What We Do & Don’t Know about “Assisted Outpatient Treatment”

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Thoughts Before We Start

- Frequently hear “sound bites” re AOT that have no deeper grounding in the literature
- Heavily criticized / problematic non-peer-reviewed reports like the 2025 ASPE Evaluation held up as “proof AOT works”
- Members of the general public who have no idea what AOT adjudication or post-adjudication services actually look like
- Huge gaps to overcome in communicating what we actually do and don’t know

What is AOT and how does it work?

Assisted Outpatient Treatment (AOT)/ Involuntary Outpatient Commitment (IOC)

- Also known as a Compulsory Treatment Order (CTO) & Mandated Outpatient Treatment (MOT) outside the US
  - A court-ordered program of community-based mental health (and/or substance use) treatment for individuals labelled with “severe mental illness”
- **Legal Framework:** Operates under civil law
  - judge or magistrate mandates a specific treatment plan while the individual lives in the community
- **Mechanisms:** Leverages the authority of the court + enforcement through threats of involuntary removal/hospitalization/medication over objection to motivate the individual to ‘adhere to treatment’ & to mandate accountability on the provider side
  - Sometimes closer to Mental Health Court models, sometimes very different

Eligibility

- Most common:
  - **18 years or older**.
  - Have a **Serious Mental Illness (SMI)** (often defined as a primary diagnosis of a psychotic or severe mood disorder)
  - **“Unlikely to survive safely in the community without supervision**”
  - History of “non-compliance” and/or “recidivism”
- Future risk variations
  - **Strict States :** evidence of **imminent danger to self or others** (closer to inpatient commitment standards)
  - **Preventative States: I**ntervention justified based on a "need for treatment" to prevent **deterioration** that would *likely* lead to harm, even if a crisis isn't happening "right now”
- Some states also require that the individual be “likely to benefit” from AOT services

Least Restrictive Alternative (LRA) standards

- “Deprivations of liberty solely because of dangers to the ill persons themselves should not go beyond what is necessary for their protection” (Bazelon in Lake v Cameron)
- However, interpretation varies by state:
- California requires that individuals are first offered a ‘voluntary’ alternative:
  - “(5) The person has been offered an opportunity to participate in a treatment plan by the director of the local mental health department, or the director’s designee, provided the treatment plan includes all of the services described in Section 5348, and the person continues to fail to engage in treatment.”
    - Operationalized in Los Angeles County as requiring a 30-day period of attempted outreach and engagement in voluntary services before AOT can be pursued
  - In other states, AOT assumed to be a “least restrictive alternative” relative to hospitalization or incarceration

THE AOT JOURNEY: FROM HOSPITAL BED TO COURT-ORDERED SURVEILLANCE

① INITIATION

Involuntary Hospitalization

Individual in distress; clinician determines AOT criteria may be met. Hospital or county files petition with court.

Individual may not understand what is happening or why; may still be experiencing acute distress or altered states when process begins.

② LEGAL PROCESS

Court Hearing

Public defender assigned — often a brief phone call, not a meeting.

Hearing may be perfunctory or waived entirely under pressure.

Varies dramatically by judge and jurisdiction.

Defense counsel may advise "just agree" to avoid contested hearing; individual may not grasp what rights are being waived.

③ COURT ORDER ISSUED

Mandated Treatment Plan

Judge signs order specifying:

- Medications (often LAIs)
- Outpatient appointments
- Substance use restrictions
- Housing placement
- Case management services

Individual discharged into community under legal mandate. Order typically 90–180 days; renewable indefinitely.

④ POST-ADJUDICATION: THE SURVEILLANCE STRUCTURE

Monitoring & Compliance

- Providers must "lay eyes on" individual regularly (weekly or more frequent visits)
- Scheduled long-acting injectable (LAI) medications — refusal = noncompliance
- Random or scheduled drug screens
- Case manager reports to court on adherence at status hearings
- SSI/SSDI representative payee may control individual's finances

Living Conditions

- Group home or supervised residential facility
- Or: still homeless — AOT does not guarantee housing
- Mandated program attendance (day programs, groups, etc.)
- Limited autonomy over daily choices, schedule, diet, money

Order renewed every 90–180 days; may continue for years with no defined endpoint.

