SUMMARY: Some individuals and organizations have raised concerns about assisted outpatient treatment. Most of these fears are based on misinformation or misunderstanding. In fact, assisted outpatient treatment is proven to successfully reduce the incidences of hospitalization, homelessness, arrest, incarceration, and victimization of those in the program, as well as harm to self and harm to others.

See the Treatment Advocacy Center’s separate briefing paper on assisted outpatient treatment for more information, including citations.

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MYTH: Assisted outpatient treatment is going to fill hospital wards.

REALITY: Assisted outpatient treatment (AOT) is designed to help people function successfully out of the hospital. It helps those with a history of noncompliance with medications to adhere to a treatment plan and helps prevent them from decompensating and becoming rehospitalized. For example, participants in New York’s AOT program, Kendra’s Law, experienced a 77 percent decrease in psychiatric hospitalizations while in the program, as compared to the three years prior to AOT. In a North Carolina study, long-term AOT combined with routine outpatient services (three or more outpatient visits per month) reduced hospital admissions by 57 percent and length of hospital stay by 20 days compared to individuals without court-ordered treatment. The results were even more dramatic for individuals with schizophrenia and other psychotic disorders for whom long-term AOT reduced hospital admissions by 72 percent and length of hospital stay by 28 days compared to individuals without court-ordered treatment.

MYTH: Assisted outpatient treatment does not work.

REALITY: Studies and experiences in Arizona, Hawaii, Iowa, New York, North Carolina, and other states have definitively proven assisted outpatient treatment works. For example, in New York, during the course of court-ordered treatment when compared to the three years prior to participation in the program, AOT recipients experienced far less hospitalization, homelessness, arrest, and incarceration. Specifically, of those in the AOT program:

- 74 percent fewer experienced homelessness;
- 77 percent fewer experienced psychiatric hospitalization;
- 83 percent fewer experienced arrest; and
• 87 percent fewer experienced incarceration.

Some insist on ignoring these results, and instead focus on a prior study of a pilot AOT program at Bellevue Hospital in NYC. Unfortunately, that study was deeply flawed because both those who were violent and those who lacked capacity to make their own decisions—the two groups the program was meant to help—were excluded from the study. In addition, those with substance abuse problems were over-represented in the court-ordered group, skewing results.

However, contrary to claims, and even with those biases, the Bellevue study clearly showed the advantages of assisted outpatient treatment. In fact, AOT cut hospital stays in half, from 101 days in the 11 months following discharge for those without court orders to 43 days of hospitalization for those with them. Thus those who did not have court-ordered treatment spent 14 weeks in the hospital, compared with six weeks for those who had a court order.

In any case, arguments based on the Bellevue study have been rendered moot by New York’s actual experience with Kendra’s Law. On March 1, 2005, New York’s Office of Mental Health issued a report detailing the results of the first five years of Kendra’s Law. In addition to the already mentioned reductions in hospitalizations (77 percent), homelessness (74 percent), arrests (83 percent), and incarceration (87 percent); significantly more individuals had improved medication compliance (103 percent) and participation in substance abuse treatment (67 percent). There were also marked reductions in harmful behaviors; and individuals who were in AOT for longer periods had even greater reductions in violent behavior. Hospital days were also reduced dramatically from an average of 50 days over a six-month period before starting AOT, to an average of 22 days during the six months of AOT, to an average of only 13 days in the six-month period after AOT – a full 74 percent reduction in hospital days six months after termination of the court order when compared with the six months prior to AOT.

**MYTH: Assisted outpatient treatment will bust the budget.**

**REALITY:** Assisted outpatient treatment is not expensive because it does not mandate any services that individuals with severe mental illnesses are not already eligible for (such as case management, medications, or rehabilitation). AOT orders require the system to facilitate treatment compliance for noncompliant individuals by providing them with the services they need to remain stable and prevent the severe consequences associated with untreated mental illnesses. Individuals subject to AOT orders rarely violate their orders, and hence interventions are infrequent.

The savings in hospital costs, forensic costs and other costs far offset any incremental expense of assisted outpatient treatment. In an article in *Schizophrenia Bulletin*, Drs. Peter Weiden and Mark Olfson calculated that nationwide, over two years, the direct costs of rehospitalization attributable to neuroleptic noncompliance is approximately $700 million.

