

RESOURCE DOCUMENT ON INVOLUNTARY OUTPATIENT COMMITMENT AND RELATED PROGRAMS OF ASSISTED OUTPATIENT TREATMENT ¹

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Involuntary outpatient commitment is a form of court-ordered outpatient treatment for patients who suffer from severe mental illness and who are unlikely to adhere to treatment without such a program. It can be used as a transition from involuntary hospitalization, an alternative to involuntary hospitalization or as a preventive treatment for those who do not currently meet criteria for involuntary hospitalization. It should be used in each of these instances for patients who need treatment to prevent relapse or behaviors that are dangerous to self or others.

Executive Summary, Conclusions and Recommendations

In 1987, the American Psychiatric Association's Task Force Report on Involuntary Outpatient Commitment endorsed its use under certain circumstances (1) and reiterated its endorsement in the 1999 Resource Document on Mandated Outpatient Treatment (2). During the decades since publication of the 1987 Task Force Report, outpatient commitment has received a great deal of

¹ Outpatient court-ordered treatment may be referred to as 'assisted outpatient treatment', 'involuntary outpatient commitment', 'mandated community treatment', or 'community treatment orders'. Some regard the term 'assisted outpatient treatment' as a euphemistic term for treatment under coercion.

In this document the term 'involuntary outpatient commitment' is used to refer to these programs. The current document is adapted from: Gerbasi JB, Bonnie RJ, Binder RL: Resource document on mandatory outpatient treatment. *Journal of the American Academy of Psychiatry and the Law* 2000; Vol 28(2): 127-144

attention by advocacy groups, researchers and legislatures (3-14). Additionally, the nation has continued to struggle with the effects of the declining supply of psychiatric beds, community treatment capacity and public and private funding for psychiatric care (15). Involuntary outpatient commitment is getting more public exposure as pressure mounts to minimize treatment non-adherence, and to find effective treatment that reduces hospitalization and is cost-effective while still respectful of individual rights (13-14). As of 2015, 45 states and the District of Columbia have commitment statutes permitting involuntary outpatient commitment -- although many of these states do not consistently implement, provide treatment resources or evaluate their involuntary outpatient commitment programs (6,9).

This Resource Document supports the view that involuntary outpatient commitment can be a useful intervention for a subset of patients with severe mental illness who 'revolve' in and out of psychiatric hospitals or the criminal justice system. These individuals often improve when hospitalized and treated, but frequently do not adhere to treatment after release, leading to a cycle of decompensation, re-hospitalization and, in many cases, arrest (3). Although important studies of involuntary outpatient commitment have been conducted within the past decade, there is no broad consensus about its effectiveness across jurisdictions (4, 6-12, 16-20). However because it is a complex community-based intervention, implemented in diverse local communities, its effectiveness would logically be expected to vary (9). Research in this field also faces substantial methodological problems (9, 21). It is difficult to separate the effects of the court order and the legal authority of the court from the effect of improved access to appropriate services. In fact, some advocates and persons with mental illness argue that both improved services and better access to services without a court order could yield comparable outcomes to those obtained by successful involuntary outpatient commitment programs.

As discussed in this Resource Document involuntary outpatient commitment programs have demonstrated improved patient outcomes when *systematically implemented, linked to intensive outpatient services* and *prescribed for extended periods of time* (9). Based on empirical findings and on accumulating clinical experience, it appears that involuntary outpatient commitment can be a useful tool in the effort to assist patients with severe mental illness with documented histories of relapse and re-hospitalization. It is important to emphasize, however, that all programs of involuntary outpatient commitment must include these elements of well-planned and executed implementation, intensive, individualized services and sustained periods of outpatient commitment to be effective (9). There is also clear evidence that involuntary outpatient commitment programs help focus the attention and effort of the providers on the treatment needs of the patients subject to involuntary outpatient commitment.

Involuntary outpatient treatment raises an ethical tension between the principles of autonomy and beneficence. Therefore states should make every effort to dedicate resources to voluntary outpatient treatment and only if such treatment fails resort to involuntary treatment. Psychiatrists must be aware of the conflict between the patient's interest in self-determination and promotion of the patient's medical best interest. In any system of treatment, including involuntary outpatient treatment, principles of non-maleficence—doing no harm—and justice

must be considered. Involuntary treatment, like any intervention, must not be discriminatory, and must be fairly applied and respectful of all persons.

The purpose of this Resource Document is to provide information to federal and state policymakers, APA District Branches and state psychiatric societies who are working on drafting or implementing legislation related to involuntary outpatient commitment. The Resource Document begins with a statement of key conclusions and recommendations based on a review of recent empirical findings and legislative developments. The body of the document contains a more detailed discussion of each issue.

