Implementation of Assisted Outpatient Treatment (AOT):
Summary of Feedback

March 2026

SUMMARY

As part of Allegheny County's efforts to engage the public and gather feedback about how and under what circumstances Assisted Outpatient Treatment (AOT), a court order that requires an individual to participate in community-based outpatient treatment, could be a viable option for serving and/or improving care for people with serious mental illness, the Department of Human Services (DHS) gathered extensive local input from stakeholders including the National Alliance on Mental Illness (NAMI Keystone PA), Mental Health America, Allegheny Family Network, the American Civil Liberties Union of Pennsylvania, and Disability Rights Pennsylvania. Additionally, DHS conducted six focus groups with 58 total participants. Participants had direct lived experience with the behavioral health system and/or the justice system and included people working as Certified Peer Specialists, people incarcerated in the Allegheny County Jail (ACJ), members of restorative justice think tank Elsinore-Bennu, and volunteers for the Western Pennsylvania Participatory Defense Hub.

Feedback from the focus groups can be grouped into the following key findings:

- **Key Finding #1 — Reintegration and Diversion**
  AOT could be a beneficial alternative to jail or inpatient care, allowing individuals to remain in or return to their community while helping to break the cycle of mental health crisis, incarceration and return/exacerbation of symptoms (decompensation).
- **Key Finding #2 — Engagement Challenges**
  Being able to maintain engagement in an AOT treatment plan is a major concern, particularly for individuals already in the community for whom consequences may feel less immediate.
- **Key Finding #3 — Prioritize the Person's Voice**
  For AOT to work, the individual's voice must be included and incorporated throughout; AOT plans should be recovery-oriented and designed to respond to the person's changing needs.
- **Key Finding #4 — Clear Communication and Training**
  Since AOT is new to Allegheny County, the county should be thoughtful in how it introduces AOT to the public, providers and other stakeholders to increase people's likelihood of engagement and to ensure understanding of its principles and processes.
- **Key Finding #5 — Availability of treatment resources**
  It can be challenging to access treatment resources and there can be long wait times for services. AOT plans and coordination should focus on getting people connected to supports as quickly as possible and ensuring they have access to the services they need to maintain wellness in the community.
- **Key Finding #6 — Protecting overreach by the criminal justice system and protecting people's civil liberties**
  AOT has the potential to deepen or create additional criminal justice involvement for people petitioned and, since this is a civil commitment, people's due process rights need to be protected throughout.

This report expands upon these six key findings and includes notes and quotes from focus group participants. We have combined this feedback with an examination of national and local research to help us determine if and how we will implement AOT in Allegheny County.

BACKGROUND

Pennsylvania passed the Assisted Outpatient Treatment (AOT) law in 2018; at that time, Allegheny County opted out of implementing this legal procedure. In December 2024, however, the County indicated its intention to more actively explore whether and how implementation could be designed to support people in a mental health crisis.

Each year, more than 5,000 people in Allegheny County are evaluated for involuntary hospitalization. The outcomes for this group are deeply troubling: despite being referred to follow-up outpatient care at discharge, fewer than half receive that care and 20% die within five years. Families, providers and partners have asked the County to consider new, compassionate tools to engage people **before** a crisis becomes life-threatening. Within the County's current legal options, families of an individual resistant to the idea of treatment are unable to intervene early and must wait for their loved one to meet the threshold of being a 'danger to themself or others before they can request involuntary treatment. They are forced to watch their loved one's health deteriorate, waiting until they are arrested or otherwise meet the criteria for involuntary hospitalization. And once the individual is released or discharged, they often repeat the same pattern of medication non-adherence, disengagement from treatment and decompensation.

AOT is a civil court process initiated by a petition from a responsible party,[1] that requires a person with serious mental illness (SMI) to receive outpatient care in the community. In AOT, the individual works with a team (including a mental health provider and a judge) to craft and monitor adherence to a treatment plan. By using person-centered planning with judicial oversight, AOT should lead to shared treatment goals, stronger therapeutic alliances and increased engagement.

