Letters to the Editor

AOT and Long-Term Use of Antipsychotics

TO THE EDITOR: It was with considerable disappointment that we read the Open Forum by Barnes and Badre (1). The core premise—that long-term antipsychotic medication is a "key treatment modality" in assisted outpatient treatment (AOT) that is administered forcibly over a long period of time—is not based on the evidence in the statutes of the 46 states and District of Columbia where AOT is authorized and is inaccurate (2). To the contrary, the laws make clear that AOT is a short-term intervention that leaves medication decisions to the supervising clinician and patient. No state allows medication over the patient's objection or defaults to automatic hospitalization.

Beyond the legal technicalities, however, is the vast body of positive outcome data about AOT that the American Psychiatric Association (APA) has found compelling and evidence based (3). In New York, where AOT is called "Kendra's Law" and is subject to mandated outcome reporting, the treatment option was found, in 2005, to have produced reductions among participants of 87% in incarceration, 83% in arrests, 77% in psychiatric hospitalization, and 74% in homelessness, along with dramatic increases in participation in critical services, such as case management (4). Subsequent studies in New York and independent research in multiple other states have found that AOT reduces violence, including victimization and suicide attempts, and improves substance abuse treatment outcomes (5). The scant negative outcome data regarding New York's experience comes from an early pilot program in the state that was replaced by "Kendra's Law" (6).

When the APA Board of Trustees in December 2015 approved a position statement finding AOT to be a "useful tool to promote recovery" (2), the APA joined a host of government agencies and mental health organizations that have examined the evidence and deemed court-ordered treatment in the community to be "part of a solution" for a "very narrow segment of the patient population" at risk of criminalization and other poor outcomes because they are "unlikely to seek or voluntarily adhere to needed treatment" for serious mental illness. Among others, these entities include the Substance Abuse and Mental Health Services Administration, Department of Justice Office of Justice Programs, National Alliance on Mental Illness, International Association of Chiefs of Police, and U.S. Congress, which created a national demonstration project of the practice and funded it in 2015.

The evidence is strong and clear that AOT—and the short-term use of medication in that context—is effective, the unsupported mischaracterizations notwithstanding.

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TO THE EDITOR: In their Open Forum, Dr. Barnes and Dr. Badre (1) argued that recent data cast doubt on the efficacy of long-term (more than one to two years) use of antipsychotics and that "involuntary use of long-term antipsychotic treatment for relapse prevention for an asymptomatic patient with severe mental illness is rarely justifiable."

The authors raise important clinical and ethical questions and rightly point to significant gaps in the research literature. However, we believe that they have conflated two distinct issues; first, the involuntary but usually short-term use of antipsychotics for high-risk individuals enrolled in assisted outpatient treatment (AOT) programs, and second, the risk-benefit ratio of long-term (more than one year) antipsychotic treatment (LTAT) for persons with schizophrenia. (Persons who experience a single episode of a psychotic illness may not have schizophrenia and may not require LTAT). Moreover, the "ethical and evidence-based treatment" Barnes and Badre rightly advocate must consider not only the patient's autonomous wishes but also the long-term health and safety of the patient.

First, with respect to antipsychotic use in AOT programs, the duration of initial court-mandated outpatient treatment

is generally brief. In 22 states, initial AOT orders are limited to 90 days or less; in 15 states, they are limited to 180 days or less (2). In New York State, 39% remain in the AOT program for no more than one year, and only 25% for more than 30 months (3). Thus, in New York State, a large percentage of AOT use of antipsychotics falls squarely within the relapse prevention period established in a study by Leucht and colleagues (4), in which antipsychotic drugs were significantly more effective than placebo in preventing relapse at seven to 12 months (relapse with drug, 27%; with placebo, 64%.)

Second, although long-term (more than one year) randomized controlled studies are lacking, several naturalistic and observational studies support the benefits of LTAT for persons with chronic schizophrenia. Ran and colleagues (5) carried out a 14-year prospective study of outcomes among people with schizophrenia (N=510) and compared the outcome of those who had never been treated with antipsychotic medication with that of patients who received medication. The investigators found that the rate of partial and complete remission among treated patients was significantly higher than the rate in the never-treated group—57.3% versus 29.8%. Moreover, the authors concluded that "never-treated/remaining untreated patients may have a poorer long-term outcome (for example, higher rates of death and homelessness) than treated patients."

Indeed, there is considerable evidence that nonuse or discontinuation of LTAT carries substantial risk for persons with schizophrenia. Tiihonen and colleagues (6) conducted an observational study of antipsychotic treatment of patients with schizophrenia and schizoaffective disorder (N=2,230; average length of follow-up, 3.6 years). Excess mortality was seen mostly for patients not taking antipsychotic drugs for whom the risk of suicide was high. Similarly, Herings and Erkens (7) found a fourfold increased risk of suicide attempts among patients with schizophrenia who interrupted their use of second-generation antipsychotics.

Finally, although we lack randomized controlled studies of AOT with versus without an antipsychotic treatment arm—arguably, omitting a medication component would be unethical in this high-risk population—we have considerable evidence that AOT substantially reduces incarceration, arrests, psychiatric hospitalization, and homelessness (8). In sum, we find compelling reasons to continue including antipsychotic treatment as a component of comprehensive, periodically monitored AOT.

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TO THE EDITOR: The Open Forum by Barnes and Badre (1) contains substantial errors in its characterization of assisted outpatient treatment (AOT). AOT, as implemented in the United States, does not mandate the use of medications and is rarely long term—and thus does not mandate the long-term use of antipsychotic medications. The false basic premises about AOT render the rest of the Open Forum moot.

Barnes and Badre state, "In most cases, AOT includes mandated medication administration." This is not the case. AOT typically involves a court order to adhere to a treatment plan for a patient who qualifies for AOT under state criteria. It does not compel any specific treatment, including medication (2). In fact, mandated outpatient medication administration is not authorized by any state AOT statute, nor known to be practiced anywhere in the United States. In ruling against a constitutional challenge to the state's "Kendra's Law," the New York Supreme Court (3) stated, "The restriction on a patient's freedom affected by a court order authorizing assisted outpatient treatment is minimal, inasmuch as the coercive force of the order lies solely in the compulsion generally felt by law-abiding citizens to comply with court directives." No court has ruled otherwise. Patients under AOT orders who receive medication over their objection do so as a function of state criteria regulating such treatment for every patient, not as a provision or remedy of AOT.

Furthermore, although Barnes and Badre imply that AOT orders are long term, this is usually not the case. The vast majority of initial AOT orders terminate in less than one year (4). Even when AOT orders are extended through court-ordered renewal, they rarely exceed two years, and mandated medication is not part of them.