⑤ IF "NONCOMPLIANT": THE COERCIVE ESCALATION PATHWAY

Missed Appointment
Refused medication, missed visit, or positive drug screen

→ **Case Manager Warnings**
Reminders about "consequences of nonadherence" (Swartz 2002)

→ **Pick-Up / Removal Order**
Court authorizes law enforcement transport to hospital

→ **Involuntary Hospitalization**
Evaluation for inpatient commitment; medication over objection order may be sought

→ **Cycle Restarts**
Re-stabilized; discharged under same or renewed order

Back to hospitalization — cycle may repeat for years

The AOT-to-Forced Medication Pipeline

How statutory protections are circumvented through regulatory gaps in Pennsylvania

CONTEXT: ALLEGHENY COUNTY, PA

AOT implemented January 1, 2026 • First active AOT program in Pennsylvania

MH Bulletin 99-85-10 (1985) still governs medication over objection in community settings

OMHSAS-25-03 (2025) updated protections apply ONLY to state mental hospitals

1 AOT ORDER ISSUED

Court orders assisted outpatient treatment under MHPA § 304(c.1)/(c.2). Treatment plan typically includes psychiatric medication, therapy, and wraparound services.

2 PERSON REFUSES MEDICATION

Individual exercises refusal of prescribed psychotropic medication. Under § 304(g)(6), the court MAY NOT hold the person in contempt or otherwise sanction them solely for noncompliance with the treatment plan.

3 TREATMENT TEAM DOCUMENTS "DETERIORATION"

Treatment team documents that medication refusal has led to clinical deterioration. Team or "any responsible party" argues the person now poses a danger to self or others, meeting the standard for involuntary emergency examination.

4 SECTION 302 PETITION FILED

Involuntary emergency examination initiated. Despite county assurances, this step often involves law enforcement for transport and physical custody. Person is taken to an inpatient psychiatric facility for up to 120 hours.

5 MEDICATION ADMINISTERED OVER OBJECTION

Under MH Bulletin 99-85-10 (1985), the facility may administer psychotropic medication over objection with only a second opinion from a colleague of the treating psychiatrist. No hearing. No independent panel. No formal appeal process. No patient advocate. The protections OMHSAS-25-03 now requires for state hospitals do not apply.

Effectiveness / Efficacy

The “Duke Study” (Swartz et al., 1999, 2000, 2001, 2002)

- Potential participants were all hospitalized, awaiting release with outpatient commitment order
  - If agreed to the study, 50-50 chance of leaving with immunity from an IOC for one year
  - 264 enrolled and were randomized, 67 “very violent” clients were non-randomized (all IOC)
  - 112 lost to follow up by 12 months (12-month analyses for 219 participants, inc. 47 non-randomized)
  - Both groups had access to case manager + outpatient services
    - Unclear what these services consisted of or how consistent they were across clients
  - **No significant differences between the groups on primary outcomes** (no effect of intervention in intent to treat analyses)
    - Hospital admissions, length of stay, violence, arrests, treatment adherence
  - **Significant effect on perceived coercion (Swartz et al 2002)**
    - IOC increased perceived coercion by 45%
    - Black participants were ~twice as likely to experience high levels of coercion as white participants, controlling for diagnosis, symptom severity, substance abuse, insight, functioning, marital status, and IOC length
  - **Modest (significant) effect on reduced victimization among IOC group**
  - However, further post hoc analysis found:
    - (Non-randomized) subgroup with sustained IOC (6+ months) and/or more intensive service engagement did better on primary outcomes (hospitalizations, violence)
    - NOTE: Evidence based review standards / Cochrane Collaborative treat post hoc subgroup findings that contradict null primary analyses as extremely tenuous; The Duke Study is treated as a null trial in systematic reviews / meta-analysis

The Bellevue Study (Steadman et al., 2001)

- 567 referred patients, 315 eligible
  - 142 completed baseline and were randomized (78 court-ordered, 64 control)
  - Excluded individuals with “history of violence”
  - **Both groups received the same enhanced service package**:
    - inpatient assessment, comprehensive discharge plan with patient participation, case management, + oversight by a dedicated coordinating team
- **No statistically significant differences on any major outcome:**
  - Rehospitalization: 51% (court-ordered) vs. 42% (control) — not significant
  - Arrests: 18% vs. 16% — non–significant (+ no participant in either group arrested for a violent crime)
  - Quality of life, symptomatology, treatment compliance, perceived coercion — non significant
- **No increase in coercion as measured but** ~ half of each group reported high coercion regarding medication and treatment
- **(Importantly) both groups “improved” significantly** compared to pre-enrollmen
  - Arguably speaking to a primary mechanism of enhanced service access

UK: Oxford Community Treatment Trial (Burns et al. 2013, 2015, 2016, 2020)

- Goal = “‘to conduct the most rigorous trial possible of CTOs with prolonged, high-quality care” (Burns et al 2016)
- Sample = Eligibility limited to psychosis
- **CTO/IOC did not reduce the rate of readmission to hospital.**
- **No impact on:**
  - **time to readmission**
  - **number and duration of hospital admissions**
  - **any measured clinical and social outcomes.**
- **No differences between CTO/IOC and control outcomes for any of the prespecified subgroups**