Conclusions and Recommendations

1. Involuntary outpatient commitment, if systematically implemented and resourced, can be a useful tool to promote recovery through a program of intensive outpatient services designed to improve treatment adherence, reduce relapse and re-hospitalization, and decrease the likelihood of dangerous behavior or severe deterioration among a sub-population of patients with severe mental illness.
2. The goal of involuntary outpatient commitment is to mobilize appropriate treatment resources, enhance their effectiveness and improve an individual's adherence to the treatment plan. Involuntary outpatient commitment should not be considered as a primary tool to prevent acts of violence.
3. Involuntary outpatient commitment should be available in a preventive form and should not be exclusively reserved for patients who meet the criteria for involuntary hospitalization. The preventive form should be available to help prevent relapse or deterioration for patients who currently may not be dangerous to themselves or others (and therefore are not committable to inpatient treatment) but whose relapse would likely lead to severe deterioration and/or dangerousness.
4. Assessment of the likelihood of relapse, deterioration, and/or future dangerousness to self or others should be based on a clearly delineated clinical history of such episodes in the past several years based on available clinical information.
5. Involuntary outpatient commitment should be available to assist patients who, as a result of their mental illness, are unlikely to seek or voluntarily adhere to needed treatment.
6. Studies have shown that involuntary outpatient commitment is most effective when it includes a range of medication management and psychosocial services equivalent in intensity to those provided in assertive community treatment or intensive case management programs. States adopting involuntary outpatient commitment statutes should assure that adequate resources are available to provide such intensive treatment to those under commitment.
7. States authorizing involuntary outpatient commitment should provide due process protections equivalent to those afforded patients subject to involuntary hospitalization.
8. Data have shown that involuntary outpatient commitment is likely to be most successful when it is provided for a sustained period of time. Statutes authorizing involuntary outpatient commitment should consider authorizing initial commitment periods of 180 days, permitting extensions of the commitment period based on specified criteria to be demonstrated at regularly scheduled hearings. Based on clinical judgment, such orders may be terminated prior to the end

of a commitment period as deemed appropriate.

9. A thorough psychiatric and physical examination should be a required component of involuntary outpatient commitment, because many patients needing mandated psychiatric treatment also suffer from other medical illnesses and substance use disorders that may be causally related to their symptoms and may impede recovery. Clinical judgment should be employed in determining when, where and how these examinations are carried out.

10. Clinicians who are expected to provide the court-ordered treatment must be involved in decision-making processes to assure that they are able and willing to execute the proposed treatment plan. Before treatment is ordered, the court should be satisfied that the recommended course of treatment is available through the proposed providers.

11. Efforts to engage patients and, where appropriate, their families in treatment should be a cornerstone of treatment, even though court-ordered. Patients and their families should be consulted about their treatment preferences and should be provided with a copy of the involuntary outpatient commitment plan, so that they will be aware of the conditions to which the patient will be expected to adhere.

12. Involuntary outpatient commitment statutes should contain specific procedures to be followed in the event of patient non-adherence and should ensure maximum efforts to engage patients in adhering to treatment plans. In the event of treatment non-adherence, provisions to assist with adherence may include empowering law enforcement officers to assume custody of non-adherent patients to bring them to the treatment facility for evaluation. In all cases there should be specific provisions for a court hearing when providers recommend involuntary hospitalization or a substantial change in the court order.

13. Psychotropic medication is an essential part of treatment for most patients under involuntary outpatient commitment. The expectation that a patient take such medication should be clearly stated in the patient's treatment plan when medication is indicated. However, involuntary administration of medication should not be authorized as part of the involuntary commitment order without separate review and approval consistent with the state's process for authorizing involuntary administration of medication on an outpatient basis.

14. Implementation of a program of involuntary outpatient commitment requires critical clinical and administrative resources and accountability. These include administrative oversight of and accountability for involuntary outpatient commitment program operations, the ability to monitor patient and provider adherence with treatment plans, the ability to track involuntary outpatient commitment orders and to report program outcomes.

15. There is limited research to evaluate the possible disproportionate use of involuntary outpatient commitment among minority and disenfranchised groups. As a result, independent evaluation of involuntary outpatient commitment programs should be conducted at regular intervals and reported for public comment and legislative review, especially in view of concerns about its appropriate use. Among several outcomes that should be assessed is any evidence of disproportionate use of involuntary outpatient commitment among minority groups and disenfranchised groups, inadequate due process protections and the diversion of clinical resources from patients seeking treatment voluntarily. Any indications of findings in these areas should be followed by program improvement plans and corrective action.

