

RAND

*The Effectiveness of
Involuntary Outpatient
Treatment*

*Empirical Evidence and the
Experience of Eight States*

M. Susan Ridgely

Randy Borum

John Petrila

**RAND Health
RAND Institute for Civil Justice**

RAND

*The Effectiveness of
Involuntary Outpatient
Treatment*

*Empirical Evidence and the
Experience of Eight States*

M. Susan Ridgely

Randy Borum

John Petrila

*Prepared for the
California Senate Committee on Rules*

**RAND Health
RAND Institute for Civil Justice**

ISBN: 0-8330-2980-0

RAND is a nonprofit institution that helps improve policy and decisionmaking through research and analysis. RAND® is a registered trademark. RAND's publications do not necessarily reflect the opinions or policies of its research sponsors.

© Copyright 2001 RAND

All rights reserved. The State of California is licensed to publish, translate, reproduce, and disseminate this report as it desires at no charge. Other individuals and organizations may reproduce this report for personal use.

Published 2001 by RAND
1700 Main Street, P.O. Box 2138, Santa Monica, CA 90407-2138
1200 South Hayes Street, Arlington, VA 22202-5050
RAND URL: <http://www.rand.org/>

To order RAND documents or to obtain additional information, contact Distribution Services: Telephone: (310) 451-7002; Fax: (310) 451-6915; email: order@rand.org

The research described in this report was sponsored by the California Senate Committee on Rules. This research was conducted under the auspices of RAND's Law and Health Initiative, which is a joint initiative of RAND Health and RAND Institute for Civil Justice.

RAND HEALTH

The mission of RAND Health is working to improve health care systems and advance understanding of how the organization and financing of care affect costs, quality, and access. The nation's largest private health care research organization, RAND Health has helped shape private- and public-sector responses to emerging health care issues for three decades. We pioneered the application of rigorous empirical research designs to health care issues. Our landmark studies of health care financing helped change the way America pays for health care services. We established the scientific basis for determining whether various medical and surgical procedures were being used appropriately. Our assessments of how organization and financing affect costs, quality, and access to care have addressed the population at large, as well as such vulnerable and hard-to-reach groups as the frail elderly, children with special health care needs, substance abusers, and HIV-positive individuals.

RAND Health research is supported by funding from federal government grants, foundations, professional associations, universities, state and local governments, and private-sector organizations. RAND Health's specialized research centers embody partnerships with other institutions, including RAND Center to Improve Care of the Dying, RAND/UCLA/Harvard Center for Health Care Financing Policy Research, Southern California Evidence-Based Practice Center, UCLA/RAND Center for Adolescent Health Promotion, UCLA/RAND Research Center on Managed Care for Psychiatric Disorders, and the VA/UCLA/RAND/UCSD Center for the Study of Healthcare Provider Behavior.

RAND Health disseminates its work widely to the health practitioner and research communities, and to the general public.

For information about RAND Health, contact

RAND Health Communications

1700 Main Street

P.O. Box 2138

Santa Monica, CA 90407-2138

Phone: 310-393-0411, x7775

FAX: 310-415-7027

Email: RAND_Health@RAND.org

A profile of RAND Health, abstracts of its publications, and ordering information can be found on the RAND Health home page on the World Wide Web at www.rand.org/organization/health/.

THE RAND INSTITUTE FOR CIVIL JUSTICE

The mission of the RAND Institute for Civil Justice is to improve public and private decisionmaking on civil legal issues by supplying policymakers and the public with the results of objective, empirically based, analytic research. The ICJ facilitates change in the civil justice system by analyzing trends and outcomes, identifying and evaluating policy options, and bringing together representatives of different interests to debate alternative solutions to policy problems. The Institute builds on a long tradition of RAND research characterized by an interdisciplinary, empirical approach to public policy issues and rigorous standards of quality, objectivity, and independence.

ICJ research is supported by pooled grants from corporations, trade and professional associations, and individuals; by government grants and contracts; and by private foundations. The Institute disseminates its work widely to the legal, business, and research communities, and to the general public. In accordance with RAND policy, all Institute research products are subject to peer review before publication. ICJ publications do not necessarily reflect the opinions or policies of the research sponsors or of the ICJ Board of Overseers.

RAND Institute for Civil Justice
1700 Main Street, P.O. Box 2138
Santa Monica, CA 90407-2138
(310) 393-0411, x7893

Director: Alan F. Charles
Research Director: Robert T. Reville

For more information about the RAND Institute for Civil Justice, contact Beth Giddens, ICJ Communications Director, e-mail: elizabeth_giddens@rand.org.

Westlaw is the online distributor of RAND/ICJ materials. The full text of many ICJ documents can be found at <http://www.westlaw.com>. A profile of the ICJ, summaries of all its studies, and electronic order forms are on RAND's homepage on the World Wide Web at <http://www.rand.org/centers.icj/>.

RAND HEALTH BOARD OF OVERSEERS

Neal A. Baer, *Executive producer of Law and Order: Special Victims Unit*
 Peter S. Bing, *Private investor; RAND Trustee*
 Robert H. Brook, *Vice President, Corporate Fellow and Director of RAND Health; Director of the Robert Wood Johnson Clinical Scholars Program and Professor of Medicine and Health Services, UCLA Center for Health Sciences*
 Yvonne B. Burke, *Supervisor, Second District, County of Los Angeles*
 Ronald I. Dozoretz, *Chairman & CEO, FHC Health Systems, Inc.*
 Mary Kay Farley, *Trustee, Hospital for Special Surgery; National Board member, Orthopaedic Research and Education Foundation; Life Trustee, International House, Columbia University*
 Pedro José Greer, Jr., *Chief of Gastroenterology, Mercy Hospital, Miami; Assistant Dean for Homeless Education, University of Miami, School of Medicine; RAND Trustee*
 Terry Hartshorn, *Vice Chairman, PacifiCare Health Systems, Inc.*
 Suzanne Nora Johnson, *Managing Director, Goldman Sachs*
 Joseph H. Kanter, *Chairman, Kanter Companies, Joseph H. Kanter Movie Productions, and the Kanter Foundation*
 Karen L. Katen, *President, Pfizer U.S. Pharmaceuticals Group; Executive Vice President, Global Pfizer Pharmaceuticals Group; Corporate Senior Vice President, Pfizer*
 Paul Koegel, *Associate Director, RAND Health*
 Eve M. Kurtin, *Partner, Pacific Venture Group Cofounder, Physician Venture Management, Inc.*
 David M. Lawrence, *Chairman and CEO, Kaiser Foundation Health Plan, Inc. and Kaiser Foundation Hospitals*
 Steve Lazarus, *Managing Partner, ARCH Venture Partners*
 Sheila T. Leatherman, *Chief Executive, The Center for Health Care Policy and Evaluation, United Health Group*
 Judy C. Lewent, *Senior Vice President & CFO, Merck*
 Charles Martin, *Chairman, President & CEO, Vanguard Health Systems*
 Paul Orefice, *Retired Chairman, Dow Chemical Company*
 David K. Richards, *Private investor, Santa Monica*
 Kenneth I. Shine, *President, Institute of Medicine, National Academy of Sciences; Professor of Medicine Emeritus at UCLA School of Medicine; Clinical Professor of Medicine at Georgetown University; RAND Trustee*
 Sir Maurice Shock, *Chairman, Nuffield Trust*
 Joseph P. Sullivan, *Chairman & CEO, Protocare, Inc.*
 James A. Thomson, *President and CEO, RAND*
 Gail L. Warden, *President and CEO, Henry Ford Health System, Detroit*

THE RAND INSTITUTE FOR CIVIL JUSTICE BOARD OF OVERSEERS

Chair: Ronald L. Olson, *Munger, Tolles & Olson*

Vice Chair: James A. Greer II

Harris Ashton

Sheila L. Birnbaum, *Skadden, Arps, Slate, Meagher & Flom*

James L. Brown, *Center for Consumer Affairs, University of Wisconsin-Milwaukee*

Kim M. Brunner, *State Farm Insurance*

Arnold I. Burns, *Arnhold and S. Bleichroeder*

Alan F. Charles, *RAND Institute for Civil Justice*

Robert A. Clifford, *Clifford Law Offices*

N. Lee Cooper, *Maynard, Cooper & Gale*

John J. Degnan, *The Chubb Corporation*

Christine M. Durham, *Utah Supreme Court*

Paul G. Flynn, *Los Angeles Superior Court*

Kenneth C. Frazier, *Merck & Company*

William B. Gould IV, *Stanford Law School*

Arthur N. Greenberg, *Greenberg Glusker Fields, Claman & Machtinger*

Terry J. Hatter, Jr., *Chief U.S. District Judge*

Deborah R. Hensler, *Stanford Law School, RAND Senior Fellow*

Patrick E. Higginbotham, *United States Court of Appeals, Fifth Circuit*

Roberta Katz, *Article III*

Steven J. Kumble, *Lincolnshire Management*

Joseph D. Mandel, *University of California, Los Angeles*

Charles W. Matthews, *Exxon Corporation*

Arthur R. Miller, *Harvard Law School*

Paul S. Miller, *Pfizer*

Robert W. Pike, *Allstate Insurance Company*

Thomas E. Rankin, *California Labor Federation, AFL-CIO*

Bradford W. Rich, *United Services Automobile Association*

Larry S. Stewart, *Stewart, Tilghman, Fox & Bianchi*

Wayne D. Wilson, *Farmers Insurance Group/Zurich US*

Page viii is

blank

PREFACE

Involuntary treatment has been the most consistently debated issue in mental health law for the last thirty years. The goals of involuntary treatment have not changed radically over time: insuring public safety, guaranteeing access to treatment for those who need it, and insuring that treatment is provided in the least restrictive environment consistent with the needs of the individual. In the last decade, however, the focus on involuntary treatment has changed as states have amended or interpreted their existing involuntary commitment statutes to allow for *involuntary outpatient treatment* and other mechanisms designed to extend the state's supervisory control over mentally ill persons into the community. This change in focus has served to intensify the controversy.

The most recent debate on involuntary treatment in California arose in response to the introduction of Assembly Bill 1800. AB 1800, introduced by Assemblywoman Helen Thomson and passed by the California Assembly last year, would have amended California's Lanterman-Petris-Short Act by expanding the criteria for involuntary treatment and creating a separate statutory provision for involuntary outpatient treatment.

After passage of AB 1800 in the Assembly, the Senate Committee on Rules commissioned RAND to develop a report on involuntary treatment. The project had three objectives: (1) to identify and synthesize the existing empirical evidence on the effectiveness of involuntary outpatient treatment and its alternatives; (2) to gather and analyze information on the experience of a select group of states where involuntary outpatient treatment is currently practiced; and (3) to assess the potential impact of such legislation on people with severe mental illness in California. This report summarizes our approach, findings, and conclusions.

We had five primary audiences in mind when conducting this research and reporting our findings: the Senate sponsors of this report; other public policymakers at the state and national level; researchers; clinicians; and advocates of all points of view. Members of all five audiences will find something of interest here. We have no doubt that those who advocate for and against involuntary outpatient treatment will use our report to support very different positions. Our task is to set out the evidence so the debate can be an informed one. It is up to others to advocate, armed with an understanding of what is known from empirical work and what remains to be known.

This report is based on research conducted under the auspices of RAND's Law and Health Initiative, which is a joint initiative of RAND Institute for Civil Justice and RAND Health. RAND ICJ's mission is to make civil justice systems more efficient and more equitable through objective, empirically-based research. RAND Health furthers RAND's mission of helping improve policy and decisionmaking through research and analysis by working to improve health care systems.

TABLE OF CONTENTS

PREFACE	ix
SUMMARY	xii
<i>Approach</i>	xiii
<i>The Comparative Effectiveness of Involuntary Treatment and Its Alternatives</i>	xiv
<i>The Experience of Other States</i>	xvii
<i>The Effect of Changes in the Lanterman-Petris-Short Act on People with Mental Illness in California</i>	xviii
<i>What We Can and Cannot Say About the Policy Question</i>	xx
ACKNOWLEDGMENTS	xxi
I. INTRODUCTION	1
II. STUDY APPROACH AND METHODS	4
<i>Evidence-Based Review of the Literature on Involuntary Treatment</i>	4
<i>Statutory and Case Law Analysis</i>	7
<i>Key Informant Interviews</i>	8
<i>Analysis of California Data on Involuntary Treatment</i>	10
III. WHAT DOES THE EMPIRICAL LITERATURE TELL US ABOUT THE EFFECTIVENESS OF INVOLUNTARY TREATMENT?	12
<i>The Evolution of Involuntary Outpatient Commitment</i>	13
<i>Legal Criteria and Provisions for Involuntary Outpatient Commitment</i>	13
<i>Practices and Challenges in the Use of Outpatient Commitment</i>	15
<i>Effectiveness of Involuntary Outpatient Commitment</i>	16
<i>Research Challenges</i>	16
<i>First Generation Studies on the Effectiveness of Outpatient Commitment</i>	17
<i>Second Generation Studies on the Effectiveness of Outpatient Commitment</i>	22
IV. WHAT DOES THE EMPIRICAL LITERATURE TELL US ABOUT THE EFFECTIVENESS OF ALTERNATIVES?	28
V. HOW HAVE OTHER STATES IMPLEMENTED INVOLUNTARY OUTPATIENT TREATMENT?	33
<i>Michigan</i>	34
<i>New York</i>	36
<i>North Carolina</i>	41
<i>Ohio</i>	44
<i>Oregon</i>	47
<i>Texas</i>	50
<i>Washington</i>	54
<i>Wisconsin</i>	57

VI. WHAT LESSONS HAVE BEEN LEARNED FROM THE EXPERIENCE OF OTHER STATES?.....	63
<i>Outpatient Commitment: Support for the Law but Qualified Support for the Practice</i>	65
<i>The Treatment System Is Critical to the Success of Outpatient Commitment</i>	67
<i>Outpatient Commitment Is Used Infrequently and Primarily as a Discharge-Planning Vehicle</i>	69
<i>Making the Outpatient Commitment Process More “Voluntary”</i>	71
<i>Are Commitment Orders “Reciprocal”: Who Is Committed Under an Outpatient Commitment Order – the Patient, the Provider or Both?</i>	71
<i>The Issue of Provider Liability Doesn’t Figure Prominently Among the List of Concerns People Have</i>	72
<i>The Specificity of Outpatient Commitment Orders – Are Medications Included?</i>	72
<i>Most Key Informants Report That Forcible Medication Is Not Allowed</i>	73
<i>The Burden of Monitoring Falls Mostly on the Treatment System – Which Has Implications for Treatment Resources</i>	74
<i>States Differ Widely in the Extent to Which Commitment Laws and Practices Have “Teeth”</i>	75
<i>Some States Are Already Looking for an Alternative Solution to the Problem of Noncompliance</i>	76
<i>Most Key Informants Report a Lack of Consistency Across Jurisdictions But Also Report That Little Is Being Done</i>	77
<i>“Closing Arguments”</i>	78
<i>Conclusion</i>	79
VII. INVOLUNTARY TREATMENT IN CALIFORNIA: WHO IS POTENTIALLY AFFECTED BY A CHANGE IN THE LANTERMAN-PETRIS-SHORT ACT?.....	81
<i>Involuntary Treatment Under the Lanterman-Petris-Short Act</i>	81
<i>Data on Civil Commitment in California</i>	84
<i>Describing the Population Subject to Current Commitment Guidelines</i>	85
<i>Profiling People in Involuntary Treatment in California in 1997-98</i>	88
<i>Service Use and Commitment History</i>	92
<i>Identifying Subcategories of At-Risk Individuals Under Expansions of LPS</i>	94
<i>Conclusion</i>	96
VIII. CONCLUSION.....	98
<i>The Comparative Effectiveness of Involuntary Treatment</i>	98
<i>The Experience of Other States</i>	99
<i>The Effect of LPS Changes on People with Mental Illness in California</i>	101
REFERENCES.....	103
TABLE OF APPENDICES.....	110

SUMMARY

In most mental health systems, there are people with severe mental illness who are persistently at high risk for relapse, have repeated hospitalizations and criminal justice contacts, and disproportionately use the most costly services. These individuals often have co-occurring alcohol or drug abuse problems and fail to take their psychotropic medications as prescribed, which contributes to episodic worsening of their psychiatric condition and even to disruptive or violent behavior. Unfortunately, for various reasons, even when treatment is made available, some individuals do not comply with the treatment regimen. Because the symptoms of their illness, when untreated, can cause them to be unable to care for themselves (i.e., gravely disabled) or become dangerous to themselves or others, legal mandates and coercive interventions have been used to leverage compliance. These mandates are believed to increase adherence, and thereby prevent deterioration and harm to the individual with mental illness or to others. In this context, involuntary treatment typically takes the form of civil commitment.

Civil commitment is a statutorily-created and court-ordered form of compulsory treatment, which historically has been used as a mechanism for admitting people involuntarily to hospitals for mental health treatment. The first laws in the United States authorizing the involuntary treatment of people with mental illness date back to the 1600s. Although the locus of mental health treatment has moved from the state mental hospital to the community since the 1960s, the goals of involuntary treatment have not changed radically over that time. These goals include insuring public safety, guaranteeing access to treatment for those who need it, and assuring that treatment is provided in the least restrictive environment consistent with the needs of the individual.

