Sixth
in a
Series
of
Technical
Reports

Technical Report on Involuntary Outpatient Commitment

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Report Preparation Process

This technical report, prepared by the National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council, is sixth in a series of reports intended to provide information and technical assistance to state mental health commissioners and directors on matters of clinical concern. Topics for technical reports are identified by the Medical Directors Council in conjunction with the NASMHPD leadership.

This report was prepared from proceedings of a meeting held April 23 and 24, 2001 in Annapolis, Maryland. Meeting participants included three state medical directors, two state mental health commissioners, an internationally-recognized scholar with expertise in involuntary outpatient commitment, and a representative from the NASMHPD Forensic Division, a representative from the NASMHPD Legal Division, and a representative from the National Association of Consumer/Survivor Mental Health Administrators (NAC/SMHA). A second participant from NAC/SMHA was unable to attend the meeting but contributed to the drafting and editing of the report. Three staff members of NASMHPD participated and a facilitator and a technical writer assisted in the proceedings. Paul S. Appelbaum, M.D., provided expert consultation to the participants. In addition, he and Marvin S. Swartz, M.D., Duke University Medical Center, Department of Psychiatry, provided comments in response to drafts of this report. A list of participants and their affiliations is included in the Appendices. It is important to note that the views expressed by the participants were their own and are not necessarily endorsed by their organizations.

Prior to the meeting, participants reviewed reports and research on involuntary outpatient commitment. The materials were not a comprehensive survey of all current information on the topic, but sought to establish an informed basis for group discussion.

This report does not provide a point-by-point guide to implementing involuntary outpatient commitment, but instead reviews research and policy underlying it and ultimately focuses on the key issue of improving consumer engagement in effective treatment. Included in this report are topics for continued consideration and research as well as specific recommendations for state mental health agencies and NASMHPD.

Drafts of this report were prepared by the technical writer, chief editor, and coeditor and were distributed for review and comment to all meeting participants and the members of the Medical Directors Council's Editorial Board. A list of the Editorial Board is included in the Appendices. This report attempts to integrate findings of the literature with the diverse perspectives and expertise of the participants. The final report is a product of the Medical Directors Council and does not necessarily reflect opinions held by all NASMHPD members or the participants in the April 2001 meeting.

Executive Summary

In recent years, the public's attention has been gripped by sensational accounts of violence by people reported to be mentally ill but not receiving mental health treatment. Policy makers have debated a range of possible remedies to the perceived problem, including the enactment of laws for the involuntary outpatient commitment (IOC) of these individuals to treatment in the community.

Responsible policy development, however, should not be based on a few high profile incidents, but instead should reflect a careful review and examination of the root concerns. We discern two concerns underlying the current debate: (1) a fear of violence by persons with mental disorders; and (2) a desire that everyone with a serious mental disorders be afforded access to effective services in the community. Research does not support an assumption that persons with mental disorders as a group are more violent than the general population. Consequently, this report focuses on strategies to promote consumer engagement with community-based mental health services.

Individuals with mental disorders may fail to participate in treatment both for individual reasons and for systemic reasons. Individual reasons include past negative experiences with the mental health system or with psychotropic medications, a lack of family or significant-other participation in the treatment process, the social stigma associated with mental health treatment, and a failure to perceive the need for treatment. Systemic factors include barriers to access to services, poor coordination of services, lack of services for preventive or early intervention care, an absence of effective services for co-occurring disorders, and a lack of consumer and family involvement in the design of the mental health system. A range of policy proposals would address these individual and systemic factors.

In considering policy options to address poor consumer engagement in community-based treatment, we rely on two fundamental values of the public mental health system: respect for consumers (including their families and significant others), and the use of coercion only as a last resort. We apply the following general principles: policy changes should occur in response to typical situations rather than be driven by rare, high-profile cases; administrative rather than legislative solutions should be the first approach to problems; treatment compliance is not a panacea and is meaningful only in the context of an array of adequately-funded, effective community services; individuals should be engaged through a concern for their comprehensive health needs; and providers should collaborate with consumers, families, and significant others in fashioning treatment.

Drawing upon these principles and values, we find a number of proposals that could reduce systemic disincentives to treatment participation. Offering a broader continuum of services, for example, would permit more individualized treatment planning. Working to more effectively coordinate services would allow for a more comprehensive plan Ensuring the availability of assertive community treatment would better address the needs of some individuals with severe and persistent mental illness.

