



Frontline Perspectives

The Neurotoxicity of Untreated Psychosis: A Legal and Medical Framework for Involuntary Treatment

Submitted by Larry T. Mimms, PhD — March 20, 2026

The intersection of severe mental illness, neurological damage, and patient autonomy creates one of the most challenging ethical and legal dilemmas in modern healthcare. This report examines the medical evidence supporting the classification of untreated psychosis as a neurotoxic condition, the implications of anosognosia in decision-making capacity, the legal framework for providing necessary treatment to those unable to consent due to their illness, and presents an evidence-based advocacy for involuntary treatment when medically necessary.

The Neurotoxic Effects of Untreated Psychosis

Emerging research strongly indicates that psychotic episodes, particularly when untreated, cause measurable structural damage to the brain. This evidence challenges traditional views of mental illness and places certain psychotic disorders in a category closer to acute neurological emergencies.

Quantifiable Brain Damage from Psychotic Episodes

Untreated psychosis can trigger a cascade of damaging neurological processes including inflammatory reactions, oxidative stress, mitochondrial dysfunction, decreased neuroplasticity, demyelination, and autoimmune responses. These processes collectively contribute to cell necrosis and irreversible neuronal atrophy^[1]. First-episode psychosis (FEP) alone can result in the loss of up to 1% of total brain volume and up to 3% of cortical gray matter.^[1] In practical terms, when FEP goes untreated, approximately 10-12 cc of brain tissue—roughly equivalent to a tablespoon of cells and myelin—may be permanently damaged^[1].

The severity of this damage is comparable to other neurological conditions that justify immediate medical intervention. Each psychotic episode appears to compound this damage, creating a progressive pattern of deterioration. Patients who experience repeated episodes of untreated psychosis typically demonstrate progressively lower levels of baseline functioning

and may require longer hospitalizations and higher medication doses to achieve remission.^[1] Research demonstrates that untreated psychosis leads to measurable cognitive decline, reduced gray matter volume, and worsening functional outcomes with each successive episode.^{[2][3]}

Duration of Untreated Psychosis as a Critical Factor

The duration of untreated psychosis (DUP) plays a significant role in outcomes. In the United States, the median DUP is approximately 74 weeks—nearly a year and a half during which neurological damage continues unchecked.^[4] Longer periods of untreated psychosis correlate with negative effects on temporal and occipitotemporal gray matter volume, which plays crucial roles in cognitive and emotional processing.^[4]

This progressive deterioration in brain structure creates a compelling parallel to other time-sensitive neurological emergencies like stroke, where "time is brain" has become a guiding principle for intervention. However, unlike stroke patients who typically receive immediate treatment, individuals experiencing psychosis often go untreated for extended periods, sometimes due to their inability to recognize their condition.

Anosognosia: The Critical Barrier to Voluntary Treatment

Understanding Lack of Insight as a Neurological Symptom

Anosognosia—the neurologically-based inability to recognize one's illness—presents a fundamental barrier to voluntary treatment for many patients with schizophrenia and other psychotic disorders. Unlike simple denial, anosognosia represents a genuine neurological deficit in self-awareness.^{[5][6]}

Estimates suggest that between 30-50% of patients with schizophrenia experience significant anosognosia, with some studies indicating rates as high as 57%.^{[7][8]} This condition manifests as a complete lack of awareness or severely distorted perception of one's mental state. Patients with anosognosia genuinely believe they are not ill, making treatment refusal appear rational from their perspective despite clear evidence of psychosis.^[5]

The neurological basis of anosognosia has been confirmed through neuroimaging studies showing structural and functional brain abnormalities in regions responsible for self-awareness, particularly the prefrontal cortex.^[9] This is not a psychological defense mechanism but rather a consequence of the same brain pathology that causes psychotic symptoms.

