Why Not “Assisted Outpatient Treatment”?

The Proposed ‘Assisted Outpatient Treatment’ bill would require people assigned to be on ‘AOT’ to adhere to a number of orders **against their will and while living out in the community** which may include taking medications, attending therapy and psychiatry appointments, attending particular day programs, submitting to drug testing, and so on. **It is the equivalent of being on probation without ever having committed a crime and asking people to do things with their body that they do not want to do and that, in some cases, may even hurt them.**

There are many reasons why Massachusetts should NOT pass legislation that brings what proponents are calling ‘Assisted Outpatient Treatment’ (AOT) and what others call Outpatient Forced Commitment (OFC) or Involuntary Outpatient Commitment (IOC) to our state.

Most who argue FOR OFC suggest that it is needed in order to ensure that people who are otherwise unaware (due to an alleged incapacity to fully assess their situation) of their need for treatment can be required to receive consistent help and remain safely in the community rather than ending up in the hospital and/or legal system. People who make this argument typically suggest that such treatment is ‘for the good’ of both the individual (who deserves an opportunity to live a full life under humane conditions) and the community (deserving to be safe). They also suggest that OFC is a key to preventing many future tragedies.

However, these arguments are based on several FALSE arguments and BAD assumptions as noted below:

FALSE ARGUMENT/BAD ASSUMPTION	TRUTH*
The treatments that OFC would force are effective and are in the best interest of the person who has been diagnosed as mentally ill.	An increasing body of research is telling us that the common treatments to be forced are not only ineffective, but may be making some people’s symptoms WORSE and/or causing irreparable harm to their brains and bodies.
There are no other more effective options.	Both national and international research tells us there are MANY more effective options, especially if the tremendous administrative cost (**over 32 million in New York State, for example!**) of OFC implementation were diverted to improved supports and services.
OFC has been effective in reducing crime and improving outcomes for individuals and the community.	Research suggests that outcomes have not improved where OFC has been employed and/or that improvements have been the result of other interventions and NOT OFC itself.
People who have been diagnosed as mentally ill are dangerous.	While there IS evidence to suggest that alcohol and drugs are linked to an increase in dangerousness, evidence does NOT suggest that people who are diagnosed as mentally ill are more dangerous than anyone else.
Had OFC been available in Connecticut, Colorado, or any of the other places where tragedies have occurred in recent years, it would have stopped them from happening.	There is no research to suggest that OFC would have been effective in stopping these recent tragedies. There is, however, a growing concern of possible links between psychiatric medication and an increase in violence in several of these situations.
OFC can be implemented in a fair and reasonable manner that does not unduly violate the rights of individuals in the community.	OFC takes away the rights of individuals who – in most instances – have committed no crime. Research also suggests that implementation of OFC suffers from the same issues with racial discrimination as does the legal system.

* See the following pages for details on each of these points.

TREATMENT TO BE FORCED IS NOT EFFECTIVE: If we are going to force a particular treatment on human beings, we should be able to have some reasonable confidence that the treatments to be forced are effective and not harmful. Most emerging research is now suggesting that treatments proposed to be forced are both INEFFECTIVE and HARMFUL. For example:

- In 2011, based on recent findings, Dr. Rif El-Mallakh (Director of the Mood Disorders Clinical and Research Program in Louisville, KY) stated, “Continued drug treatment may induce processes that are the opposite of what the medication originally produced.” This may, “cause a worsening of the illness, continue for a period of time after discontinuation of the medication, **and may not be reversible**.” (*El-Mallakh, R. “Tardive dysphoria: The role of long-term antidepressant use in inducing chronic depression. Medical Hypotheses 76 (2011): 769-773.)*
- In 2002, Psychiatrist Emmanuel Stip was quoted as saying, “After fifty years of neuroleptics, are we able to answer the following simple question: Are neuroleptics effective in treating Schizophrenia? [There is] **no compelling evidence on the matter, when ‘long-term’ is considered**.” (*European Psychiatry*, 2002)
- In 2011, Dr. Nancy Andreasen reported that the **brain shrinkage** previously associated with the ‘natural course’ of Schizophrenia as well as the worsening of ‘Schizophrenic’ symptoms was actually due **to psychiatric medications**. (*Ho, B. “Long-term antipsychotic treatment and brain volumes.” Arch Gen Psychiatry 68 (2011):128-37.)*
- In 2012, a European brain imaging study confirmed **that brain shrinkage was “significantly more severe**” in medicated patients. (*J. Radua. “Multimodal meta-analysis of structural and functional changes in first episode psychosis and the effects of antispychotic medications.” Neuroscience and Biobehavioral Review, in press as of 9/04/2012.)*
- In 2012, Martin Harrow (Professor at the University of Illinois, Department of Psychiatry) reported on his long-term study of individuals diagnosed as psychotic and found that **medicated individuals had significantly worse outcomes in EVERY area** studied including anxiety, cognitive function, psychotic symptoms, and overall recovery. (*Harrow M. “Do all schizophrenia patients need antipsychotic treatment continuously throughout their lifetime? A 20-year longitudinal study.” Psychological Medicine, (2012):1-11.)*
- It is a widely accepted and reported statistic that people who have been diagnosed with mental illness and are receiving treatment in the mental health system are **dying, on average, 25 years younger that the average citizen.** *(“Cornerstones for Behavioral Healthcare Today and Tomorrow.” National Association of State Mental Health Program Directors, 2012)*