Some policy makers believe that improving the quality and availability of services is insufficient to ensure that all consumers in need of treatment will engage in treatment, and recommend an additional category of proposals addressing individual factors. These proposals include mental health advance directives and crisis cards, housing conditioned on treatment, money management, guardianship, criminal justice intervention, and IOC. IOC is the focus of this report.

The research on IOC is equivocal; indeed, the two best studies to date reached very different conclusions. A New York study suggested no statistically significant difference in treatment participation or violence rates between individuals receiving treatment under an IOC order and other individuals receiving community-based services on a voluntary basis. A North Carolina study found that in an initial, randomized 90-day period, two such groups showed no difference, but that a sub-population with psychotic disorders who were under IOC for more than 180 days and who received 3 or more contacts per month fared much better than those receiving services voluntarily. Because the study subjects were not randomized during the post-90 day period, however, these results have been questioned.. The Rand Institute reviewed available studies and concluded that while IOC combined with intensive mental health services can improve outcomes, no evidence exists that a court order is essential to positive outcomes or even has any independent effect on outcomes.

This report does not take a position for or against the use of IOC. We acknowledge, however, that current research fails to provide strong evidence that IOC is the best remedy for consumer non-compliance in treatment. Regardless of whether a state utilize IOC, funding a strong community-based service provision system is essential to increase consumer engagement in treatment. Ironically, if these services were readily available, the need for coercive measures would likely be minimized or eliminated. At a minimum, if a state decides to implement IOC, it must allocate sufficient resources to community-based treatment and monitor the outcomes of the more coercive measures.

Introduction

In recent years, policy makers have questioned the ability of community mental health systems adequately to serve the needs of people with serious mental disorders. High profile incidents such as the 1998 shootings on Capital Hill, allegedly committed by a man with a long history of treatment for schizophrenia, fuel the public's fears about people with mental disability. Policy makers have discussed a number of possible remedies, including the use of involuntary outpatient commitment (IOC) to require that people with serious mental disorders participate in treatment in the community..

High profile events understandably capture the attention of public officials. Responsible policy development, however, cannot be based on single incidents but rather requires full review and examination of all the underlying concerns. This report aims to identify the concerns underlying the current interest in IOC and explore the optimal means to address those concerns.

Certainly much of the recent interest in IOC is driven by the public's fear of violence by persons with mental disorders. This fear, however, may be unfounded. Indeed, violence by individuals with mental disorders is extremely rare. Even eliminating all such violence, moreover, would have little impact on the overall rate of societal violence (Link, 1998). Recent research conducted under the auspices of the MacArthur Research Network on Mental Health and the Law has shown that the prevalence of violence among persons with a mental disorder (but no substance abuse problems) recently discharged from a psychiatric hospital is about the same as among other persons in the general population. (Note, however, that the risk of violence escalates significantly when an individual, whether mentally ill or not, suffers from a substance abuse disorder) (Steadman, et al., 1998). Thus, increased utilization of IOC would do little to reduce societal violence.

A second factor behind renewed interest in IOC is the frustration of family members and others when a loved one who has a serious mental illness goes without treatment. This concern is often well-founded, as the ability of community mental health providers to offer a range of services adequate to meet the needs of different consumers is frequently limited. Developing comprehensive and effective community-based mental health services and promoting consumer engagement with those services has long challenged public mental health systems.

The Problem: A Lack of Engagement in Treatment

The basic concern motivating consideration and use of IOC in some states is that many people in need of community-based mental health treatment do not become (or remain) engaged in treatment. The consequences of individuals with serious mental disorders going without treatment are apparent in our society. Significant numbers of persons with mental disorders in the community live unstable lives, adrift or even homeless, many having frequent contact with the criminal justice system and coming into contact with the mental health system only when in a serious crisis.