OCTET Cont’d

- 36-month follow up: “**We identified no evidence that increased compulsion leads to improved readmission outcomes or to disengagement from services in patients with psychosis over 36 months.** … The findings from our 36-month follow-up support our original findings that CTOs do not provide patient benefits, and the continued high level of their use should be reviewed.”
  - “**The continuing spread of CTO legislation and their increased use, despite no evidence of benefit in all three published trials, is surely contrary to psychiatry's declared commitment to evidence-based practice. Further trials or modifications of the policy and practice are urgently needed.”** (Burns et al 2015)
- 2020 Cost-Effectiveness analysis: “CTOs are unlikely to be cost-effective. No evidence supports the hypothesis that CTOs decrease hospitalization costs or improve quality of life. Future decisions should consider impacts outside the healthcare sector such as higher informal care costs and legal procedure burden of CTOs”

Cochrane Review (2017)

- Systematic review + meta-analysis of the three RCTs, following rigorous Cochrane methodology and standards
- Conclusion: no significant effect of IOC on any outcome except victimization (from the Duke Trial)
- Number need to treat for benefit from meta-analysis: **would take 142 orders to prevent one readmission**

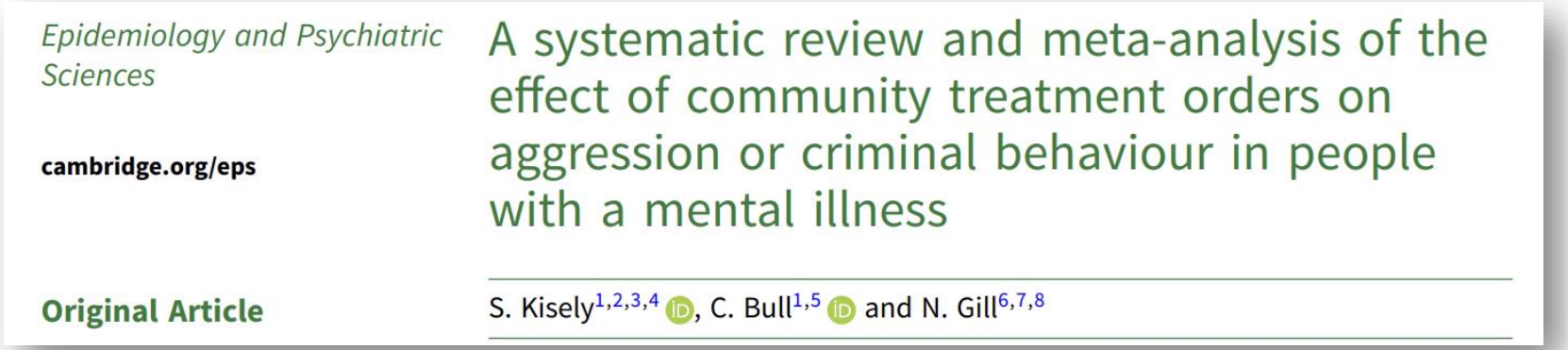
US non-experimental studies

- Larger number of US non-experimental studies – pre-post and/or matched controls
- The caveats?
  - Pre-post studies of access to/enrollment in virtually any enhanced services, including housing access and SSI/SSDI access, improve at least some outcomes
  - Pre-post studies are structurally unable to disambiguate benefits of service and housing access (access component) from an involuntary court order (legal coercion component)
    - Further confound = provider accountability for AOT/IOC clients
  - “Regression to the mean” – people for whom AOT/IOC is initiated when at their worst point will tend to improve after even in the absence of intervention, can only be accounted for in comparison to a control group

New York State Studies inc Duke Evaluation

- Swartz et al 2010: Pre-post comparisons using NY claims data – no control group
  - Reduced hospitalizations
  - Increased psychotropic prescriptions / receipt (*intrinsic to AOT orders in NY)
  - Increased case management (*intrinsic to AOT orders in NY)
- Phelan et al 2010: Non-randomized matched comparisons
  - 76 individuals court ordered to assisted outpatient treatment compared to 108 comparison individuals recently discharged from a psychiatric hospital who "were attending the same outpatient facilities as the assisted outpatient treatment group"
  - **No difference in level of psychosis symptoms or quality of life**
  - **Significant reductions in suicide risk scores and violent behavior** (**BUT based on only 6 events in the entire sample – 5 in the control group, 1 in AOT)**
    - Further no examination of matching on the basis of substance use, how groups differed on substance use or whether substance use moderated outcomes – SU is the single most replicated predictor of violence
  - **No difference in self-reported stigma or coercion**
  - The authors also controlled for case management "we controlled for the availability of a case manager in supplementary analyses and found that in some instances the significant or marginally significant effect sizes for assisted outpatient treatment became slightly stronger or slightly weaker"
  - Author's conclusion: "people's lives seem modestly improved by outpatient commitment. However, because outpatient commitment included treatment and other enhancements, these findings should be interpreted in terms of the overall impact of outpatient commitment, not of legal coercion per se."