Background

Throughout the U.S., there is a substantial population of persons with severe mental illness whose complex treatment and human service needs have not been met by community mental health programs. For many, their course is frequently complicated by non-adherence with treatment and as a result, they frequently relapse, are hospitalized or incarcerated (15). They also interact with a variety of human service agencies— substance use disorder treatment programs, civil and criminal courts, police, jails and prisons, emergency medical facilities, social welfare agencies, and public housing authorities. The pressing need to improve treatment adherence and community outcomes, has led policymakers to focus on a range of legal mechanisms to improve treatment adherence, including court-ordered treatment or involuntary outpatient commitment (3). As a result many states have focused on involuntary outpatient commitment as one of several tools to address high rates of treatment non-adherence.

Involuntary outpatient commitment is a civil court procedure wherein a judge orders a person with severe mental illness to adhere to an outpatient treatment plan designed to prevent relapse and dangerous deterioration (2-4). Persons appropriate for this intervention are those who need ongoing psychiatric care owing to severe mental illness but who are unable or unwilling to engage in ongoing, voluntary, outpatient care. It should be distinguished from 'conditional release,' a form of treatment wherein a patient committed to an inpatient hospital is released to the community but remains under the ongoing supervision of the hospital -- if the patient's condition deteriorates he or she can be returned to the hospital (see Figure 1.). Additionally, there are three types of involuntary outpatient commitment: 1) the most common type is outpatient commitment as part of a discharge plan from an involuntary hospitalization; 2) an alternative to hospitalization for patients who otherwise meet the criteria for involuntary hospitalization; and 3) a 'preventive' treatment for those patients who do not presently meet criteria for inpatient hospitalization, but who are in need of treatment to prevent such decompensation. Orders initiated as a 'stepdown' from involuntary inpatient commitment (Type 1) are often later renewed as a method to prevent relapse (Type 3).

Figure 1. General types of involuntary outpatient commitment

Type 1	Post-discharge involuntary outpatient commitment plan unattached to hospital supervision
Type 2	Alternative to hospitalization for those meeting civil commitment criteria but for whom outpatient commitment is sufficient
Type 3	Preventive treatment for individuals who do not meet criteria for inpatient hospitalization but are in need of treatment to prevent decompensation

Although recently enacted statutes use the term 'assisted outpatient treatment', other phrases, such as 'mandatory outpatient treatment', 'community treatment orders' or 'involuntary outpatient commitment,' are also in use. The phrase "involuntary outpatient commitment"

implies a more coercive approach than is envisioned by proponents of judicial treatment orders, however the term 'assisted outpatient treatment' is sometimes criticized as euphemistic. In practice, these legal devices are intended to reinforce the patient's own resolve to adhere to a treatment plan while marshalling the resources of local mental health authorities to more effectively serve the patient. In this Resource Document, the phrase 'involuntary outpatient commitment' will be used. In addition with a few exceptions the Document will focus on U.S. experience with outpatient commitment.

Studies on the Effectiveness of Involuntary Outpatient Commitment

The empirical data on outpatient commitment in the U.S. broadly consists of two groups of studies (2, 4). The 'first-generation' studies, conducted prior to the mid-1990s, are largely observational or quasi-experimental in nature. They have been critiqued on a variety of methodological grounds, including the comparability of committed and non-committed observed groups, the comparability of treatment received, the variability of outcome measures across studies, the limited use of statistical controls and potential selection bias inherent in naturalistic studies selecting for candidates thought likely to succeed under involuntary outpatient commitment (21). Nevertheless, these studies, taken as a whole, suggest that outpatient commitment can be effective in reducing re-hospitalizations and improving other outcomes when effectively implemented, adequate services are provided and the programs have the support of the treatment providers (9).

Since the mid-1990s, several 'second-generation' studies of outpatient commitment have been conducted (4, 12-14, 16-20). These studies attempted to control for potentially confounding factors such as selection bias, varying intensity of treatment across patients and various sources of coercion designed to enhance treatment adherence. Most importantly, these studies sought to determine whether the court order itself was necessary, that is, whether the court order itself improves treatment outcomes over and above the effect of the provision of a well-designed and coordinated treatment plan.

The Duke Mental Health Study in North Carolina was the first randomized controlled trial of outpatient commitment (13, 16, 22). Under the study design, consenting hospitalized patients with severe mental illness who were being discharged from the hospital under a previously authorized outpatient commitment order were randomly assigned to remain on the outpatient commitment order while provided case management ('OPC' group) or be released from the order and receive case management services alone (the 'control' group). An additional group of patients with a recent history of serious violence also leaving the hospital on outpatient commitment were placed in a nonrandomized comparison group while staying on outpatient commitment (owing to ethical considerations that precluded them from being assigned to the control group). Involuntary medication is not authorized for patients under outpatient commitment in North Carolina. The outpatient commitment group was significantly less likely than the control group to be re-hospitalized in the 12-month follow-up period in repeated measures analyses examining the likelihood of re-hospitalization each month. In addition patients who underwent sustained periods of outpatient commitment for 180 days or more had

57% fewer admissions and 20 fewer hospital days over the study period compared to controls (16). Moreover, sustained outpatient commitment was shown to be particularly effective for patients suffering from non-affective psychotic disorders (72% decrease in readmissions and 28 fewer hospital days) (16). In further analyses they reported that sustained outpatient commitment was most effective when combined with frequent outpatient services (a median of three or more services per month), thus emphasizing the need to combine the court order with frequent outpatient services (16).