In addition to helping individuals before they reach a crisis, AOT may be applied either to divert someone from incarceration or hospitalization or to help them transition out of incarceration or hospitalization. It is intended to provide more structured support in the immediate months after release, support that can break the cycle of crisis, incarceration and decompensation. AOT is not punitive, meaning that a client will not be arrested, punished or hospitalized due to non-adherence to treatment; instead, non-adherence should prompt the provider and client to adjust the treatment plan. The judge's oversight is intended to hold treatment providers partially accountable for client adherence, which is a significant incentive for deliberate and creative problem-solving and treatment.

While exploring if and how AOT should be implemented in Allegheny County, DHS engaged with a broad range of stakeholders, including government partners, behavioral health providers and hospitals, family advocacy organizations, civil rights and disability rights organizations, and people with lived experience in the behavioral health and/or justice systems. The following sections describe the feedback process,including a series of focus groups with people with lived experience.

[1] A "responsible party" could be a family member, a friend, a treatment provider, or anyone else who has an invested interest in the individual's health, wellness, and safety and recognizes a person may benefit from structured and monitored treatment.

METHODOLOGY

From December 2024 through December 2025, DHS collected feedback from a variety of stakeholders, including the National Alliance on Mental Illness (NAMI Keystone PA), Mental Health America, Allegheny Family Network, the American Civil Liberties Union of Pennsylvania, and Disability Rights Pennsylvania. DHS, in partnership with Community Care Behavioral Health, also hosted multiple meetings with local behavioral health executive directors.

Additionally, from August through November 2025, DHS conducted six focus groups (total of 58 people) to understand their thoughts about 1) the impact that AOT could have on Allegheny County's behavioral health system and its clients and 2) how the county could best design AOT to ensure its success. We held three focus groups with organizations that provide Certified Peer Specialist services in Allegheny County (UPMC Western Psychiatric Hospital, Resources for Human Development and Peer Support Advocacy Network). These organizations serve Allegheny County adults with an SMI diagnosis and the potential of benefiting from AOT. Focus group participants were Certified Peer Specialists (peers) on the staff of these organizations. In addition to the focus groups with the Certified Peer Specialists, we held one focus group with individuals incarcerated in the ACJ who had histories of involuntary commitments and behavioral health challenges. The final two focus groups were hosted in collaboration with the Abolitionist Law Center, a nonprofit law firm with a community organizing project led by people who've been directly impacted by the criminal justice system. One group included attendees from the Elsinore-Bennu Think Tank,[2] a justice-oriented think tank, and the other included representatives from Western Pennsylvania Participatory Defense Hub,[3] a coalition helping individuals navigate the justice system. (See **Table 1**)

TABLE 1: Focus Groups by Organization, Role and Number of Participants

ORGANIZATION	PARTICIPANT ROLES	NUMBER OF PARTICIPANTS
UPMC Western Psychiatric Hospital	Certified Peer Specialists for inpatient mental health clients	9
Resources for Human Development – Allies	Certified Peer Specialists for community-based and/or forensic mental health clients	12
Peer Support Advocacy Network	Certified Peer Specialists for community-based mental health clients	5
ACJ Behavioral Health Unit	Incarcerated individuals with mental health needs	9
Elsinore-Bennu Think Tank	Community-based restorative policy advocates	14
Western Pennsylvania Participatory Defense Hub	Community-based advocates helping clients presently involved in the justice system	9

2 https://healer.network/elsinore-bennu-think-tank-for-restorative-justice-ebtt/

3 https://www.participatorydefense.org/hubs-old

Focus group materials were created by staff from DHS's behavioral health and client experience (CX) teams, with feedback from people with lived experience. The focus groups were facilitated by two behavioral health staff, one a recovery specialist and one with expertise in AOT, and both with extensive experience in and knowledge of the behavioral health and criminal justice systems. Both facilitators were trained in focus group facilitation by the CX team.

Facilitators introduced each session with an explanation of informed consent and provided participants with a consent form to complete (**Appendix B**). Participants were informed that the group would be recorded to assist in summarizing the results **only** if all participants approved; as a result, only one session was recorded. Facilitators established ground rules and expectations for participating in the focus group (as detailed in the Focus Group Guide in **Appendix C**).

Facilitators explained AOT at the beginning of each session, distributing a handout (**Appendix A**) and describing a scenario in which AOT could be implemented (Appendix D). Participants were asked to talk about ways in which Allegheny County could implement AOT successfully, generally following the Focus Group Guide in **Appendix C**.

Members of the CX team attended and took notes at each session, then summarized and organized insights into the key findings presented in the following section.

