National Coalition for Mental Health Recovery

Involuntary Outpatient Commitment (IOC)[1] Myths and Facts

Under Involuntary Outpatient Commitment, a person with a serious mental illness is mandated by the court to follow a specific treatment plan, usually requiring the person to take medication and sometimes directing where the person can live and their daily activities. Proponents of IOC claim that it is effective in reducing violent behavior, incarcerations, and hospitalizations among individuals with serious mental illnesses.[2] However, the facts show that IOC by itself is not effective, has high costs with minimal returns, is not likely to reduce violent behavior, and that there are alternatives that are more effective and efficient. In sum, as *Mental Health: A Report of the Surgeon General* noted, "Almost all agree that coercion should not be a substitute for effective care that is sought voluntarily."[i]

Comprehensive services are effective, not IOC.

IOC has consistently been found to not be a substitute for comprehensive mental health services.[3] 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."[4] Proponents of IOC use the findings from the North Carolina study to claim that IOC is effective, but do not account for the additional resources put into the service delivery system in the form of increased funding for mental health services and supports. A second study, conducted in the mid-1990s at Bellevue Hospital in New York City, before Kendra's Law was passed, found that, "[o]n all major outcome measures, no statistically significant differences were found between the two groups" (IOC and control groups).[5,6]

Another study, published in *The Lancet* on March 26, 2013, reported: "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."[ii] And the RAND Corporation, which studied the implementation of IOC in eight states, found: "There is no evidence that a court order is necessary to achieve compliance and good outcomes," and reported that the literature provides clear evidence that "alternative community-based mental health treatments can produce good outcomes for people with severe mental illness."[iii]

New York's Kendra's Law is one of the better known state IOC statutes. In addition to mandating IOC for certain individuals with serious mental illnesses, it is significant that the law also provided for greatly increased funding for mental health programs. For example, 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.[7]

IOC has high costs with minimal returns.

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.[8] 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."[iv]

Other mental health interventions are more effective.

Research has shown that other interventions are a more efficient and effective use of resources than is IOC.[8,9,10] In

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California, some counties already have in place proven voluntary treatment programs without the expense and coercion of court-ordered treatment. In Orange County, the Full Service Partnerships[v] have reduced hospitalizations by 50%, incarcerations by 88% and homelessness by 70%. Assertive community treatment, in which multidisciplinary teams of highly trained mental health professionals provide community-based care, also has good outcomes for persons with serious mental illnesses.[9] In addition, Dr. Joseph Parks, who has served as medical director for the Missouri Department of Mental Health for 20 years, recommends that resources should be spent on programs such as early identification and treatment of mental illnesses, including effective early treatment of psychotic illnesses such as schizophrenia.[11]

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 illnesses, and not on IOC.

Notes:

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 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. 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.
4. 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.
5. 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.
6. Outcome measures included re-hospitalization, arrest, quality of life, symptomatology, treatment compliance, and perceived level of coercion.
7. 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.
8. Kisely, S., Campbell, L., and Preston, N. 2009. Compulsory community and involuntary outpatient treatment for people with severe mental disorders. *Cochran Database of Systematic Reviews.*
9. 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.*
10. Dieterich, M., Irving, C., Park, B, and Marshall, M. Intensive case management for severe mental illness. *Cochrane Database of Systematic Reviews* 2010, Issue 3.
11. Parks, Joseph. "Examination of 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.

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[i] U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General.* MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

[ii] Prof. Tom Burns DSo , Jorun Rugkåsa Ph.D., Andrew Molodynski MBCChB, John Dawson LL.
"Community treatment orders for patients with psychosis (OCTET): a randomized controlled trial. The Lancet, Early Online Publication, 26 March 2013; doi:10.1016/S0140 – 6736(13)60107 – 5.

[iii] "The Effectiveness of Involuntary Outpatient Treatment, Empirical Evidence and the Experience of Eight States," RAND Report, 2001.

[iv] ("AOT cost effectiveness study stirs national debate," August 22, 2013, *Behavioral Healthcare*)

[v] http://ochealthinfo.com/bhs/about/pi/mhsa/fsp