The outpatient commitment group also had lower rates of violent behavior (22). During a one-year follow-up period patients who underwent sustained periods of outpatient commitment had significantly fewer violent incidents in the community as compared to patients who were released from outpatient (control group) and to patients who underwent shorter periods of commitment (23% versus 37% and 40% rates of violence, respectively) (22). The authors also found that patients who underwent sustained outpatient commitment and frequent outpatient services and who additionally abstained from substance use and were adherent with medications, had the lowest likelihood of any violence (13% predicted probability versus 53% predicted probability for patients who did not undergo regular, sustained outpatient commitment, misused substances and were medication non-adherent) (22). The authors also reported that patients who received sustained outpatient commitment had significantly lower total treatment and criminal justice costs (13).

Another randomized controlled trial of mandatory outpatient commitment was conducted in New York City (17). In 1994, the New York State legislature passed a bill providing for a three-year pilot project of involuntary outpatient commitment at Bellevue Hospital in New York City for a target population of patients with severe mental illness and contracted with Policy Research Associates, Inc. to evaluate the pilot program. Substantively, the program provided for a range of intensive outpatient treatment, including assertive community treatment or intensive case management. During the 11-month follow up period, inpatients at Bellevue Hospital who were deemed appropriate for outpatient commitment were randomized to receive intensive community treatment with a court order ("outpatient commitment") or intensive community treatment alone ("control"). The investigators found no statistically significant differences between the outpatient commitment and control groups in re-hospitalization or number of hospital days during the study period (17). However, both groups experienced a significantly fewer re-hospitalizations during the study period than during the year preceding the target admission (17). The authors of the study concluded that, although the court order itself did not seem to produce better patient outcomes, "the service coordination/resource mobilization function of the program seemed to make a substantial positive difference in the [patients'] experiences" (17). Observers of this study noted that, under the pilot program, no enforcement of the orders for non-adherence was available in NYC and that the study sample was likely too small to have detected meaningful difference between study groups. Another study reported that many participants in the control group receiving intensive service but no court order thought they were under a court order as well (23).

In August, 1999 the New York State legislature enacted a statewide outpatient commitment

statute that required reauthorization in five years. It termed the program as 'assisted outpatient treatment' rather than 'involuntary outpatient commitment' and differs from the pilot program in that treatment can be court-ordered in a preventive form without a current hospitalization, and prohibited forced medication for non-adherent patients (18).

Several subsequent evaluations of New York's Assisted Outpatient Treatment program have been conducted since the statewide AOT statute went into effect. An evaluation of the program was conducted by the New York State Office of Mental Health in 2005 (18) and found an 89% increase in use of case management services among AOT recipients, and substantial increases in the use of substance use disorder treatment and housing support services. They also reported significant improvements in self-care and community functioning and a 44% decline in the incidence of harmful behaviors (e.g., suicide threats, self-harm, and harm to others). They also reported that rates for hospitalizations, homelessness, arrests, and incarcerations declined significantly (18).

A subsequent independent evaluation of the program ordered by the state was conducted by Duke University, Policy Research Associates, Inc. and the MacArthur Research Network on Mandated Community Treatment (14, 19, 24). Several sources of administrative data were linked to examine whether recipients under Assisted Outpatient Treatment experienced reduced rates of hospitalization, reduced length of stay and other related outcomes (24). Multivariable analyses controlling for relevant covariates were used to examine the likelihood that assisted outpatient treatment produced these effects. The investigators reported that the likelihood of psychiatric hospital admission was significantly reduced by approximately 25% during the initial 6 month court order and by over one-third (during a subsequent 6 month renewal period compared to hospitalization records before initiation of the court order) (19,24). Similar significant reductions in days of hospitalization were evident in initial and subsequent renewals of court orders. Improvements were also evident in receipt of psychotropic medications and intensive case management services. The study concluded that assisted outpatient treatment recipients appeared to experience a number of improved outcomes: reduced hospitalization and length of stay, increased receipt of psychotropic medication and intensive case management services, and greater engagement in outpatient services. The study reported: "On the whole, AOT recipients and non-AOT recipients have remarkably similar attitudes and treatment experiences. That is, despite being under a court order to participate in treatment, current AOT recipients feel neither more positive nor more negative about their mental health treatment experiences than comparable individuals who are not under AOT. This suggests that positive and negative attitudes about treatment during AOT are more strongly influenced by other experiences with mental illness and treatment than by recent experiences with AOT itself (24)." The report also evaluated reports of racial bias in selection of patients for assisted outpatient treatment. Since 1999 about 34% of AOT recipients have been African-Americans who make up only 17% of the state's population. However, the vast majority of AOT cases are clustered in New York City where 25% of the population is African American. The report documents that individuals eligible for AOT are largely drawn from a population where blacks are overrepresented: psychiatric patients who have had multiple hospitalizations in public facilities. Among those *eligible* for AOT by dint of