Impact on Decision-Making Capacity

Individuals experiencing anosognosia face a profound paradox: the very neurological condition that requires treatment prevents them from recognizing their need for treatment. This creates a

situation where the disease mechanism itself blocks access to life-saving intervention.^[6] When patients lack insight into their condition:

1. They typically resist or refuse medications, believing them unnecessary
2. They may interpret treatment recommendations as malicious or conspiratorial
3. They often experience worsening psychiatric symptoms as a result of medication non-adherence
4. They frequently cycle through periods of deterioration followed by crisis intervention^[6]

The impairment of decision-making capacity in these situations is comparable to that seen in patients with other neurological conditions like advanced Alzheimer's disease or acute stroke, where surrogate decision-making is readily accepted as necessary and appropriate.^[5]

Legal Framework for Involuntary Treatment

Current Legal Standards and Evolving Definitions

The legal standards for involuntary psychiatric treatment vary by jurisdiction but typically center on immediate dangerousness to self or others. However, these standards often fail to recognize the long-term neurological harm caused by untreated psychosis.

In the landmark case *Washington v. Harper*, the Supreme Court established that an incarcerated person could be involuntarily medicated if: (1) they are gravely disabled and pose a likelihood of serious harm to themselves or others, and (2) the medication is in their best interest.^[10] This framework acknowledges both immediate safety concerns and the overall medical benefit to the patient.

California Senate Bill 43: Modernizing the Definition of Gravely Disabled

In October 2023, California enacted Senate Bill 43 (SB 43), representing the first major update to the state's Lanterman-Petris-Short (LPS) Act in over 50 years.^{[11][12][13]} This legislation significantly expanded the criteria for involuntary psychiatric holds and conservatorships, addressing critical gaps in the prior legal framework.

Expanded Qualifying Conditions

Previously, a person could only be considered "gravely disabled" if their impairment was caused strictly by a mental health disorder or chronic alcoholism. SB 43 broadens this scope by including individuals who suffer from:

- Severe substance use disorder (SUD) alone
- Co-occurring mental health disorder and severe SUD^{[11][12]}

Expanded Inability Criteria

Under the old LPS Act guidelines, an individual was only considered gravely disabled if they were unable to provide for their basic needs of food, clothing, or shelter. The revised legislation adds two critical new dimensions:

- Inability to provide for personal safety
- Inability to access necessary medical care^{[12][13]}

Consequently, individuals who refuse life-saving medical treatment for serious injuries or repeatedly place themselves in highly dangerous situations due to severe addiction or mental illness can now qualify for involuntary care. This expansion directly addresses the neurotoxic harm of untreated psychosis by recognizing that inability to seek treatment constitutes a form of grave disability.

Implementation Timeline

Although the law was enacted at the state level in late 2023, individual counties were permitted to defer adoption to properly prepare their local healthcare and legal infrastructures. Many major jurisdictions, including Los Angeles and San Diego counties, officially implemented the new SB 43 standards on January 1, 2026.^{[13][14]}

Impact on 5150 Holds and Conservatorships

SB 43 directly impacts the 5150 involuntary hold process (72-hour psychiatric detention) by:

- Allowing peace officers and mobile crisis teams to initiate holds based on severe SUD alone or co-occurring disorders
- Requiring assessment of whether impairment prevents ensuring personal safety or accessing medical care
- Expanding the population eligible for extended 5250 holds (up to 14 additional days) and long-term LPS conservatorships^{[13][15]}

The legislation also streamlines conservatorship proceedings by expanding the types of medical and expert testimony that can be submitted without requiring in-person cross-examination, making it easier to present evidence of grave disability.^{[15][16]} However, SB 43 maintains important protections by mandating that courts investigate and consider less restrictive alternatives (such as California's CARE Court) before granting permanent conservatorships.^{[15][16]}

Federal and Multi-State Considerations

While California's SB 43 represents significant progress, comprehensive reform requires both federal legislation and adoption by other states. The legal standards in states like New York and New Jersey differ substantially, creating inconsistent protections for individuals with severe mental illness across state lines. Federal legislation establishing minimum standards for

intervention in cases of anosognosia and untreated psychosis would ensure more uniform access to life-saving treatment nationwide.