States cannot afford not to use assisted outpatient treatment, as it makes existing services more effective. For instance, many states have Assertive Community Treatment (ACT) teams that comprise the most progressive community service model for people with severe mental illnesses. ACT provides 24-hour, seven-day a week mobile treatment teams that travel to clients' homes to provide treatment. In states that do not utilize assisted outpatient treatment, ACT teams cannot require clients to take medication. The ACT Model manual recognizes that sometimes a court order may be required to ensure that clients benefit from these services. In 1989 in Dane County, Wisconsin, where ACT originated, nearly 25 percent of the chronically mentally ill population had community medication court orders. Without the ability to require treatment in certain instances, ACT teams cannot achieve optimal effectiveness and services are wasted.
MYTH: Assisted outpatient treatment is unconstitutional.

REALITY: Forty-four states and the District of Columbia have assisted outpatient treatment laws – some almost 20 years old. The U.S. Supreme Court has not overturned any of these laws.

At the state level, AOT laws have been upheld wherever challenged. For instance, Kendra’s Law in New York has been upheld through a series of challenges. With the latest ruling In the Matter of K.L., a total of twelve judges in New York have examined the constitutionality of Kendra’s Law; each of them has found the law constitutional, including the state’s highest-ranking ones.

MYTH: Assisted outpatient treatment infringes on civil liberties.

REALITY: It is the illness and its consequent symptoms, not the treatment that restricts civil liberties. Assisted outpatient treatment minimizes the need for incarceration, restraints, and involuntary inpatient commitment, allowing individuals to retain more of their civil liberties. Treatment can free individuals from the “Bastille of their psychosis” and enable them to engage in a meaningful exercise of their civil liberties.

MYTH: Assisted outpatient treatment requires individuals to take life-threatening medications.

REALITY: Medicines used to control neurobiological disorders have been determined by the U.S. Food and Drug Administration to be safe when used according to labeling requirements. Overdosing on these medicines is difficult. However, all medicines, including those used to treat neurobiological disorders, have different efficacy and side effect profiles. The practice of balancing the side effects of the medicines with the likely benefits is not superceded by assisted outpatient treatment laws.

MYTH: If we had more community treatment, we wouldn’t need assisted outpatient treatment.

REALITY: There is no doubt that an improved community-based system would reduce the number of individuals who need intervention. AOT is not an alternative to community treatment; it is a way to see that community treatment is utilized to help those who lack insight into their illness.

It is often claimed that "if you make the psychiatric services attractive enough and culturally relevant, then individuals with serious mental illnesses will utilize them." This is not true. In fact, one recent study showed that the single most significant reason why individuals with schizophrenia and bipolar disorder fail to take their medication is because of their lack of awareness of their illness (anosognosia). Such individuals will not voluntarily utilize psychiatric services, no matter how attractive those services are, because they do not believe that they have an illness.

In New York, Kendra’s Law not only helps the individuals in the program, it is also helping the system better provide treatment to all those in need. The New York Office of Mental Health detailed some of these systemic benefits in its final report: "Counties and stakeholder groups statewide have reported that the implementation of processes to provide AOT to individuals under court orders has resulted in beneficial structural changes to local mental health service delivery systems… The implementation of AOT has also supported the development of more collaborative relationships between the mental health and court systems. AOT has been instrumental in increasing accountability at all system levels regarding delivery of services to high need individuals."
The increased accountability led to a shift in the manner in which treatment to high need individuals was viewed: “Local mental health systems began to identify the potential risk posed by not responding to individuals in need, and as a result, those systems improved their ability to respond more efficiently and effectively.”

**MYTH:** Since voluntary treatment is preferable to forced care; the solution is simply improving services so that people will voluntarily participate in their treatment.

**REALITY:** Voluntary services are an important part of any effective mental health system. However, this proposition fails to recognize the reality that for some individuals, voluntary treatment is simply impossible. The only individuals subject to assisted outpatient treatment are those who are incapable of participating in voluntary services because they are unable to understand that they are ill. AOT intervenes on behalf of these individuals, and provides treatment until they reach the point that they are able to make treatment decisions for themselves. By providing a “safety net” for the most severely ill, AOT fosters the ability to participate in voluntary services.