this hospitalization history, African Americans are represented roughly on par with the demographic profile of those other demographic groups who are eligible. That is, racial differences in receipt of assisted outpatient treatment reflect the demographics of persons who are eligible for assisted outpatient treatment (24). Other reports from this and other evaluations found reduced arrests for AOT participants and sustained improvements in reduced hospitalization after recipients left the AOT program (25).

Critics of this study argue that only randomized controlled studies and control of selection bias offer definitive evidence of the effectiveness of outpatient commitment and that the 'before-after' nature of these studies are subject to 'regression to the mean', whereby patients identified in their relapsed states might naturally return to their baselines, seemingly improved by the intervention. The investigators countered that this effectiveness study evaluated a 'real-world' program, employed rigorous quasi-experimental methods, including propensity score adjustments, to evaluate the experience of several thousand persons—far more than a randomized trial might reasonably recruit (9).

A follow-up cost analysis of the program using administrative, budgetary, and service claims data was conducted for 36 months of observational data from assisted outpatient treatment and voluntary recipients of intensive community-based treatment in New York City and 5 counties elsewhere in New York State (14). Using multivariable time-series regression analysis, controlling for relevant covariates, the investigators reported that in the New York City assisted outpatient treatment group, net costs declined 43% in the first year after assisted outpatient treatment began and an additional 13% in the second year. In the 5-county assisted outpatient treatment group, costs declined 49% in the first year and an additional 27% in the second year (14). Regression analyses showed significant declines in cost associated with both assisted outpatient treatment and voluntary participation in intensive services, though the assisted outpatient treatment-related cost declines were about twice as large as those seen for voluntary services. They concluded that AOT requires a substantial investment of state resources, but can reduce overall service costs for individuals with serious mental illness.

The Oxford Community Treatment Order Evaluation Trial (OCTET) conducted in the United Kingdom, was the third randomized trial of outpatient commitment's effectiveness (20). In OCTET, individuals who were involuntarily hospitalized were randomly assigned to be released in one of two study conditions. The experimental condition consisted of a community treatment order, the U.K. equivalent of assisted outpatient treatment authorized under the 2007 Mental Health Act. The control condition consisted of an authorized 'leave of absence from hospital,' a form of conditional release authorized under Section 17 of the U.K.'s 1983 Mental Health Act. The primary outcome for the OCTET trial was whether or not the person was readmitted to the hospital during the 12 month follow-up period. Secondary outcomes included length of time to the first readmission, number of readmissions, total amount of time spent in hospital, clinical functioning, and social functioning. No significant differences were found across any of the outcomes at the 12 month follow-up (20). While this trial seemed to provide evidence of the lack of benefit of outpatient, commitment critics of this study suggest that it was not a clear

replication of the previously conducted RCTs in the U.S. because OCTET lacked a true 'voluntary' treatment arm (26-29).

After several generations of studies, evaluations, legislative and systematic reviews of the evidence for involuntary outpatient commitment, there is no clear consensus about its effectiveness across different jurisdictions, including a recent Cochrane review (9, 12, 30). The evidence on the effectiveness is mixed, with effectiveness largely a function of systematic and effective implementation, the availability of intensive community-based services and the duration of the court order. However, rather than framing the question as to whether outpatient commitment orders 'are effective' –as if comparing Drug A to Drug B--it appears to be more appropriate to ask, "under what conditions, and for whom, *can* involuntary outpatient commitment orders be effective?" This Resource Document identifies the elements that can optimize its effectiveness.

Criteria for Involuntary Outpatient Commitment

Because of the liberty interests at stake under any scheme of involuntary outpatient commitment, it should be ordered by a court only after a hearing at which the judge finds, on the basis of clear and convincing evidence, that the patient meets the statutorily-prescribed criteria for involuntary outpatient commitment. Based on a review of the literature and statutes, this Resource Document proposes the following criteria as necessary and appropriate to limit the use of involuntary outpatient commitment to individuals who have demonstrated a strong probability of relapse and deterioration by their behavior and clinical histories. The criteria are listed below, followed by commentary on several of the key elements.