Ethical Considerations: Balancing Autonomy and Beneficence

The Ethics of Non-Intervention

The ethical debate around involuntary treatment often focuses on patient autonomy. However, this standard approach assumes that patients possess the capacity to make informed decisions about their treatment. In cases of severe anosognosia, patients lack the neurological capacity to recognize their illness, creating a situation where strict adherence to autonomy paradoxically leads to harm.^[7]

The consequences of non-intervention can be severe, including homelessness, incarceration, violence, or suicide.^[5] Additionally, each untreated psychotic episode potentially causes further brain damage, diminishing future opportunities for recovery and autonomy.^[1] This raises the question of whether respecting a decision made under the influence of a neurological condition that impairs judgment truly honors autonomy.

Compassionate Intervention as an Ethical Imperative

Current ethical guidelines suggest that involuntary treatment should be considered when:

1. It is clinically essential to ensure the imminent safety of the patient
2. There are no other less restrictive options available
3. The patient lacks capacity to make their own medical decisions^[7]

Under this framework, the documented neurotoxicity of untreated psychosis and the impairment of decision-making capacity due to anosognosia provide a strong ethical basis for intervention. Just as we would not leave a stroke patient untreated because they cannot recognize their stroke symptoms, there is an ethical argument for not abandoning psychotic patients to the damaging effects of their untreated condition.

The Evidence Regarding Treatment Effectiveness: Voluntary vs. Involuntary Approaches

The Failure of Voluntary Treatment Alone

A common argument against involuntary treatment is that it "doesn't work in the long run." However, this criticism fundamentally misunderstands both the evidence base and the reality that voluntary treatment acceptance also demonstrates poor long-term adherence and outcomes in patients with severe mental illness and anosognosia.

High Rates of Non-Adherence in Voluntary Treatment

Medication non-adherence represents one of the most significant challenges in treating severe mental illness, even among patients who initially accept treatment voluntarily:

- Studies show that 56%[^] of patients with schizophrenia are non-adherent to antipsychotic medications^{[17][18]}
- In bipolar disorder, non-adherence rates range from 20-60%, with an average around 40%^{[18][19]}
- Among patients with serious mental illness (SMI), medication non-adherence is the leading cause of psychiatric readmission, accounting for up to 40% of hospital readmissions^{[20][21]}

The presence of anosognosia dramatically worsens these outcomes. Patients with poor insight into their illness demonstrate:

- Three times higher risk of medication non-adherence compared to those with intact insight^[22]
- Significantly higher rates of relapse, hospitalization, and homelessness^[9]
- Progressive deterioration with each episode of untreated psychosis^{[1][3]}

The Revolving Door Without Intervention

Without sustained treatment—whether voluntary or involuntary—patients with SMI and anosognosia experience a predictable cycle:

1. Crisis intervention during acute psychosis
2. Brief stabilization on medication during hospitalization
3. Discharge with voluntary outpatient treatment plan
4. Discontinuation of medication due to lack of insight
5. Progressive deterioration and accumulating brain damage
6. Return to crisis, often with worse baseline functioning^{[1][20]}

This cycle demonstrates that the absence of involuntary treatment mechanisms does not result in successful voluntary engagement—it results in preventable neurological damage and progressive decline.

The Evidence Supporting Involuntary Treatment

While critics emphasize the limitations of involuntary treatment, a substantial body of research demonstrates significant benefits, particularly for outpatient involuntary treatment programs.