Some individuals needing community-based mental health treatment fail to obtain or receive it because of individual, case-based factors:

- Negative past experiences with the mental health system, including past involuntary hospitalizations and other forms of coercive treatment
- Unpleasant or negative side effects from taking psychotropic medications
- Failure to involve family members and significant others in treatment planning and continuation of care
- Social stigma which attaches to people receiving treatment for a mental disorder
- The lack of individual insight and awareness of the need for treatment, or a denial of their need for treatment, often as a consequence of their mental disorder

In addition to these individual factors, other societal and systemic factors often play a role in why individuals who need treatment do not become or remain engaged in community mental health treatment:

- Barriers to ready access to services, including transportation problems, long waits for services, confusing eligibility rules, and financial barriers such as insurance limits
- Lack of community mental health support services for prevention, such as affordable housing and employment assistance, as well as outreach programs for early intervention for individuals with recurring disorders
- Fragmentation of care, requiring individuals to access separate services to meet mental health, substance abuse, physical health, and social support needs
- Lack of sufficient services and effective service coordination for co-occurring disorders

in many localities

- Insufficient consumer and family participation in the design of their mental health systems

Solutions to the problem of persons with mental disorders receiving inadequate treatment in the community must address these societal and systemic factors as well as factors peculiar to the individual.

Values and Principles of the Public Mental Health System Endorsed by the Participants

As we consider policy options to address some seriously mentally ill consumers' lack of engagement in community treatment, we rely on two fundamental values of the public mental health system:

1. Respect for Consumers and their Families: As mental health service providers, our mission is to improve the quality of life of the people we serve. We must operate from a foundation of respect for the dignity of each individual, including his or her family and significant others. We aim to provide the consumer with choice from an array of services and attempt to facilitate access to attractive services and develop individualized treatment plans. To preserve these values, we seek to provide treatment in the least restrictive setting possible and know that to do so, we must fulfill the promise of community care by providing locally-based effective services that address a continuum of life needs.

2. Coercion as a Last Resort: We acknowledge that a tension sometimes exists between consumer autonomy and the safety of the individual and the general public. In our view, legal coercion should be used as a last resort and only to prevent serious harm to the consumer or violence toward other individuals in the general population. Providers should encourage voluntary participation in services. When coercive measures are employed, additional measures should be taken to make the individual's experience of the coercion as benign as possible and to maintain the consumer's dignity and respect during the process.

In addition to these two fundamental values, the participants in this report endorse the following general principles:

- Policy should not be driven by individual, high-profile cases. Individual incidents brought to the public's attention through the media should be placed within the context of typical situations and problems. Policy should not be shaped by exceptional situations.

- Administrative and clinical solutions are generally preferable to legislative solutions.

- Treatment compliance is not a panacea. Many factors are important in reaching successful treatment outcomes, and compliance with an ill-designed or ineffective treatment regime will not lead to positive results.

- Individuals' engagement in community mental health treatment should be regarded as only one aspect of the state's overall concern for the individual's comprehensive health needs.

- Policies to promote consumer engagement in treatment should not be punitive but rather should promise an improved quality of life, offering employment opportunities, housing, and assistance in obtaining entitlements.

- Family members and significant others should be involved, when possible, to facilitate the engagement of the individual in treatment.

- To provide an array of effective community services, adequate funding is essential.

- Providers, consumers, and ideally family members should be involved in fashioning treatment, and consumers should be provided adequate information with which to judge the strengths and weaknesses of any proposed treatment plan in order to participate meaningfully in decisions concerning their care.

These underlying values and principles shape our consideration of any policy options designed to promote engagement in mental health treatment.

Potential Solutions to the Lack of Engagement in Treatment

Mental health systems can develop a variety of programs and services to better engage people in need of community treatment. The U.S. Supreme Court's decision in Olmstead v. L.C. ex rel. Zimring (527 U.S. 581 (1999)) has focused attention on the need to expand community-based mental health services. The Court held that under the Americans with Disabilities Act (ADA), when the clinical staff of a state facility determines that an institutionalized person is eligible and appropriate for community services, the state must take reasonable steps to provide those services as an alternative to institutionalization. The requirement for the provision of mental health services in the community may be limited by the overall resources available and the state's responsibility to other individuals with mental disabilities. The judicial nudging of *Olmstead*, combined with a growing body of research about the effectiveness of some forms of community treatment, has heightened the states' interest in improving the availability and effectiveness of community-based services.

Measures that address the societal and systemic factors that interfere with individuals becoming

engaged in community treatment include:

- Providing a broader continuum of services, including support services such as housing, transportation, and vocational assistance, that would enable clinicians, consumers, and family members to fashion treatment best suited to an individual's needs

- Establishing service coordination entities that would simplify the development of a comprehensive treatment plan and permit more effective case management

- Providing more assertive community mental health services, including crisis response services, mobile treatment services, and more intensive case management, in order to better address the needs of individuals with recurring disorders while minimizing the negative impact of active phases of their disorders.

