

Involuntary Outpatient Commitment¹ Myths and Facts

Under Involuntary Outpatient Commitment (IOC), a person with a serious mental health condition is mandated by a court to follow a specific treatment plan, usually requiring the person to take medication and sometimes directing where the person can live and what his or her daily activities must include. Proponents of IOC claim that it is effective in reducing violent behavior, incarcerations, and hospitalizations among individuals with serious mental health conditions.² However, repeated studies have shown no evidence that mandating outpatient treatment through a court order is effective; to the limited extent that court-ordered outpatient treatment has shown improved outcomes, these outcomes appear to result from the intensive services that have been made available to participants in those clinical trials rather than from the existence of a court order mandating treatment. In addition, studies have shown that force and coercion drive people away from treatment.³ “By its very nature, outpatient commitment may undermine the treatment alliance and increase consumers’ aversion to voluntary involvement with services,” according to a study cited in “Opening Pandora’s Box: The Practical and Legal Dangers of Involuntary Outpatient Commitment,” published in *Psychiatric Services*.⁴

There is ample evidence that intensive services provided on a *voluntary* basis can bring tremendous improvements in outcomes such as reduced hospitalizations, reduced arrests, longer tenure in stable housing, and reduced symptoms; there is no evidence that mandating outpatient services through a court order has any additional benefit.

Involuntary outpatient treatment has high costs with minimal returns, is not likely to reduce violent behavior, and there are alternatives that are more effective and efficient.

No evidence that using court orders to mandate outpatient treatment is effective.

Two systematic reviews have been done of studies concerning involuntary outpatient commitment. Both reached the same conclusion: there is no evidence that mandating outpatient treatment is more effective than providing such treatment on a voluntary basis. The RAND review concluded in 2001 that the existing studies:

[did] not prove that treatment works better in the presence of coercion or that treatment will not work in the absence of coercion.⁵

More recently, a review by the Cochrane Collaborative concluded:

Based on results from this review, there is no strong evidence to support the claims made for compulsory community treatment that make it so attractive for legislators. It does not appear to reduce health service use or improve patients’ social functioning. It also does not significantly reduce perceived coercion.⁶

IOC has consistently been found to not be a substitute for comprehensive mental health services.⁷ In the late 1990s, Jeffrey W. Swanson, Ph.D., and colleagues conducted a field study in North Carolina that found that IOC can be effective only if combined with other intensive

treatment. The authors concluded, “This use of outpatient commitment is not a substitute for intensive treatment; it requires a substantial commitment of treatment resources to be effective.”⁸ In this study, participants were provided with additional intensive mental health services beyond what was typically available in North Carolina’s service delivery system.

A study of IOC conducted in the mid-1990s at Bellevue Hospital in New York City found that, “[o]n all major outcome measures, no statistically significant differences were found between the two groups” (IOC and control groups).⁹ A later study of Kendra’s Law—New York’s IOC law that requires the provision of intensive services for IOC participants—found improved outcomes, but did not assess whether providing these services on a voluntary basis would be equally effective as providing them through a court order.¹⁰ The most recent study, done in the United Kingdom, found:

In well-coordinated mental health services the imposition of compulsory supervision does not reduce the rate of readmission of psychotic patients. We found no support in terms of any reduction in overall hospital admission to justify the significant curtailment of patients’ personal liberty.¹¹

This continued research shows that “after more than 20 years of mandates and programs, outpatient commitment remains a costly, coercive, and unproven approach.”¹²

Moreover, IOC has not been shown to prevent violence. Dr. Swanson of Duke University, who has studied Kendra’s Law extensively, told *Behavioral Healthcare*: “[P]eople who understand what outpatient commitment is would never say this is a violence prevention strategy.”¹³

IOC is a costly intervention.

IOC is a costly program that needs significant resources to have an impact. However, research has shown that, for the cost, there is minimal impact. It would take 27 IOC orders to prevent one instance of homelessness, 85 to prevent one (hospital) readmission, and 238 to prevent one arrest.¹⁴

Notably, the 2005-2006 Fiscal Year budget for Kendra’s Law operations was \$32 million, and that same budget included an additional \$125 million to expand case management services, to improve service access and utilization, and to increase the availability of other mental health services and supports.¹⁵

Other mental health interventions are effective.