Assisted Outpatient Treatment (AOT) Outcomes

Hospitalization Reduction:

- AOT reduces psychiatric hospitalizations by 43-72% across multiple studies^{[23][24]}
- A recent multi-site study found 57% reduction in psychiatric hospital admissions among AOT participants^[25]
- Hospital days decreased by an average of 56%^[23]

Treatment Engagement and Adherence:

- AOT participants showed 73% improvement in treatment adherence compared to baseline^[23]
- Medication compliance increased significantly, with sustained improvements even after AOT orders ended^{[24][25]}
- Participants were 3 times more likely to remain in treatment compared to voluntary treatment alone^[23]

Functional Outcomes:

- Reduced homelessness by 74%^[23]
- Reduced arrest rates by 83%^[23]
- Decreased substance abuse by 48%^[23]
- Improvements in social functioning, independent living, and employment^{[25][26]}

Quality of Life and Patient Perception:

Importantly, research on patients' subjective experiences with involuntary treatment reveals surprising findings:

- In long-term follow-up studies, 60-80% of patients retrospectively acknowledged that involuntary treatment was necessary and beneficial^[27]
- Patients reported improved quality of life after stabilization, even when initially resistant to treatment^[28]
- Many expressed gratitude for intervention that prevented further deterioration or harm^[27]

Neurological Protection:

The most compelling argument for involuntary treatment comes from neuroscience: treatment during acute psychosis prevents ongoing brain damage. Studies demonstrate:

- Antipsychotic medications can halt or slow the neurotoxic processes of untreated psychosis^{[1][2]}
- Early intervention and shorter DUP correlate with better long-term cognitive and functional outcomes^{[3][4]}
- Treatment improves insight and self-awareness, with the most significant improvements occurring in the first three months^[9]

This final point is crucial: involuntary treatment can create the neurological conditions necessary for patients to develop insight and subsequently make informed decisions about their care.

Addressing the "It Doesn't Work" Argument

The claim that involuntary treatment "doesn't work in the long run" must be contextualized against realistic alternatives:

False Comparison: Critics often compare involuntary treatment outcomes to an idealized vision of sustained voluntary treatment engagement. The appropriate comparison is between:

- Involuntary treatment with its imperfect adherence and relapse rates, versus
- No sustained treatment at all, with progressive brain damage and functional decline

Long-Term Outcomes: While it is true that some patients discontinue treatment after involuntary orders end, the evidence shows:

- AOT creates a "therapeutic bridge" during which brain damage is prevented and insight may improve^{[9][23]}
- Even temporary periods of adherence prevent irreversible neurological harm^{[1][3]}
- Many patients develop improved insight and voluntary engagement after experiencing medication benefits^{[9][25]}

Systems Failures vs. Treatment Failures: Poor long-term outcomes often reflect inadequate follow-up, lack of community services, and premature discontinuation of legal mandates—not failures of the treatment itself. Well-implemented AOT programs with adequate community support demonstrate sustained benefits.^{[23][24][25]}

A Synthesized Legal-Medical Advocacy for Involuntary Treatment

Based on the medical evidence, legal developments, and ethical considerations, a comprehensive argument for expanding involuntary treatment in cases of psychosis with anosognosia includes:

Medical Necessity and Neurological Emergency

Untreated psychosis causes demonstrable, progressive brain damage similar to other neurological emergencies like stroke. Each episode compounds this damage, creating urgency for intervention.^{[1][3][4]} The neurotoxic nature of psychosis justifies the same "time is brain" urgency applied to stroke treatment.

Incapacity Due to Neurological Deficit

Anosognosia represents a genuine neurological inability to recognize illness, not a rational choice or psychological denial. This neurological deficit directly impairs the capacity to make informed medical decisions.^{[5][6][9]} Between 30-57% of patients with schizophrenia experience significant anosognosia, creating a population for whom voluntary treatment is neurologically impossible without initial stabilization.^{[7][8]}

Evidence-Based Effectiveness

Involuntary treatment, particularly AOT, demonstrates significant measurable benefits:

- 43-72% reduction in hospitalizations^{[23][24][25]}
- 74% reduction in homelessness^[23]
- 83% reduction in arrests^[23]
- 73% improvement in treatment adherence^[23]
- Retrospective patient acknowledgment of benefit in 60-80% of cases^{[27][28]}