On Violence: Recent Meta-Analysis of the International Literature (Kisely et al., 2025)



"Results. Thirteen papers from 11 studies met inclusion criteria. Nine papers came from the United States and four from Australia. Two papers were of RCTs. **Results for all outcomes were non-significant, the effect size declining as study design improved from non-randomised data on self-reported criminal behaviour, through third party criminal justice records and finally to RCTs.** Similarly, there was **no significant finding** in the subgroup analysis of serious criminal behaviour."

ASPE Evaluation

- Limited & heavily critiqued but currently cited as a primary reference in some jurisdictions in support of AOT implementation
  - Conducted by RTI International, Policy Research Associates (PRA) & Duke (Swanson & Swartz)
  - 6 case study sites selected from 18 funded programs
    - Note: 3 original sites were replaced mid-study due to "insufficient capacity for data collection or too many programmatic limitations”
  - Mixed methods: structured clinical interviews w AOT participants at baseline, 6 months, and 12 months
    - Data collected via interviews conducted by “AOT program staff, most frequently non-primary treating clinicians”
    - supplemented with Medicaid claims data, arrest records, hospitalization records
    - Also family survey and cost questionnaire
  - Comparison group = single voluntary ACT program at one of the sites

TABLE 1-2. In-Depth Sites for Implementation Evaluation	
Grantee	**Implementing Location(s)**
AltaPointe Health Systems, Inc.	Baldwin Co, AL
Cook County Health & Hospital System	Chicago, IL
Hinds County Mental Health Commission	Jackson, MS
Doña Ana County	Las Cruces, NM
Alcohol, Drug Addiction & Mental Health Services Board of Cuyahoga County (ADAMHSBCC)	Cleveland, OH
ODMHSAS	Oklahoma, Tulsa, Rogers, Washington, Ottawa, and Delaware Counties, OK

TABLE F-1. Comparison Group Results at 6-month Follow-up, Regression-Adjusted								
	Comparison Group Baseline, mean/%	AOT Group Baseline, mean/%	Comparison Group Follow-up, mean/%	AOT Group Follow-up, mean/%	Relative Change	95% CI	P-Value	Bayes Factor
Appointment adherence, %	47.6%	84.8%	78.5%	96.1%	1.0	(-4.9, 6.8)	0.746	0.0
Medication adherence, %	43.3%	70.8%	78.8%	92.4%	3.3	(-5.5, 12.1)	0.468	0.2
MCSI score, mean	3.5	3.9	4.2	4.7	0.0	(-0.3, 0.3)	0.814	1.5
Perceived MH as excellent, %	3.9%	12.5%	9.5%	18.1%	22.9	(10.5, 35.3)	<0.001	>100
Life satisfaction score, mean	4.4	5.0	4.8	5.4	0.0	(-0.4, 0.4)	0.955	1.1
Working alliance inventory, goal scale, mean	12.4	12.3	14.8	14.7	2.3	(-0.2, 4.7)	0.066	50.8
Working alliance inventory, task scale, mean	12.3	12.3	14.8	14.8	1.9	(-0.6, 4.4)	0.129	18.6
Working alliance inventory, bond scale, mean	13.6	13.5	16.2	16.1	1.5	(-1.0, 3.9)	0.233	9.4
Any violent behavior, %	31.4%	15.7%	7.1%	3.0%	0.7	(-4.2, 5.6)	0.781	19.4
Any suicidal ideation, %	20.9%	17.5%	5.9%	4.7%	-1.9	(-7.4, 3.6)	0.498	0.5
Any MH ED visits, %	11.9%	2.9%	5.9%	1.3%	2.8	(-0.9, 6.5)	0.139	26.3
Any psychiatric IP encounters, %	68.8%	71.3%	15.1%	16.6%	-14.0	(-27.5, -0.4)	0.043	16.3
Number of psychiatric IP nights, mean	5.6	15.9	-1.2	9.1	-11.6	(-17.5, -5.7)	<0.001	>100
Any arrests in past 6 months, %	21.0%	30.4%	2.1%	3.5%	3.7	(-3.9, 11.2)	0.344	0.1
Any illicit drug use in past 6 months, %	47.4%	26.5%	25.9%	11.7%	-5.5	(-17.3, 6.4)	0.365	1.1
Any homelessness in past 6 months, %	5.4%	12.3%	3.8%	9.1%	-1.5	(-13.2, 10.2)	0.799	1.9