**MYTH:** All consumers oppose assisted outpatient treatment.

**REALITY:** There are a variety of viewpoints within the consumer community. Some consumers oppose assisted outpatient treatment. Other consumers support assisted outpatient treatment. The Treatment Advocacy Center has consumers on its board and staff, and in its membership, all of who support wider use of this valuable treatment mechanism.

In a survey of people with schizophrenia concerning preferences related to AOT, “being free to participate in treatment or not” was the least important outcome. When asked to rank their preferences, consumers responded that reducing symptoms, avoiding interpersonal conflict, and avoiding rehospitalization all outranked avoidance of outpatient commitment. An informal survey of consumers of services for people with severe mental illnesses by a fellow consumer revealed that a majority supported outpatient commitment. A formal survey published in July 2004 found that a majority of consumers regard mandated treatment as effective and fair. In fact, the authors of a survey of consumers which asked whether AOT caused them to fear treatment concluded that, “[g]iven the often-strident debate about the chilling effect of involuntary outpatient commitment on voluntary help-seeking, it is significant that we find no evidence for such an association in these data.”

But the most compelling argument for assisted outpatient treatment comes from those consumers who’ve actually participated in an AOT program. Researchers with the New York State Psychiatric Institute and Columbia University conducted face-to-face interviews with AOT recipients in New York to assess their opinions about the program, perceptions of coercion or stigma associated with the court order and, most importantly, quality of life as a result of AOT. While the interviews showed that the experience of being court-ordered into treatment made about half of recipients feel angry or embarrassed, after they received treatment, AOT recipients overwhelmingly endorsed the effect of the program on their lives:

- 75 percent reported that AOT helped them gain control over their lives;
- 81 percent said that AOT helped them to get and stay well; and
- 90 percent said AOT made them more likely to keep appointments and take medication.

Additionally, 87 percent said they were confident in their case manager’s ability to help them; and 88 percent said that they and their case manager agreed on what is important for them to work on.
MYTH: Andrew Goldstein, the man who pushed Kendra Webdale into the train, tried to get help but was repeatedly refused community and voluntary services.

REALITY: Portraying Andrew Goldstein as an individual actively seeking help is a serious misrepresentation of the facts. Following the highly publicized death of Kendra Webdale, the New York State Commission on Quality of Care for the Mentally Disabled and the Mental Hygiene Review Board investigated and issued a report on the history of services provided to Mr. Goldstein. The report shows clearly that Mr. Goldstein was an excellent example of why assisted treatment is necessary.

According to the Commission, Mr. Goldstein received 199 days of inpatient and emergency room services, on 15 different occasions, in six different hospitals from 1997 to 1999 (the year Kendra was killed). In 1998 alone, the State of New York spent $495,075 for his mental health and residential care. Unfortunately, New York did not have assisted treatment at the time, and there was little that could be done to ensure that Goldstein maintained his treatment.

Consequently, the two years prior to Kendra Webdale’s death were characterized by repeated emergency room visits, medication noncompliance after release from the hospital, and at least eight incidents of unprovoked violence against others. Whenever Mr. Goldstein requested services, he either changed his mind before arrangements could be made or failed to follow through. At no point during this time did he appear to take his medication regularly.

Mr. Goldstein is exactly the type of person that AOT is designed to help. He was very sick and unable to understand that he needed to consistently maintain his treatment. He repeatedly stopped taking his medication while cycling in and out of the system. But when he was required to do so, Mr. Goldstein took his medication and responded well.

MYTH: AOT law’s place too much focus on violence by mentally ill persons and create even more stigma for people with severe mental illnesses.

REALITY: Rather than focusing on violence, AOT laws allow courts and treatment providers to move away from assessing imminent dangerousness as the entirety of the mental health determination. With these laws, the state is able to step in for individuals who have a history of deterioration and refusing treatment before they reach the point of imminent and active dangerousness. Families and treatment professionals are not forced to wait with their hands tied until an individual has becomes so symptomatic that he is unable to refrain from committing an act of violence.

Focusing solely on violence does a disservice to those with a severe mental illness. Violence is just one of the many repercussions of treatment laws that fail to utilize these types of provisions. AOT laws also reduce homelessness, incarceration, suicide, and victimization – all very real consequences of untreated mental illness.

MYTH: The real problem is that there aren't enough services. Since the solution is simply more funding for mental health treatment, we should eliminate AOT programs and increase mental health funding.