Voluntary treatment alone fails at comparable or higher rates due to anosognosia-driven non-adherence (40-60%), making the relevant comparison between involuntary treatment versus progressive deterioration, not involuntary versus idealized voluntary engagement.^{[17][18][19][20]}

Temporary Intervention for Long-Term Autonomy and Recovery

Evidence suggests that appropriate treatment can improve insight, potentially restoring decision-making capacity and allowing for more autonomous choices in the future. The most significant improvements in self-awareness occur during the first three months of treatment.^[9] This creates a pathway where temporary involuntary intervention enables future voluntary participation.

Expanded Definition of Self-Harm Under SB 43

California's SB 43 recognizes that inability to access necessary medical care and ensure personal safety constitute grave disability^{[11][12][13]}. The legal standard of "danger to self" now appropriately includes allowing preventable brain damage to continue, even without immediate suicide risk. This expansion aligns legal frameworks with neurological reality.

Precedent in Other Neurological Conditions

We routinely allow surrogate decision-making for patients with other conditions that impair insight and judgment (Alzheimer's, stroke, traumatic brain injury). The neurobiology of psychosis with anosognosia justifies similar consideration.^[5] Treating psychotic patients differently than other neurologically impaired patients lacks medical and ethical justification.

Protection of Future Autonomy and Human Dignity

The ultimate goal of involuntary treatment is restoration of autonomy, not its permanent restriction. By preventing progressive brain damage, involuntary treatment:

- Preserves cognitive capacity for future decision-making
- Prevents trajectories toward homelessness, incarceration, or death

- Creates opportunities for recovery and meaningful life engagement
- Honors the person the patient would be with intact neurological functioning

Addressing Opposition to Involuntary Treatment

Civil Liberties Concerns

Organizations like the ACLU have historically opposed involuntary psychiatric treatment, with some advocates stating their goal should be "nothing less than the abolition of involuntary hospitalization."^[29] These positions typically emphasize concerns about civil liberties and potential abuses of psychiatric authority.

However, this perspective often fails to account for the neurobiological reality of conditions like anosognosia and the documented brain damage caused by untreated psychosis. Just as we would not consider it a violation of civil liberties to treat an unconscious accident victim, there is a compelling argument that allowing preventable brain damage to occur due to a neurological condition that impairs insight is not truly protecting liberty.

True liberty requires a functioning brain. Progressive neurological damage from untreated psychosis destroys the very neurological substrate necessary for autonomous decision-making. Protecting "freedom" to refuse treatment while allowing brain destruction represents a hollow and ultimately self-defeating conception of civil liberties.

Safeguards and Procedural Protections

Expansion of involuntary treatment must be accompanied by robust safeguards:

- Judicial oversight and regular review of treatment orders
- Medical certification by qualified psychiatrists
- Right to legal representation and appeal
- Use of least restrictive alternatives when appropriate
- Time-limited interventions with clear criteria for discontinuation
- Patient advocacy and monitoring for potential abuses

California's SB 43 includes such protections by requiring courts to investigate less restrictive alternatives before granting conservatorships and maintaining due process rights throughout involuntary treatment proceedings.^{[15][16]}

Finding Middle Ground: Temporary Intervention for Long-Term Autonomy

A balanced approach recognizes that short-term involuntary treatment may actually preserve long-term autonomy by preventing neurological damage and allowing patients to regain insight. Research indicates that antipsychotic medications can improve insight, with the most

significant improvements occurring during the first three months of treatment.^[9] Similarly, psychological interventions like motivational interviewing can help patients develop better awareness of their condition when their brain chemistry has been stabilized.^[9]

This suggests that temporary intervention during acute psychosis could create the neurological conditions necessary for patients to make more informed decisions about their ongoing care, ultimately supporting rather than undermining their autonomy.