KEY FINDINGS

It is helpful to keep in mind that participants naturally, and sometimes as directed by the facilitators, compared AOT to existing interventions, notably involuntary commitments (302s) and incarceration. This section contains the key findings, with detailed descriptions and supporting evidence from the focus group sessions, and recommendations in response to each finding.

Key Finding #1 — Reintegration and Diversion: AOT would be a beneficial alternative to jail or inpatient care, allowing individuals to remain in or return to the community while breaking the cycle of mental health crisis, incarceration and decompensation.

AOT can help clients transition from jail or inpatient care back to their communities. Focus group participants supported this application, noting the stark lifestyle differences between living in highly structured restrictive settings and living at home. One respondent stated that "structure is key" that "helps calm the chaos" during the first 30 days post-release from an inpatient facility. Several peers emphasized that a client would show whether they would adhere to a treatment plan within the first 30 days post-release and suggested that they should receive closer attention during this period. Heightened attention and stability through structure during this post-release period, a feature that current programs lack, has the potential to break the cycle of mental health crisis, incarceration and decompensation.

Housing emerged as a major concern for people who are transitioning out of jail or inpatient care. Several participants noted that individuals are often discharged from hospital or released from jail without appropriate housing—or without any housing at all—which immediately places them at high risk. Participants emphasized that a person in AOT should not be released into a "toxic" living environment. In discussing this need, many participants suggested that housing should be included in AOT plans. More on this theme is discussed in Key Finding #3.

AOT can also be used as a diversion from hospitalization or incarceration, giving individuals a structured treatment plan with the oversight of a civil commitment while allowing them to remain in their community. Participants noted both positive and negative views of this application. One supportive participant stated, "Everyone is going to function better in the community." Another supportive participant stated that AOT may have prevented them from spending extended time hospitalized in behavioral health units. However, participants expressed doubt that a person who does not perceive jail or hospitalization as a possibility will be likely to engage with an AOT plan. This theme is further discussed in Key Finding #2.

Recommendations

- The County can be confident that AOT is a potentially helpful way to transition a person back into living in the community. The AOT treatment plan and oversight must include heightened attention during the first 30-60 days of the AOT commitment, as this time frame appears to be critical to helping clients establish a sustainable, stable and independent lifestyle.
- Inpatient settings or jail, while restrictive, may offer certain individuals a more stable living situation than the alternatives (on the streets, homeless shelters, a toxic home environment). The team should consider if/how housing opportunities will be included in AOT and how to verify that an individual leaving a hospital or jail with an AOT commitment has a safe place to go before being released.

Key Finding #2 — Engagement Challenges: Maintaining engagement is a major concern, particularly for individuals already in the community whose consequences may feel less immediate than those already in institutional settings.

A client may be apprehensive about engaging in mental health services for many reasons, including past negative experiences with these systems, not recognizing or believing they need mental health care, or simply not wanting to disrupt their normal routine. Regardless of the reason(s) for not wanting to participate, AOT will only be effective if clients are actively engaged in their treatment plan. However, since AOT is not punitive (i.e., the client will not be arrested, punished or hospitalized due to non-adherence) the perceived lack of consequences caused several focus group participants to question the program's potential effectiveness.

Many participants emphasized that having a person who the client could relate to, such as a Certified Peer Specialist, would encourage engagement by helping the client feel more comfortable meeting mental health providers, expressing their needs to providers, and interacting with courts. However, some of the Certified Peer Specialists warned that attempts to initially engage clients in non-voluntary treatment might undermine trust and push them further away. Because it is their duty to advocate for their clients, one Certified Peer Specialist felt it would be a "massive overstep" for them to be involved in drafting a petition or as part of a coercive treatment plan for someone who does not want to engage.

AOT may require clients to participate in review hearings to monitor treatment adherence and consider adapting treatment plans. Some peers asserted that this feature of AOT, while intended to empower clients, still places an additional burden on their normal routines. To make this point, one peer asked the room, "Who wants to go to court every month?" Many participants (the Certified Peer Specialists, in particular) expressed doubt that a

previously unengaged client would become engaged simply because of an AOT petition or a judge's oversight. One made the point this way, "You can have an entire court system telling you to go to the therapy session, but [you] still don't have to go to the session."