OTHER TREATMENT AND SUPPORTS ARE EFFECTIVE: Laws such as the Olmstead Act (***Olmstead v. L.C.**, [527 U.S. 581](527 U.S. 581),1999*) suggest that people have the right to live and receive treatment in the least restrictive environments possible. While OFC would not confine people to a hospital and in fact seeks to reduce the need for hospitalization (though has been shown to be unsuccessful in doing so), it is nonetheless an extremely restrictive measure in a world where there are many examples of non-restrictive supports being far more effective. These options are also often much less expensive than the costs of implementing OFC and related traditional treatments. For example:

- Open Dialogue, developed by Jaakko Seikkula, PhD and others in Northern Finland, has been shown to have the **highest documented rates of recovery in the world** with only minimal use of medication (over 60% have treated have never been exposed) and while supporting people to stay in the community. (*Seikkula, J. “Five-year experience of first-episode nonaffective psychosis in open-dialogue approach.” Psychotherapy Research 16 (2006):214-28.)*
- The Family Care Foundation, developed by psychotherapist Carina Hakansson and others in Sweden, is also **having tremendous success** through combining clinical knowledge and a ‘foster family’ approach with minimal medication and hospital interventions. *(‘Healing Homes,’ Daniel Mackler, 2011.)*
- The Hearing Voices approach (developed by Dr. Sandra Escher and Professor Marius Romme in collaboration with voice hearer, Patsy Hage) was developed in the Netherlands and has become wide

spread in Europe where groups are regularly held in a variety of environments (including prisons), for adults and children, **with life changing results for many.** *(Making Sense of Voices, Marius Romme & Sandra Escher, 2000.)*

- There is a growing evidence base for peer-run crisis alternatives (such as Afiya House based in Western Massachusetts and facilitated by the Western Mass Recovery Learning Community). Research so far has suggested that **these alternatives result have higher positive impact than hospitalization** *(Greenfield, Stoneking, Humphreys, Sundby, & Bond, 2008),* while also improving self-direction and personal satisfaction *(SAMHSA, 2004).*
- It is also **widely accepted that reduced isolation and alienation and increased connection to fellow human beings can be instrumental in reducing violence and increasing overall outcomes and satisfaction in one's life**. These sorts of supports are now increasingly being offered by places like the Massachusetts Recovery Learning Communities.

OUTCOMES HAVE NOT IMPROVED AS A RESULT OF AOT: Although some have argued that there have been multiple improvements demonstrated following the implementation of OFC in the 44 states where it now exists in the United States, the data simply does not support this assertion. For example:

- In 2013, Nursing Times reported that a University of Oxford research study found no statistical difference in hospital readmissions for individuals who were under 'AOT' orders and those who were not. Researchers concluded by saying that there is "**no support in terms of any reduction in overall hospital admission to justify the significant curtailment of patients' personal liberty**."
- Although 'AOT' is legal in 44 states, there are only 12 states that report actually making use of the law. *("Responding to the Challenge of Involuntary Outpatient Commitment", NYAPRS, Harvey Rosenthal, 2013*.)
- In 2001, the results of a 3-year study at Bellevue Hospital were shared, reporting that "On all major outcome measures, **no statistically significant differences were found** between" those who were offered improved but voluntary services and those who were offered the same services with a court order. *("Assessing in the New York City Involuntary Outpatient Commitment Pilot Program", Steadman et al, 2001.)*
- Based on lack of demonstrated effectiveness, Drs. Kirsley and Campbell (who were highlighted by the Cochrane Database of Systematic Reviews, the gold-standard of peer reviewed psychiatric research) assessed the number of outpatient commitment orders (OPC – the equivalent of OFC in the United Kingdom) it would take to prevent one re-hospitalization. They concluded "it takes 85 OPC orders to prevent one readmission, 27 to prevent one episode of homelessness and 238 to prevent a future arrest". Ultimately, that suggested that, **84 people would need to be subjected to a unnecessary (i.e., would not make a difference in their outcomes) forced treatment program in order to reduce just one re-hospitalization.** *(Kisely S, Campbell LA, Preston N. Compulsory community and involuntary outpatient treatment for people with severe mental disorders. The Cochrane Database of Systematic Reviews 2005, Issue 3.)*
- Studies that have showed improved outcomes (e.g., Duke Study, 2005) have failed to offer controls for improvements due to simultaneous voluntary service enhancements. In other words, it is **impossible to tell if improvements were the result of OFC or the results of improvements to the overall system** that happened at the same time.