Conclusion: Towards a More Humane and Evidence-Based Approach

The current approach to severe mental illness often results in a cycle of deterioration, crisis, brief intervention, and premature discharge—leading to more brain damage, poorer outcomes, and diminished quality of life. By recognizing the neurotoxic nature of psychosis and the neurological basis of anosognosia, the legal and medical systems can adopt a more humane approach that prevents avoidable harm.

California's SB 43 represents a significant step forward by expanding the definition of "gravely disabled" to include inability to access medical care and ensure personal safety, and by recognizing severe substance use disorders alongside mental illness^{[11][12][13]}. This legislative evolution acknowledges that traditional frameworks inadequately addressed the reality of neurological impairment in severe mental illness.

The evidence base supports expanded use of involuntary treatment—particularly Assisted Outpatient Treatment—as an effective intervention that:

- Prevents ongoing brain damage during critical windows
- Significantly reduces hospitalization, homelessness, and incarceration
- Improves treatment adherence and functional outcomes
- Creates opportunities for insight development and eventual voluntary engagement
- Is retrospectively endorsed by the majority of patients as necessary and beneficial

Moving forward requires:

1. Legal reform recognizing brain damage from untreated psychosis as a form of self-harm requiring intervention
2. Viewing anosognosia as a neurological condition that impairs decision-making capacity, similar to other recognized neurological deficits
3. Implementing evidence-based involuntary outpatient treatment programs with adequate community support and judicial oversight
4. Federal legislation establishing minimum standards for intervention across all states
5. Adequate funding for community mental health services, AOT programs, and psychiatric treatment capacity
6. Ongoing research into improving insight, adherence, and long-term outcomes
7. Robust safeguards to prevent abuse while enabling necessary intervention

Such changes would better align our treatment of psychotic disorders with our approach to other acute neurological conditions, potentially saving countless individuals from preventable brain damage and its lifelong consequences. The goal is not to restrict liberty, but to preserve the neurological capacity necessary for liberty to have meaning—protecting both the person who is ill today and the person they could become with appropriate treatment.

References

- [1] Nasrallah, H. A. (2021). Psychosis is toxic to the brain. MDedge Psychiatry. <https://www.mdedge.com/psychiatry/article/219773/schizophrenia-other-psychotic-disorders/psychosis-toxic-brain>
- [2] Pantelis, C., et al. (2005). Neuroanatomical abnormalities before and after onset of psychosis: a cross-sectional and longitudinal MRI comparison. *The Lancet*, 361(9354), 281-288.
- [3] Hui, C. L., et al. (2013). Impacts of duration of untreated psychosis on cognition and negative symptoms in first-episode schizophrenia. *Psychological Medicine*, 43(9), 1883-1893.
- [4] Treatment Advocacy Center. (2023). Duration of Untreated Psychosis Research Summary. <https://www.tac.org/wp-content/uploads/2023/12/DUP-Research-Summary.pdf>
- [5] Medical News Today. (2024). Anosognosia: Symptoms, causes, and treatment. <https://www.medicalnewstoday.com/articles/anosognosia>
- [6] Palms Behavioral Health. (2024). Anosognosia and medication adherence. <https://palmsbh.com/anosognosia-and-medication-adherence/>
- [7] Psychiatric Times. (2024). Ethical considerations of involuntary psychiatric treatment. <https://www.psychiatrictimes.com/view/ethical-considerations-of-involuntary-psychiatric-treatment>
- [8] Amador, X. F., et al. (1994). Awareness of illness in schizophrenia and schizoaffective and mood disorders. *Archives of General Psychiatry*, 51(10), 826-836.
- [9] Treatment Advocacy Center. (2024). Anosognosia Research Summary. <https://www.tac.org/wp-content/uploads/2024/01/Anosognosia-Research-Summary.pdf>

[10] Washington v. Harper, 494 U.S. 210 (1990).

[11] California Department of Health Care Services. (2023). Senate Bill 43 FAQs.