Involuntary treatment remains controversial; it has been the most consistently debated issue in mental health law for the last thirty years. In the last decade, however, the debate has become even more intense as states have amended or interpreted their existing civil commitment statutes to allow for involuntary outpatient treatment. *Involuntary outpatient treatment is a form of civil commitment in which the court orders an individual to comply with a specific outpatient treatment regimen.* Theoretically, outpatient commitment can allow a person with mental illness increased autonomy while, at the same time, extending the state's supervisory control beyond the hospital and into the community.

At last count, thirty-eight states and the District of Columbia had statutes that make specific provisions for involuntary outpatient treatment and several other states have considered such proposals. These proposals are proliferating despite the ongoing controversy in the field about the role of coercion in mental health treatment. Debates on involuntary outpatient treatment tend to be framed in ideological terms and largely driven by anecdote rather than by empirical data. *Although the perceptions and positions of stakeholders, including mental health consumer/survivors, advocates, scholars, and treatment providers must be judiciously considered, an equally legitimate consideration is whether the proposed intervention actually works; that is, whether involuntary outpatient treatment, as intended, is effective in improving compliance and treatment outcomes among those who refuse or fail to comply with community-based treatment.*

The most recent debate on involuntary treatment in California arose in response to the introduction of Assembly Bill 1800. AB 1800, introduced by Assemblywoman Helen Thomson and passed by the California Assembly last year, would have amended California's civil commitment statute, the Lanterman-Petris-Short Act. Among other provisions, AB 1800 would have enhanced the commitment statute's *preventive* function by broadening the current commitment criteria (i.e., to allow the state to intervene to reduce the risk of deterioration or recidivism *before* the individual becomes gravely disabled) and would have created a separate statutory provision for involuntary outpatient treatment.

After passage of AB 1800 in the Assembly, the Senate Committee on Rules commissioned RAND to develop a report on involuntary treatment. The project had three objectives:

- To identify and synthesize the existing empirical evidence on the effectiveness of involuntary outpatient treatment and its alternatives;
- To gather and analyze information on the experience of a select group of states where involuntary outpatient treatment is currently practiced; and
- To assess the potential impact of such legislation on people with severe mental illness in California.

This report summarizes our approach, findings, and conclusions.

Approach

We conducted an evidence-based review of the empirical literature on involuntary outpatient treatment, and compiled and synthesized evidence-based reviews on alternatives to involuntary outpatient treatment. Alternatives included community-based mental health interventions such as assertive community treatment, intensive case management, crisis intervention, and supported housing. *Although other investigators have reviewed the involuntary outpatient treatment literature, this is the first attempt to use an evidence-based approach to examining and synthesizing the research.* An evidence-based review, in contrast to a literature review, is a scientific investigation that attempts to resolve conflicts in the literature by critically analyzing the research rather than simply reporting findings of all studies conducted in a particular content area. Evidence-based reviews are designed to support public policymaking by providing decisionmakers with reliable evidence about the specific effects of interventions.

We also reviewed statute and case law on involuntary treatment in eight states chosen because they met one or more of the following criteria:

- Their statutes included provisions for involuntary outpatient treatment and/or had expanded grave disability criteria;
- Their involuntary outpatient treatment systems had been the subject of well-designed research studies; and/or
- They represented mental health systems that, like California's, are large, urban and rural, and ethnically diverse, and where authority for providing mental health care resides at the county level.

In addition, we systematically gathered information on the implementation of these laws from in-depth, semi-structured interviews with prosecuting and defense attorneys, county behavioral health officials, and psychiatrists in the eight states. Perhaps the most novel aspect of the study is this collection of extensive information from stakeholders involved in the day-to-day execution of these statutes. These interviews allowed us to juxtapose their reported experiences and perspectives with the analysis of statutory and case law on involuntary outpatient treatment in their state.

Finally, we analyzed data from the California Department of Mental Health's Client Data System (CDS), which contains service records for all persons served by California's county mental health contract agencies (approximately one million service records a year, representing about 380,000 individuals). The CDS includes demographic, clinical, and service information, including legal status at admission and discharge.

Unfortunately, not all inpatient admissions are reflected in our analysis because admissions under Medi-Cal Inpatient Consolidation are not reported in the CDS and the Medi-Cal claims database does not include legal status as a data element. *This limitation effectively means that there is no way at present to obtain a complete picture of involuntary treatment in the State of California.* Nevertheless, we use the CDS data from the most current year for which complete data are available (fiscal year 1997-98) to describe the target population and to attempt to predict who might be affected by proposed changes in the Lanterman-Petris-Short Act.

Based on our analysis of the empirical literature, statute and case law, experience and insights of key informants in eight states, and data from the California CDS, we draw the following conclusions:

The Comparative Effectiveness of Involuntary Treatment and Its Alternatives

There are two generations of research on the effectiveness of involuntary outpatient treatment. The first generation of studies mostly found limited positive results from involuntary outpatient treatment; however, these studies were plagued by significant methodological limitations. These limitations reduce the confidence we can place in their findings. In addition, this body of research did not specify for whom, how, or under what circumstances court-ordered outpatient treatment may work.

Data from the second generation of research, which builds on the foundation of earlier studies, are just beginning to accrue. There have been only two randomized clinical trials of involuntary outpatient treatment, one in New York City and the other conducted by Duke University investigators in North Carolina. These studies came to conflicting conclusions.

The investigators in New York found no statistically significant differences in rates of rehospitalization, arrests, quality of life, psychiatric symptoms, homelessness or other outcomes between the involuntary outpatient treatment group and those who received intensive services but without a commitment order. However, a number of limitations in the New York study (e.g., small sample size, non-equivalent comparison groups, lack of enforcement of court orders), may have affected the findings and make it difficult to draw definitive conclusions.

In contrast to the New York study, the Duke study, which is the better of the two, suggests that a sustained outpatient commitment order (180+ days), *when combined with intensive mental health services*, may increase treatment adherence and reduce the risk of negative outcomes such as relapse, violent behavior, victimization, and arrest. According to the Duke investigators, the two most salient factors associated with reduced recidivism and improved outcomes among people with severe mental illness appear to be intensive mental health treatment and enhanced monitoring for a sustained period of time. In the Duke study, outcomes were only improved for those under court order who received intensive mental health services. *Whether court orders without intensive treatment have any effect is an unanswered question.*

The experiences of our interview respondents in North Carolina also suggest that there may be important practical limitations to the generalizability of the Duke study.

First, the stakeholders we interviewed in North Carolina emphasized that the Duke study was a well-funded research demonstration. As such, people in the study may have received more outpatient services, or services delivered more routinely, than individuals in other areas of North Carolina. Data from California's CDS suggest that this caution is an important one for California policymakers. According to our analysis of the CDS, almost 40 percent of people who experienced an involuntary hold for treatment and evaluation in California in 1997-98 had received *no* outpatient mental health services in the prior 12 months. Even among the 60 percent who had received some outpatient treatment, the median number of outpatient treatment encounters was three in the prior 12 months – well short of the intensity of treatment associated with positive outcomes in the Duke study (a median of greater than three treatment encounters, with an average of seven treatment encounters, *per month*).

Second, Duke investigators also employed a study protocol to ensure that the enforcement provisions in the involuntary outpatient treatment statute were used when applicable. Use of enforcement provisions may not be as systematically implemented in usual community practice.

Third, the Duke sample was limited to patients discharged from hospitals; thus, the findings may not be generalizable to people initially placed under involuntary commitment in the community.

Fourth, because subjects in the Duke study were not randomized to different lengths of commitment, conclusions about the significance of the duration of commitment orders must be drawn cautiously.

In contrast to the paucity of studies on involuntary outpatient treatment, our review of the literature found clear evidence that alternative community-based mental health treatments can produce good outcomes for people with severe mental illness. The best evidence from randomized clinical trials supports the use of assertive community treatment programs – which involve the delivery of community-based care by multidisciplinary teams of highly trained mental health professionals with high staff-to-client ratios. Because these interventions are staff-intensive, they are also more expensive to implement than traditional community-based mental health programs. Thus, it may be more cost-effective to target assertive community treatment programs to those people with severe mental illness who are at highest risk for negative outcomes. There is additional evidence, albeit weaker, for some of the other popular community-based mental health interventions, and some of the lesser-studied interventions, such as supported housing and supported employment, are regarded by researchers as “promising” although unproven at this time.

The question left unanswered by the research to date is whether involuntary outpatient treatment and voluntary alternatives produce equally good outcomes. In other words, is a court order necessary to achieve the kind of compliance and good outcomes evident in the Duke study? One of the reasons this question cannot be answered is that it rests on an artificial dichotomy.

Involuntary outpatient treatment by definition includes a treatment intervention. As a result, there is no study that proves that a court order for outpatient treatment *in and of itself* has any independent effect on outcomes. No randomized clinical trials have examined the relative efficacy of involuntary outpatient treatment and assertive community treatment – the alternative with the best record of producing positive outcomes for people with severe mental illness. In addition, assertive community treatment may also employ high levels of monitoring and supervision, similar to the kinds of monitoring found in involuntary outpatient treatment but without the coercive element of a court order. We simply do not know whether such forms of supervision and monitoring are as effective.

There are no empirical data that allow us to assess the policy tradeoffs between involuntary outpatient treatment and alternatives such as assertive community treatment. However, we believe the policy question can be explicitly reframed: *Does adding a court order to the provision of intensive treatment significantly improve outcomes over and above the intensive treatment itself?*” and, if so, *“Is the addition of such orders cost-effective?”* Unfortunately, the existing empirical studies do not provide a definitive answer to these questions either.

The Duke study did not achieve outcomes that were superior to outcomes achieved in studies of assertive community treatment alone. The investigators did attempt, however, to identify some subgroups for whom involuntary outpatient treatment was especially effective in reducing hospital readmissions and shortening lengths of stay. Their findings suggest that people with psychotic disorders and those at highest risk for bad outcomes benefit from intensive mental health services provided in concert with a sustained outpatient commitment order. But, again, the precise cause of the effect is not yet clear and these findings cannot be generalized to suggest that involuntary outpatient treatment would be more effective than alternative, non-coercive interventions for *all* target populations.

In sum, the Duke study does *not* prove that treatment works better in the presence of coercion or that treatment will not work in the absence of coercion. In addition, other evidence-based reviews prove that alternative interventions such as assertive community treatment have similar positive effects.

The Experience of Other States

The eight states we studied (Michigan, New York, North Carolina, Ohio, Oregon, Texas, Washington, and Wisconsin) have statutory provisions that permit involuntary outpatient treatment, reflecting the growing popularity of these kinds of provisions nationally. These statutes have faced little challenge in the courts and none has been overturned.

We were surprised to find a trend among these states to use outpatient commitment as a discharge-planning mechanism rather than as a community-initiated alternative to hospitalization. Rather than creating a new class of patients for whom the community is the staging ground for commitment, these states are using involuntary outpatient treatment at the time of discharge to extend close supervision and monitoring into the community.

Many of the states are departing from prior practice by revising statutes to explicitly permit the use of a person’s prior treatment or behavioral history in determining whether that person meets the standard for involuntary treatment. The adoption of these so-called *preventive* criteria for grave disability represents a major shift from laws that for the prior two decades had focused on the evaluation of contemporaneous behavior. However, in states like Wisconsin, where a separate commitment standard combines the question of competency with the prospect of deterioration in the absence of treatment, the standard is used sparingly. In most of the eight states we studied, the issue of competency to refuse treatment, including the right to refuse medication, continues to be handled separately from commitment. By and large, court orders for involuntary outpatient treatment do not

allow forced administration of medication.

It also appears that these states are handling the issues around involuntary treatment in a more nuanced manner than in the past. States are attempting to apply commitment law in ways that minimize overt coercion while continuing to acknowledge the importance of protecting public safety. For example, in Wisconsin, a “settlement agreement” permits the person who is the subject of a commitment petition to waive a hearing if he or she agrees to 90 days of treatment. This provision was praised by interview respondents in Wisconsin as enabling a person with mental illness to obtain treatment, while foregoing the stigma attached to commitment. Similarly, in New York, behavioral health officials in some counties have chosen to use “voluntary compliance agreements” rather than pursue court orders for involuntary outpatient treatment.

Among the attorneys, behavioral health officials, and psychiatrists we interviewed, there was widespread support for involuntary outpatient treatment – perhaps partly explained by a consensus that noncompliance with treatment (leading to relapse and rehospitalization) is a significant problem for at least some proportion of people with severe mental illness. However there was also some skepticism and uncertainty about the practical application of these laws. Most respondents were concerned about inadequacies in the service systems in their own community. *They emphasized that outpatient commitment is not a “silver bullet” and that it simply cannot work in the absence of intensive clinical services and mechanisms for enforcement of the court orders.*

The Effect of Changes in the Lanterman-Petris-Short Act on People with Mental Illness in California

California’s civil commitment practice is governed by the Lanterman-Petris-Short (LPS) Act, which was signed into law by Governor Ronald Reagan in 1967. The LPS was revolutionary in its time and significantly influenced mental health law across the United States by emphasizing voluntary treatment, moving away from indefinite confinement, and adopting behavioral criteria rather than “need for treatment” justifications for confinement. Currently, the LPS allows for confinement under successive periods of longer duration, beginning with a 72-hour hold for evaluation and treatment.

Among the most interesting findings from our analysis of the Department of Mental Health’s Client Data System (CDS) is that less than 1 percent of the 58,439 individuals who were involuntarily treated in California in fiscal year 1997-98 continued in the commitment system after an initial 14-day commitment. In fact, only 12 percent of those who experienced a 72-hour hold for evaluation and treatment moved on to a lengthier commitment. These data also suggest that the lengthier commitments are used for those with more severe illnesses and lower functioning. Among those who are held for

evaluation and treatment (72-hour hold), most are treated in crisis or emergency settings rather than hospital settings, and at least one-quarter are discharged as voluntary patients.

It is very difficult to estimate from existing data how many people might be affected by a change in California's Lanterman-Petris-Short Act. We attempted to do so by taking a closer look at the service use and commitment histories of people with severe mental illness whose most restrictive commitment in 1997-98 was a 72-hour hold.

In order to estimate the number of individuals who might be affected by the addition of an involuntary outpatient treatment program, we looked at the number of people who might be considered "revolving door" involuntary patients. By revolving door patients we mean those who experience multiple episodes of involuntary treatment but do not utilize outpatient services when they are in the community.

The CDS data indicate that there were 16,445 people who experienced more than one 72-hour hold in California in 1997-98. Of these individuals, 7,388 were people with schizophrenia or other psychotic disorders. A significant number of these individuals (2,735) received *no* outpatient services in the prior 12 months and the data suggest there may be a significant number of others who were not being adequately served by the community-based mental health treatment system. Unfortunately, we cannot tell from administrative data *why* these people were not receiving outpatient services in the 12 months prior to their 72-hour hold. We cannot tell whether lack of compliance or problems in access to community-based services (or both) are the explanatory factors. If lack of compliance is the principal problem, this subgroup might represent an at-risk target population for involuntary outpatient treatment.

Another analysis indicates there were 9,094 severely mentally ill individuals who were evaluated and treated on a 72-hour hold but not hospitalized, perhaps because they did not meet the current commitment criteria. Most of these individuals had accessed outpatient services in the prior 12 months, but 27 percent (2,463) had prior involuntary treatment as well. We cannot tell anything more from administrative data about why these individuals were released from emergency or crisis settings without hospitalization. We do not know, for example, what proportion of these individuals were released because they did not meet the LPS commitment criteria for grave disability (but might have been held under more expanded commitment criteria) or received treatment that resolved their clinical crisis quickly and so did not require further involuntary treatment. Further research, including a medical records analysis, would allow us to refine both sets of estimates considerably.

In any event, the experience of other states suggests that we should be circumspect about estimating the potential impact of changes in commitment criteria or processes. The experience of New York is illustrative. New York City officials estimated that the passage of Kendra's Law in 1999 would result in 7,000 individuals being placed on outpatient commitment orders. As of September 2000, only 235 involuntary outpatient commitment petitions had been filed, although the number appears to be growing. The experience of the eight states also suggests that involuntary outpatient commitment will be used primarily as a discharge-planning vehicle. In this case, the numbers of people entering the involuntary treatment system may not increase at all.

What We Can and Cannot Say About the Policy Question

Our systematic literature reviews, examination of the experience of other states, and analysis of the California data do not permit us to answer the question of whether the development of an involuntary outpatient treatment system in California is worth the additional cost to mental health treatment systems, the courts, and law enforcement. There is some evidence that the combination of court orders and intensive treatment has salutary effects on the outcomes in which policymakers are keenly interested (e.g., reducing rates of hospitalization, violent behavior, and arrests). However, there is no direct evidence to suggest that simply amending the statutory language is likely to produce the desired results. Investments would need to be made in developing and sustaining an infrastructure for implementation. These investments would need to include funding for the development of intensive clinical services and supports, tracking systems for supervision and monitoring, and effective enforcement mechanisms in every community in California. Such efforts would, at a minimum, require the enthusiastic support of the courts, law enforcement, and the mental health treatment community.