GAO Report on ASPE & SAMHSA Evaluations

To describe how HHS assessed the effects of the AOT grant program on participants' health and social outcomes, and what HHS's assessment efforts have revealed, we reviewed documentation related to HHS's assessments of the AOT grant program and interviewed cognizant agency officials. Specifically, **we reviewed documentation for the impact evaluation conducted by contractors for the Office of the Assistant Secretary for Planning and Evaluation (ASPE)—the HHS component agency that coordinates HHS's evaluation, research, and demonstration activities.[8] Documentation included published reports describing the methods and results of the evaluation, contract documentation for the contractors who completed the evaluation on ASPE's behalf, and other documentation from those contractors to better understand the evaluation. Our review included unpublished information that we requested and received from ASPE's primary contractor, RTI International. In this report, we describe the methods and data sources of ASPE's evaluation. However, we decided not to include the evaluation's results because (1) we determined that ASPE and RTI International lacked information needed to help understand the extent to which the results represented all AOT participants included in SAMHSA's grant program; and (2) our analysis of information we received from RTI International showed a high level of uncertainty for some of the results.[9]**

[9]We requested and received standard errors, which are a measure of the uncertainty associated with an estimate, for some of ASPE's analyses. We used standard errors provided by ASPE's contractor to calculate relative standard errors, which are calculated by dividing the standard error of an estimate by the estimate itself, then multiplying that result by 100. Relative standard errors for most measures indicated that estimates may be unreliable.

Effectiveness Evidence Summary

- Three RCTs (Duke, Bellevue, OCTET) **null on primary intent-to-treat analyses**
  - **no significant effect of court orders on hospitalizations, arrests, violence, or functioning**
- Duke study's positive subgroup findings rest on non-randomized variation in commitment duration and include 67 non-randomized participants (treated as a null trial by Cochrane systematic reviews)
- Cochrane meta-analysis: **NNT of 142 court orders to prevent one readmission**
- **Most recent Global meta-analysis of available research on AOT/CTO impacts on violence and offending finds no significant impacts.**
- Duke study's most robust finding: **45% increase in perceived coercion, with Black participants ~2x more likely to experience high coercion**
- US non-experimental studies (NY State, Ohio) **cannot separate effects of enhanced services from court orders**
  - Regression to the mean
  - Systemic failure to measure multiple major areas of harm
- ASPE federal evaluation (2024): numerous flaws including outcomes measurement under de facto threat
  - GAO declined to report results due to "high level of uncertainty" – going so far as to question whether reported numbers are even accurate
- **Bottom line: no study has demonstrated that involuntary court orders adds value beyond the enhanced services & system accountability that accompanies it**

Judicial Process and Procedural Justice

Player (2015) – Kendra's Law in New York City Courts

- *Judges on Expert testimony*
- "Many judges reported that they rely on clinical recommendations particularly when the clinician has appeared before them in prior hearings and established a reputation for credibility. "**This is a field, and I'd like to think all the other judges have said this too, or admitted this, that quite honestly, it's heavily weighted in favor of medical testimony**," one judge explained (Judge 8). To that end expert witnesses generally perform two functions during AOT hearings. The first is simply to educate the court on unfamiliar diagnoses and medications. The second is to provide a clinical recommendation regarding the necessity of assisted outpatient treatment. In doing so judges are particularly attuned to how doctors answer questions on cross examination and whether their answers are credible. As one judge commented: "**I rely heavily on what the doctor says, meaning everything the doctor says, so if this is a contested AOT obviously that includes the doctor's responses to cross-examination questions** (Judge 8)."

Judicial deference (Player cont'd)

- "Some judges (3 of 13) explained that while they are willing to modify AOT orders based on the "legitimate concerns" of AOT patients, they are reluctant to deny an AOT petition outright unless an expert testifies on his or her behalf. As one judge put it: **I am not a mental health professional so if a mental health professional testifies that this is what is needed I have no basis to say "No." When I actually get a presentation from the other side I take it seriously…But I need a basis** (Judge 9). When asked whether testimony from the respondent would provide such a basis, the judge responded: "**It rarely makes a difference. Sometimes it does and sometimes what I've done is modify the proposed order to meet the legitimate concerns of the patient" if, for example, an AOT patient raises a reasonable concern regarding the side effects of a medication or a particular provider** (Judge 9). Or as another judge remarked, "**If the patient happens to testify, there may be elements in what the doctor says, but I really rely very, very heavily on what the doctor says**" (Judge 8)."