<https://www.dhcs.ca.gov/provgovpart/Documents/SB-43-FAQs.pdf>

[12] Disability Rights California. (2024). SB 43 and CARE Court: Community FAQ.

<https://www.disabilityrightsca.org/publications/sb-43-and-care-court-community-faq>

[13] San Diego County Health and Human Services Agency. (2026). Senate Bill 43.

https://www.sandiegocounty.gov/content/sdc/hhsa/programs/bhs/senate_bill_43.html

[14] County News Center. (2025). State law expanding involuntary behavioral health treatment takes effect Jan. 1.

<https://www.countynewscenter.com/state-law-expanding-involuntary-behavioral-health-treatment-takes-effect-jan-1/>

[15] Los Angeles County Department of Mental Health. (2026). SB 43 Information.

<https://dmh.lacounty.gov/sb-43/>

[16] Governor Gavin Newsom. (2023). Modernizing conservatorship law - SB43.

<https://www.gov.ca.gov/2023/10/10/modernizing-conservatorship-law-sb43/>

[17] Lacro, J. P., et al. (2002). Prevalence of and risk factors for medication nonadherence in patients with schizophrenia: A comprehensive review of recent literature. *Journal of Clinical Psychiatry*, 63(10), 892-909.

[18] Semahegn, A., et al. (2020). Medication non-adherence and associated factors among patients with schizophrenia. *Neuropsychiatric Disease and Treatment*, 16, 2641-2663.

[19] García, S., et al. (2016). Adherence to antipsychotic medication in bipolar disorder and schizophrenic patients. *Journal of Clinical Psychopharmacology*, 36(4), 355-371.

[20] Kentucky Legislative Research Commission. (2018). Medication non-adherence in individuals with serious mental illness. [https://apps.legislature.ky.gov/CommitteeDocuments/347/13542/Medication Non-adherence.pdf](https://apps.legislature.ky.gov/CommitteeDocuments/347/13542/Medication%20Non-adherence.pdf)

- [21] Haddad, P. M., et al. (2014). Nonadherence with antipsychotic medication in schizophrenia: Challenges and management strategies. *Patient Related Outcome Measures*, 5, 43-62.
- [22] Olfson, M., et al. (2000). Awareness of illness and nonadherence to antipsychotic medications among persons with schizophrenia. *Psychiatric Services*, 51(2), 205-211.
- [23] Treatment Advocacy Center. (2023). Assisted Outpatient Treatment: Improving outcomes and saving money. <https://www.tac.org/wp-content/uploads/2023/12/AOT-Research-Summary.pdf>
- [24] Swanson, J. W., et al. (2000). Can involuntary outpatient commitment reduce hospital recidivism? *American Journal of Psychiatry*, 157(12), 1968-1975.
- [25] Swartz, M. S., et al. (2025). Clinical and social functioning outcomes of assisted outpatient treatment. *JAMA Psychiatry*, 82(5), 512-521.
- [26] Brain & Behavior Research Foundation. (2025). Study: Court-ordered assisted outpatient treatment (AOT) improved broad range of outcomes. <https://bbfoundation.org/content/study-court-ordered-assisted-outpatient-treatment-aot-improved-broad-range-outcomes-people>
- [27] Swartz, M. S., et al. (2003). Effects of involuntary outpatient commitment on subjective quality of life. *Behavioral Sciences and the Law*, 21(4), 473-491.
- [28] Ziegenbein, M., et al. (2014). To what extent is treatment adherence of psychiatric patients influenced by their participation versus coercion in hospital admission? *European Psychiatry*, 29(8), 474-479.
- [29] Mental Illness Policy Org. (2024). ACLU positions on mental health and civil liberties. <https://mentalillnesspolicy.org/myths/aclu-mental-health-liberties.html>

Disclaimer:

Frontline Perspectives are authored by individual members of the National Shattering Silence Coalition and reflect their personal experiences and viewpoints. The opinions expressed do not necessarily represent the official positions, policies, or views of the National Shattering Silence Coalition.