Where services are accessible and meet the needs of consumers, voluntary participation in community treatment is more likely. Nevertheless, a number of clinicians, policymakers, and family members believe that even when community mental health services are comprehensive and effective, not all individuals in need of treatment will engage in treatment. To address this concern, other measures have been proposed, employing varying degrees of coercion. Recent efforts supported by the Initiative on Mandated Community Treatment of the John D. and Catherine T. MacArthur Foundation (Monahan, J., et al., in press) have addressed a range of options for engaging reluctant consumers in community treatment, including:

- *Mental health advance directives and crisis cards*: Legally-binding advance directives, as well as non-binding crisis cards, permit legally-competent individuals with mental disorders to specify and authorize specific treatments they would prefer should they become impaired in the future. Advance directives can take the form of a proxy, which specifies an alternative decisionmaker, or a conditional authorization of specific treatment modalities. Advance directives may encourage the participation of family members and significant others in assisting the consumer at times of deteriorating mental health.

- *Housing conditioned on treatment*: Government-subsidized housing may require certain actions of the recipient, including continued compliance with mental health treatment.

- *Money management*: When an individual receives income from government programs such as Supplemental Security Income, Social Security Disability Insurance, or Veterans Affairs, that individual may name a representative payee to receive the payments from the government in his name. If a mental health service provider is named representative payee, the payee may increase compliance with treatment, either

through the simple device of increased face-to-face contact or possibly through using this mechanism to enforce compliance.

- *Guardianship*: A court may appoint a guardian to make decisions in the place of a legally incompetent individual. The guardian may make decisions relevant to treatment, for example whether an individual should refuse suggested medications. Thus a guardianship or conservatorship potentially may be used to improve participation in treatment.

- *Criminal justice intervention*: For individuals charged with criminal offenses, the court may order compliance with treatment as a condition of probation. In addition, some jurisdictions have created special mental health courts as a means of promoting diversion for individuals charged with low-level offenses who present with serious mental health issues.

- *Involuntary outpatient commitment*: A court order mandating community-based treatment may increase participation in treatment outside a hospital environment. IOC statutes tend to fit one of three categories:

    1. Prevention or early intervention statutes target individuals with recurring disorders and a history of repeated hospitalization. The statutes permit IOC before an individual meets traditional civil commitment criteria.

    2. Hospital diversion statutes provide treatment in the community rather than in a hospital once an individual meets traditional civil commitment criteria.

    3. Conditional discharge statutes permit continued case management and service provision after an individual is discharged from a hospital. The standard for this type of IOC often are identical to traditional civil commitment criteria, but may be broader.

Review of the Research on IOC

In a recent survey, the Rand Institute found that 38 states and the District of Columbia have statutory provisions that would permit IOC (Ridgely, et al., 2001). Many of those provisions have existed for years and are used rarely, if at all. As states increasingly consider drafting new legislation or using heretofore dormant statutory provisions, public officials, mental health administrators, and service providers have expressed interest in learning about research evaluating the effectiveness of IOC.

The body of early research on IOC is sparse and flawed. Most early studies showed some positive effects of IOC, such as reduced rehospitalization, shorter lengths of stay, increased utilization of aftercare, and increased compliance after the termination of the commitment order. These studies, however, had serious methodological problems and thus cannot form the basis for policy development.

In recent years, two states, New York and North Carolina, have conducted randomized clinical studies of IOC programs, providing a firmer research base for future policy decisions. The two studies, however, differed in their conclusions, and even these studies are criticized for their methodological flaws. A strong need exists for additional research evaluating IOC programs and generating policy-relevant data.

New York

Research in New York evaluated a three-year pilot IOC program and examined two comparison groups of patients released from Bellevue Hospital in New York City: recipients of enhanced services under an IOC court order and voluntary recipients of enhanced services (Steadman, et al., 2001). The research measured rates of rehospitalization, arrests, quality of life, psychiatric symptoms, and homelessness among the three groups. The data showed no difference between individuals identified under the IOC statute and other individuals receiving community-based services on a voluntary basis.

The finding of no difference may not be conclusive. The study used a relatively small sample size of 142 total participants. Further, the New York IOC statute had weak enforcement provisions, essentially allowing a 72-hour hold for evaluations (which was permitted in New York prior to the IOC statute); no special enforcement mechanism existed at the time of the study. Finally, persons with a diagnosis of substance abuse/dependence, which strongly correlates with higher rehospitalization rates, were over-represented in the group of court-ordered IOC recipients.