A person would be eligible for involuntary outpatient commitment if:

1. The person is suffering from a severe mental disorder [e.g., an illness, disease, or other condition that (a) substantially impairs the person's thought, perception of reality, emotional process, or judgment, or (b) substantially impairs behavior as manifested by recent disturbed behavior]; and
2. In view of the person's treatment history, the person now needs treatment in order to prevent a relapse or severe deterioration that would predictably result in the person becoming a danger to himself or others or becoming substantially unable to care for him or herself in the foreseeable future and/or meeting the state's inpatient commitment criteria in the foreseeable future; and
3. As a result of the person's mental disorder, he or she is unlikely to seek or voluntarily adhere to needed treatment; and
4. The person has been hospitalized or admitted to a crisis facility for treatment of a severe mental disorder within the previous two years and has failed to adhere on more than one occasion to the prescribed course of treatment after discharge; and
5. An acceptable treatment plan has been prepared which includes specific conditions with which the patient is expected to adhere, together with a detailed plan for reviewing the patient's medical status and for monitoring his or her adherence with the required conditions of treatment; and

6. There is a reasonable prospect that the patient's disorder will respond to the treatment proposed in the treatment plan if the patient adheres to the treatment requirements specified in the court's order; and
7. The physician or treatment facility which is to be responsible for the patient's treatment under the commitment order has agreed to accept the patient and has endorsed the treatment plan.

The major purpose of involuntary outpatient commitment is to facilitate effective treatment of persons with mentally illness before their conditions deteriorate to the point where they relapse and are unable to live safely in the community. This goal is best served by substantive standards for involuntary outpatient commitment based chiefly on the need for and the availability of appropriate treatment to prevent substantial mental or emotional deterioration. Several statutes permit outpatient commitment of patients who currently may not be dangerous to themselves or others (and are not therefore committable to inpatient treatment), but whose predictable deterioration would lead to such dangerousness. For example, the New York statute criterion is: "In view of the patient's treatment history and current behavior, the patient is in need of involuntary outpatient commitment in order to prevent a relapse or deterioration which would be likely to result in serious harm to the patient or others (24)."

Several states like New York require that predictions of a "likely deterioration leading to dangerousness" be based on past treatment records. This approach has the virtue of providing specific evidence of past behavior, however the burden of obtaining certified treatment records – as is the case in New York - creates unnecessary procedural barriers to effective use of involuntary outpatient commitment. Attestation by the examining physician or psychologist to the requisite clinical history of hospitalization or dangerousness is preferable for documentation of the treatment history.

The suggested criteria also require development of a treatment plan that includes specific conditions with which the patient will be expected to adhere. The treatment plan should specify components of the patient's care, including classes of medications and other aspects of the treatment. It should also specify which substantive changes in treatment require court review in order to afford flexibility in treatment approaches and to avoid unnecessary hearings on adjustments to the treatment plan that are not substantive, in nature. Additionally, since a number of studies have shown that a large proportion of patients brought for psychiatric treatment also suffer from significant medical illness (31) - some of which are causally related to their psychiatric symptoms - a thorough medical examination should be a required component of outpatient commitment to psychiatric treatment. Clinical judgment should be employed in determining when, where, and how such examination is carried out.

The criteria require that the proposed treatment plan include services adequate to successfully treat the patient. Several authors have pointed out that effective outpatient treatment, whether voluntary or involuntary, presupposes the availability of the resources necessary to implement community-based treatment under involuntary conditions that may not be forthcoming. Many observers fear that involuntary outpatient commitment might authorize increased control by the

mental health system, without the benefits of treatment to justify the intrusion (3, 8). These arguments are well-grounded in the history of involuntary commitment in general, and any system of involuntary outpatient commitment must provide both increased protections for those at risk, and increased resources to guarantee that effective treatment can be provided.

Clinicians who are expected to provide the involuntary outpatient commitment plan and court testimony must be directly involved in the decision-making process and the development of the treatment plan. Before involuntary outpatient commitment is ordered, the judge should be satisfied that the recommended course of treatment is available through the proposed providers and has a high likelihood of being effective. These requirements, if taken seriously, would prevent the arbitrary use of commitment as a form of social control, a use of commitment laws that arouses opposition to the expanded use of involuntary outpatient commitment. Such requirements also would involve the outpatient providers directly in the planning of the treatment. Some of the most vocal critics of involuntary outpatient commitment have been clinicians at outpatient facilities who have feared they would be inundated with uncooperative patients who would not benefit from any treatment available at the facility, but for whom the facility would be held responsible.

