously, absentee ballots and voting proxies are ways in which confined psychiatric patients can vote. Access to the patient is necessary for these methods to be effective. Forensic and secure facilities have specific protocols and policies that have the potential to restrict access to patients.

Citizenship-oriented care is especially important at the intersection of the mental health and criminal justice systems.[51] Historically, in the United States, felons have been ineligible to vote.[52] Psychiatric patients in forensic and secure facilities may be ineligible to vote based on a felony conviction. However, in the past decade, some states have revoked the felony ineligibility statute. Currently, there is a spectrum of laws restricting felons' rights to vote in various ways (the interested reader is referred to the National Conference of State Legislatures, which has categorized individual states).[52] Felons retain their ability to vote, even while incarcerated, in Maine and Vermont.[52] Felons lose their voting rights only while incarcerated in 14 states and the District of Columbia. In 21 states, felons are ineligible to vote during incarceration and automatically have their rights restored after their sentence is complete, which may include postincarceration supervision.[52] In 13 states, felons are indefinitely ineligible to vote without additional action, such as receiving a governor's pardon or completing a postsentence waiting period.[52] In these 13 states, the key difference is that rights are not automatically restored, but may be restored by some

additional action, and in some states, certain offenses result in permanent disenfranchisement.

Making Accommodations

While great strides have been made to pass the aforementioned laws, there is still progress to be made, including becoming more aware of who is responsible for carrying out the regulations. As previously described, the VRA requires that people with mental disabilities be allowed to designate someone of their choice to assist them when voting.[10] This agent cannot be the voter's employer, an agent of the employer, or a representative of the voter's union.[53] The chosen agent must respect the voter's choices and is prohibited from making assumptions about how the individual wants to vote. Interpretation of the meaning of the word "assistance" has ranged from picking up and returning absentee ballots for patients currently hospitalized to filling out ballots for individuals not physically capable.

Elections officials are also required to provide mentally disabled voters with assistance.[54] This assistance may be in the form of making voting systems readily accessible or making reasonable modifications to help mentally disabled individuals register to vote.[14] One method by which an election official can fulfill this obligation is by ensuring that residents of nursing homes and care settings are aware of how to apply for, complete, and submit absentee ballots. For election officials to be able to help voters in their precinct, they must first know the rules themselves. For example, prior to election day, officials are to be made aware that service animals must be allowed in the polling place, that people with disabilities are allowed to have assistance from a person of their choice, and that additional modifications may be needed and should be provided to accommodate voters with disabilities.[11]

If a voter is currently staying or living in a facility that is providing care, such as a hospital, group home, or nursing home, the facility is required to make reasonable efforts and modifications to assist them in exercising their right to vote.[14] These efforts should include providing information about how to register to vote, how to apply for and submit an absentee ballot sufficiently in advance, and offering assistance if help is needed with these tasks.[11] Additional responsibilities include allowing for voter education on-site so that residents are able to make informed decisions.[14] To fulfill this responsibility, hospital employees need to be aware of local rules and regulations around voting and to be educated on how best to have conversations with patients regarding their right to vote. Even with several agencies responsible for educating, empowering, and assisting voters with mental disabilities to access the polls, there appears to be little enforcement of these regulations, which means there is a great need for advocacy.

Role of the General and Forensic Psychiatrist

General psychiatrists are in a unique position to address the barriers to voting among people with mental illness by educating the community about these rights as well as facilitating means to vote. To do this, general psychiatrists must be familiar with the state laws affecting the voting rights of people with mental disabilities in the jurisdiction in which they practice, especially in states with specific legal guidelines to determine whether a person has the capacity to vote. In addition, guardians should be reminded that the individual retains certain capacities, including the capacity to vote, unless noted otherwise.

Forensic psychiatrists may be asked to determine whether an individual has the capacity to vote. There is no consensus on what capacities a person actually requires to be able to vote.[54] Most states restrict the reasons that a voter's capacity may be challenged, and some states do not permit challenges based on the perception of incompetence.[19] As previously mentioned, the CAT-V operationalized the *Doe* standard into a structured assessment tool.[32] Although no standard currently exists to determine an individual's voting capacity, one may consider administering the CAT-V given the preliminary data in individual cases in which a person's right to vote is being challenged. Other screening tools or psychological or cognitive testing do not specifically address an individual's understanding of the voting process.

After an individual has been adjudicated incompetent to vote, forensic psychiatrists could be asked to opine about the likelihood of restoration to voting competence. Although this may not be a common referral question, the finding of incompetency related to voting is not necessarily a permanent state. Certainly, individuals with mental illness may experience periods of time during which they are more symptomatic and their decision-making capacities are compromised. However, with adequate treat-

Table 1 Suggestions for Reducing Barriers to Voting by Hospitalized Psychiatric Patients

- Educate facility staff and patients about anti-discrimination laws that allow hospitalized patients to vote (e.g., informational handouts and posters around the hospital).
- Understand state laws affecting the voting rights of people with mental disabilities.
- Encourage hospital to promote voter registration year-round.
- Liaise with local election commission office.
- Organize staff and volunteers to help hospitalized patients who have expressed desire to vote to apply for, complete, and submit absentee ballots.

ment, it is likely that individuals with mental illness can be restored to voting capacity.

The voting rights of psychiatric patients are an integral component of the citizenship-based model of psychiatric care.[3] As Kelly points out, a large proportion of psychiatric inpatients are often unaware of their right to vote, which likely contributes to their decreased participation in elections.[55] Nash concludes in his work on social inclusion that "having the right to vote in principle is one thing, being able to exercise it is another and mental health professionals should be fully aware of this" (Ref. 56, p 702).

These observations and the residents' experiences described in this article demonstrate the need to raise awareness among both patients and providers. Table 1 provides suggestions for psychiatrists and other mental health professionals to help address the barriers to voting in the psychiatric population.

Countries around the world have recognized the importance of the voting rights of individuals with mental illness and have made strides to protect these rights. In the United States, the VRA, NVRA, ADA, and HAVA were passed to protect the suffrage of marginalized populations. Recognizing that persons with psychiatric disabilities may face unique barriers to voting, such as inpatient hospitalization, guardianship, and the perception of incompetence, these laws obligate health care providers to facilitate patients' access to the polls. As Rowe and Baranoski conclude, "the citizenship of all strengthens the community as a whole and enhances the citizenship of each member, while the non-citizenship of some impoverishes the community and weakens the citizenship of each member" (Ref. 57, p 263). This citizenship-oriented approach to care not only respects a patient's health, but also their rightful place in society.

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