SMIAdviser
A Clinical Support System for Serious Mental Illness

An APA and SAMHSA Initiative

AMERICAN PSYCHIATRIC ASSOCIATION

SAMHSA Substance Abuse and Mental Health Services Administration

In Partnership With

TREATMENT ADVOCACY CENTER

MYTHS and FACTS about AOT

MYTH: AOT needs "teeth" to work

FACTS: AOT is mandatory treatment under a civil court order. Non-adherence to treatment in violation of the court order is common in AOT programs, especially early in the court-ordered period. When judges are advised that they should never use punitive measures in response to treatment non-adherence, they often ask, "How can this be effective if the court order has no 'teeth'?" But the absence of punishment does not mean that there are no consequences to treatment non-adherence. While the specifics vary among the state laws, non-adherence typically provides the grounds for an AOT participant to be detained for a short period of clinical evaluation, provided there is genuine concern that the participant may be in need of a more restrictive level of care.

Participants succeed in AOT not because of a perceived threat, but because with the support of the treatment team and court they come to recognize benefits of treatment engagement.[1] Research suggests that communicating this to participants requires a shared sense of mission and a consistent message from the court, providers and family. Motivation may be boosted by an increase in insight that comes with adherence and response to medication. Even without restored insight, improvements in quality of life that result from treatment adherence, including reduction in the number of days spent in the hospital, can inspire continued participation in treatment.

MYTH: AOT is incompatible with recovery and person-centered treatment

FACTS: Critics often claim that AOT violates a basic tenet of recovery-centered treatment because it is not "self-directed." While it is undeniable that AOT places limits on self-direction in the short term, recovery principles are embraced in the day-to-day hard work of helping participants find their path to a better life. Some states' AOT laws expressly require person-centered planning. But even without statutory guidance, every

attempt should be made to *maximize* self-direction without taking it to dangerous extremes. In the end, this common-sense balance empowers the participant to truly take control of their own destiny.[2]

Post-AOT, when there is no longer a court order in the picture, success in recovery relies on engagement in treatment. This is why AOT programs must focus on treatment *adherence* rather than *compliance*. "Compliance" is paternalistic and suggests that the participant should passively do what they are told. "Adherence" implies self-direction and agency. We strive for adherence in AOT so that when the court order expires, the participant will continue to adhere to treatment. Research shows that turning involuntary participants into adherent voluntary participants is best achieved by emphasizing person-centered care and empowerment tactics.[3]

"Advocating for a person in a decompensated state of mind to be able to refuse treatment is not a protection of liberties. Rather, it serves to deny a diagnosed person's ability to pursue liberty and choice, as liberty and choice are suffocated by the presence of untreated/under-treated SMI. Freedom, choice, and liberty cannot and do not exist until one becomes stabilized and sane. AOT is one of the best ways to accomplish this and does so by way of civil/non-criminal court proceedings, recognizing that mental illness is not a crime."

Eric Smith, AOT Graduate

MYTH: AOT is too expensive

FACT: AOT saves money in a system by replacing inpatient treatment with more cost-effective outpatient care.

- In New York City, mental health system expenditures on the average participant declined 43% in the first year after AOT began and an additional 13% in the second year.[4]
- Legal and administrative costs of AOT are small in comparison to the cost of frequent shifting from inpatient to outpatient utilization.[5]

MYTH: Offering comprehensive community-based services eliminates any need for AOT

FACT: By obligating the mental health system to actively engage those whose illness prevents them from seeking treatment voluntarily, AOT helps ensure that available resources will be directed to those most in need.

- The mental health system is incentivized to provide care to those who voluntarily present for services. Providers are not reimbursed for outreach to those too sick to seek treatment on their own.
- Not everyone has access to pre-existing comprehensive services. AOT provides services to those who may otherwise not receive them.[6]

MYTH: AOT causes participants to feel coerced into treatment and/or stigmatized

FACT: AOT participation need not lead to a heightened sense of coercion or stigma.

- A New York study found that AOT participants were no more likely to feel they had been coerced into treatment or stigmatized by the treatment system than were voluntary recipients of public mental health services.[7]

MYTH: AOT efficacy is unsupported by data

FACT: AOT efficacy is supported by substantial peer-reviewed data.

- Although data stems from particular states with particular laws, there is substantial evidence to show AOT's effectiveness for individuals with schizophrenia and other psychotic disorders who meet certain legal criteria (including histories of non-adherence to treatment).
- Studies in New York found that long-term AOT coupled with intensive outpatient services led to a 72% reduction in hospitalizations[8] and reduced the risk of arrest by 74% compared to similarly situated individuals who did not receive AOT.[9]

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