Recommendations

- The AOT team should be prepared to have difficulty engaging clients who are not currently living in a restrictive setting. The treatment team needs to have a plan for how potential clients living in the community will hear about AOT. The team also needs a plan for how petitioned clients who do not appear willing to engage can be encouraged to participate in treatment.
- The treatment team should be careful not to over-pursue clients. They need to find a way to sell the potential upsides of treatment adherence without coercing clients and/or risking their trust in care providers. The team should lean on Certified Peer Specialists to help with this communication, as clients are more likely to engage with a peer than with police or court workers.
- Certified Peer Specialists should be available to support individuals in AOT, but they should not be part of the AOT plan to ensure they are seen and operate as impartially as possible. They should be there to support the individual in AOT, not the AOT process.
- The treatment team should find ways to make AOT desirable to potential clients. For example, they could work with individuals to explore their treatment preferences, possibly including non-traditional therapies and recovery-oriented opportunities.
- The treatment team should explore using incentives to encourage adherence to medications and treatment.

Key Finding #3 — Prioritize the Person's Voice: For AOT to work, the client's voice needs to be included and heard throughout. Thus, AOT plans should be recovery-oriented and designed to respond to the person's changing needs.

AOT needs the individual, treatment providers and Judge to ensure that the treatment plan meets the individual's needs and honors their rights. The collaborative and multidisciplinary approach is intended to give clients a say in their treatment throughout the AOT plan. Focus group participants shared their belief that this structure, by including court hearings and having Certified Peer Specialists involved, will hold providers accountable and shift responsibility away from clients alone; it can also help individuals build trust with the system. Participants emphasized that every member of the treatment team should be operating from recovery-oriented and trauma-informed lenses and knowledgeable about mental health conditions and treatment if they are going to make decisions about clients' cases.

To encourage more engagement and to fully serve the client, AOT plans should centralize the client's voice and be prepared to tailor services to their individual needs and interests. Participants stressed the importance of incorporating a wide variety of services the client might find engaging (e.g., outpatient treatment, physical/

4 Visit the following site to learn more about the eight dimensions of wellness: https://pmc.ncbi.nlm.nih.gov/articles/PMC5508938/

occupational therapy, art & music therapy, horseback riding). One participant suggested that AOT incorporate the eight dimensions of wellness.[4] Another noted that courts currently tend to elevate substance use-related treatments above other physical or behavioral health needs and suggested that AOT not let substance use overshadow or dominate other needs.

Focus group participants asserted that AOT plans should continuously adapt to serve a client's whole health needs throughout their treatment, not just during the initial plan design. They provided examples of how a person's needs evolve, including housing, as described in Key Theme #1, and medication management. Regarding medication, participants pointed out that it can take a long time to find a medicine that is effective without causing too many side effects, and treatment providers need to respect and act on the client's opinion about their medication. Court oversight and peer support should decrease the likelihood of needs such as these going unaddressed

One participant expressed concern about the "exit plan" component of AOT commitment. They stated that civil commitments can be extended indefinitely, which keeps a person engaged in treatment or the criminal justice system much longer than what may be necessary. They urged the county to consider how a client's civil commitment will be considered complete and lifted.

Recommendations

- Regularly scheduled court oversight and peer support involvement should help prioritize clients' needs. The AOT team should pay close attention to whether clients appear to be expressing their needs to providers. The AOT team needs to have a plan in place to guarantee clients are comfortable expressing their needs and that plans can and are being adjusted to meet their needs.
- As suggested by Certified Recovery Specialists, the treatment team should use the eight dimensions of wellness to structure treatment plans. Clients should have access to a wide range of services and teams should be prepared to add other services as needed or requested by a client.
- The treatment team needs to have an exit plan to avoid indefinitely extending a client's commitment. Clients should be aware of how/when their commitment will be considered complete.

Key Finding #4 — Clear Education and Training: Since AOT is new to Allegheny County, DHS should carefully introduce AOT to the public and providers, to increase understanding of its principles and processes and the likelihood of engagement.

All focus group participants have had experiences with involuntary commitments and/or law enforcement, as will many individuals who may benefit from AOT. A person's past experiences with/conceived understanding of these systems will influence their perception of AOT. Focus group participants stressed that the county should carefully introduce AOT to the public and make it clear how a person can use the new legal option. One participant, who is currently court-involved, expressed frustration with how hard it is to know and understand what treatment options are available. Another participant separately suggested there should be free community training sessions to educate the public about SMIs, the symptoms associated with SMIs, and the treatment options, including AOT, that are available to them.