Player Cont'd: NY Judges on evidence standard

Clear and convincing evidence. The standard of proof for an assisted outpatient treatment order is clear and convincing evidence. Although New York courts have defined clear and convincing evidence as evidence which makes the existence of a fact "highly probable," 47 only a few judges defined the standard of proof in similar terms (2 of 13). Most defined clear and convincing evidence broadly as more than a preponderance of the evidence but less than proof beyond a reasonable doubt (11 of 13). Others suggested that, in practice, the important question in AOT cases is whether the respondent would benefit from the AOT program and whether the treatment plan makes sense. Judge 9: "*It's mostly evidence that shows this person has a problem and would benefit from AOT*." Judge 11: "*I listen to what they have to say and I go with what makes the most sense*." Judge 3: "*I do what I think is right*." Judge 2: "*Judges will do what they feel is the right thing*."

Player cont'd AOT Attorney (n = 20) Views on Judicial Bias

4.2.1.1.3. Judicial attitudes toward the mentally ill. Several attorneys (5 of 20) indicated that judicial attitudes toward people with mental illnesses and the assisted outpatient treatment program also make it difficult to win cases. As one attorney said, judges tend to think that people with mental illnesses are all "crazy" and "nuts" because "every once in a while some guy goes on a rampage and does something terrible" (Attorney 1). Nor do judges see much downside in granting AOTs. "They figure. What is the harm? The person is going to be provided with services. It's protecting the community should anything happen" (Attorney 13). A handful of attorneys in both Judicial Departments also reported that judges do not credit their client's testimony (3 of 20):

> Attorney: One of the other major problems with AOT is that the client's testimony means nothing. It's not given any credit or any weight.
>
> Interviewer: How can you tell that the judge is not taking that into account?
>
> Attorney: Because they'll say things off the record about it which you don't see in the transcripts

Player cont’d: AOT Attorney

Expert testimony. Many attorneys (5 of 19) noted that AOT hearings are particularly difficult to win without expert testimony. Part of the problem stems from the criteria for issuing an AOT order. For example, **section 9.60(5) of Kendra's Law requires clear and convincing evidence that “as a result of his or her mental illness” the respondent is unlikely to participate in outpatient treatment voluntarily.45 Section 9.60(1) requires evidence that the respondent is “unlikely to survive safely in the community.”46 As one attorney remarked “That’s pure opinion. There's no fact…[Judge X] is always going to side with the doctor and that's part of the problem”** (Attorney 4). Attorney 4 explained that the only way to win an AOT hearing *before Judge X is* to win on a “tiny technicality,” for example, the patient was hospitalized three times in the past three years, but not within the required time frame

Player cont'd: Attorneys on Judicial Reliance on Expert Testimony

- Attorneys also indicated that judicial reliance on expert testimony may be faulty in a further respect – in most cases, the psychiatrist who has been designated to testify on behalf of the AOT Team has not provided services to the respondent and has had no other interaction with the respondent aside from the AOT evaluation. The average AOT evaluation lasts from fifteen or thirty minutes to an hour. AOT evaluations are also few and far between – once before AOT recipients are discharged from the hospital into the community and again when the Director of Community Services requests a renewal order. As a result, at least some attorneys (4 of 20) felt that testifying psychiatrists don't always know as much as they should about their clients, how they have fared in the community since the initial court order or the day to day requirements of the treatment plan. Further not only do AOT evaluations tend to be cursory, but attorneys in both Judicial Departments explained that evaluations are primarily fact-finding exercises designed to gather evidence for an AOT order (4 of 20). Attorney 4, a principal attorney in the Second Department (MHLS), put it this way:
  - ***It's really a fact-finding hunt whereby AOT doctors gather factual information which can then be used to make out the eight criteria for an AOT order…They'll ask how old you are. Then they have factual information which they're going to use as part of their case-in-chief. Then the opinion stuff comes in…Instead of saying "What were the circumstances that led to hospitalization?" they'll say "You were hospitalized because you weren't takingmedication, right?" They're clearly leading. It may or may not be the case that the person was hospitalized due to noncompliance.…But the questions are invariably posed in a way that is intended to elicit responses that then go into this checklist which becomes the Order to Show Cause*** (Attorney 4).

In Their Own Words: Judges and Attorneys on AOT Hearings

From Player (2015): 13 NYC judges and 20 attorneys with AOT adjudication experience

ON JUDICIAL DEFERENCE TO PSYCHIATRISTS

"I am not a mental health professional so if a mental health professional testifies that this is what is needed I have no basis to say 'No.'"