REALITY: Assisted outpatient treatment seeks to help those individuals who illness has rendered them incapable of understanding that they are sick. For this subset of the mentally ill, no amount of money spent on services will ever be enough to induce their compliance with treatment.

Studies show that a small percentage of individuals with schizophrenia or bipolar disorder are physically unable to recognize their condition. These individuals suffer from a condition known as anosognosia – literally “to not know a disease.” For these individuals, the delusions (e.g. the
woman across the street really is being paid by the CIA to spy on him/her) and the hallucinations (e.g. the voices really are instructions being sent by the President) are real, and no amount of voluntary services will ever suffice. Even with a “perfect” treatment system, people who are unable to understand that they are ill will never seek necessary treatment.

AOT laws recognize this situation and seek to provide a viable treatment option so that these individuals are not allowed to slip through the cracks of the mental health system simply because they are unable to understand their need for treatment.

**MYTH: AOT programs such as Kendra’s Law destroy the therapeutic relationship between the consumer and his or her treatment team.**

**REALITY:** This unsubstantiated myth is often perpetuated by opponents of AOT. We know now that this simply isn’t the case. Actual data from studies of individuals participating in AOT programs show that AOT fosters working alliances between recipients and their case managers, while ensuring that individuals receive care who would otherwise be lost to the symptoms of their illness.

An ongoing study of New York’s Kendra’s Law program presents a compelling case for the positive role of AOT in the therapeutic relationship. More than 75 face-to-face interviews have been conducted with participants in New York’s program to assess their opinions about AOT, including their perceptions of coercion or stigma associated with the court order and their quality of life as a result of AOT. Contrary to what AOT opponents speculate, the interviews of AOT recipients showed that when asked about the impact of the pressures and other measures that people took to get them to stay in treatment:

- 75 percent reported that AOT helped them gain control over their lives,
- 81 percent said that AOT helped them to get well and stay well, and
- 90 percent said AOT made them more likely to keep appointments and take medication.

When interviewed concerning the effect AOT had on their working alliance with their case manager, 87 percent of AOT recipients said they were confident in their case manager’s ability to help them – and 88 percent said they and their case manager agreed on what is important for them to work on. In contrast to what opponents of AOT often argue, Kendra’s Law enhanced the relationship between provider and consumer, benefiting everyone.

**MYTH: AOT unfairly focuses on violent individuals, and ignores the fact that the majority of individuals with severe mentally illnesses are nonviolent.**

**REALITY:** As intended, individuals placed in assisted outpatient treatment (AOT) are among the most severely ill. This does not mean that every individual on AOT is violent; as violence is only one small part of the consequences of untreated mental illness. Even more common consequences include victimization, homelessness, repeated hospitalization, substance abuse, incarceration and arrest.

The characteristics of AOT recipients in New York’s Kendra’s Law bear this out. In the three years prior to the court order, almost every participant – 97 percent – had at least one psychiatric hospitalization (with an average of three hospitalizations per recipient). When compared with a similar population of mental health service recipients, those placed in AOT had been twice as likely to have been homeless, 50 percent more likely to have had contact with the criminal justice system, and 58 percent more likely to have a co-occurring mental illness and substance abuse condition. Only 15% of individuals helped by Kendra’s Law had physically harmed another at the
onset of the AOT court order, but nearly 70% (66 percent) were not exhibiting good adherence to medication. AOT is not a program to prevent violence, although it does; it is a program to help the most severely mentally ill and prevent the most common and debilitating consequences of untreated mental illness.

**MYTH: Law enforcement agencies will oppose AOT because of its cost and increased responsibilities for officers.**

Assisted outpatient treatment enjoys broad support from law enforcement agencies because it is their officers who are called on to deal with individuals in the midst of a psychiatric crisis. They see first-hand the victimization, criminalization, homelessness and substance abuse that often accompanies untreated mental illness. Consequently, law enforcement officers are some of the strongest supporters of AOT. In 2004, the Florida Sheriffs Association led their state’s successful legislative drive to enact AOT legislation. Other law enforcement agencies throughout the country have passed resolutions in support of AOT, including the National Sheriffs Association, the Florida Chiefs of Police, the New York State Association of Chiefs of police, the New Jersey State Association of Chiefs of Police, the Maine Sheriffs’ Association, and the Maine Chiefs of Police Association.