As an alternative, policymakers in California might consider the more conservative approach taken by the New York legislature. Faced with a fierce debate on the merits of involuntary outpatient treatment and concerned with the potential impact of such a law across a large and diverse state, the New York legislature passed a limited statute for purposes of testing involuntary outpatient treatment in New York City. Passing a limited statute associated with a large, well-designed, and adequately-funded evaluation would provide specific data to answer some of the policy questions that remain unanswered.

Unfortunately, there are no cost-effectiveness studies that would provide policy guidance on the relative return on investment for developing an involuntary outpatient treatment system as opposed to focusing all of the available resources on developing state-of-the-art community-based mental health treatment systems in every California community. Clearly, either approach will require a sustained administrative and financial commitment by the legislative and executive branches of government.

ACKNOWLEDGMENTS

Many people contributed their time and energy to this project. We owe thanks to the staff of the California Senate Committee on Rules and John Burton, President pro Tempore of the Senate, for commissioning this work and giving us the opportunity to delve into this important area of public policy. We are also greatly indebted to the staff of the California Senate Office of Research for developing a clear set of objectives to guide the project, for reviewing and commenting on drafts of the report, and for their unfailing support over the many months of the project. In particular, we have been ably assisted by our project officer, Peter Hansel, and director, Elisabeth Kersten. Our draft report also benefited from the comments of a number of Senate staff.

We would also like to acknowledge the contribution of Assemblywoman Helen Thomson, and her legislative consultant, Nancy Chavez, who provided a wealth of material from their work on AB 1800 and related issues.

We are grateful for the cooperation we received from the Statistics and Data Analysis Unit of the California Department of Mental Health. Kathy Styc and her staff, Sara Gilb and Bryan Fisher, worked patiently with us, sharing data, helping us with our analysis plan, and reviewing and commenting on a draft. We gratefully acknowledge their help; any mistakes in the final analysis are ours.

In addition, a host of individuals, including consumer/survivors, researchers, attorneys and clinicians, provided copies of published articles, papers, and manuscripts on topics related to involuntary treatment. Unfortunately those who contributed are too numerous to mention individually. We would like to acknowledge four researchers who provided copies of their unpublished manuscripts which were used in the analysis: Dr. Marvin Swartz of Duke University; Dr. Virginia Hiday of North Carolina State University; Dr. John Monahan of the University of Virginia; and Dr. Sandra Newman of Johns Hopkins University.

We are indebted to dozens of people who generously provided the information that represents some of the core data used in our analysis. The interview respondents included Dr. Spencer Bayles, Debra Belinky, Marvin Bernstein, Melinda Brents, Dr. Oliver G. Cameron, Mark A. Cody, Emmett J. Creahan, Dr. Christos Dagadakis, Bruce S. Dix, Peter R. Freed, Gerald Goffin, William P. Harper, Paul Harris, Alan Hart, Sidney Hirschfeld, Michael Kirkman, David M. LeVine, Fran Lewis, William Martin, Sharon Maynard, Dr. Beth Melcher, Dr. Gene Minard, Christine Morton, Dr. Mark Munetz, Madeline Olson, Mary Opgenorth, Terrance Ryan, Richard Slipsky, Rob Stranahan, Galen Strebe, John Tauriello, Dr. Howard Telson, Dr. Richard Templeton, Dr. Darold Treffert, Paul Wagner, Dr. John Wagnitz, and Dr. Timothy Wiedel. We thank them all for their time and insights.

We also received invaluable assistance in identifying and recruiting interview respondents from Kathleen Gross, Gregory J. Kershul, David Lalumia, Dr. Carol Duncan-Clayton, Robert T. Hargett, Robin Huffman, David Brownell, Seth Stein, Jim Havel, Philip Workman, Jeffrey Davis, John H. McCulley, Jeffrey J. Wahl, John Bush, Cathy B. Campbell, James Goche, Kathy Eilers, and Edward Levin.

A number of our RAND colleagues and consultants contributed their time and expertise in support of the project. Alan Charles and Dr. Robert Reville of the Institute for Civil Justice and Dr. Paul Koegel, Yasmin Facey and Gwen Parker of RAND Health provided administrative support. We thank Dr. Audrey Burnam, Dr. Ruth Klap and Fuan-Yae Kung for their work on the data analysis; Roberta Shanman for designing and implementing the literature search strategy; Drs. Lisa Shugarman and Marjorie Pearson for assistance in abstracting articles; Christopher Kelly, Miriam Polon and Paul Murphy for their editorial and production assistance; and Dr. Elizabeth Giddens and Dr. Mary Vaiana for assistance with communications. We thank Sophia Washam for arranging the interviews, conducting web searches, and providing administrative assistance.

Finally, we are indebted to our technical reviewers – Dr. John Monahan, Henry and Grace Doherty Professor of Law and Associate Director of the Institute of Law, Psychiatry and Public Policy at the University of Virginia; Dr. William Fisher, Associate Professor of Psychiatry and Associate Director of the Center for Mental Health Services Research at the University of Massachusetts Medical School; and Linda Demaine, RAND Associate Policy Analyst – for their timely, thoughtful and constructive comments and suggestions.

I. INTRODUCTION

Nationally, a number of factors seem to be working together to cause a renewed interest in the use of involuntary treatment in the mental health field. These influences have their origins in clinical, programmatic, and fiscal concerns that have arisen over the last two decades. In the 1980s and 1990s, mental health professionals and policymakers focused their attention on two problems concerning the care of people with severe mental illness.¹ The first was disproportionately high service utilization and the costs associated with so-called "high utilizers."² In an era of cost containment, policymakers were interested in providing appropriate community-based care while decreasing the use of expensive acute psychiatric and emergency services, as well as the use of detoxification units and jails. In addition, clinicians focused on treatment non-adherence, labeling some patients who refuse mental health services "treatment-avoidant" or "noncompliant." These labels have been attached to people who are homeless and suffer from mental illness, especially those who have co-occurring chronic alcohol and drug problems. In recent years there has also been a growing public outcry concerning the homeless, resulting in panhandling legislation in some communities, as well as "quality of life" arrests and other efforts to reduce the visibility of homeless individuals.³

What is not clear is whether these phenomena are a cause or an effect of the dramatic changes in mental health care over the last three decades, or of the more recent focus on cost containment as the field moves into an era of managed care. To a certain extent, the identification of these groups was fostered by the need to determine where the mental health dollars were being spent (for whom and for what services) in order to create plans for cutting costs. The increasing need to control the utilization of mental health services, as well as the desire to provide needed mental health treatment, has created an environment conducive to ideas for engagement and retention of people in treatment.

At the same time, organizations representing families of people with severe mental illness expressed considerable concern about the narrowing of commitment laws in the 1960s and 1970s in response to civil rights concerns. The National Alliance for the Mentally Ill (NAMI), a national family advocacy group, has advocated a broadening of state statutory criteria (and the reinterpretation of existing laws to broaden commitment authority) to enable families and professionals to seek involuntary treatment of people with severe mental illness who are not overtly dangerous to themselves or others (i.e., assaultive or suicidal), but rather are dangerous to themselves as a result of an inability to adequately

¹ Severe mental illness is generally defined as including DSM-IV diagnoses of schizophrenia, other psychosis, bipolar disorder, and major depression. Regardless of diagnosis, mental illness is considered severe when it is enduring enough to cause lasting disability (APA, 1999).

² People with severe mental illness account for a high percentage of mental health expenditures. A recent analysis found that 2.2% of mentally ill people account for 33% of public sector costs of mental health care in the United States. See Frank and McGuire, 1996; and Taube, Goldman, and Salkever, 1990.

³ Mental Health Weekly, 1995.

provide for their own needs in the community (i.e., *gravely disabled*). More recently, the Treatment Advocacy Center has strongly advocated an expansion of the grave disability concept to add a “need for treatment” provision. Such a provision would allow for “preventive” commitment for those who currently do not meet commitment criteria but have a past history of repeated noncompliance, relapse, and rehospitalization that provides a rationale for timely intervention.

The emphasis on involuntary treatment has intensified despite the increased visibility of the mental health consumer/survivor movement. Many mental health consumer/survivor organizations originally focused on self-help, but ultimately became a force advocating large-scale changes in the way mental health services are organized, provided, and evaluated.⁴ Mental health consumer/survivor organizations have aggressively fought the use of involuntary treatment in its many forms.⁵ Instead, mental health consumer/survivors advocate enhancement of community services, arguing that development of new state-of-the-art treatment programs, enhancing the quality of routine clinical care in existing mental health services, and development of supports such as meaningful supported housing and supported employment programs would abrogate the need for involuntary interventions.

Nevertheless, involuntary treatment has rapidly expanded into the community. There is a small but growing body of research on outpatient commitment. Some advocates claim the research proves that outpatient commitment is a useful method for increasing mental health consumer/survivors’ participation in outpatient care, improving the mental health of those committed,⁶ while others argue that such studies have not been able to disentangle the effects of the treatment from the effects of the commitment. Many of these studies have been natural field experiments, lacking rigorous designs or appropriate statistical controls,⁷ making interpretation of their findings difficult. However, in the last several years, a second generation of studies has directly addressed the question of the effectiveness of outpatient commitment. Is the benefit observed in some of the earlier studies an effect of the commitment or an effect of the treatment? Is there any evidence to suggest, as many mental health consumer/survivors argue, that if people with severe mental illness were offered community-based treatment that addressed their needs and preferences, involuntary commitment would be unnecessary?

This year the California Legislature may consider proposals to amend California’s involuntary treatment statute, the Lanterman-Petris-Short (LPS) Act. In order to assist the Legislature, the Senate Committee on Rules asked RAND to take a fresh and objective look at the experiences of other states and provide a more *evidence-based* review of the empirical literature. The Senate did not ask, and we will not offer, recommendations on specific legislative proposals. In this report we will share our

⁴ Van Tosh, 1993.

⁵ Blanch and Parrish, 1992.

⁶ Torrey and Kaplan, 1995.

⁷ Hiday, 1992.

analysis of the empirical evidence on involuntary treatment, our analysis of the statutes and case law in eight states, as well as the views of key informants in the commitment systems in those eight states. Our work contributes to – and begins to fill some significant gaps in – a growing body of knowledge about involuntary commitment in the community.

The remainder of this report comprises seven sections. In the next section, we briefly describe our study approach and methodology. Section III summarizes the literature on involuntary treatment – providing an analysis of both the first and second generations of studies of outpatient commitment. The evidence-based review emphasizes findings from the best studies and provides guidance on the strength of the findings. Section IV summarizes what we know about the effectiveness of alternatives to involuntary treatment – including services such as crisis intervention, assertive community treatment, case management and supported housing. The evidence we present is derived from our compilation of evidence-based reviews completed by other investigators. Sections V and VI provide an analysis of the current commitment practices in eight states derived from their statute and case law and a series of interviews with key informants in the commitment process. In these sections, prosecuting and defense attorneys, as well as county behavioral health officials and psychiatrists, share the lessons learned from their experiences with outpatient commitment. Section VII describes involuntary treatment in California, including the current statutory framework and an analysis of data from the California Department of Mental Health. Finally, the concluding section considers the implications for public policymaking on the issue of involuntary treatment.

We hope that the information offered enables readers to develop an enhanced understanding of the legal and clinical contexts of involuntary treatment and the wide range of factors that can influence the outcomes of legislation. If so, the report may contribute by clarifying issues that have been somewhat obscured, and therefore have a positive effect on the public debate on this crucial topic.

II. STUDY APPROACH AND METHODS

RAND's study on involuntary civil commitment focuses on three research questions posed by the Senate Office of Research:

- How effective is involuntary treatment compared to other types of intervention and treatment?
- What has been the experience of other states with implementation of involuntary treatment laws and programs?
- Who is potentially impacted by a change in the involuntary treatment criteria in California?

In order to address these complex questions, we have employed a variety of different methods. Each of those methods will be described in some detail below.

Evidence-Based Review of the Literature on Involuntary Treatment

For this effort we utilized a method that is loosely based on methods employed by RAND's Southern California Evidence-Based Practice Center.⁸ To our knowledge, this is the first attempt to use an evidence-based approach to examining and synthesizing evidence on involuntary treatment.

In brief, an evidence-based review attempts to integrate the lessons learned from empirical research, typically by summarizing large bodies of literature using critical appraisal techniques. These are scientific investigations that employ strategies to limit bias and random error, including the following: a comprehensive search of all potentially relevant articles; the use of explicit reproducible criteria in the selection of articles for review; appraisal of research designs and study characteristics; and interpretation of results.⁹ The quality of a review depends on the extent to which scientific review methods have been employed.

Based on these principles, our review of the involuntary treatment literature attempts to resolve conflicts in the literature by critically analyzing the research rather than simply

⁸ The Southern California Evidence-Based Practice Center is a consortium of institutions established and coordinated by RAND to conduct systematic literature reviews with the aim of critically examining and synthesizing evidence on specific medical conditions or procedures. The Center's work is funded by the federal Agency for Healthcare Research and Quality (AHRQ) and other public and private sources.

⁹ An evidence-based review produces a descriptive summary of evidence and bases its conclusions on that evidence. A meta-analysis takes the analysis one step further by including a statistical synthesis that is a "pooling" or combining of the data across studies (Cook, Mulrow and Haynes, 1997).

reporting findings of all studies conducted in a particular topical area.¹⁰ Evidence-based reviews are designed to support public policy decisionmaking by providing decisionmakers with reliable evidence about the specific effects of health interventions. As stated by the Cochrane Collaboration, pioneers in the field of evidence-based review in medicine,

Forms of care that have been shown to do more good than harm should be encouraged, while those that do more harm than good need to be discarded. The many forms of care which have unknown effects should, as far as possible, be used in the context of a research program to find out whether they help or do harm.¹¹

An evidence-based review involves an extensive search for relevant studies. The RAND Library performed searches on the following databases: Medline, HealthSTAR, PsycINFO, Mental Health Abstracts, Sociological Abstracts, and Social SciSearch. Searches were limited to the years 1980–2000 and only English-language material was accepted. The search terms selected were derived from term lists provided by the senior investigators.¹² Forms of the terms were taken from subject heading lists used by some of the databases; where no subject heading existed, free-text terms which could appear in the titles or abstracts of the citations were used. The initial search yielded 6,719 references.

It is worth noting that we intentionally began with a very broad search to uncover the highest possible number of potentially relevant leads, and then began to narrow the field by sequentially applying limiters in order to identify only the best studies with the highest degree of relevance. All titles were downloaded and were first evaluated by the librarian. After eliminating a very large number of titles that did not pertain to the research topic at all or covered an aspect that was not within the project scope, the remaining titles were sent to the senior investigator, who selected full citations and abstracts for review. In addition, the senior investigator received mailings that included articles submitted by legislators, advocate organizations, and researchers who were aware of our study. We also searched for and reviewed a number of existing reviews of this literature, as well as using their reference lists to identify additional studies.¹³ Another level of screening by the senior investigator identified articles that appeared to pertain directly to the research topic (i.e., the effectiveness of involuntary outpatient treatment). A third level of screening identified articles that reported some empirical data.

Ordinarily an evidence-based review in medicine is limited to randomized clinical trials; however, the Senate Office of Research asked us to be as inclusive as possible in our

¹⁰ Cooper and Hedges, 1994.

¹¹ The Cochrane Library on the Web at <http://www.cochranelibrary.com>.

¹² The search strategy (including specific search terms) is described in more detail in Appendix A.

¹³ Some of those reviews included reports by the California Institute of Mental Health, 2000 and the American Psychiatric Association, 1999; as well as published review articles, including Mulvey, Geller and Roth, 1987; Lidz, 1998; and Keilitz, 1990.

review. Given the state of the research in the involuntary commitment field, we decided to include quasi-experimental as well as experimental designs. These articles were then screened for the final time based on the following inclusion/exclusion criteria:

- Does the article pertain to the policy issue of interest (i.e., whether involuntary outpatient treatment is effective in improving compliance and treatment outcomes)?
- Was the study reported in the article conducted in either the United States, Canada, or Britain?¹⁴
- Does the article report data from an empirical study (i.e., report outcomes in addition to any legal analysis or commentary)?
- At a minimum, does the study design include a comparison or control condition or employ a pre/post design?

The screening was performed by two of three reviewers. If the answer to any of the screening questions was “no,” the article was excluded from further review.¹⁵ Articles reporting on empirical studies that met criteria for review (22) were read and evaluated, again by two reviewers, and then material was abstracted using an abstraction form developed for this study.¹⁶ The abstraction form was used to describe the content and methodology of the study, including such key factors as unit of analysis, intervention characteristics, study design, data analytic strategies, and reported outcomes. Reviewers also made overall assessments of the quality of the study.

Evidence tables were developed to summarize what is known about involuntary treatment and where significant gaps in our understanding remain. These findings are described in Section III of this report.

Answering the first study question (i.e., how effective is involuntary treatment as compared to alternatives?) also required a summary and analysis of existing evidence-based reviews of the empirical literature on other forms of intervention designed to improve treatment outcomes of people with severe mental illness. These include community-based interventions such as intensive case management, assertive community treatment, dual diagnosis treatment, and supported housing, as well as forms of coercive intervention in the community (e.g., representative payee, using housing as “leverage”). Our review of this empirical literature involved a similar set of search tasks to those

¹⁴ We limited the search to English language publications and to countries with legal systems similar to that of the United States, given that the issue of interest, involuntary treatment, occurs in the context of the legal system.