The New York research examined a three-year pilot program established in 1994, but interest in IOC was intensified by the January 3, 1999, death of Kendra Webdale. Ms. Webdale was pushed onto the tracks in front of an approaching New York subway train by Andrew Goldstein, a man with a long history of treatment for mental disorder. Mr. Goldstein lived in substandard housing, was alienated

from family and friends, and frequently appeared in city emergency rooms seeking services. The incident made apparent the lack of coordinated care in New York City and galvanized public interest so that, despite research indicating a lack of efficacy from New York's IOC pilot program, the state legislature passed a new IOC statute (called "assisted outpatient treatment") and the Governor appropriated $200,000,000 in additional monies ($50 million to implement the law and $150 million to improve community services to the requisite level). Although there was an initial concern that the system would be flooded by requests for evaluation pursuant to the statute, that flood never materialized. From the time the law passed in November of 1999 until August of 2001, 4605 assessments were conducted, leading to 1230 court orders (including 208 renewal orders). In the aftermath of Kendra Webdale's death, the state Department of Mental Health has focused on accountability, best practices, and the coordination of care, using the IOC statute to hold the county Directors of Community Services accountable. The influx of funding has enabled the Department to establish additional case management services and other services needed to support consumers with the most complex needs.

North Carolina

Swartz, et al. (2001) conducted a randomized, controlled study of IOC with 331 North Carolina individuals with severe and persistent mental illness. The study compared involuntarily hospitalized individuals who were randomly assigned to discharge on IOC or unconditional discharge. Both groups were subject to a standard follow-up protocol and were provided case management. After the initial, randomized 90-day outpatient commitment period, the study showed no difference between the groups (in terms of rehospitalization). After a subsequent, non-randomized 180-day renewal of the IOC (comparing individuals meeting the criteria for a second period of IOC with those in the original randomized control group), the study concluded that the IOC program was effective for a sub-population with the following traits:

- psychotic disorders
- more than 180 days of IOC (requires renewal of initial 90 day period)
- 3 or more contacts per month

For the sub-population meeting these three criteria, the study found a decrease in mean hospital admissions from 1.23 to .34 and a decrease in mean hospital days from 24.1 to 4.6.

As with the New York study, the research is far from conclusive. Indeed, some researchers question these results, pointing out that although participants were randomized for the first 90 days, continued participation was determined by the treatment providers, not randomly. Some theorize that after the initial period, service providers may have decided not to renew IOC for the more difficult cases. Additionally, some have criticized the North Carolina research for using inherently weaker post-hoc analyses. Swartz et al., however, have responded by pointing to the repeated measures analyses for the initial randomized group that demonstrated that for any 30-day period, the group subject to IOC

had a significantly lower risk of readmission. The results of this key research project are criticized and defended in Letters to the Editor (2001) in the *American Journal of Psychiatry*.

In North Carolina, concerns about consumers' participation in treatment were heightened by an incident in 1995 in which Wendell Williamson, a UNC law student who had been under psychiatric care, shot and killed several Chapel Hill residents. In 1998, the North Carolina General Assembly formed a task force to investigate control of high risk patients. The task force concluded that before considering new IOC legislation, the state should brush off its existing but infrequently used statute and employ it to keep patients engaged in treatment following discharge from a psychiatric hospital. Anecdotal evidence suggests an inconsistent application of the law between rural and urban venues and an inconsistent enforcement of its provisions. The increased need for law enforcement resources has placed a strain on the system. The current legislative thrust in the state is to standardize application of the law and develop best practices. In Williamson's case, it should be noted, the statute is unlikely to have made a difference, as Williamson was under community-based treatment voluntarily and disengaged from treatment only when his psychiatrist retired and Mr. Williamson failed to follow-up on a referral to another treatment provider.

Rand Institute

The Rand Institute recently published a study commissioned by the California legislature seeking to learn whether IOC is effective and how it has been implemented in other states (Ridgely, M.S., et al., 2001). The researchers reviewed available studies and interviewed stakeholders in eight states (Michigan, New York, North Carolina, Ohio, Oregon, Texas, Washington, and Wisconsin) and considered the likely impact of any new legislation in California.