By requiring that a treatment plan be presented to the hearing officer before outpatient commitment may be ordered, judges would be able to make better informed decisions and outpatient clinicians would be able to exercise appropriate control over which patients are committed to them and under what treatment conditions. The patient should also be provided with a copy of the treatment plan so that he/she will be aware of the conditions with which he/she will be expected to comply. A plan for involuntary outpatient commitment should also take into consideration any reasonably possible alternative treatments preferred by the person, as potentially expressed in an advance directive. For example, New York's Assisted Outpatient Treatment law specifies: "If the subject of the petition has executed a health care proxy, the appointed physician shall consider any directions included in such proxy in developing the written treatment plan (24)."

If outpatient treatment is to be ordered on release from inpatient treatment, information sharing between inpatient and outpatient treatment staffs should be authorized and not be prohibited by any regulations governing confidentiality.

Length of Treatment

Since the patients for whom involuntary outpatient commitment is most effective generally suffer from chronic or recurring disorders, it is important that the statutes allow for continued extensions of commitment, based on specified grounds to be demonstrated at regularly scheduled hearings. Brief, time-limited periods of involuntary outpatient commitment are unlikely to be effective with these patients; the conditions which required the initial commitment order are quite likely to continue for significant periods of time. As noted above, the North Carolina and New York experiences indicates that benefits of mandatory outpatient treatment are realized when patients participate in the program for an extended period of time (180 days)

(16, 24). During all hearings on extensions of commitment, the court must find, on the basis of clear and convincing evidence, that the patient continues to meet all criteria for involuntary outpatient commitment; otherwise, the patient must be released from the court order.

Response to Non-adherence

Formulating reasonable procedures for enforcing adherence to an involuntary outpatient commitment plan is a challenging task. The treating clinician should attempt to obtain the patient's voluntary adherence with the treatment plan. After reasonable effort is exerted, however, if the patient remains substantially non-adherent, the statute must contain a mechanism for some intervention to promote adherence. One option is to include in the commitment order an explicit authorization for law enforcement officers to transport a non-adherent patient for further evaluation upon receiving notice from the responsible clinician. The patient would be transported to the outpatient facility for a short period of time for evaluation, where it can be hoped that the patient will be persuaded to accept the prescribed treatment without requiring another hearing. This is the statutory scheme in several jurisdictions, including the District of Columbia and Utah. Alternatively, the law could provide that police custody may be asserted only on the authorization of a judicial officer, upon a reliable and adequate showing of non-adherence by the responsible clinician. This is the strategy employed by Georgia and North Carolina, where the treating clinician can petition the court for an order authorizing a peace officer to take the patient to the treating facility or the nearest emergency room for evaluation. In New York City, a Citywide Assistance Team (CAT) is deployed to transport the patient to a hospital emergency room for evaluation.

In sum, it is important for involuntary outpatient commitment statutes to ensure that the treatment orders empower and mandate a crisis team such as a CAT or law enforcement officers to transport non-adherent persons for evaluation upon notification from the treatment providers. In addition, law enforcement officers should be carefully educated about the need for an expedient response to non-adherence in order to forestall their resistance to involvement. Law enforcement acting on these court orders may benefit from training on trauma-informed approaches as well as strategies for intervention and de-escalation of individuals with mental illness.

Beyond whether this function of law enforcement transport is provided for by statute, however, the statute must also authorize treatment providers to petition the court for a supplemental commitment hearing in the event of substantial non-adherence. At that hearing, the court should have three options: it could continue the involuntary outpatient commitment if the patient continues to meet all the statutory criteria and the court finds that it remains appropriate (with any modifications necessary to the treatment plan, as discussed and developed by the patient and his treatment team); it could order involuntary admission to the hospital if the patient meets inpatient commitment criteria; or it could discharge the patient from involuntary outpatient commitment.

The statute should also specify what liability protections are afforded clinicians involved either in

seeking an order or treating a patient under involuntary outpatient commitment. Outpatient clinicians should not be subject to greater liability for treating patients under involuntary outpatient commitment. Fears of increased liability could generate inappropriate pressures and further discourage clinicians from agreeing to accept patients under judicial mandates.

If involuntary outpatient commitment is to be ordered, solutions to administrative problems -- including political, financial and legal barriers to the transfer of and accountability for patients between facilities and providers, and the continuity of their care -- must be explicitly provided in any enabling legislation or regulations. Such provisions may be necessary because different facilities and providers may be funded and/or operated by different state, county or private entities. In addition, the spread of public and private managed care plans may provide unique financial barriers to implementation of involuntary outpatient commitment. For example, payment for an involuntary outpatient commitment plan might not be fully authorized under managed care utilization review that requires medical necessity criteria are met and under some privatization schemes where the authority and responsibility for involuntary outpatient commitment may be unclear and should be addressed in any enabling legislation or regulations. Separate from the financial considerations the capacity to transfer information between facilities and providers should be unimpeded. Statutory changes may be required to overcome existing regulations designed to protect patient privacy by preventing disclosures of information without explicit voluntary consent.

