Badre and Barnes are also incorrect in stating that California mandates its AOT patients be placed on a 72-hour involuntary hold in a locked facility for failure to comply with treatment plans. In fact, no such mandate exists. Provisions in California's "Laura's Law" regarding involuntary hospitalization for evaluation stipulate that if an individual under a "Laura's Law" court order fails to comply, if a physician finds that there is reason to suspect that the patient meets criteria for inpatient admission, and if reasonable efforts have been made to solicit compliance, then the individual may be picked up for a psychiatric evaluation, which itself does not require hospitalization (5). The same intervention is authorized under the 5150 provisions of California law for every citizen.

Long-term antipsychotics have their critics, and court-ordered outpatient treatment has its. The Open Forum by Barnes and Badre conflates unexamined, untrue, or unrelated criticisms from each camp to question the merits of a practice that does not exist as the authors describe it.

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AOT and Long-Term Use of Antipsychotics: In Reply

TO THE EDITOR: We appreciate the comments and criticisms of several leaders in the field who responded to our Open Forum essay with letters to the editor. The strong comments made by the influential writers of these letters speak to the clinical and political volatility of AOT and LTAT. We are not opposed to either one in principle but hope for a sound scientific and ethical foundation for both. We observe that the evidence for AOT and LTAT is ambiguous and often conflicting and therefore allows reasonable people to disagree.

Dr. Sharfstein, Dr. Lieberman, and Dr. Talbott insist that there exists a "vast body of positive" and "scant negative" outcome data for AOT, leading to "strong and clear" evidence of its efficacy. The literature on AOT does not support this view. In addition to several citations in our original report, we point to three essays in the June 2014 *Psychiatric Services* (1–3), which review the debate. The introductory essay notes that "there is yet little agreement about whether [AOT] works" (1). A 2015 standard textbook of psychiatry, coedited by Dr. Lieberman, notes "whether or not [AOT] improves outcomes remains controversial" (4). While Dr. Sharfstein and his colleagues correctly highlight studies that support their view, they neglect to consider a substantial body of literature critical of AOT.

Dr. Frances and Dr. Pies believe that we have conflated evidence for LTAT and what they believe is the short-term nature of AOT. They rightly point to the lack of randomized, well-controlled data on LTAT and, instead, turn to several naturalistic-observational studies supporting it. However, if we accept that a lack of well-controlled data requires us to look further afield, we must also consider studies discussed in our Open Forum essay (5–7), which report a very different LTAT outcome. The flaws in these long-term studies cited by both us and Dr. Frances and Dr. Pies are legion and would require discussion in a longer format. However, this mixed and conflicting evidence is troubling when compulsory long-term use is considered. Regarding Dr. Frances and Dr. Pies' assertion that AOT is essentially short term, they cite a New York State report on AOT (Kendra's Law) that actually contradicts their assertion (8). This report estimates the median length of time a patient is committed on Kendra's Law to be 12 to 18 months. Furthermore, 25% are committed for over 30 months. The actual length of commitment over 30 months is not reported, however, meaning that the longest periods of commitment are unknown. In actual practice, we believe AOT will often last much longer than Dr. Frances and Dr. Pies assert. With antipsychotics as the primary tool of AOT, we are concerned that AOT leads to LTAT—and there is no clear evidence for LTAT.

Dr. Munetz and Ms. Fuller take issue with our characterization of AOT laws. They correctly point out that AOT does not explicitly mandate forced medication administration. However, AOT does typically permit detention for evaluation of psychiatric hold if patients deviate from their treatment plan, including medications. We see the threat of involuntary detention as a coercive proxy for mandated medication. In response, we have clarified our original essay by changing the original sentence, which read, "In most cases, AOT includes mandated medication administration" to "Although AOT laws do not allow forcible restraint and medication injection, they permit involuntary detention if patients deviate from their treatment plan, and the treatment plan will likely include antipsychotic medication."

Regrettably, it is disingenuous for the Treatment Advocacy Center, on whose Psychiatric Advisory Board Dr. Sharfstein, Dr. Lieberman, Dr. Talbott, and Dr. Munetz serve, to reassure readers that AOT protects against mandated medication, when they argue the opposite on their Web site (9), defining AOT as "court-ordered treatment (including medication) for individuals with severe mental illness . . . [V]iolation of the court-ordered conditions can result in the individual being hospitalized for further treatment." A clear

example of the intention of AOT as mandated medication comes from Dr. Sharfstein (10), who has written, "One solution is that of involuntary outpatient treatment. Thus, a paranoid schizophrenic with a history of multiple rehospitalizations for dangerousness will be informed by authorities that he must comply with outpatient treatment and take his medication or he will be detained against his will." Although the letter of the law does not explicitly mandate medication administration, descriptions of AOT from its strongest supporters reflect the coercive intention of mandated medication through threat of detention.

In conclusion, we are concerned that AOT may be long term, unnecessarily coercive, and result in compulsory LTAT, for which evidence is lacking. The history of psychiatry is littered with those who have argued for a more coercive approach, and our field has suffered for it. We recognize the substantial benefits of antipsychotic medication in many cases and routinely *recommend* both short-term and long-term medication in our practice. However, we question whether the evidence is strong enough to *compel* a competent patient into LTAT, which is often facilitated by AOT.

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Editor's Note: *As noted by Dr. Barnes and Dr. Badre, a sentence was changed in the introduction to their Open Forum essay that was originally published online ahead of print on March 15, 2016. The original version was replaced online by the clarified version on April 21, 2016. The Open Forum that appears on page 784 of this issue is the clarified version.*

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Compulsory Community Treatment and Homicide: Insufficient Evidence Now and in the Future

TO THE EDITOR: In their Open Forum commentary, Barnes and Badre (1) expressed concerns about mandated outpatient treatment—in particular, the use of antipsychotic medication in such treatment. They noted that there is no empirical evidence that compulsory community treatment reduces admissions to the hospital or bed use (2). Furthermore, as they described, compulsory community treatment almost always implies long-term use of antipsychotic medication, which can have a negative influence on social functioning (3). Barnes and Badre also commented that in most jurisdictions compulsory community treatment is introduced after a public outcry when a person with mental illness has killed someone. In none of the studies that they cited was reduction of danger to others a primary outcome, and if Barnes and Badre had wanted to focus on randomized controlled trials to assess whether compulsory community treatment reduces danger to others, it would have been impossible for them to do so.

Murder or manslaughter by a psychiatric patient is a rare event. Even if patients stop taking their medication, they rarely become violent. Randomized controlled trials are not suitable to investigate rare events, because researchers cannot recruit millions of participants. They have to use nonrandomized studies with large samples. Immediately after the introduction of compulsory community treatment in England, there was a reduction in the number of homicides committed by people with mental illness, but this trend did not continue (4)—and even if it had, the evidence would not have been sufficient to support a causal influence (5).

Therefore, Barnes and Badre could have drawn an even stronger conclusion. Not only is there insufficient empirical evidence for the effectiveness of compulsory community treatment, but it is also very unlikely that there will be sufficient evidence in the future, at least if reduction of violence toward others is the main aim.

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