Participants suggested that AOT practices should avoid encounters with law enforcement, common under current and past practices, to make individuals more amenable to treatment and reduce negative experiences being associated with AOT. One Certified Peer Specialist advised against informing individuals of their AOT via

a mail summons, sharing they would have been angry and unwilling to engage if they had received a summons in that way. Additionally, some focus group participants urged that treatment non-adherence—not an arrest—should trigger a re-evaluation of the clients' needs. One participant specifically recommended that, when a client is picked up for re-evaluation, that pick-up should be done by a community-based team, NOT the police. Focus group participants shared some thoughts about ensuring high quality throughout AOT. Several suggested there should be designated teams who work with all AOT cases rather than having many workers who periodically work with AOT. In that way, staff involved are more familiar with AOT's structure. Teams should include health workers, court workers and Certified Peer Specialists. Teams should receive continuous training akin to that of mandatory reporters, guaranteeing retraining about current laws and recovery best practices every two years. This training should include criteria for AOT, potential warning signs, and different options available for people experiencing a mental health crisis.

While considering AOT teams, one participant currently incarcerated in ACJ expressed discomfort knowing their mental health provider was working in tandem with the court; even a friendly judge is still a judge, and that can be stressful for the client.

Recommendations

- The AOT team should be very careful in how it frames AOT. The team should consider using terms that are new or distinct from other services when it does not want to evoke feelings from past interactions with the behavioral health or justice systems.
- The County should prepare public training sessions aimed at informing potential petitioners about AOT, its goals and its processes. They should regularly hold these sessions at various locations in Allegheny County to make sure information about AOT is adequately disseminated and remembered by County residents.
- The County should consider having a dedicated Judge and service coordinator for AOT and ensuring that everyone, including treatment providers and peers who may work with people in AOT, receive ongoing training to remain up-to-date on best practices in recovery and mental health treatment.

Additionally, throughout the feedback process we heard the following themes:

Key Finding #5 — Availability of treatment resources: It can be challenging to access treatment resources and there can be long wait times for services. AOT plans and coordination should focus on getting people connected to supports as quickly as possible and ensuring they have access to the services they need to maintain wellness in the community.

People have experienced long wait times for behavioral health services in the past and respondents felt that there was not enough existing capacity in service coordination or care management, services they felt were necessary to make AOT work.

Recommendations

- The county should ensure dedicated service coordination to individuals under AOT petitions to create and maintain connections to care. This coordination should be in regular contact with the person's treatment team and escalate challenges in connecting to care to trouble shoot immediately.

AOT plans should account for availability of services and be continuously monitored to ensure that people are getting connected to services quickly and that they are comprehensive in addressing people's needs.

Key Finding #6 — Protecting overreach by the criminal justice system and protecting people's civil liberties: AOT has the potential to deepen or create additional criminal justice involvement for people petitioned and, since this is a civil commitment, people's due process rights need to be protected throughout.

Stakeholders stressed the importance of AOT as diversionary, noting that the use of law enforcement to transport people or execute warrants could be extremely harmful. They discussed concerns about the potential negative consequences that could arise from police interaction with these individuals, including harm to the person who is the subject of the petition or the police officer and/or the possibility of new criminal charges being filed because of the interaction.

Additionally, the law provides the right to defense during this process and stakeholders stressed the importance of a hearing that ensures due process to all participants. This includes the use of an in-person hearing with a Judge (not a hearing officer) where evidence is presented and supports for person who is subject to the petition to ensure they understand and can fully participate in the process.

Finally, people stressed that every effort should be made to ensure that individuals are offered voluntary services first, treatment is in the least restrictive environment and that it is recovery-oriented care.

Recommendations

- People should be notified of the petition via summons, and warrants should not be issued if people do not show up for court. Law enforcement should not be involved in transporting individuals to AOT hearings, and the team should create specialized training for law enforcement about AOT.
- The team should prioritize assertive, and active engagement with participants from a consistent provider to ensure that needs are being assessed on an ongoing, regular, basis with attention to early identification of potential problem situations and prioritization of care to address those situations in a proactive manner; including amending the AOT plan of care to add additional supports as needed.
- People who are subject to the petition should be offered a certified peer specialist that is not part of the AOT process and can be a support throughout the process and after it concludes.
- People should be provided with attorneys who are well versed in mental health law and can provide robust defense.