— Judge 9

ON THE EVIDENCE STANDARD

"It's mostly evidence that shows this person has a problem and would benefit from AOT."

— Judge 9

"I do what I think is right." — Judge 3

ON CLIENT TESTIMONY

"One of the other major problems with AOT is that the client's testimony means nothing. It's not given any credit or any weight."

— AOT Defense Attorney

ON WINNING AOT HEARINGS

"[Judge X] is always going to side with the doctor and that's part of the problem. The only way to win an AOT hearing before Judge X is to win on a tiny technicality."

— Attorney 4

ON AOT PSYCHIATRIC EVALUATIONS

"It's really a fact-finding hunt whereby AOT doctors gather factual information which can then be used to make out the eight criteria for an AOT order... The questions are invariably posed in a way that is intended to elicit responses that then go into this checklist."

— Attorney 4 (principal attorney, MHLS)

ON JUDICIAL ATTITUDES

"Judges tend to think people with mental illnesses are all 'crazy' and 'nuts'... Nor do judges see much downside in granting AOTs. 'They figure, what is the harm? The person is going to be provided with services. It's protecting the community.'"

— Attorney 1; Attorney 13

Average AOT evaluation: 15–60 minutes. Evaluating psychiatrist typically has no prior treatment relationship.

Judges report they will not deny a petition without expert testimony opposing it — which is almost never provided.

Source: Player, M. (2015). Kendra's Law in New York City Courts. Qualitative study of 13 judges and 20 attorneys.

Coercion & Due Process in AOT versus Mental Health Courts

- **Mental Health Court** context:
  - Formal competency assessment; must be competent to proceed with agreement to Court & case resolution agreement
    - Protects against decision making while experiencing acute distress / altered states
  - Entry into court is ‘voluntary’
  - Based on principles of “therapeutic jurisprudence” – relationship with judge is central and baked into court design
  - Following ’competency restoration process, collaborative development of treatment / community integration plan

Munetz et al (2014) Ohio MHC AOT Comparison

- 35 misdemeanor mental health court participants; 17 AOT
  - Authors note that perceived benefits of misdemeanor courts potentially perceived as significant lesser than felony courts in which the participant may be avoiding years of prison time
- In comparison to MHC participants, AOT recipients reported
  - Significantly higher perceived coercion
    - Every dimension measured (decisional agency, choice, control, freedom)
  - Significantly lower procedural justice in interactions with judge
    - Every dimension measured (including respect, fair treatment, investment on part of judge, listening to / understanding client circumstances)
  - Significantly less respect after completion of AOT than prior
  - Significantly less hopeful after completion of AOT than prior

Judicial Process Summary

- **Judges overwhelmingly defer to the single evaluating psychiatrist**
  - In Player's study, judges explicitly state clinical testimony overrides all other evidence
  - Evidence standard ("clear and convincing") is applied loosely — judges described their standard as "what makes the most sense" and "what I think is right"
  - Defense attorneys reported that client testimony "means nothing" and judges make dismissive comments about individuals with mental illness off the record
- **Psychiatric evaluations are often brief (15–60 minutes), conducted by clinicians with no treatment relationship, and may be structured as "fact-finding hunts" to meet statutory criteria**
- **Contrast with mental health courts:**
  - MHC requires competency assessment, voluntary entry, therapeutic jurisprudence principles
  - Munetz et al. (2014): AOT recipients reported significantly higher coercion, lower procedural justice, less respect, and less hope than mental health court participants

Harms

Coercion & Unmeasured Potential Harm

- Coercion
  - Note on standardized measures versus in-depth interviews:
    - Known problems with close item measures versus in-depth interviewing
      - Internalized stigma – adaptive preferences – low expectations
        - You can talk in greater depth about this in an interview, in a close ended measure may result in very misleading responses
        - Empirical examination of this – Yanos et al (2019) study of closed ended measures versus interviews focused on the therapeutic relationship and coercion in AOT & ACT
  - Yanos study is only published US paper examining coercion in AOT qualitatively

Other Sources of (Potential) Harm

- Medication side effects
  - Polypharmacy is widespread in AOT, including regimens such as 3+ antipsychotics + Lithium + anxiolytic + multiple medications to address psychotropic side effects (including those with high anticholinergic burden)
    - Can lead to multiple very serious side effects – kidney or liver toxicity, cognitive decline and dementia secondary to anticholinergic effects, extreme lethargia and cognitive slowing, metabolic syndrome, heart disease and Type II Diabetes
  - Medication effects compounded by poverty and poverty-related (de facto) segregation and lack of access to nutritious food, exercise facilities or green space (pronounced for individuals ordered to many residential facilites or groups homes)
- Research in the US? 0 (we're working on it)