Research has shown that other interventions are efficient and effective in achieving the same goals as IOC. Three examples of such interventions are Peer-Run Crisis Respite (PRCRs), supported housing, and mobile crisis teams. In **Peer-Run Crisis Respite**, usually located in houses in residential neighborhoods rather than on distant and sprawling hospital campuses, people can live for a while during a mental health crisis. Run by individuals who are in recovery from a mental health condition – peers administer, staff and operate the center; and at least 51 percent of the board members identify as peers – PRCRs offer a nonmedical, trauma-informed environment that approximates the feeling of being at home. A randomized controlled trial of a PRCR (Greenfield, Stoneking, Humphreys, Sundby, & Bond, 2008, pp. 142-143) found that the average rate of improvement in symptom ratings was greater in the alternative than in the hospital comparison group, and that the peer-run alternative group had much greater service satisfaction. The cost was significantly less: \$211 per day for PRCR versus \$665 per day for hospitalization. The study authors concluded that this alternative was “at least as effective as standard care” and a “promising and viable alternative.”¹⁶

Supportive housing affords individuals with SMI the chance to live in their own apartments or homes, scattered in mainstream areas and buildings throughout the community, in addition to a flexible array of support services, including case management, life skills training, homemaker services, substance abuse treatment, and employment supports.¹⁷ A study of the Pathways to Housing program in Philadelphia, which provides supportive housing to formerly homeless individuals with serious mental illness and substance abuse disorders, found that the program reduced participants' shelter episodes by 88 percent, hospitalization episodes by 71 percent, crisis response center episodes by 71 percent, and prison system episodes by 50 percent.¹⁸

Mobile crisis services provide community-based psychiatric assistance (including psychiatric nurses, social workers, and paraprofessionals rather than law enforcement) to people in crisis situations. A national survey of mobile crisis services found that the services prevented hospitalization 55 percent of the time compared to only 28 percent for regular police intervention.¹⁹

The effectiveness of these voluntary, evidence-based services for individuals with serious mental health conditions has been widely demonstrated, but they are not sufficiently available to meet the need in any state.²⁰ Rather than investing in unproven strategies like involuntary outpatient treatment, we should invest in voluntary services—such as supportive housing, supported employment, peer-run crisis respites, and mobile crisis services—that have a proven track record of success. Additionally, offering individuals the services that they need early on, in order to prevent crises and the need for high-end services, is a far more effective approach than waiting for individuals to fail and then providing services on a coercive basis (with the effect of driving many individuals away from the service system).^{21 22}

Given the limited impact of IOC when compared to the high cost, it is imperative that the resources of the United States be used to fund programs that have a positive and significant impact on improving the lives of persons with serious mental health conditions, and not on IOC.

¹ Some call this process Assisted Outpatient Treatment, but that terminology is not a proper reflection of the process, so this document uses the more common and accurate phrase, "Involuntary Outpatient Commitment."

² Torrey, E Fuller. "Examining SAMHSA's Role in Delivering Services to the Severely Mentally Ill." Oversight and Investigations Subcommittee of the U.S. House of Representatives Committee on Energy and Commerce. Washington, D.C. May 22, 2013.

³ Campbell, J. and R. Schraiber (1989). *The Well Being Project: Mental Health Clients Speak for Themselves*. Office of Prevention, California Department of Mental Health: Sacramento, CA.

⁴ Allen, M., and Smith, V.F. (2001). *Opening Pandora's Box: The Practical and Legal Dangers of Involuntary Outpatient Commitment*. *Psychiatr. Serv.* 2001 Mar;52(3):342-6.

⁵ Ridgely, M., Borum, R., and Petrila, J. 2001. The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States. RAND Institute for Civil Justice.

⁶ Kisely, S., Campbell, L., and Preston, N. 2009. Compulsory community and involuntary outpatient treatment for people with severe mental disorders. Cochrane Database of Systematic Reviews.

⁷ Swartz, M. and Swanson, J. 2004. Involuntary Outpatient Commitment, Community Treatment Orders, and Assisted Outpatient Treatment: What's in the Data? *Canadian Journal of Psychiatry*. September, 2004.