The Issue of Involuntary Medication

Since involuntary outpatient commitment often works most effectively with patients who do well on psychotropic medications but repeatedly are non-adherent, the initial hearing should determine the role of medications as part of the treatment plan. Successful involuntary outpatient commitment programs need some legal authority to promote treatment adherence. Statutes generally do not authorize forced medication without a separate legal determination of involuntary medication. All techniques short of force should be used to promote adherence. For example, the judge or hearing officer should make it clear that (if it is so decided) taking medications will be expected of the patient, and the taking of prescribed medication should be specified as one of the patient's obligations in the court order. If the patient does not adhere to court-ordered medication, that fact should be sufficient evidence of lack of adherence with the treatment plan for the patient to be taken to the outpatient treatment facility for re-evaluation. Once at the facility, the medication could again be offered to the patient, even if it would not be involuntarily administered if refused. It is likely that the prospect of repeated involuntary visits to the treatment facility would result in medication adherence for many patients. Moreover, a study in North Carolina indicates that, in spite of the fact that the statute does not authorize the involuntary administration of medication, most patients do believe that mandatory outpatient treatment requires medication adherence (32).

In summary, psychotropic medication is an essential part of treatment for most patients who are appropriate for involuntary outpatient commitment. The expectation that a patient take such medication should be clearly stated in the patient's treatment plan, and proactive measures

should be taken to promote adherence. However, the involuntary administration of medication should not be authorized as a consequence of refusal to take medication as prescribed without subsequent review consistent with the state's process for authorizing involuntary administration of medication.

The Issue of Potential Racial Disparities

Several advocacy organizations, including the New York Lawyers for the Public Interest, have raised concerns that African Americans and other minorities are over-represented in programs such as NYS's AOT program (33). Whether this potential over-representation is unfair and represents racial discrimination rests, in part, on whether AOT is regarded as beneficial or detrimental to persons under court order. The concern over any potential over-representation of minorities in the program raises over-arching policy questions of whether AOT is regarded as a positive mechanism to improve access to services, outcomes for an under-served population and as a less restrictive alternative to involuntary hospitalization, or as a program without benefit that subjects minorities to a further loss of civil liberties. As discussed previously rates of AOT by race shows about 34% of AOT recipients have been African-Americans who make up only 17% of the state's population. However, racial differences in rates of AOT largely mirror the rates of eligibility for AOT among different minority groups. The New York AOT evaluation report concluded: "We find no evidence that the AOT Program is disproportionately selecting African Americans for court orders, nor is there evidence of a disproportionate effect on other minority populations (24, 34)." The research on this issue is limited to a single jurisdiction. As a result, independent evaluation of involuntary outpatient commitment programs should be conducted at regular intervals and reported for public comment and legislative review, especially in view of concerns about its appropriate use. Among several outcomes that should be assessed is any evidence of disproportionate use of involuntary outpatient commitment among minority groups and disenfranchised groups, inadequate due process protections and the diversion of clinical resources from patients seeking treatment voluntarily. Any indications of findings in these areas should be followed by program improvement plans and corrective action.

Conclusions

Involuntary outpatient commitment has received increasing public attention, owing in large part to occasional, highly publicized incidents of violence by persons with severe mental disorders who are non-adherent with treatment, and to other difficulties posed by the 'revolving-door' patients who suffer from severe mental illnesses and who are difficult to engage in ongoing treatment. Over the past twenty plus years, as discussed in this Resource Document, the body of scientific literature on the effects of involuntary outpatient commitment has grown considerably, and many jurisdictions have enacted or are considering enacting outpatient commitment statutes.

This Resource Document supports the view that involuntary outpatient commitment can be effective when systematically and effectively implemented, linked to intensive outpatient services and prescribed for extended periods of time. Clinical experience in a number of

jurisdictions provides further support for these conclusions. Second, there is no evidence that a judicial order reduces or undermines the positive effects of enhanced treatment; the only question is whether it has additive effect - and the existing studies suggests that it does. Third, there is clear evidence that enacting and implementing involuntary outpatient commitment concentrates the attention and effort of the providers; that is, the judicial order may help to enhance the services by 'committing' providers to the patients' care. Finally, enacting involuntary outpatient commitment may also help to 'commit' legislatures to provide the funding needed to provide enhanced community services for all patients, whether or not they are subject to a commitment order. In a political context, involuntary outpatient commitment may provide the leverage for increased funding for community mental health services, and particularly for persons with severe mental illnesses.

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