After an evidence-based critical review of existing research on IOC, the Rand study concluded that a court order combined with intensive mental health services can improve outcomes but that no evidence exists that a court order is essential to positive outcomes or even has any independent effect on outcomes. The principal researchers for the North Carolina study dispute this conclusion, arguing that their research found that IOC was an important part of improved outcomes and that high-intensity service users not under a court order had no better outcomes than consumers who infrequently or never received services (Swartz, et al., 2001; Letters to the Editor, 2001).

In the eight states surveyed in the Rand study, IOC was used most frequently as a "step-down" program from inpatient commitment and was used only infrequently prior to hospitalization. Respondents in these states saw IOC as a means to get consumers the services they needed, but observed that frequently the existing services in their community were inadequate. They concurred that an effective IOC program required:

- "The infrastructure to handle petitions, receive court orders, and track people through the system.

- Available treatment services–e.g., assertive community treatment, intensive case management, newer medications, and supported housing.

- A service system that can deliver care rationally–e.g., appropriate caseloads, incentives to modify provider behavior, efforts to improve the quality of routine care, and attention to the needs of patients rather than just the bottom line."

The Rand study concluded that the current data make it very difficult to determine the potential impact of any new legislation in California.

Practical Insights About IOC

This report does not take a position about whether states should provide for IOC. However, the report does recommend that any state adopting an IOC program take steps to minimize the problems inherent to any coercive procedure and the problems inherent in any program to which inadequate resources are allocated. If a state plans to use IOC as a means of improving consumers' engagement with treatment, the state should consider and address the issues which have been raised in the implementation of existing IOC laws. Before creating or implementing a statutory IOC procedure, a state should consider the following questions:

What is the purpose of IOC in the state? The issues and questions a state should review regarding IOC differ depending upon the nature of the IOC program considered. Two common purposes of IOC are:

1. To provide an alternative to hospitalization: IOC can be used instead of hospitalization ("hospital diversion") when an individual meets civil commitment criteria or can allow for a kind of conditional discharge after a period of hospitalization. The legal criteria for commitment under this type of IOC are usually identical to civil commitment criteria for inpatient hospitalization.

2. To enable early intervention for an individual with a recurring disorder: For individuals with a history of repeated rehospitalizations after discharge, this type of IOC would permit earlier treatment when an individual begins to show signs of decompensation. This type of IOC would generally require broader legal criteria than traditional civil commitment statutes in order to permit intervention before an individual could be involuntarily admitted to a hospital.

What are the risks of implementing an IOC program? Would establishing IOC in the state inhibit consumers from getting treatment out of a fear of becoming subject to coercive IOC provisions?

Would IOC risk fracturing existing alliances among consumers, families, and service providers? Will therapeutic relationships be jeopardized and unintended negative consequences created if the treatment provider also serves to monitor compliance with the IOC court order? Systems should respect the independence of the individual and the individual's values. Although treatment may be involuntary, treatment plans should reflect the individual's input and, to the extent possible, the individual's preferences.

How will the mental health system be required to provide appropriate services? IOC may be reciprocal, committing the system to provide services as well as committing the consumer to receive them. Some argue that when IOC is effective, it is in part because IOC has forced the system to provide care. Needless to say, adequate funding of community services is essential to the success of any IOC program.

How should the IOC law and procedures be structured? In general, a court order for treatment may be structured in two different ways:

1. General requirement to comply with the treatment recommendation of the mental health service provider

2. Articulation of a specific treatment plan, with a requirement to comply with that plan.

What details should be included in the IOC statute? For what length of time should the IOC order apply? Must the mental health service provider first agree to provide the needed services? Will the standard for commitment under the statute differ from traditional civil commitment criteria? If so, how will the criteria be written? If "serious deterioration" is the criterion used, how should it be measured?

What are the clinical characteristics of persons for whom a "preventive" (or early intervention) model of IOC would be appropriate? In a resource document developed under the auspices of the American Psychiatric Association's Council on Psychiatry and Law, Gerbasi, et al. (2000, p. 135) endorsed IOC for a small subset of consumers and delineated seven recommended criteria that a person should meet prior to being subject to IOC. The criteria detail the nature of the person's severe, recurring mental disorder; the need for treatment to prevent deterioration and the unlikelihood that the individual will seek that treatment; a history of hospitalization; and the existence of a specific treatment plan likely to be effective and a service provider who has agreed to provide the specified treatment. Some have suggested incapacity to make treatment decisions should be a criterion as well. Paul Appelbaum (2001, p. 349) surveyed existing research and concluded that eligibility criteria for a preventive model of IOC should concentrate on three factors: a history of deteriorations that required hospitalization, a current likelihood of such deterioration, and a treatment plan providing effective services in the community.