¹⁵ We applied the first criteria rather strictly, excluding, for example, research on associated topics such as the evaluation of dangerousness, factors in judges’ decisionmaking about commitment, issues in procedural justice, and so forth.

¹⁶ Copies of the screening and abstraction forms are included in Appendix A.

described above, except in this case we were searching for and analyzing evidence-based reviews rather than primary research articles. We restricted our search to Medline and the Cochrane Library. Our search strategy employed a combination of the terms “review” and “mental health services” with specific terms (such as “housing,” “outreach,” “case management, etc.). In addition, we searched using the term “review” in combination with “treatment” and with “schizophrenia,” “bipolar,” and “personality disorder.” This search identified a limited set of articles that were supplemented by requests from identified experts in the field. These requests produced two prepublication reviews that met our screening criteria (one on housing and another on mandated community treatment.) The senior investigator then screened the abstracts to identify evidence-based reviews (or, in situations where there was no evidence-based review, a review that, at a minimum, described search strategy, terms, inclusion and exclusion criteria, and made judgments on the quality of the studies rather than simply reporting findings). Again, in an attempt to be as inclusive as possible, we incorporated material in this analysis from 23 articles, only 17 of which were evidence-based reviews.

The second study question asked RAND to describe and analyze the experience of a select number of other states. Together with the Senate Office of Research, we developed criteria to identify states for review. The eight states chosen for analysis (Michigan, New York, North Carolina, Ohio, Oregon, Texas, Washington and Wisconsin) met *one or more* of the following criteria:

- States that had experience with outpatient commitment (either as a separate statutory section or as part of a general involuntary commitment statute);
- States that had commitment programs on which research had been conducted (e.g., the Duke Study in North Carolina, the Bellevue Study in New York);
- States that had expanded “grave disability” commitment criteria;
- States that are large and have an ethnically diverse population (i.e., comparable to California);
- States that have a decentralized mental health system operating at the county level (i.e., comparable to California).

To adequately capture the commitment experience other states, we employed both electronic search strategies and key informant interviews.

Statutory and Case Law Analysis

Using *Westlaw/LEXIS* search engines, we identified and downloaded information on the relevant commitment statutes and case law in the eight states. Our analysis included attention to the following factors:

- Commitment criteria (including definitions of key terms such as “gravely disabled,” “in need of treatment” and “dangerous”);
- The process of commitment (i.e., detention, evaluation, treatment, release);
- Due process requirements (i.e., right to hearing, right to counsel);
- Settings (inpatient, outpatient);
- Length of commitment;
- The manner in which noncompliance is addressed;
- The manner in which competency to refuse medication is addressed.

This information was verified with interview respondents and we specifically inquired whether there had been judicial decisions interpreting the statutes that were not reported in *Westlaw/LEXIS*. Summaries of the statutory and case law materials were prepared in a standard format and are included in Section V.

Key Informant Interviews

To address the second study question, we also interviewed key informants in the eight states. In brief, using case study methods, we identified potential interview respondents, developed a semi-structured interview protocol, obtained RAND Human Subjects Protection Committee review of the consent procedures, obtained consent, conducted interviews, and synthesized our field notes to identify key areas of consensus and disagreement in the experiences of respondents in the eight states.

Together with Senate Office of Research staff, we considered groups of key informants to include in the interviews. We were limited to a total of four interviews per state because of time and resource constraints. Therefore we recognized it would be impossible to tap all relevant stakeholder groups, as well as difficult to determine the extent to which the views of the single person we interviewed represented the views of that entire stakeholder group.¹⁷ Nevertheless, we were systematic in interviewing representatives of the same four groups across the eight states, and in using the same methods to identify respondents within each group across the eight states. These data are more important in showing the extent to which there is consensus on some key issues across the states than they are in representing the views of either specific stakeholder groups or specific states.

¹⁷ We did not, for example, have the resources to conduct a large-scale mail survey that might have indicated whether the views of the key informants we talked to were representative of the views of the larger stakeholder group from which they were chosen.

In consultation with the Senate Office of Research staff, we made the final determination as to which groups of key informants would be included in the study. We chose representatives of four key groups deemed to be centrally involved in decisions about commitment on a day-to-day basis – prosecuting attorneys, defense attorneys, psychiatrists, and representatives of local behavioral health authorities. These informants could help us clarify the law and procedures (attorneys), understand the clinical implications of the law (psychiatrists), and understand the organizational and financial implications of the law (local behavioral health directors).¹⁸ We developed a project description and list of interview questions that were used to recruit the interview participants.¹⁹

We identified prosecuting attorneys by starting with the list of state mental health attorneys from the website of the National Association of State Mental Health Program Directors. If the state mental health attorney handled commitment issues (and thus could give us a statewide perspective) we interviewed that attorney. If not, we asked the state mental health attorney to identify a local prosecutor. Once the prosecuting attorney was identified, we asked the prosecutor to identify a defense attorney – either a public defender or a member of the private bar. To identify psychiatrists, we started with the American Psychiatric Association web site and contacted the state psychiatric society for each of the eight states, sent a facsimile of the interview questions, and asked that they identify a member of their organization who was most qualified to answer the questions. We also accessed the web site of the National Association of County Behavioral Health Directors to identify the state organizations of county behavioral health officials. After identifying the state organizations, we contacted each of the organizations and asked for the name of a representative who was most knowledgeable about civil commitment. In this way we identified a total of 32 potential respondents. Of the 32 potential respondents, we had one refusal and were unable to schedule an appointment for two other interviews, despite repeated attempts to do so.²⁰ In a few states we interviewed more than one respondent in a category, so that our total number of respondents was thirty-seven.²¹

¹⁸ We recognize that other important stakeholders are not represented, in particular consumer/survivors and their families. While we did not attempt to recruit representatives of the National Alliance for the Mentally Ill, in fact several of our respondents identified themselves as affiliated with NAMI, so perhaps the most glaring omission is in representation of the views of consumer/survivors themselves. While we did hear from the defense bar, it cannot be assumed that defense attorneys necessarily represent the views of consumer/survivors.

¹⁹ Copies of the Project Description, the list of the investigators, and a copy of the interview protocol are included in Appendix B. The same interview questions were used for all four groups of respondents; however, the legal questions were emphasized in the interviews with attorneys and the clinical and programmatic questions were emphasized in the interviews with the other respondents.

²⁰ The prosecuting attorney in Michigan declined to participate and we were unable to identify an alternative respondent in time. The other nonrespondents were a county behavioral health official and a defense attorney in Texas. We identified and contacted a number of potential respondents, but all declined to participate, explaining that they lacked sufficient experience with outpatient commitment to address the questions in the protocol.

²¹ A complete copy of the list of interview respondents is included in Appendix B.

Our interview procedures conformed to the requirements of RAND's Human Subjects Protection Committee. Each potential respondent was informed of the purpose of the study and was told that we would identify him or her by name in this report. Each received a copy of the interview questions in advance. The planned duration of the interviews was 60 minutes but some extended to two hours. The interview protocol was used as a guide during the interview, but subjects were not necessarily addressed in the order in which they appeared in the protocol, and not every question was addressed to every respondent. Telephone interviews were conducted by one or two of the senior investigators and contemporaneous notes were taken. These notes were synthesized and that material appears in Sections V and VI of this report.

Analysis of California Data on Involuntary Treatment

To address the third study question, the Senate Office of Research requested that RAND conduct secondary analysis of administrative data to describe the population of persons subject to current involuntary treatment guidelines, including information on diagnosis, grounds for commitment, demographic characteristics, living arrangements, treatment and commitment history, and past utilization of services. Also, to the extent possible given the available data, RAND agreed to attempt to identify categories of persons at risk of commitment or more lengthy commitment under expanded commitment criteria and processes. Only one California Department of Mental Health (DMH) dataset was available for secondary analysis – the California Client Data System (CDS).

After obtaining approval from the RAND Human Subjects Protection Committee and exemption²² from the California Health and Human Services Agency Committee for the Protection of Human Subjects, we obtained a de-identified CDS data file from the California Department of Mental Health. The CDS is a service and demographic database with the capability to unduplicate clients across all service types within county. For these analyses we used data from the most current complete year (fiscal year 1997-98). The CDS is used to report on all clients served by county mental health contract agencies and includes both inpatient and outpatient services paid for by Short-Doyle/Medi-Cal,²³ as well as services for non-Medi-Cal persons (most of whom are indigent). The database is made up of separate service records (about 1 million records a year) representing about 380,000 unduplicated people. Information available from the CDS includes demographic, clinical, and service information, including admission and

²² Exemption was granted because our study utilizes existing data and the information in the data file is recorded so subjects cannot be identified either directly or indirectly.

²³ In 1957 California established the Short-Doyle program (named for the legislators responsible for the authorizing legislation) to “encourage counties to develop community mental health services.” In 1965, California established the California Medical Assistance Program (or Medi-Cal) and in 1971, Short-Doyle was “folded into” MediCal (Little Hoover Commission, November 2000).

discharge legal status. The data presented are for the state of California as a whole – aggregated from data reported by local mental health authorities.²⁴ In Section VII we discuss our analysis strategy in more detail and report our findings.

²⁴ California has 59 local mental health authorities – 56 counties, two cities, and one joint mental health authority (Yuba and Sutter counties) (Little Hoover Commission, November 2000).

III. WHAT DOES THE EMPIRICAL LITERATURE TELL US ABOUT THE EFFECTIVENESS OF INVOLUNTARY TREATMENT?

In most mental health systems, there are people with severe mental illness who are persistently at high risk for relapse, have repeated hospitalizations and criminal justice contacts, and disproportionately use the most costly services. These individuals often have co-occurring alcohol or drug abuse problems and fail to take their psychotropic medications as prescribed, which contributes to episodic worsening of their psychiatric condition and even to disruptive or violent behavior. Unfortunately, some high-risk patients do not respond well to traditional community-based mental health services. For various reasons, even when treatment is made available, they do not comply. Because the symptoms of their illness, when untreated, can cause them to be unable to care for themselves or become dangerous to themselves or others, use of legal mandates and coercive interventions has been proposed as a necessary supplement to community-based treatments. These mandates are believed to increase adherence, and thereby prevent deterioration and harm from occurring to the patient or others. In this context, involuntary treatment typically takes the form of civil commitment.

Civil commitment is a statutorily-created and court-ordered form of compulsory treatment, which historically has been used as a mechanism for admitting people involuntarily to hospitals for psychiatric treatment. Generally speaking,

Involuntary civil commitment is the legal process – operating at the confluence of the public safety, justice, and social service systems – whereby an individual found to pose a harm to self or others as a result of mental or physical impairment or disability is forced to undergo treatment or care.²⁵

Laws pertaining to the restraint and confinement of people with mental disability are among the oldest statutes in the country. One of the first of these was enacted in Massachusetts in 1676 and provided for the involuntary restraint of mentally ill persons (then called “insane”) who were potentially violent. Civil commitment procedures for the involuntary hospitalization of people with mental illness are available in every state²⁶ and are often used to leverage treatment compliance for those whose mental illness and refusal or failure to follow through with treatment causes them to become gravely disabled or even dangerous.

²⁵ Garcia and Keilitz, 1991.

²⁶ Weiner and Wettstein, 1993.

The Evolution of Involuntary Outpatient Commitment

Although civil commitment has traditionally been used as a mechanism for involuntary hospitalization, there has been a more recent focus on its applicability to outpatient treatment. These legal provisions are generally referred to as involuntary outpatient commitment or assisted outpatient treatment. Outpatient commitment is “a form of civil commitment in which the court orders an individual to comply with a specific outpatient treatment program.”²⁷ Theoretically, outpatient commitment can allow a person with a mental illness increased autonomy in a less restrictive treatment environment (i.e., less restrictive than a hospital), while permitting the provider to monitor compliance and detect early signs of relapse or decompensation.

Currently, almost all states permit – or do not explicitly prohibit – outpatient commitment in some form. At last count, thirty-eight states and the District of Columbia had statutes that make specific provisions for outpatient commitment; and several other states are currently considering outpatient commitment legislation.²⁸ Other countries including Canada and Britain also have outpatient commitment provisions in their laws.²⁹ The use of outpatient commitment – or at least the popularity of these laws – appears to be increasing, since currently there are twelve more states allowing outpatient commitment than in 1987.³⁰

Legal Criteria and Provisions for Involuntary Outpatient Commitment

Outpatient commitment began as an alternative to traditional involuntary hospitalization. Accordingly, the criteria for both forms of compulsory treatment were originally identical. However, the degree of infringement on a person’s liberty and autonomy may differ significantly between inpatient and outpatient commitment, so that different criteria or policy considerations may be warranted to ensure treatment in the least restrictive setting. Since the mid-1980s, there have been recommendations and laws enacted to broaden the scope of the population eligible for outpatient commitment, in order to enhance its preventive function – that is, to reduce the risk of deterioration or recidivism *before* the individual becomes gravely disabled or dangerous.³¹

The specific criteria, mechanisms, and provisions for outpatient commitment vary somewhat across states; however, there are three primary ways in which civil commitment procedures are used for community-based mental health treatment:

²⁷ Torrey and Kaplan, 1995, p. 778.

²⁸ In addition, states may also be using nonstatutory mechanisms.

²⁹ Swartz, Burns, Hiday, et al., 1995; McCafferty and Dooley, 1990; Hiday, 1992; Torrey and Kaplan, 1995.

³⁰ Schwartz and Costanzo, 1987. New York had previously been identified as the only state that specifically prohibited outpatient commitment; however, in 1999, the New York State Legislature enacted an outpatient commitment statute referred to as Kendra’s Law.

³¹ Miller, 1988; Keilitz and Hall, 1985.

(1) Meets inpatient commitment criteria – mandated to outpatient treatment: In this circumstance, an individual is found by the court to meet statutory criteria in the jurisdiction for involuntary hospitalization or commitment (e.g., mentally ill and dangerous to self or others or gravely disabled), but rather than being hospitalized, the respondent is mandated to a mental health center or provider for outpatient treatment.

(2) Meets inpatient commitment criteria – conditional release from hospital: In this circumstance, an individual who has been involuntarily committed to a psychiatric hospital and who presumably continues to meet statutory criteria for involuntary hospitalization or commitment (e.g., mentally ill and dangerous to self or others or gravely disabled), is “conditionally released” from the hospital. If the patient fails to comply with outpatient treatment, he or she can ostensibly be remanded directly back to the hospital without an additional court order, because the initial order for hospitalization remains in effect.

Under both of these types of provisions, the court or provider would release into the community individuals whom they had explicitly deemed to be dangerous or gravely disabled.

(3) Meets preventive commitment criteria – mandated to outpatient treatment: In this circumstance, a person with a severe mental illness whose condition, without treatment, is likely to deteriorate to the point where he or she becomes dangerous (or potentially gravely disabled) can be court-ordered to comply with a community-based treatment plan. If the person fails to comply with treatment, the mental health provider can usually request that a law enforcement officer transport the patient to the treatment center for examination, but the patient cannot be automatically admitted (or readmitted) involuntarily to the hospital. For that to occur, a new petition for involuntary hospitalization would have to be initiated and the patient would have a right to a new hearing on that petition. Similarly, although preventive outpatient commitment orders do require that the patient comply with the provider’s treatment plan – which may include medication – involuntary or forced medication generally is not permitted. For this, the patient typically must be judged by a court to be legally incompetent. Thus, the preventive outpatient commitment statutes do have the potential to increase early identification of patients who may not be adhering to their treatment plan and consequently deteriorating, but it does not necessarily give a provider authority to enforce the order by subjecting the patient to involuntary medication, hospitalization, or psychosocial intervention.³²

³² The outpatient commitment statute in North Carolina provides an example of prevention-oriented criteria – see Section V of this report.

Practices and Challenges in the Use of Outpatient Commitment

Although it appears that many states are adopting or considering outpatient commitment statutes, in practice these laws have been inconsistently utilized. National data gathered in 1986, prior to implementation of a number of newer outpatient commitment statutes, concluded that outpatient commitment accounted for only 9.8% of new outpatient admissions and 7.1% of cases continuing in outpatient treatment.³³ More recent survey data reported that respondents in 13 states and the District of Columbia estimated the use of outpatient commitment in their jurisdiction to be common or very common, whereas in 21 states the use of outpatient commitment was reported to be rare or very rare.³⁴ In North Carolina the use of outpatient commitment is reported to vary quite dramatically between local mental health authorities operating under the same outpatient commitment statute.³⁵

Those who reported using outpatient commitment infrequently gave many reasons for this pattern, including concerns about infringement on civil liberties, liability, monitoring costs, possible increase in the need for hospital beds due to noncompliance, overly stringent criteria, lack of enforcement, or disinterest in treating the target population of people with severe mental illness. Another key cause of infrequent use was believed to be a lack of information. As early as 1984, in more than one out of four states, the state mental health directors and the state attorneys general disagreed about whether outpatient commitment was even currently permitted.³⁶ Ten years later, the Torrey and Kaplan survey suggests that lack of awareness persists.