Custodial Iatrogenesis

- “Institutionalization” in the community
- Residential facilities that also function as SSI rep payees and control or seriously constrain all money, food, transportation, social life etc
  - Creating dependency, internalized powerlessness and lack of agency
  - Resignation to a life without meaningful social involvement or inclusion, poverty
- Research in the US? Zero in the specific context of AOT (we’re working on it)

Disruption of Family Bonds and Ties; Reproductive Injustice

- Pregnancy
  - Complex and multiple medications with potential direct or indirect iatrogenic effects
    - E.g. indirect through cardiometabolic and glycemic dysregulation
    - Direct through impacts on developing fetus
- Loss or fear of loss of custody and rights over minor children or older adults for whom the AOT recipient is a caregiver
  - AOT orders can be exploited by family members / ex-partners seeking custody of children
- Physical separation that disrupts bonds
  - E.g. parent moved to a mandated supervised residential facility far away from minor children, disrupting ability to visit and bond; custodial caregiver afraid of exposing children to the potentially traumatic residential environment (decaying facility infrastructure, rate and bedbug infestations, etc.)
- Research in the US? Zero in the specific context of AOT (we're working on it)

Social Defeat

- Definition - **chronic experience of being excluded, subordinated, or rendered powerless by one's social environment**
  - Ironically heavily implicated in the development of psychosis (social epidemiology)
- Involves:
  - **Loss of autonomy over one's own body**: medications are mandated, not chosen; refusal redefined as noncompliance; testiminonial delegitimization; the individual's own assessment of whether a medication helps or harms them carries no weight etc
  - **Loss of control over daily life**: where to live, when to show up, what substances to avoid, how to spend one's money (via rep payee) — determined by others and enforced by legal authority
  - **Chronic subordination to institutional authority**: the individual exists in a web of surveillance where case managers, judges, psychiatrists, and law enforcement all hold power over them, and they hold power over none of these actors

Social Defeat Continued

- **Repeated experience of having one's voice disregarded**
- **Social and structural racism compounds defeat**: POC who are already forced to navigate structural racism and disproportionate exposure to coercive systems
- **The "noncompliance" framework itself is a defeat mechanism**: any assertion of autonomy (refusing medication, missing an appointment, using a substance) is reframed as evidence of illness or defiance rather than as a comprehensible human response to loss of control
- **No defined endpoint**: unlike incarceration, which has a sentence, AOT orders can be renewed indefinitely
  - Individual cannot "earn" their way out through good behavior in any guaranteed way
  - Renewal is at the discretion of clinicians and judges & this indeterminacy removes the psychological resource that often makes subordination tolerable (the knowledge that it will end)
  - Common theme in memoirs from prison, detention and carceral systems without clear endpoints – Russian Gulag, Concentration Camps, ICE detention, detention as political prisoners etc.

Harms Summary

- Medication side effects
- Custodial iatrogenesis
- Disruption of family bonds and ties
- Reproductive injustice
- Social defeat
- …among others

Overall Summary & Recap: What we do and don’t know

What we know:

- All 3 RCTs have found null primary results = court orders do not improve outcomes when services & system accountability are held constant
- AOT significantly increases perceived coercion, disproportionately for Black individuals
- The average AOT judicial process provides minimal procedural protections
    - Psychiatrist testimony is functionally dispositive
- Potential harms including medication side effects, custodial iatrogenesis, disruption of family bonds, social defeat systematically unmeasured

What we don't know:

- Whether court orders add anything beyond the enhanced services they unlock
- The full scope of harm, including impacts on future voluntary treatment-seeking (and all harms above)
- Deeper investigation and documentation of social and structural racism, its impacts in the context of AOT, and broader systems impacts (as POC are disproportionately funneled away from other services into AOT)
- Experiences of individuals under AOT in their own words (not a single fully qualitative study in the US)
- Long-term outcomes

Overall Summary & Recap: What we do and don't know cont'd

What we do know works:

- **Intensive voluntary services have a strong evidence base without the documented harms of legal coercion**
  - Promising models focused on non-coercive support (INSET in NY, Peer Supported Open Dialogue, Alternatives 2 Suicide, etc) should be further evaluated and implemented
- **Policy question not "does AOT help people?" but "does the court order help beyond what the same services and accountability reforms would achieve voluntarily?"**
  - Answer per RCTs = no
- **Bar needs to be much higher than either ACT or AOT or other mainstream intensive service models**
  - Trieste
  - Contemporary reforms in the Netherlands
  - + other jurisdictions that have fundamentally reimagined services and systems

Interested in access to AOT/IOC Research Articles? Future Research and Evaluation Reports? Advocacy Resources? Fill out this form!