NEXT STEPS

The feedback, concerns and suggestions detailed in this report are informed by the personal and professional experiences of people who have navigated the behavioral health and justice systems. It is important to include people with these experiences in planning processes and there should be a commitment to using this feedback to inform the design and implementation of AOT.

While the stakeholders and focus group participants have substantial experience with various behavioral health and/or justice interventions, readers should note that they have not experienced AOT. Concerns and feedback expressed in this report are influenced by past experiences and are speculative about AOT's implementation. Additionally, readers should note that the views expressed here are naturally limited by the scale and scope of the discussions. If AOT is implemented, the team should continuously collect information from clients and other stakeholders about their experiences to ensure ongoing adjustments and quality improvement.

APPENDIX A: AOT HANDOUT

A O T

Assisted Outpatient Treatment

What is AOT?

Assisted Outpatient Treatment, (AOT), is a collaborative effort by the court system and treatment system to ensure vulnerable individuals receive health services they need to transition back to voluntary care when appropriate. 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.

AOT is a legal procedure which mandates mental health treatment for individuals with Serious Mental Illness, (SMI.)

How does someone get involved with an AOT Program?

- Step Down
  - Transitioning from a more restrictive care setting to treatment in the community-discharge from a psychiatric hospitalization to ensure comprehensive treatment and services that support recovery in the community
- Step Up
  - Directly from the community to prevent hospitalization, incarceration, psychiatric deterioration. Petition originates from community provider or family member (invested party) to help people get treatment before a more restrictive setting becomes necessary
- Step Over
  - Criminal charges dismissed upon civil commitment to AOT – for people that are likely to restore to competency, do not prove a risk to public safety when treated, and history of not participating in voluntary treatment

How are AOT court orders enforced?

It is not unusual or alarming for an AOT participant to miss one or more scheduled appointments, or even to stop taking prescribed medication, in violation of the AOT court order. This alone would not be legal grounds to revoke outpatient status and commit the person to a hospital. (With or without AOT, hospital commitment requires the same findings of need under state law.) Nor should it ever be grounds to hold a participant in contempt of court (a counter-therapeutic response prohibited in many states) or to forcibly administer medication. Non-adherence to the court order may trigger a re-evaluation of the person's current clinical needs (which may require a short-term hold for a psychiatric exam) and a re-appearance before the judge considers a change in legal status.

APPENDIX B

CLIENT - Consent to Participate in a Focus Group

The purpose of the focus group and the nature of the questions have been explained to me. I consent to take part in this focus group about my opinions and experiences.

My participation is voluntary. I understand that I am free to leave the focus group at any time. If I decide not to participate at any point in time, my decision will in no way affect the services that I receive in Allegheny County.

None of my experiences or thoughts will be shared with anyone outside of Allegheny County Department of Human Services unless all identifying information is removed first. The information that I provide during this focus group will be grouped with answers from other people so that I cannot be identified.

The focus group will be audio-recorded only with your permission. If applicable, select quotes may be used to illustrate a specific example.

Thank you for your participation.

_____ I agree to have the focus group audio-recorded.

_____ _____
Please Print Your Name (Participant) Date

_____ _____
Please Sign Your Name (Participant) Desired Pseudonym (optional)

As a DHS employee, the interviewer is a state mandated reporter of suspected child or adult abuse.
If you have any questions, please contact
Cassie Alexander, Department of Human Services, ATP
412-350-3199
cassandra.alexander@alleghenycounty.us

APPENDIX C: FOCUS GROUP GUIDE

Introduction

****Approximately 5-10 Minutes****

"Hi, my name is [NAME] and I work for Allegheny County Department of Human Services. I'm here with [NAME] and [NAME], also from DHS, and we're here to talk to you about Assisted Outpatient Treatment, or AOT.

Today we will be asking for your feedback on how AOT can be implemented in Allegheny County. We're looking for feedback on how AOT will affect the system, not necessarily the individual.

Please keep in mind that there are no right or wrong answers to these questions and your name will not be connected to your responses in any reporting that we do, and nothing you say will affect you or your job.