PEOPLE DIAGNOSED AS MENTALLY ILL ARE NOT MORE DANGEROUS: In 2003, the President's New Freedom Commission reported that "61% of Americans think that people with Schizophrenia are likely to be dangerous to others." The media (both news and entertainment) continues to feed into that idea. However, evidence suggests quite the opposite reality. For example:

- Results of the 1998 Macarthur Violence Risk Assessment Study (www.macarthur.virginia.edu) reported that people diagnosed with mental illness were no more likely to be violent than the general population except (just like the general population) when they abuse alcohol or drugs. In a more recent review, Dr. Dan Fisher reported, "In this study, the **prevalence of violence among those with a major mental**

disorder who did not abuse substances was indistinguishable from their non-substance abusing neighborhood controls." *("Violence and Mental Illness." Dan Fisher. 2012.)*

- If there is a particular vulnerability among those who have been diagnosed, research suggests that it is to be the **VICTIM of a crime rather than the perpetrator**. *("Crime Victimization in Adults with Severe Mental Illness." Teplin et al. 2005.)*
- Research has also suggested that, as a group, **people diagnosed with mental illness contribute less to overall community violence than would be suggested simply by looking at overall rates of violence in the community as a whole.** **(***Swanson, J.W. Mental disorder, substance abuse, and community violence: an epidemiologic approach. In: Monahan, J., Steadman, H.J. editors. Violence and mental disorder: developments in risk assessment. Chicago: University of Chicago Press. (1994). pp. 101–136.)*

OFC WOULD NOT HAVE BEEN LIKELY TO PREVENT RECENT TRAGEDIES: Although it's natural for communities to ask 'why' a tragedy happened and to seek to prevent future tragedies, there is no evidence to suggest that OFC would have prevented any of the recent publicized occurrences of mass violence. For example:

- Many of the people responsible for some of the recently publicized acts of violence (e.g., Andrew Goldstein, Julio Perez, Lee Coleman, David Kostovski, etc.) **WERE in treatment that failed them**. *("Responding to the Challenge of Involuntary Outpatient Commitment", NYAPRS, Harvey Rosenthal, 2013*.)
- Aaron Alexis (responsible for the most recently publicized act of mass violence in the Washington Navy Yard) was actually reportedly in **treatment and on psychiatric medication at the time of the shooting**. *(New York Times, September 18, 2013.)*
- Although people are inclined to make generalizations about the potential impact of OFC on individuals responsible for some of the most recent tragedies, the reality is that **most of these events occurred in states where OFC is already available.**

OFC IS NOT ENACTED IN A FAIR OR JUST MANNER: Many consider OFC to be the equivalent of being put on probation before ever having committed a crime, and thus see it as a clear human rights violation. Additionally, many see the treatments then forced to be harmful to an individual's body and mind and thus see these treatments, when forced, as an act of torture. Additionally, there is clear evidence to suggest that systems are not able to implement OFC laws in a fair and non-discriminatory manner. Although this finding is widespread, New York offers us many important examples including:

- According to the New York Office of Mental Health's final report on Kendra's Law, **63% of people being court-mandated under the law were identified as black and Hispanic**. *(Mental Health E-News, NYAPRS, 2005.)*
- **Black people were found to be 5 times more likely to be put on OFC** orders in New York State. *("Responding to the Challenge of Involuntary Outpatient Commitment", NYAPRS, Harvey Rosenthal, 2013*.)
- In a 2005 report, the New York Lawyers for the Public Interest called the **implementation of OFC in New York State, "Severely biased.**" *("Responding to the Challenge of Involuntary Outpatient Commitment", NYAPRS, Harvey Rosenthal, 2013*.)
- In New York State, **82% of OFC orders occurred in New York City**, although there is no reason to believe that there is actually that disproportionate of a difference between individuals diagnosed with mental illness in that region of the state. *("Responding to the Challenge of Involuntary Outpatient Commitment", NYAPRS, Harvey Rosenthal, 2013*.)

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