Lack of awareness, however, is not the only impediment to broader outpatient commitment policies. Some mental health consumer/survivors and advocates are deeply concerned that outpatient commitment extends coercive social control into the community and that the aversion to coercion deters people with mental illness from seeking treatment.³⁷ Indeed, coercion has been a centerpiece in the ongoing debate about the appropriateness of outpatient commitment. Controversy even exists as to whether outpatient commitment increases coercion (by extending mandated treatment to the community), decreases coercion (by allowing a community-based alternative to restrictive hospitalization), or is irrelevant (because many of the laws have no functional enforcement power). *While the perceptions and positions of mental health consumer/survivors, advocates, and scholars must be judiciously considered in this policy decision, an equally legitimate consideration is whether the proposed intervention actually works; that is, whether outpatient commitment, as intended, is effective in improving compliance and treatment outcomes.*

³³ Swartz, Burns, Hiday, et al., 1995.

³⁴ Torrey and Kaplan, 1995.

³⁵ Fernandez and Nygard, 1990.

³⁶ Miller, 1985.

³⁷ Mulvey, Geller, and Roth, 1987; Schwartz and Costanzo, 1987; Campbell and Schraiber, 1989; Stefan, 1987.

Effectiveness of Involuntary Outpatient Commitment

The following sub-section reviews and summarizes the empirical research literature on the effectiveness of outpatient commitment in improving outcomes for people with severe mental illness. It begins with an introduction to the challenges inherent in studying and interpreting this research and the implications of these challenges for understanding why some studies should be given greater weight than others for purposes of developing policy. We then present a brief description of the findings and conclusions from studies on the effectiveness of outpatient commitment, with a focus on the second generation studies – those with designs that have a higher degree of scientific integrity and arguably provide the best test of the intervention.

Research Challenges

Studying involuntary outpatient commitment and determining the effectiveness of a coercive, community-based intervention poses a myriad of ethical and scientific challenges.³⁸ While clinical studies of outpatient commitment have historically suffered from some of the same methodological problems apparent in some other types of intervention research (such as small sample size and lack of comparison groups), there are also serious threats to outpatient commitment studies in particular that undermine the strength of any conclusions. Four of the most common problems with these studies include:

Selection bias: People chosen to receive outpatient commitment are selected in many cases because they already had certain characteristics (e.g., many hospitalizations, history of noncompliance). This makes it more difficult to determine whether any effects (or lack of effects) are caused by outpatient commitment or other patient factors.

Unclear target population: Many studies fail to identify and apply systematic inclusion and exclusion criteria to determine who is eligible for the study. This makes it difficult to know whether outpatient commitment works. At a minimum, it clouds the question of *for whom* the intervention may be effective.

Unclear operationalization of outpatient commitment: The definitions of what outpatient commitment is and what it can do are often not clear to patients or providers involved in the study. Additionally, the procedures for using outpatient commitment in practice (e.g., when and how to enforce the order) are often not systematically studied as a part of the research design. This creates a problem for interpreting results because we cannot know whether an intervention is effective unless we know how it was used and applied. For example, a study could show that patients on outpatient commitment did not do any better than patients not on outpatient commitment, but if the court orders were never enforced, the strength of the intervention would be significantly diluted.

³⁸ Swartz, Burns, George, et al., 1997; Swanson, Swartz, George, et al., 1997.

Unmeasured variability in treatment: An outpatient commitment order requires that a respondent comply with a treatment plan, but the appropriateness, nature, and quality of that plan (including type, frequency, and intensity of treatment) may also affect outcomes – whether or not the court order exists. Unless the treatment information is considered in the statistical analysis it will be difficult to know whether outpatient commitment is effective – because any difference between the groups may be due to differences in treatment received rather than the existence of the court order.³⁹

For purposes of developing effective policy, it is advisable to rely more heavily on studies that provide the clearest test of the intervention and that have minimized the “background noise” associated with these other factors. To that end, the empirical research on outpatient commitment can be classified into *two generations of studies*, based not necessarily on when the study was conducted, but on the sophistication and rigor of the design. First generation studies were exploratory or developmental and had more of these design limitations. Second generation studies attempted, at least in part, to address some of these major threats to validity. In the following section, we review the major findings from both first and second generation studies, which are also summarized in Tables C.1 and C.2 in Appendix C.

First Generation Studies on the Effectiveness of Outpatient Commitment

Early studies on the effectiveness of outpatient commitment were plagued by numerous methodological limitations. Nevertheless, they did provide preliminary evidence and established a foundation for further inquiry.⁴⁰ These studies also highlight the challenge of distinguishing the effects of the legal mandate *per se* from other treatment and nontreatment effects.

North Carolina: More studies of outpatient commitment have been conducted in North Carolina than in any other state. Not surprisingly, the first published study of outpatient commitment was conducted in a North Carolina catchment area.⁴¹ That study examined retrospectively the readmission rates of 167 patients who had been released from the hospital with a court order to comply with community treatment. The preventive outpatient commitment statute noted above was not yet in place, so all patients in the study met the restrictive inpatient criteria for being mentally ill and dangerous to themselves or others. During the first 90-day period after release, 29% of court-mandated patients were returned to the hospital for a rehearing, although only 12.5 % (1 in 8) were determined to be dangerous and in need of involuntary hospital confinement.⁴² The authors concluded that this was a reasonable index of short-term success. This study, however, had no comparison

³⁹ Swartz, Burns, George, et al., 1997.

⁴⁰ Hiday, 1988; Maloy, 1992.

⁴¹ Because this study did not use a pre/post sample comparison or separate comparison group, it did not meet the criteria we set for inclusion in the evidence-based review; however, we nevertheless mention this study because of its significance as the first of its generation.

⁴² Hiday and Goodman, 1982.

group, so the rate of rehospitalization without a court order is unknown. Also, patients who were selected for the community-based court order were selected because they were employed or had family support or other factors that made it more likely that they would be successful. Thus, the study could not determine whether the readmission rate under outpatient commitment was different from the rate without outpatient commitment, and patients selected for the order were those who already had the greatest likelihood of success, so it is unclear if success had anything to do with outpatient commitment.

In 1979, the commitment statutes were revised in North Carolina, effectuating two significant changes: (a) the designated community provider was required to agree with the proposed treatment plan, and (b) committed patients (who still met the restrictive inpatient commitment criteria) could be automatically rehospitalized if they failed to comply with the treatment plan. To examine the impact of these changes, Miller and Fiddleman conducted a retrospective analysis of 67 cases that had come through one hospital in the six months before and after the modified law and asked community mental health providers for their opinions about the impact of the statutory changes.⁴³ In the six months before the law, nine of the patients had been readmitted to the hospital, whereas, after the new law, nine patients had been readmitted, six of which were readmitted as a direct result of the court order. Community mental health providers reported that, after the changes, they were more likely than before to take some action if the patient failed to comply with treatment (49.2% before and 64.3% after), and that the court notified them more frequently when they committed patients to their care (62.1% before and 77.8% after). The design of this study does not permit any clear conclusions about the effectiveness of outpatient commitment *per se*, but it does offer some perspective on the impact of statutory changes on the operation of outpatient commitment, at least according to provider self-report.

In 1984, further revisions were made to the commitment statute in North Carolina. At that time the outpatient commitment criteria were revised to the less-restrictive preventive commitment criteria. Three studies examined the effectiveness of outpatient commitment in North Carolina under this new statutory scheme. The first was a study of 740 patients who had been involuntarily hospitalized and, after a judicial hearing, were either released, committed to inpatient treatment, or committed to outpatient treatment. After a six month follow-up period, the three groups were compared on a range of outcomes including living situation, rehospitalizations, number of hospital days, social contacts, employment, dangerousness, and arrest. Patients released under outpatient commitment *and who actually began treatment* did not fare significantly better on these outcome measures than people in the other two groups; however, they did have much lower rates of medication refusal and of treatment noncompliance and tended to stay longer in treatment, even after the outpatient commitment order had expired.⁴⁴ Similar results were found when the investigators looked at a more limited sample – those who were “chronically mentally ill” and had a history of prior hospitalizations, medication

⁴³ Miller and Fiddleman, 1984.

⁴⁴ Hiday and Scheid-Cook, 1987.

refusal, and dangerousness. Those on outpatient commitment (and who began treatment) showed no differences in hospital use, arrest, or other system outcomes, but did show higher rates of participation in community treatment (76% for outpatient commitment versus 46% for inpatient commitment and 24% for those released) and greater retention in treatment at six months (84% for outpatient commitment compared to 46% and 42% respectively), although the differences were not statistically significant.⁴⁵ In both studies, however, there was no *pre-test* outcome measurement. Further, the studies were limited by selection bias, the effect of which was compounded by the fact that the comparison group was not matched or really equivalent. That is, people who met criteria for outpatient commitment and were selected to receive it by definition probably differed in important ways from people who did not.

Finally, a retrospective medical records study of 4,179 patients examined patterns of hospital use for the three-year period after North Carolina's adoption of the prevention-oriented standard. The researchers in this study found that the average number of involuntary hospitalizations per patient declined 82% (from 3.66 before the initial outpatient commitment to 0.7 after outpatient commitment). The average standardized total length of stay also declined by 33%, dropping from 53.4 days to 23.8 days.⁴⁶ This study, however, included no comparison controls (to differentiate effects from secular trends), and was subject to the same limitations because of selection bias as the prior study.

Minnesota: Although Minnesota does not have a formal outpatient commitment statute, Greeman and McClellan examined the effects of mandatory treatment in the community for patients who were functionally under a type of outpatient commitment when their involuntary hospitalization was stayed.⁴⁷ They compared the adjustment of "stayed" patients to that of patients released after 72-hour emergency admissions and patients involuntarily hospitalized. As indices of outcome and community adjustment, they focused on patients' compliance with medication and scheduled appointments and absence of disruptive symptoms. At follow-up they found few patients in any of the groups doing very well; however, more of the patients in court-ordered community treatment showed positive adjustment compared to patients in the other two groups (24% versus 14% and 4% respectively). As with the studies by Hiday and Scheid-Cook in North Carolina, the validity of the study was limited by selection bias and nonequivalent comparison groups.

Massachusetts: Massachusetts also does not have a specific statute or separate criteria for involuntary outpatient commitment; however, its guardianship law permits a finding of "decisional incapacity" that is specific to mental health treatment. Using a "substituted judgment" standard, the court may order an individual to comply with a community-based treatment plan. In this study, Geller and his colleagues refer to this as involuntary outpatient

⁴⁵ Hiday and Scheid-Cook, 1989; 1991.

⁴⁶ Fernandez and Nygard, 1990.

⁴⁷ Greeman and McClellan, 1985.

treatment (IOT). Nineteen patients under IOT were matched with a comparison group on demographic and clinical factors, and on prior hospital days and admissions. Results suggest that patients on IOT showed significantly greater reductions in the number of admissions (1.05 versus 105) and in the number of hospital days (a decrease of 68.4 versus 3.7) than the matched control subjects during the six-month follow-up period. While this study did attempt to account for potentially important between-group differences, it was based on a very small sample (19 patients).⁴⁸

New Hampshire: New Hampshire does not have a specific outpatient commitment statute; however, because conditional discharge has been proposed as one way in which mandatory outpatient treatment may be used, a research team there studied the outcomes of 26 patients discharged from the hospital under the condition that they receive community-based treatment.⁴⁹ All subjects included in the study had severe mental illness and had been in outpatient treatment for one year before their hospital commitment. Analyses examined clinical and social adjustment variables such as hospital days, medication compliance, substance abuse, violence, employment, and housing stability in the year prior to the patients' conditional release and compared them to the two-year period after their conditional release. They found that

Conditional discharges were associated with statistically significant improvements in both the first and second year after discharge for medication compliance, substance abuse, and violence. Furthermore, there was significant improvement in the first year, but not the second, for days in the hospital, number of moves per year, and months of employment.⁵⁰

In addition to the usual limitations of a retrospective design, this study also had an extremely small sample and lacked any comparison group.

District of Columbia: Zanni and deVeau attempted to minimize the effects of selection bias that had plagued prior studies by using a single group of patients and comparing their patterns of hospital use in the year before they were placed on outpatient commitment (they previously had been on voluntary inpatient status) to their use in the year after they were placed on outpatient commitment. In this sample of 42 patients, there were significantly fewer hospitalizations per patient after outpatient commitment (.95 versus 1.81), and a tendency (although not statistically significant) toward shorter stays (38 versus 55 days).⁵¹ The most serious limitations in this study were the extremely small sample size and the lack of a comparison group.

⁴⁸ Geller, Grudzinskas, McDermeit, et al., 1998.

⁴⁹ O'Keefe, Potenza, and Mueser, 1997.

⁵⁰ O'Keefe, Potenza, and Mueser, 1997, p. 410.

⁵¹ Zanni and deVeau, 1986.

Arizona: Van Putten and colleagues conducted a retrospective medical records review of 384 patients who had been committed to a county hospital in Tucson.⁵² They compared three groups: (1) patients committed to inpatient treatment in the six months before the outpatient commitment law was enacted, (2) those committed in the first six months under the new outpatient commitment law, and (3) those committed in the second six months of the new law. Their results indicated that the average length of stay in the hospital was significantly shorter after the statutory change (21 days before the law, compared to 11 in the first six months and 8 days for the second 6 months under the outpatient commitment law). They also reported that, while under an active outpatient commitment order, none of the patients caused serious harm or was subjected to serious victimization. Additionally, 71% of patients who had been placed under an outpatient commitment order voluntarily used community mental health services after their court orders expired. This follow-up rate reflected a substantial increase. Although positive outcomes were reported, there was no comparison group, patients were all from a single hospital, and the actual sample of people under the outpatient commitment was fairly small.

Ohio: A small study of involuntary outpatient treatment in Ohio was conducted on a sample of 20 patients with severe mental illness and a history of noncompliance and recurrent hospitalizations but who also had good treatment response.⁵³ The criteria for assignment to outpatient commitment were identical to those for inpatient commitment, but forced medication and automatic rehospitalization were not permitted. Changes were examined in the patients' patterns of service use in the year prior to and following assignment to outpatient commitment. Significant reductions were found in visits to the psychiatric emergency service, hospital admissions, and lengths of stay. Despite the significant methodological limitations of a retrospective study design, small sample size, and lack of a control group, the authors suggested that involuntary civil commitment to a community setting could be effective for improving treatment compliance and diminishing hospital usage, particularly for revolving-door patients with psychotic disorders and a history of positive response to treatment.

Iowa: Rohland conducted a five-year retrospective study of Iowa's outpatient commitment statute in which 57 patients were committed to outpatient treatment.⁵⁴ Thirty-nine of these patients met criteria for inclusion in the study – specifically, that they were at least 18 years of age and had a diagnosis of schizophrenia or other psychotic illness. Many subjects had a history of treatment noncompliance, substance abuse, and difficulties in responding to clinical treatment. These subjects were compared to a group that had an inpatient admission at some point in the study period. Positive results included improved treatment compliance in approximately 80% of patients, and reductions in hospital and emergency room use. As with other studies, selection bias poses a significant threat to inferring that outpatient commitment caused the observed

⁵² Van Putten, Santiago, Berren, et al., 1988.

⁵³ Munetz, Grande, Kleist, et al., 1996.

⁵⁴ Rohland, 1998.

changes. Additionally, the small sample size and poorly matched comparison group are significant limitations.

Tennessee: A study of Tennessee's mandatory outpatient treatment (MOT) law is the only first generation study to report no positive outcomes associated with assignment to outpatient commitment. Bursten conducted a retrospective medical records review of all 78 people discharged with an MOT order from four state hospitals in the first 14 months after the law was enacted.⁵⁵ The only outcome examined was hospital admission rates before and after time on MOT. He compared the rates of decline in admissions for MOT subjects to those of a matched group of patients from a fifth state hospital that did not use MOT, and to a matched group of patients from the same hospital. Bursten found the decline in readmission rate of MOT patients to be no different from a decline in the readmission rate among the comparison groups. Bursten concluded that mandatory outpatient treatment was ineffective in reducing readmissions among revolving door patients; however, he acknowledges that readmission rates may not be the best index of the effectiveness of MOT. Furthermore, the comparison groups were somewhat problematic and invite a host of competing explanations for the difference (or lack of difference) between groups. Similarly, because there was strong evidence that the outpatient law was not being enforced, his conclusions must be considered with caution.

In summary, most of the first generation studies of mandatory outpatient mental health treatment point to limited positive outcomes under outpatient commitment. *However, these studies were plagued by significant methodological limitations such as small sample sizes (limiting generalizability), lack of or poorly matched comparison groups (making it difficult to differentiate effects from secular trends), and retrospective study designs (allowing for competing explanations for any differences found between the experimental and comparison groups).* These flaws are important to note because they limit the confidence we can place in the findings from the first generation of research. In addition, this body of research does not specify for whom, how, and under what circumstances court-ordered outpatient mental health treatment works.

Second Generation Studies on the Effectiveness of Outpatient Commitment

Building on the foundation of these earlier efforts, two more recent studies have considerably advanced our collective understanding about the effectiveness of outpatient commitment by attempting to address the methodological limitations of the first generation studies. Table C.2 in Appendix C summarizes these studies.

The first is the Duke Mental Health Study, a randomized controlled trial of outpatient commitment among 331 people with severe mental illness in North Carolina.⁵⁶ All

⁵⁵ Bursten, 1986.