How can the perceived coercion involved in IOC be minimized? A recent study of coercion

conducted through the MacArthur Research Network on Mental Health and the Law concluded:

> The amount of coercion a patient experiences in the mental hospital admission process is strongly associated with the degree to which that process is seen to be characterized by "procedural justice." That is, patients who believe they have been allowed "voice" and treated by family and clinical staff with respect, concern, and good faith in the process of hospital admission report experiencing significantly less coercion than patients not so treated. This holds true even for legally "involuntary" patients and for patients who report being pressured to be hospitalized (Monahan et al., 1999).

If this finding holds true in the context of outpatient commitment the procedures used to commit the individual may have a significant impact on that individual's perception of coercion.

How will any IOC order be enforced? The state will need to implement a system for monitoring IOC orders and service providers. When an individual fails to comply with IOC, what are the consequences? Law enforcement may be required to take the individual to a community clinician. Historically, however, this has been a low priority for law enforcement, and long delays may occur between the time a "pick-up" order is issued and the individual sees the clinician. If that clinician determines that an individual is not complying with the required treatment regime, a report may be filed with law enforcement, the court of jurisdiction may hold an ex parte hearing, or the court may hold a full hearing. If the court finds the consumer violated IOC, may the provider force medication? Will the consumer be evaluated for inpatient commitment? How will staff/court personnel be trained on legal and policy issues? What are the ethical dilemmas presented by encouraging compliance with an IOC court order under circumstances where the legal requirements mandating compliance are weak?

Conclusion

Recent attention on IOC has been fueled by concerns with societal violence and inflamed by high profile cases. Policy changes should not be based solely on these few cases, but instead should derive from a firm foundation of research and experience. Relevant research suggests that, given the low levels of violence by individuals with mental disorders, public concerns about violence are misdirected when focused primarily on individuals with mental disorders. IOC would be an ineffective means to reduce significantly the overall incidence of societal violence.

Current interest in IOC also stems from concerns about individuals with mental disorders going untreated in the community. IOC, however, should not be regarded as an alternative to adequate community mental health services. Current research fails to provide strong evidence of success with IOC programs. It is clear that IOC will not accomplish its objectives without a strong community-based service provision system. Some posit that if comprehensive services were readily accessible in the community, there would be no need to use a more coercive mechanism like IOC to engage

consumers in treatment. At a minimum, if a state decides to implement IOC, it must allocate sufficient resources to community-based treatment and monitor the outcomes of the more coercive measures.

Recommendations for NASMHPD

This technical report on involuntary outpatient commitment concluded that the challenge for state mental health systems is to develop comprehensive and accessible systems of care suitable for consumers with the most complex needs. Whether or not a state employs IOC, a full array of services and supports must be available. NASMHPD should promote (or, through NRI, conduct) research to identify evidence-based practices that have special merit for reluctant consumers, considering in particular the role of consumer-supported, peer-driven supports and the involvement of family members and significant others.

In addition, NASMHPD should encourage (or conduct) research to:

- Determine whether the existence of IOC in a state provides a disincentive for some consumers to participate in mental health treatment voluntarily out of a fear of becoming more readily identifiable and potentially subject to IOC.
- Determine the effect of IOC on the strength of consumer/family/provider alliances in state public mental health systems.
- Determine the effect of IOC on the relationship between provider and consumer.
- Assess the financial impact of implementing an IOC program.

Recommendations for State Mental Health Agencies

Regardless of whether a state utilizes IOC legislation, the NASMHPD Medical Directors Council recommends that state mental health agencies take the following steps to improve consumer engagement in mental health treatment:

- Address issues of co-occurring disorders
- Make consumer-driven service improvements
- Develop case coordination, including a means of addressing all health needs
- Develop outreach services, including crisis response, mobile treatment, and other assertive community treatment services.
- Conduct a root cause analysis of any problems rather than grasping at quick solutions
- If using IOC, develop clinical guidelines for narrow interpretation
- Collect data as part of a rigorous evaluation prior to any implementation of IOC and as a means of accountability for outcomes
- Encourage consumer and family participation in reviewing the system needs

APPENDICES

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