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- ⁸ Swartz, M, Swanson, J, Wagner, H, Burns, B, Hiday, V, Borum, R. 1999. Can Involuntary Outpatient Commitment Reduce Hospital Recidivism?: Findings From a Randomized Trial With Severely Mentally Ill Individuals. *American Journal of Psychiatry*. 156(10): 1968-1975.
- ⁹ Steadman, H., Gounis, K., Dennis, D., Hopper, K., Roche, B., Swartz, M., and Robbins, P. 2001. Assessing the New York City Involuntary Outpatient Commitment Pilot Program. *Psychiatric Services*. 52(3): 330-336. Outcome measures included re-hospitalization, arrest, quality of life, symptomatology, treatment compliance, and perceived level of coercion.
- ¹⁰ Swartz, M., Introduction to the Special Section on Assisted Outpatient Treatment in New York State, *Psychiatric Services*. 61(10): 1-3.
- ¹¹ Burns T, Rugkåsa J, Molodynski A, et. al, Community treatment orders for patients with psychosis (OCTET): a randomised controlled trial, *Lancet* 381:1627-33, 2013.
- ¹² Rowe, M., Alternatives to outpatient commitment, 2013, *J. of Am. Acad. of Psychiatry and the Law*, 10:33:3358. In this article, there is also a discussion of the most recent study of Kendra's Law in New York. As Dr. Rowe points out, the most recent study "lacks randomization or a true matched sample."
- ¹³ Knopf, A., AOT Cost Effectiveness Study Stirs National Debate, *Behavioral Healthcare* (Aug. 22, 2013).
- ¹⁴ Kisely, S., Campbell, L., and Preston, N. 2009. Compulsory community and involuntary outpatient treatment for people with severe mental disorders. *Cochrane Database of Systematic Reviews*.
- ¹⁵ New York State Office of Mental Health. 2005. Kendra's Law: Final Report on the Status of Assisted Outpatient Treatment. Retrieved from <http://bi.omh.ny.gov/aot/files/AOTFinal2005.pdf> on November 26, 2013.
- ¹⁶ Greenfield, T. K., Stoneking, B. C., Humphreys, K., Sundby, E., & Bond, J. (2008). A randomized trial of a mental health consumer-managed alternative to civil commitment for acute psychiatric crisis. *American Journal of Community Psychology*, 42(1), 135-144. Cited in *A Case Study of the Peer-Run Crisis Respite Organizing Process in Massachusetts* http://ncmhr.org/downloads/Ostrow_Groundhogs-case-study.pdf
- ¹⁷ See Substance Abuse and Mental Health Service Administration, *Permanent Supportive Housing Evidence-Based Practices (EBP) KIT* (2010); Department of Justice, Justice Department Obtains Comprehensive Agreement to Ensure New York City Adult Home Residents with Mental Illness Are Afforded Opportunities to Live in the Community (July 23, 2013); North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, DOJ Settlement - Transition to Community Living Initiative (Aug. 23, 2012).
- ¹⁸ Fairmount Ventures, Inc., *Evaluation of Pathways to Housing PA* (Jan. 2011), available at <http://pathwaystohousing.org/pa/wp-content/themes/pathways/assets/uploads/PTHPA-ProgramEvaluation.pdf>.
- ¹⁹ Roger Scott, *Evaluation of a Mobile Crisis Program: Effectiveness, Efficiency, and Consumer Satisfaction*, 51 *Psychiatric Services* 9, 1153-6 (Sept. 2000).
- ²⁰ Substance Abuse and Mental Health Service Administration. 2012 CMHS Uniform Reporting System Output Tables, 2012. Only 2 percent of all individuals served by state mental health agencies receive ACT services and only 2.6 percent receive supported housing services.
- ²¹ Campbell, J. and R. Schraiber (1989). *The Well Being Project: Mental Health Clients Speak for Themselves*. Office of Prevention, California Department of Mental Health: Sacramento, CA.
- ²² Allen, M., and Smith, V.F. (2001). *Opening Pandora's Box: The Practical and Legal Dangers of Involuntary Outpatient Commitment*. *Psychiatr. Serv.* 2001 Mar;52(3):342-6.