⁵⁶ Swanson, Borum, Swartz, et al. (under review); Swanson, Swartz, Borum, et al., 2000; Swartz, Hiday, Swanson, et al., 1999; Swartz, Swanson, Hiday, et al. (under review); Swartz, Swanson, Wagner, et al., 1999.

potential participants in the Duke Study⁵⁷ had already been hospitalized and were awaiting a trial of outpatient commitment. By agreeing to participate in the study, they had a 50-50 chance of being released from the outpatient commitment court order. Patients were randomly assigned to one of two conditions – that they would continue on the outpatient commitment order or that their order would be dismissed.⁵⁸ One of the clear advantages of the Duke Study was the random assignment to conditions because randomization helps insure against the problems with selection bias noted in the first generation studies.

Patients in both groups were, at a minimum, assigned a case manager and received outpatient treatment at one of four participating area mental health programs.⁵⁹ Outcomes were assessed by means of follow-up interviews with patients, families, and case managers every 4 months for a period of 16 months. Service records, hospital admissions and arrest data were obtained for a period of two years. The key outcomes studied in this project were hospital use, violent behavior, and arrest.

When the patterns of hospital use were initially compared for persons with any outpatient commitment and those with no exposure to outpatient commitment, at a simple bivariate level, there were no significant differences between those on outpatient commitment orders and the control group. Further analysis, however, revealed that patients who had an extended period of outpatient commitment (180+ days) and received relatively intensive outpatient treatment had 57% fewer readmissions to the hospital and 20 fewer hospital days than the control group. The effect of sustained outpatient commitment was particularly strong for people with schizophrenia and other psychotic disorders (as compared to those with mood disorders). When these patients were on outpatient commitment for an extended period, they had 72% fewer readmissions to the hospital and 28 fewer hospital days than the non-outpatient commitment group.⁶⁰ These reductions, however, were not related exclusively to the outpatient commitment order itself. *Extended outpatient commitment reduced hospital readmissions only when combined with a higher intensity of outpatient services (i.e. above a median of 3+ service events a month, and averaging approximately 7 services per month).* These findings show that outpatient commitment can work to reduce hospital readmissions and total hospital days when the court order is sustained and combined with intensive outpatient services. The investigators concluded that outpatient commitment may help prevent rehospitalization,

⁵⁷ Eligible subjects included patients with schizophrenia, schizo-affective disorder, other psychotic disorders, and major mood disorders (e.g., bipolar disorder). Approximately two-thirds of the study population were diagnosed with schizophrenia or other psychotic disorders and about half suffered from co-occurring substance abuse disorder.

⁵⁸ An exception to the randomization procedure was necessary for ethical reasons in the case of subjects with a recent history of serious assault involving weapon use or physical injury to another person within the preceding year.

⁵⁹ Beyond assignment of a case manager, the Duke study protocol did not dictate that any specific type, amount, or duration of outpatient treatment would be provided; however, patients on outpatient commitment were subject to the court-order treatment plan.

⁶⁰ Swartz, Swanson, Wagner, et al., 1999.

but that the court order is a supplement to, not a substitute for, intensive treatment. When the Duke investigators examined the possible effect of outpatient commitment in reducing violent behavior, they found a similar effect. The rate of violence during the year of follow-up was significantly lower among patients who received extended outpatient commitment than for those with briefer periods or no outpatient commitment (23% versus 39%). *Again, outpatient commitment was found only to have an effect when combined with a higher intensity of outpatient services – defined as three or more visits per month (48% versus 24%).* Outpatient commitment did not reduce violence risk in respondents with fewer than three service events per month. At least part of the positive effect appears to have resulted from reduced substance abuse and increased medication adherence. The patients with the lowest risk during the year were those who had extended outpatient commitment and frequent outpatient services and who concurrently took their psychiatric medications as prescribed and did not use alcohol or drugs (13%). In contrast, those who did not have extended outpatient commitment with regular services, and who were noncompliant with prescribed medication and persisted in their substance abuse, had the highest rate of violence within the year (52%). Those receiving outpatient commitment were also significantly less likely to report being a victim of crime during the follow-up year (25% versus 38%).

Finally, the Duke Study examined the effect of outpatient commitment on arrest rates among people with severe mental illness. As with patterns of hospital use, when arrest rates for outpatient commitment and the control group were initially compared, there were no significant differences – approximately 19% of individuals in both groups had at least one arrest during the follow-up year. However, it was anticipated that outpatient commitment might not reduce the risk of arrest for all people with severe mental illness, but more specifically for the subgroup whose reasons for criminal justice contact were more strongly related to their illness. Thus, further analysis examined the subgroup of individuals who had a prior history of *both* hospital recidivism and criminal behavior (i.e., two or more admissions plus violence/arrest/police encounters) in the prior year. For this subgroup, more days on outpatient commitment was significantly associated with less risk of arrest: there was only a 12% predicted risk of being arrested among those who had extended outpatient commitment, compared to 44% for those with briefer outpatient commitment orders and 47% for those with no outpatient commitment. The data further suggest that the lessened risk of arrest was affected, in part, by reducing the risk of violence.

There were, of course, a number of limitations in the Duke Mental Health Study as well. First, while participants were randomly assigned to a condition (outpatient commitment versus no outpatient commitment), the *length of time* on outpatient commitment could not be randomly assigned. That is, some participants assigned to outpatient commitment improved over the course of the study to the extent that they no longer met legal criteria for commitment. It would not be ethically or legally permissible to apply a legal mandate to people who do not meet legal criteria. Indeed, study participants at highest risk for relapse were more likely to get their outpatient commitment orders renewed and thus to have a longer period of commitment. On balance, however, any bias of this type would

probably operate to *diminish* the likelihood of finding an effect for outpatient commitment. Second, to increase treatment fidelity for research purposes, the Duke study implemented an outpatient commitment “adherence protocol” to insure that the enforcement provisions in the law were used when applicable. However, regular use of enforcement provisions may not be systematically implemented in actual community practice. Finally, the sample in the Duke study was limited to patients discharged from hospitals and therefore the findings may not be generalizable to patients treated in other settings.

In summary, the results of the randomized controlled trial of outpatient commitment in North Carolina were as follows:

- There was no simple bivariate difference in the patterns of hospital use between persons with any outpatient commitment and those with no exposure to outpatient commitment, although in multivariate analyses, outpatient commitment did reduce the probability of readmission.
- Intensive treatment (3+ service encounters per month), when combined with sustained outpatient commitment (180+ days), significantly reduced hospital admissions.
- Intensive treatment, when combined with sustained outpatient commitment, was especially effective in reducing admissions and shortening lengths of stay for people with schizophrenia and other psychotic disorders.
- Intensive treatment, when combined with sustained outpatient commitment (180+ days), significantly reduced violent behavior.
- People under outpatient commitment orders were less likely to report being a victim of crime.

The second major randomized clinical trial of outpatient commitment occurred in New York City as a result of a legislatively mandated outpatient commitment pilot program at Bellevue Hospital Center.⁶¹ The team of evaluators compared a group of patients who had been court-ordered to treatment under the “assisted outpatient treatment” (AOT) provision (78 patients) to a comparison group of patients who were not under court orders (64 patients).⁶² Patients were recruited for the study while they were in the hospital and followed for one year after discharge. One important feature of this study was that *both* groups received a package of enhanced services including intensive community treatment and priority eligibility for supportive housing. *The findings from the New York study differ from those in the North Carolina study in that the New York investigators found no*

⁶¹ In New York, outpatient commitment is referred to as Assisted Outpatient Treatment (AOT).

⁶² Steadman 1998; Steadman, Gounis, Dennis, et al. (in press); Telson, Glickstein, and Trujillo, 1999.

*statistically significant differences between the AOT and non-AOT groups with regard to rates of rehospitalization, arrests, quality of life, psychiatric symptoms, homelessness, or other outcomes.*⁶³

Both groups received specialized, intensive services that are not generally available to people with severe mental illness in New York, and it has been argued that the increase in services may have muted the effect of the court order. Critics of outpatient commitment have argued that outpatient commitment and other mandated treatment would not be necessary in a system where services (such as assertive community treatment and supported housing) were plentiful and designed to meet the preferences and needs of mental health consumer/survivors. Unfortunately, this is not the case in mental health service systems in most communities in the United States. But because such services were made available under this pilot program, the Bellevue study may not have been the optimal circumstance in which to test the effectiveness of the court mandate *per se*. Furthermore, there were a number of limitations in the Bellevue study that may also have affected the findings. First, at least during the early phase of the study, providers were not making a clear distinction between those on AOT and those not on AOT – everyone on the study was simply seen as “part of the Bellevue Program.” Consequently, AOT court orders were not consistently enforced.⁶⁴ Second, although the study was designed with random assignment procedures, persons with co-occurring substance abuse were selected significantly more often for the court-ordered group (56% versus 39%). Since patients with substance abuse problems generally have worse outcomes than those without, this may have dampened the ability to detect an effect of AOT. Third, the Bellevue study had a relatively small number of subjects, which may have statistically diminished the ability to detect a difference between the groups. Finally, the study has been criticized as having weak measures of compliance. Taken together, these limitations make it difficult to draw definitive conclusions regarding any effect of the court order on outcomes.

In summary, the results of the second generation of research on outpatient commitment are consistent in supporting the need for intensive community-based services to prevent relapse, violent behavior, and criminal recidivism among people with severe mental illness. They are less consistent, however, in providing clear and convincing evidence concerning the importance of the court mandate *per se*. In the large-scale North Carolina study, a positive effect was found for having a sustained period of outpatient commitment (180+ days) in combination with intensive mental health services, particularly for people with schizophrenia and other psychotic disorders. For those with more modest tenure on outpatient commitment orders, however, the court mandate did not appear to have the same effect in reducing bad outcomes.

⁶³ Steadman, 1998; Steadman, et al. (in press).

⁶⁴ For example, law enforcement mechanisms for pick-up orders for noncompliance were not worked out until the end of the study.

In conclusion, the research on court-ordered mental health treatment suggests that the two most salient factors in reducing recidivism and problematic behavior among people with severe mental illness appear to be enhanced services and enhanced monitoring. In the Duke Study, among those ordered to participate in outpatient treatment, outcomes were only improved for those who also received intensive mental health services. In the Bellevue Study, both the court-ordered and non-court-ordered groups received an enhanced package of services that included intensive community treatment and priority for supportive housing. Both groups improved to a similar extent. *While there may exist a subgroup of people with severe mental illness for whom a court order acts as leverage to enhance treatment compliance, the best studies suggest that the effectiveness of outpatient commitment is linked to the provision of intensive services. Whether court orders have any effect at all in the absence of intensive treatment is an unanswered question.* If the policy objective is to reduce episodes of relapse and dangerousness, there is no simple solution to be found in ordering patients to comply with treatment. Instead, resources need to be directed toward intensive services and monitoring for those individuals who are at highest risk.

IV. WHAT DOES THE EMPIRICAL LITERATURE TELL US ABOUT THE EFFECTIVENESS OF ALTERNATIVES?

As described in the Methods section, the analysis of literature on alternatives to involuntary treatment involved a search for evidence-based reviews on community-based treatment alternatives for people with severe mental illness. Because of time and resource constraints we were not able to conduct our own evidence-based review of the voluminous research literature on community-based alternatives. Our review, therefore, was restricted to peer-reviewed, published literature, and within that published literature, to evidence-based reviews rather than primary research articles.⁶⁵

Because our task was limited to a search for existing evidence-based reviews, we restricted our search to Medline and the Cochrane Library. To conduct our search we employed a combination of the terms “review” and “mental health services” with specific terms such as “housing,” “outreach,” “dual diagnosis,” “case management,” “assertive community treatment,” “vocational,” and “employment.” In addition, we searched using the term “review” in combination with “treatment” and with “schizophrenia,” “bipolar,” and “personality disorder.”

Where we were unable to locate a published evidence-based review on an important community-based alternative identified by the Senate Office of Research (e.g., supported housing), we contacted experts and asked if such a review existed. Where we were able to identify unpublished manuscripts that had either undergone peer review or were in the process of peer review, we included those manuscripts in our review.

The following findings are drawn from our analysis of 23 reviews of the empirical literature on interventions designed to improve treatment outcomes of people with severe mental illness. These interventions include community-based interventions such as assertive community treatment and case management, psychological and psychosocial interventions, other supportive interventions, community interventions for people with co-occurring disorders, and medical interventions such as inpatient care and psychopharmacology. In addition, we reviewed a forthcoming paper on coercion in the community, prepared under the auspices of the MacArthur Foundation Initiative on Mandated Community Treatment.⁶⁶ The findings from our review are presented in detail in Tables D.1 through D.5 in Appendix D. We begin here with a few definitions:

Assertive community treatment (ACT) is “a team-based approach aimed at keeping [mentally] ill people in contact with services, reducing hospital admissions and

⁶⁵ We acknowledge, with appreciation, the many individuals who provided materials (directly and through the Senate Office of Research) on a variety of treatment interventions, self-help programs, and other alternatives such as physical health screening and pet therapy. These materials, along with evaluations of the AB 34 pilot projects and the Los Angeles County Adult Targeted Case Management Services Program, were very informative; however, they did not meet the inclusion criteria for our study.

⁶⁶ Monahan, Bonnie, Appelbaum, et al., October 19, 2000.

improving outcomes, especially social functioning and quality of life.”⁶⁷ ACT typically employs a multidisciplinary, mobilized team that provides psychiatric treatment, care coordination, and assistance in meeting basic life needs.

Case management is “a means of coordinating care of severely mentally ill people in the community.”⁶⁸ Case managers typically provide assessments, develop care plans, arrange for services to be provided, monitor the care provided, and maintain contact with the person over time.

Psychological and psychosocial interventions include psychodynamic and supportive individual and group psychotherapies, psychosocial and life skills training programs, crisis intervention programs, family psychosocial and psychoeducational interventions, and patient psychoeducational interventions. These interventions include psychotherapies designed to treat symptomatology, educational and skill-building programs designed to improve functioning, crisis intervention designed to forestall relapse and rehospitalization, family programs designed to improve family coping and family/patient interaction, and patient educational programs designed to increase awareness and enhance a person’s control over their own recovery.

Other supportive interventions include programs that particularly target homeless people (including, for example, outreach and housing placement), housing associated with service supports, vocational rehabilitation programs, and supported employment programs. Each of these target practical needs rather than treatment needs. Housing and employment are issues of great importance in increasing the community tenure of people with severe mental illness.

Community interventions for co-occurring disorders are treatment programs within psychiatric settings for people with severe mental illness and co-occurring substance abuse disorders or severe mental illness and co-occurring personality disorders. These programs typically employ an integrated approach to treating dual disorders in the context of community-based models of care.

Medical interventions include inpatient care and psychopharmacology. While a full review inpatient and pharmacological interventions is outside the scope of this report, we identified one recent review on brief hospitalization and two on the relative efficacy of the newer, atypical antipsychotic medications.

Several findings are worth emphasizing. Evidence-based reviews of the literature provided strong evidence of the effectiveness of ACT (assertive community treatment) which is a multidisciplinary, community-based intervention that combines the delivery of clinical treatment with intensive case management. Reviewers concluded that ACT is “a clinically effective approach to managing the care of severely mentally ill people in the

⁶⁷ Marshall and Lockwood, 2000.

⁶⁸ Marshall, Grey, Lockwood et al., 2000.

community,”⁶⁹ although a review of cost-effectiveness studies suggested that high costs may be associated with these programs, unless they are carefully targeted to high utilizers.⁷⁰ The evidence-based reviews we analyzed did not produce similarly convincing evidence of the effectiveness of case management, which, ironically, has become the “cornerstone” of many public mental health systems. Reviewers for the Cochrane Collaboration concluded that case management does appear to increase contact with the mental health system (including increased hospitalization rates) but has not been shown to produce clinically significant improvements in mental health, social functioning, or quality of life.⁷¹ These reviewers concluded that case management was an intervention of “questionable value.”

There is somewhat weaker evidence of effectiveness for a number of psychological and psychosocial interventions such as supportive psychotherapy,⁷² skills training,⁷³ and home-based crisis intervention.⁷⁴ There is conflicting evidence on family interventions. The Schizophrenia PORT⁷⁵ review reported substantial evidence that family psychoeducational interventions reduce the rate of relapse (without conclusive evidence of effects on other important outcomes). However, a more recent review concluded that family intervention has only a “moderate effect” when added to standard treatment.⁷⁶ The Cochrane Collaboration review also reported some positive effects, but concluded that the data are “few and equivocal.”⁷⁷ Evidence suggests that there may be some effect of patient psychoeducation on patients’ well-being but not on other outcomes such as insight or attitudes toward medication.⁷⁸

Supportive programs (such as programs targeted to homeless people, housing programs, vocational rehabilitation programs, and supported employment programs) have been studied, but all of the reviews included quasi-experimental as well as randomized controlled trials so the evidence, in general, is somewhat weaker. The review of homelessness programs concluded that there is evidence that programs specifically

⁶⁹ Marshall and Lockwood, 2000; Scott and Dixon, 1995a.

⁷⁰ Latimer, 1999.

⁷¹ Marshall, Gray, Lockwood, et al., 2000.

⁷² Scott and Dixon, 1995b.