Your participation in this focus group is voluntary, and you can leave at any time. We expect this group to last no more than 1 hour.

We will be recording the focus group today. The recording will be audio only and will be password protected. You will have the option to pick your own pseudonym for the purposes of this focus group. Cassie will be taking notes today.

If you agree to participate, please sign the consent forms in front of you and we will go around and collect them.

While we're collecting those, let's go over some basic ground rules for this focus group:

Ground Rules

1. Respect others
2. We want a way to acknowledge when it's someone's turn to talk, what's a good signal.
3. Stories leave, not names.
4. No laptops, mute/silence cell phones. If you need to answer a call or text, please go into the hallway (Movie theater rules)
5. Mindful Disclosure and safe communication- participants will use discretion when sharing personal experiences and will limit disclosure to that which may be relevant to the focus of the materials.
6. Content being discussed may be sensitive for some and trigger unfavorable thoughts or memories, anyone experiencing an unwanted reaction is welcomed to take care of their needs as they see fit to maintain personal wellness and safety. If you need to talk to someone after this group is over, please let us know.
7. Are there any other ground rules that you as a group would like to implement?

"Do you have any questions before we get started?

Great, lets get started.

Let's go around the room and introduce ourselves. Share the name you would like to use, pronouns, and something that brings you joy."

****Approximately 30 Minutes****

"To begin, I want you to think about the following scenario:

Individual "A" was admitted to the behavioral health unit of the regional hospital after a 302 petition was approved and was stipulated to a longer stay to stabilize symptoms of major depressive episode that led to "A" not eating, bathing, or, leaving the bedroom to engage with family or the newly assigned service coordinator, who has reported in treatment team that they will be closing the case due to non-engagement. The severity of this episode was noticeably more acute and has lasted longer than the most recent, which also resulted in a hospitalization and medication change, eight months prior. "Individual A" does not participate in programming or therapy while on the Behavior Health Unit and does not agree that they are experiencing significant symptoms of depression, or even that they have depression. "A" wants to return to their apartment, which has been reported as being in neglected condition and potentially hazardous for health since "A's" deterioration in all aspects of Activities of Daily Living.

Briefly discuss treatment plan options as they are right now

(Pass out AOT handout and explain AOT)

With AOT, "A" would have a court approved outpatient commitment to adhere to a treatment plan for community living that "A" and the community provider develop. "A" would have regular (30day) reviews with a judge or hearing officer to hold "A" and the team accountable to the plan of care. Revisions to that plan can be made to ensure that there are more positive outcomes for "A" than what they've experienced in the past year. Should "A" begin to slip into past behaviors of not taking care of themself and their mental health needs, the court could suggest that they get an evaluation for a medication review in a proactive attempt to stay well in the community.

- Court ordered outpatient treatment
- Plan of Care reviewed by judge, self-representation with PD
- Ongoing accountability for person subject to AOT and provider
- Intention to re-engage individuals at a voluntary level of treatment

Now thinking about the scenario I just shared with you:

- What are the benefits you see?
- What are the challenges you see?
- How can we help reduce the negative impacts on different racial or ethnic groups in the county?
- What type of support or resources does that person need?
- Do you imagine that this would increase their engagement in their treatment?

****Approximately 20 Minutes****

Now that you know what AOT and how it applies to individuals, let's think about how it would apply to the community on a whole.

- If we were to implement this, what are the system-wide benefits?
- If we were to implement this, what are some of the system-wide challenges?
- What should provider accountability/responsibility look like?
- Are there any domains that AOT should not drive?

APPENDIX D: SCENARIO

Individual "A" was admitted to the behavioral health unit of the regional hospital after a 302 petition was approved and was stipulated to a longer stay to stabilize symptoms of major depressive episode that led to "A" not eating, bathing, or, leaving the bedroom to engage with family or the newly assigned service coordinator, who has reported in treatment team that they will be closing the case due to non-engagement. The severity of this episode was noticeably more acute and has lasted longer than the most recent, which also resulted in a hospitalization and medication change, eight months prior. "Individual A" does not participate in programming or therapy while on the Behavior Health Unit and does not agree that they are experiencing significant symptoms of depression, or even that they have depression. "A" wants to return to their apartment, which has been reported as being in neglected condition and potentially hazardous for health since "A's" deterioration in all aspects of Activities of Daily Living.