⁷³ See Scott and Dixon, 1995b; however, contrast these findings with those in Nicol, Robertson and Connaughton, 2000, who reported on RCTs only and found no clear effects for life skills programs.

⁷⁴ Joy, Adams and Rice, 2000.

⁷⁵ In 1992 the Agency for Health Care Research and Quality (AHRQ) and the National Institute of Mental Health (NIMH) funded The Schizophrenia Patient Outcomes Research Team (PORT) to develop and disseminate recommendations for the treatment of schizophrenia based on existing scientific evidence. One of the first tasks undertaken by the PORT was an exhaustive review of the treatment outcomes literature. Reviews of that literature were published in *Schizophrenia Bulletin*, 21(4), 1995.

⁷⁶ Barbato and D’Avanzo, 2000.

⁷⁷ Contrast the findings in Dixon and Lehman, 1995 with those in the Cochrane review in Pharoah, Mari and Streiner, 2000.

⁷⁸ Pekkala and Merinder, 2000.

targeted to homeless individuals are “modestly more effective” than standard care but may also be more expensive.⁷⁹ The findings from the only two quality studies to report on the therapeutic benefits of housing (i.e., whether housing has a therapeutic benefit that operates independent of the services provided) were mixed – suggesting that additional research is needed to understand the relationship between housing and mental health outcomes.⁸⁰ The review of vocational rehabilitation by the Schizophrenia PORT provided no definitive conclusions on the effectiveness of vocational interventions (in regard to competitive employment) but did suggest that these programs enhance the vocational activity of people with severe mental illness.⁸¹ A more recent study on supported employment suggested that supported employment is a “promising” although unproven approach.⁸²

Evidence on the effectiveness of integrated community treatment programs for people with co-occurring severe mental illness and substance abuse problems is a topic of some controversy in the field. The Cochrane Collaboration review found “no clear evidence” supporting the advantage of dual diagnosis community treatment over standard care, and no evidence to suggest the superiority of a particular approach to dual diagnosis treatment.⁸³ On the other hand, another team of investigators, while acknowledging the significant limitations of the research, argued that the “weight of the evidence” is in favor of integrated treatment.⁸⁴ A review of community-based teams for another dually-diagnosed population (people with severe mental illness and personality disorders) suggested that these teams are not inferior to standard treatment and are “superior in promoting greater acceptance of treatment.”⁸⁵

Finally, we reviewed one evidence-based review on hospitalization (a comparison of outcomes of short and long-term stays)⁸⁶ and two reviews on the use of atypical antipsychotic medications⁸⁷ – the new armamentarium in medical treatment of severe mental illness. The Cochrane review on short-term hospitalization concluded that short stays are not encouraging the “revolving door” of hospitalization but that questions remain about the relative effect of short-term hospitalization on important outcomes. In regard to medication, the reviews suggested there is some evidence that the newer, atypical antipsychotic medications “offer significant advantages” over older antipsychotic

⁷⁹ Rosenheck, 2000.

⁸⁰ Newman, 2000.

⁸¹ Lehman, 1995.

⁸² Bond, Drake, Mueser et al., 1997.

⁸³ Ley, Jeffrey, McLaren, et al., 2000.

⁸⁴ Drake, Mercer-McFadden, Mueser, et al., 1998. It should be noted that the Drake et al. review included quasi-experimental as well as experimental studies, while the Cochrane Review analyzed only randomized clinical trials.

⁸⁵ Tyrer, Simmonds, Joseph, et al., 2000.

⁸⁶ Johnstone and Zolse, 2000.

⁸⁷ Lindenmayer, 2000; Tuunainen, Wahlbeck and Gilbody, 2000.

medications, but the reviewers concluded that further research is needed to demonstrate the superiority of the newer medications over clozapine.⁸⁸

In addition to these evidence-based reviews, a recent report sponsored by the MacArthur Foundation Initiative on Mandated Community Treatment summarizes the evidence on the use of coercion to achieve compliance with mental health treatment in the community.⁸⁹ Examples reviewed in the report include the use of money as “leverage” (e.g., representative payee), the use of access to housing as leverage, the avoidance of jail as leverage (e.g., mental health courts), the avoidance of hospitalization as leverage (e.g., outpatient commitment), and the use of advance directives.⁹⁰ Based on their review of the research, Monahan and his colleagues concluded,

Little hard evidence exists on the pervasiveness of the different forms of mandated treatment for people with mental disorders, how the leverage is imposed, or what the effects of using leverage actually are for different types of patients or different kinds of mental health systems. The many vexing legal, ethical, and political questions surrounding mandated treatment have not yet been thoroughly addressed. Yet there are a number of indications that mandated treatment is expanding at a rapid pace, not just in the United States, but throughout the world. If mental health law and policy are to incorporate – or to repudiate – some or all of these types of leverage, an evidence-based approach must rapidly come to replace the ideological posturing that currently characterizes the field.⁹¹

In summary, there is clear evidence that some community-based mental health interventions, when implemented in compliance with the treatment model, can produce good outcomes for people with severe mental illness. Some of the lesser-studied interventions are also regarded by researchers as “promising.” More research is needed – as is a more evidence-based approach to decisions about which interventions should be supported in public mental health systems.

⁸⁸ Reviewing the evidence on each of the atypical antipsychotics was beyond the scope of this inquiry; however, the reader is referred to the Cochrane Library for reviews on a number of the atypical antipsychotics (as compared to either clozapine and to typical antipsychotics).

⁸⁹ Monahan, Bonnie, Appelbaum, et al., October 19, 2000.

⁹⁰ An instructional or proxy directive that tells treatment providers what to do regarding treatment in the event that the individual becomes incapacitated. See Monahan, Bonnie, Appelbaum, et al., October 19, 2000.

⁹¹ Monahan, Bonnie, Appelbaum, et al., October 19, 2000, p. 35-36.

V. HOW HAVE OTHER STATES IMPLEMENTED INVOLUNTARY OUTPATIENT TREATMENT?

As mentioned in the Methods Section, we reviewed the civil commitment laws of eight states. They included states that had revised their commitment laws (e.g., to add outpatient commitment programs, to expand grave disability criteria), had outpatient commitment programs on which research had been conducted (e.g., North Carolina, New York) or were comparable to California (e.g., large states with diverse populations, states with large service systems, states that used funding mechanisms that assign financial responsibility for care to local boards or county government). The statutory reviews of these states revealed several common themes:

- **Each of the states (most by statute, one by judicial interpretation) have a “grave disability” provision. This reflects the growing popularity of such provisions nationally.**
- **Most states have provisions permitting outpatient treatment as part of the commitment process. While the processes and substantive criteria used by the states vary, the traditional model of civil commitment as a vehicle primarily for inpatient treatment has eroded.**
- **Many of these states have different standards for outpatient and inpatient commitment. While the procedural standards tend to be the same (except in North Carolina, where counsel is not required in outpatient commitment proceedings) the length of commitment as well as the substantive standards may vary between inpatient and outpatient commitment.**
- **Some states permit outpatient treatment as part of commitment only on a showing that resources are available to provide treatment.**
- **Many of these states explicitly permit the use of the person’s prior treatment or behavioral history in determining whether a person meets commitment standards. This represents a shift from laws that for the last two decades have tended to focus on behavior contemporaneous with the period in which the commitment hearing is held.**
- **In general, medication compliance is handled separately from the civil commitment hearing (Wisconsin is an exception), and states do not use extended hospitalization as a consequence for non-adherence to treatment.**

In addition to our case law analysis, interviews with prosecuting and defense attorneys suggest that outpatient commitment is used most frequently at the point at which an individual is going to be discharged from the hospital. It appears to be a vehicle designed to further community control and monitoring of individuals considered to require such monitoring in order to make their community tenure more viable.

The following are summaries of the statutes of the eight states. The summaries follow a standard format. Each begins with three or four key points from the state law highlighted. A fairly detailed account of the statute then follows. Certain issues are emphasized. These include definitions (particularly of “mental illness” and “danger”), the process by which commitment occurs, and differences, if any, between inpatient and outpatient commitment. The manner in which the state addresses noncompliance with community treatment is also addressed, as is the manner in which the state handles forced medication issues. Points made during the attorney interviews are summarized at various points throughout the statutory summary; other interviews are summarized in the next section of this report.

Michigan

The Michigan civil commitment statute:

- 1. Has three dispositional options, including one for combined hospitalization and alternative treatment;**
- 2. Contains a grave disability provision, as well as a provision permitting treatment of an individual with impaired judgment who as a result may be at risk for physical harm; and**
- 3. Provides for different lengths of commitment for inpatient treatment and alternative treatment.**

The statute defines “mental illness” as “a substantial disorder of thought or mood that significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life” (§ 330.1400(g)).⁹² “Involuntary mental health treatment” means court-ordered hospitalization, alternative treatment, or combined hospitalization and alternative treatment” (§ 330.1400(f)).

Definitions of risk are contained within the definition of a “person requiring treatment,” defined as either:

1. an individual who has mental illness, and who as a result of that mental illness can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure himself or herself or another individual, and who has engaged in an act or acts or made significant threats that are substantially supportive of the expectation;

⁹² The citations to Michigan law are taken from the Michigan Consolidated Laws Annotated (West 1999).

2. an individual who has mental illness, and who as a result of that mental illness is unable to attend to those of his or her basic physical needs such as food, clothing, or shelter that must be attended to in order for the individual to avoid serious harm in the near future, and who has demonstrated that inability by failing to attend to those basic physical needs;
3. an individual who has mental illness, whose judgment is so impaired that he or she is unable to understand his or her need for treatment and whose continued behavior as the result of this mental illness can reasonably be expected, on the basis of competent clinical opinion, to result in significant physical harm to himself or herself or others. This individual shall receive involuntary mental health treatment initially only under the provisions of sections 434 through 438 of this act (which deal with short-term hospitalization) (§ 330.1401).

Initial detention may occur through one of three routes. First, a physician or psychologist can certify that an individual is a person requiring treatment (§ 330.1423-1425). Second, a peace officer may detain a person based on his or her observation that the person requires treatment (§ 330.1427). Finally, a court can order an initial examination based on the application of an individual (§ 330.1428). The hospital or admission unit receiving the person under one of these provisions may detain the person for evaluation for no more than 24 hours (§ 330.1429). Notice is provided to the court, the patient, a guardian if applicable, and the patient's attorney (§ 330.1431).

The court must schedule a hearing within seven business days of the receipt of an application for hospitalization (§ 330.1452). The court is to order a report from the community mental health service program assessing the current availability and appropriateness of alternatives to hospitalization, including alternatives after an initial period of hospitalization (§ 330.1453a).

In reaching a decision, the court must have available in court or by deposition the testimony of at least one physician or psychologist who personally examined the individual (§ 330.1461). The court also provides law enforcement with any order for involuntary treatment so that the order is entered into the law enforcement information network (§ 330.1464a).

In disposing of the case, the court, if it does not dismiss the petition, has three alternatives. It may order hospitalization; it may order treatment that is an alternative to hospitalization; or it may order a program of combined hospitalization and alternative treatment (§ 330.1468). Before ordering treatment, the court is to review the report on alternatives to hospitalization noted above. After review of the report, the court must determine whether alternative treatment is adequate to meet the individual's treatment needs while preventing harm to self or others. The court also must determine whether an agency or mental health professional is available to supervise the person's alternative treatment program, and also inquire as to the individual's desire regarding alternatives to

hospitalization. The court order is to state the arrangements that have been made to provide alternative care, as well as the name of the agency or mental health professional responsible for supervising the person's treatment. The order may also direct that if an individual refuses to comply with a psychiatrist's order to return to the hospital, a peace officer may take the person into protective custody for transport to the hospital (§ 330.1469a).

The length of commitment under the order varies with the type of disposition. An initial order of hospitalization is not to exceed 60 days, while an initial order for alternative treatment is not to exceed 90 days. An order for combined hospitalization and alternative treatment is not to exceed 90 days, with no more than 60 days of hospitalization permitted (§ 330.1472a). A second order of hospitalization cannot exceed 90 days, with second orders for alternative treatment not to exceed one year. Combined treatment may be ordered for a year, with hospital care not to exceed 90 days within the year. Subsequent orders for each type of treatment may not exceed 1 year, with hospital care in the combined order not to exceed 90 days. At hearings for additional treatment beyond the initial order, the person must be found to be a "person requiring treatment," the standard for the initial hearing.⁹³

The statute also provides that a person who is on an order for combined hospitalization and alternative treatment can be returned to hospital care from community care for the maximum amount of hospitalization permitted under the order without hearing and as deemed clinically appropriate (§ 330.1474a). This provision has survived a challenge that it violated due process requirements.⁹⁴ However, a person hospitalized without hearing after placement in an alternative treatment program may, upon objection, obtain a court hearing.

New York

New York's civil commitment law:

- 1. Provides for up to sixty days of involuntary inpatient confinement based on the certificates of two physicians;**
- 2. Contains one of the most detailed outpatient commitment laws in the United States, with detailed eligibility criteria; and**
- 3. Is supported by significant appropriations for intensive community-based services.**

⁹³ *Book v. Hooker*, 268 N.W.2d 698 (App. Mich. 1978).

⁹⁴ *In re K.B.*, 562 N.W.2d 208 (App. Mich. 1997).

Involuntary inpatient care

New York defines “mental illness” as “an affliction with a mental disease or mental condition which is manifested by a disorder or disturbance in behavior, feeling, thinking, or judgment to such an extent that the person afflicted requires care, treatment and rehabilitation” (MHL § 1.03.20).⁹⁵

An individual may be admitted for emergency inpatient care, for up to 15 days, if the person is alleged to have a mental illness “for which immediate observation, care, and treatment in a hospital is appropriate and which is likely to result in serious harm to himself or others.” “Likelihood of serious harm” is defined as a “substantial risk of physical harm to himself as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that he is dangerous to himself” or “a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm.” (MHL § 9.39(a)). The person can be held beyond 15 days only after a court hearing.

However, if the person is to be confined beyond the 15 days permitted for emergency care and observation, or if the person is admitted involuntarily on medical certification for up to 60 days, the statutory standard is whether the person is “in need of involuntary care and treatment” (MHL § 9.27). This phrase is defined statutorily as meaning “that a person has a mental illness for which care and treatment as a patient in a hospital is essential to such person’s welfare and whose judgment is so impaired that he is unable to understand the need for such care and treatment” (MHL § 9.01). This phrase, in addition to a need for a finding of mental illness, requires two additional elements: first, that hospital care is “essential” to the person’s welfare, and second, that the person lacks capacity (“whose judgment is so impaired”) to understand the need for treatment.

This part of the statute was challenged on several grounds, including that too much time could elapse before judicial hearings were required and that the statute did not on its face require a finding of dangerousness as manifested by an overt act for involuntary confinement. The federal courts rejected these arguments, upholding the constitutionality of the statute.⁹⁶ The court of appeals upheld the statute in part because in its view, the New York courts had already interpreted the statute to require a finding of dangerousness.⁹⁷ The court of appeals also held that an overt act was not required to prove dangerousness.

While the New York inpatient statute does not have a provision for “grave disability,” New York appellate courts, considering whether sufficient evidence exists to confine an individual, appear to have interpreted “danger to self” broadly enough to include at least

⁹⁵ The citations to New York law are taken from the New York Mental Hygiene Law (MHL), (McKinney 1996). Where noted as MHL Supp., the material is taken from the 2000 Supplement.

⁹⁶ *Project Release v. Prevost*, 722 F.2d 960, 2d Cir. 1983.

⁹⁷ *Scopes v. Shah*, 398 N.Y.S.2d 911, 3d Dept. 1977.

implicitly the notion that an individual unable to meet his or her basic needs for food, shelter, and medical care can be involuntarily hospitalized.⁹⁸

Involuntary outpatient treatment

New York originally adopted a pilot outpatient civil commitment statute in 1994, effective until 1998. That pilot was subject to an evaluation described in Section III of this report.

In 1999, New York adopted “Kendra’s Law,” a statute named after a woman who had been pushed to her death in a subway station by a person with a long history of mental illness. The statute permits what it calls “assisted outpatient treatment” or AOT (see generally MHL § 9.60). We provide a number of sections of this statute verbatim here because the statute’s detail is one of its distinguishing features.

Assisted outpatient treatment is defined as “categories of outpatient services which have been ordered by the court pursuant to this section. Such treatment shall include case management services or assertive community treatment services to provide care coordination, and may also include any of the following categories of services: medication; periodic blood tests or urinalysis to determine compliance with prescribed medications; individual or group therapy; day or partial day programming activities; educational and vocational training or activities; alcohol or substance abuse treatment and counseling and periodic tests for the presence of alcohol or substance abuse; supervision of living arrangements; and any other services within a local or unified services plan..., prescribed to treat the person’s mental illness and to assist the person in living and functioning in the community, or to attempt to prevent a relapse or deterioration that may reasonably be predicted to result in suicide or the need for hospitalization” (MHL Supp. § 9.60(a)(1)).

A person is eligible for this statute if the person is 18 years of age or older; he or she suffers from a mental illness; the person is unlikely to survive safely in the community without supervision; the person has a history of lack of compliance for mental illness that has, at least twice in the last 36 months, been a significant factor in requiring hospitalization or services in a forensic or correctional unit or resulted in acts, threats, or attempts at serious physical harm to self or others within the last 48 months; the person because of mental illness is unlikely to participate voluntarily in recommended treatment; and in view of the person’s past treatment history and behavior the person needs assisted outpatient treatment to prevent a relapse or deterioration which would likely to result in serious harm to the person or others; and it is likely that the person will benefit from assisted outpatient treatment (MHL Supp. § 9.60 (c)(1)-(7)).

⁹⁸ See, for example, *Donaldson v. Daley*, 614 N.Y.S.2d 525, 1st Dept. 1994; *Seltzer v. Hogue*, 594 N.Y.S.2d 781, 2d Dept. 1993; *Boggs v. New York City Health and Hospitals Corp.*, 523 N.Y.S.2d 71, 1st Dept. 1987.

The definition of likelihood of harm is defined as noted above in the discussion of emergency confinement. In other words, the statutory threshold for being ordered into assisted outpatient treatment is a definition of harm that rests on “physical harm to self or others,” not grave disability. However, the statute broadens the inquiry into such behavior to the last 48 months, includes a focus on the person’s treatment history within the last 36 months, and posits treatment as necessary to “prevent a relapse or deterioration” that would likely result in harm. These features are not present in the inpatient commitment law.

A petition for treatment may be filed by a variety of parties, including family, a person residing with the individual subject to the petition, a qualified psychiatrist, a director of community services, a parole or probation officer, or the director of an institution in which the person resides (MHL Supp. § 9.60(e)). The petition has to be accompanied by the affidavit of a physician who has examined or attempted to examine the individual within 10 days of the filing of the petition (MHL Supp. § 9.60(e)(3)).

A judicial hearing must be scheduled within three business days of receipt of the petition. The person has a right to counsel (this is in contrast for example to the North Carolina law, where provision of counsel is discretionary, based on the individual’s request), as well as a right to examine witnesses against him.

The court can order assisted outpatient treatment only if the examining physician testifies in person at the hearing (MHL Supp. § 9.60(h)(2)). The court can also order assisted outpatient treatment only if a proposed written treatment plan is presented to the court. The plan must include case management or assertive community treatment to provide care coordination. The plan also must contain each of the categories of services noted above in the definition of assisted outpatient treatment that the physician recommends the person receive. In addition, if the treatment plan includes medication, it must state whether the medication is to be self-administered or administered by others, and specify the type and dosage most likely to provide “maximum benefit” to the individual. If alcohol or drug abuse treatment is suggested, the plan may also include provisions for screening to determine whether the person is using illegal substances or alcohol. In the plan’s development, the subject of the petition, the treating physician, and at the person’s request someone close to him or her is to be involved (MHL Supp. § 9.60(i)(1)).

If the court finds by clear and convincing evidence that the person meets statutory criteria, the court may order an initial period of treatment not to exceed 6 months. Treatment may be renewed on a yearly basis after the initial period (MHL Supp. § 9.60(j)(2); 9.60(k)).

If the person does not comply with treatment, the person may be involuntarily confined for examination to determine whether he or she meets inpatient commitment standards. Law enforcement officials are to transport the person to a hospital for evaluation on the request of the director of the outpatient treatment program or the patient’s physician (MHL Supp. § 9.60(n)). However, the person can be held after the initial 72-hour

evaluation period only if he or she meets inpatient commitment standards. In addition, while the court ordering assisted outpatient treatment may direct that the medication be included in its order, a person can be forced to take medication only in an emergency or after a judicial hearing in which the court makes a threshold finding that the person lacks capacity to make decisions regarding medication.⁹⁹

The constitutionality of Kendra's Law was specifically upheld by a New York court in late fall.¹⁰⁰ The court ruled that the New York legislature had not violated constitutional guarantees in enacting New York's outpatient commitment statute. Plaintiffs had argued that the decision of the New York Court of Appeals in *Rivers v. Katz* required a finding of incapacity before an individual could be treated against his or her will, and that outpatient commitment constituted forced treatment requiring an incapacity adjudication. The court rejected this argument, finding that the statute was remedial and designed to permit state intervention before the person decompensated. In addition, the court found that the provision of the statute permitting examination of the person for noncompliance with treatment was not punitive, but simply led to "heightened scrutiny of physicians for a seventy-two hour evaluation period." Plaintiffs apparently have decided not to appeal the court's ruling, which has the practical effect of settling, at least for now, the constitutionality of the New York outpatient commitment statute.

There are several things worth noting about the application of this statute. First, it is reported that the statute has been applied more frequently in New York City than elsewhere in the state.¹⁰¹ Second, individuals committed under the AOT statute receive a priority for case management services, since such services by definition must be made available to individuals committed under the statute.¹⁰² Fourth, the statute to date has been used primarily at the point an individual is discharged from inpatient care (something noted in other states as well). Finally, one group of interview respondents noted that New York City apparently is going to begin using the statute for mentally ill individuals being released from Rikers Island. This jail, one of the largest anywhere, may add scores of individuals to the rolls of those committed under the AOT statute. It was not necessarily anticipated at the time the statute was enacted that this jail might become a major utilizer of the statute, and the implications for implementation of the statute if this develops, in terms of resources such as case management and the use of urine and laboratory screens to monitor compliance with the conditions of release, are unclear at this point.¹⁰³ It was suggested, however, that the California legislature may want to consider the potential impact on treatment resources if California's urban jails become heavy users of an involuntary outpatient commitment process.¹⁰⁴

⁹⁹ *Rivers v. Katz*, 67 New York 2d 485, 495 N.E.2d 337, 1986.

¹⁰⁰ *Urcuyo v. James D.*, 714 N.Y.S.2d 862 (Kings Co. 2000).

¹⁰¹ Counsel for the Office of Mental Health (OMH) and defense attorneys with the New York Mental Hygiene Legal Service.

¹⁰² Counsel for OMH and defense attorneys.

¹⁰³ Defense attorneys.

¹⁰⁴ Defense attorneys.

North Carolina

North Carolina's civil commitment law:

- 1. Contains an outpatient commitment provision that differs in significant respects from its inpatient commitment statute, for example, making counsel discretionary in an outpatient proceeding and containing different substantive criteria from those used for inpatient commitment;**
- 2. Defines “outpatient treatment” statutorily;**
- 3. Explicitly permits the use of prior history in making a judgment about civil commitment; and**
- 4. Contains a grave disability criterion.**

North Carolina defines mental illness, when applied to an adult, as “an illness which so lessens the capacity of the individual to use self-control, judgment, and discretion in the conduct of his affairs and social relations as to make it necessary or advisable for him to be under treatment, care, supervision, guidance, or control” (N.C.Gen.Stat. § 122C-3(21)).¹⁰⁵

Dangerousness to self is defined as meaning that within the “relevant past” the individual has acted in such a way as to show:

1. a) that he would be unable, without care, supervision, and the continued assistance of others not otherwise available, to exercise self-control, judgment and discretion in the conduct of his daily responsibilities and social relations, or to satisfy his need for nourishment, personal or medical care, shelter, or self-protection and safety; and

b) that there is a reasonable probability of his suffering serious physical debilitation within the near future unless adequate treatment is given...A showing of behavior that is grossly irrational, of actions that the individual is unable to control, of behavior that is grossly inappropriate to the situation, or of other evidence of severely impaired insight and judgment shall create a prima facie inference that the individual is unable to care for himself; or
2. the individual has attempted suicide or threatened suicide and that there is a reasonable probability of suicide unless adequate treatment is given...; or

¹⁰⁵ The citations to North Carolina law are taken from the North Carolina General Statutes (Matthew Bender 1999).

3. the individual has mutilated himself or attempted to mutilate himself and that there is a reasonable probability of serious self-mutilation unless adequate treatment is given...(N.C.Gen.Stat. § 122C-3(11)(a)).

Dangerousness to others means that “within the relevant past, the individual has inflicted or attempted to inflict or threatened to inflict serious bodily harm on another, or has acted in such a way as to create a substantial risk of serious bodily harm to another, or has engaged in extreme destruction of property; and that there is a reasonable probability that this conduct will be repeated.” Previous episodes of dangerousness to others, when applicable, may be considered when determining reasonable probability of future dangerous conduct. Clear, cogent, and convincing evidence that an individual has committed a homicide in the relevant past is prima facie evidence of dangerousness to others (N.C.Gen.Stat. § 122C-3(11)(b)).

Like New York, North Carolina also defines outpatient treatment. Outpatient treatment, as used in the outpatient commitment statute, means “treatment in an outpatient setting and may include medication, individual or group therapy, day or partial day programming activities, services and training including educational and vocational activities, supervision of living arrangements, and any other services prescribed either to alleviate the individual’s illness or disability, to maintain semi-independent functioning, or to prevent further deterioration that may reasonably be predicted to result in the need for inpatient commitment to a 24-hour facility” (N.C.Gen.Stat. § 122C-3(27)).

Involuntary admissions

Any person having knowledge of an individual who is mentally ill and dangerous as defined above (including a person in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness) may execute an affidavit to this effect before a clerk of the court and petition the court for an order to take the person into custody for exam by a physician or psychologist (N.C.Gen. Stat. § 122C-261). A clerk or magistrate may issue an order to law enforcement for the detention of the person on a finding that the facts alleged in the affidavit are probably true.

An individual may also be admitted under the emergency procedure made available by statute, if the person requires immediate hospitalization to prevent harm to self or others (N.C.Gen.Stat. § 122C-262). Within 24 hours of admission under either of these procedures, the court, the person, and with the person’s consent next of kin are to be notified of the admission by the hospital.

After admission, an examination is to be conducted within 24 hours. The statute specifies the inquiry in a manner that differentiates between the person’s “fit” with outpatient or inpatient commitment:

1. If the examiner finds that the person is mentally ill; is capable of surviving safely in the community with available supervision from family, friends, or

others; based on psychiatric history, is in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness; and the person's mental status or illness limits or negates the person's ability to make an informed decision to seek voluntarily or to comply with recommended treatment, then the examiner is to note this on the report and recommend outpatient commitment. The examiner is also to show on the report the name, address, and telephone number of the proposed outpatient treatment physician or center. The person is then to be returned to his regular residence or to the home of a consenting individual in the originating county, and the person is to be released from custody.

2. On the other hand, if the examiner finds that the person is mentally ill and dangerous to self or others, the examiner shall recommend inpatient commitment. The person is then to be taken to a 24-hour facility (a facility designated or licensed as appropriate for the custody and treatment of involuntary clients) pending hearing.

When the clerk of the court is notified that outpatient commitment is recommended, the clerk is to calendar the hearing, notifying the person and the proposed outpatient treatment center or physician. If inpatient treatment is recommended, the hearing is placed on the calendar and counsel is assigned. Counsel is not automatically assigned if outpatient commitment is recommended (N.C.Gen.Stat. § 122C-264(a)-(b)). When outpatient commitment is recommended, the person cannot be physically forced to take medication or forcibly detained for treatment pending the court hearing on commitment (N.C.Gen.Stat. § 122c-265(c)).

A hearing on outpatient commitment is to be held within 10 days of the time the person was initially taken into custody (N.C.Gen.Stat. § 122C-267(a)). The person may but need not be represented by counsel, though if the court decides that the legal or factual issues are of such complexity that the assistance of counsel is necessary it may appoint counsel (N.C.Gen.Stat. § 122C-267(d)). A hearing on inpatient commitment is also to be held within 10 days, but as noted earlier the person has a right to counsel (N.C.Gen.Stat. § 122C-268).

If the court after hearing finds by "clear, cogent, and convincing evidence" that the person is mentally ill; that he or she is capable of surviving safely in the community with available supervision from family, friends, or others; that based on the person's treatment history he or she is in need of treatment to prevent further disability or deterioration that would predictably result in dangerousness as defined in the statute; and that the person's mental status or illness limits or negates his or her ability to make an informed decision to seek voluntary treatment or to comply with recommended treatment, the court may order outpatient commitment for a period of up to 90 days (N.C.Gen.Stat. § 122C-271). The court must also find that outpatient treatment is available and show on the order the identity of the center or physician who will be responsible for the person's care. If the

person continues to meet criteria for outpatient commitment, a subsequent order may be obtained for commitment of 180 days (N.C.Gen.Stat. § 122C-275).

If the court finds that the person is dangerous, it may order 90 days of inpatient treatment. The court also has the option of ordering a combination of inpatient and outpatient care for up to 90 days (N.C.Gen.Stat. § 122C-271(b)(2)). In addition, a person committed originally as an inpatient can be committed as an outpatient when no longer in need of inpatient care (N.C.Gen.Stat. § 122C-277).

If a person is committed to outpatient care, the outpatient physician may “prescribe or administer” “reasonable and appropriate medication and treatment.” If the person does not comply, treating staff are first to make “all reasonable efforts” to solicit his or her cooperation. If the person still does not comply, the center may request the court to order the person taken into custody for examination to determine if the person meets the criteria for inpatient commitment. Medication still cannot be compelled absent immediate danger to self or others (N.C.Gen.Stat. § 122C-273). A person on conditional release may also be taken into custody (N.C.Gen.Stat. § 122C-205).

One interview respondent reported that outpatient commitment is used most frequently as a “step-down” program from inpatient commitment.¹⁰⁶ In other words, most orders were issued as part of the discharge process from inpatient care. He also reported that outpatient commitment is sometimes applied inconsistently between rural and urban areas, and that there is a problem with enforcement, in part because sheriffs are sometimes reluctant to bring people who have not complied with orders back to the hospital, not wishing to be used as a “taxi service.” He believes North Carolina’s definitions for commitment are good ones, and worth examining by other states for possible adoption.

Ohio

Ohio’s civil commitment law:

1. **Is a fairly traditional civil commitment law;**
2. **Is applied in an environment in which legal and financial responsibility for the care of those who are civilly committed rests with local boards of alcohol, drug addiction, and mental health services; and**
3. **The fact that the boards have financial responsibility for civil commitment is the most important feature of the Ohio system, because it creates incentives to limit the use of commitment to people with severe mental illness and behavioral needs and to create community services designed to ameliorate the use of commitment.**

¹⁰⁶ Counsel, North Carolina Department of Mental Health.

Key civil commitment provisions

Ohio law permits the civil commitment of individuals who present physical harm to self or others or who meet a standard that is functionally equivalent to a grave disability standard, though that phrase is not used within the statute. “Mental illness” means “a substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life” (Ohio Rev. Code § 5122.01(B)).¹⁰⁷

The Ohio statute defines a “mentally ill person subject to hospitalization” as a person who because of mental illness

1. represents a substantial risk of physical harm to self as manifested by evidence of threats of, or attempts at, suicide or serious self-inflicted bodily harm;
2. represents a substantial risk of physical harm to others as manifested by evidence of recent homicidal or other violent behavior, evidence of recent threats that place another in reasonable fear of violent behavior and serious physical harm, or other evidence of present dangerousness;
3. represents a substantial and immediate risk of serious physical impairment or injury to self as manifested by evidence that the person is unable to provide for and is not providing for the person’s basic physical needs because of the person’s mental illness and that appropriate provision for those needs cannot be made immediately available in the community; or
4. would benefit from treatment in a hospital for his mental illness and is in need of such treatment as manifested by evidence of behavior that creates a grave and imminent risk to substantial rights of others or himself (Ohio Rev. Code § 5122.01(B)(1)-(4)).

In determining whether an individual meets these standards, a trial court has “broad discretion” to review a person’s past history, including current or recent behavior as well as prior dangerous propensities.¹⁰⁸

A person may be taken into emergency detention and hospitalized for no more than three court days by a psychiatrist, licensed clinical psychologist, licensed physician, health officer, or various law enforcement officials based on reason to believe that the person

¹⁰⁷ The citations to Ohio law are taken from the Ohio Revised Code (Anderson Publishing Company 1998).

¹⁰⁸ See *In re Burton*, 464 N.E.2d 530 (Ohio 1984); *In the Matter of the Mental Illness of Perry White*, 1996 Ohio. App. LEXIS 459 (9th App. Dist. 1996).

meets the statutory criteria noted above and represents a substantial risk of physical harm to self or others if not confined pending examination (Ohio Rev. Code § 5122.10).

An affidavit filed with the court and alleging that the person meets statutory criteria for commitment initiates the judicial commitment process. If the person has not already been confined under an emergency detention, the court may order his or her confinement upon receipt of the affidavit (Ohio Rev. Code § 5122.11). Notice of any scheduled hearing after receipt of the affidavit is provided to the person, spouse and legal guardian, the person filing the affidavit, the facility to which the person is currently detained, the person's counsel, and the board of alcohol, drug addiction, and mental health services for the person's county of residence (Ohio Rev. Code § 5122.12). The board or its designee is then to review the affidavit and other information relevant to whether the person meets statutory criteria and report to the court. The report, however, is not admissible as evidence on the question of the statutory criteria, but is to be considered by the court in making a determination regarding an appropriate placement after the person is found to meet statutory criteria (Ohio Rev. Code § 5122.13).

The court also appoints a physician or clinical psychologist to examine the person and report whether the person requires treatment in a mental hospital. The local boards may designate clinicians for this purpose (Ohio Rev. Code § 5122.14). The court then is to conduct an initial hearing within five court days from the time the person has initially been detained or when the affidavit is filed with the court. The court may release or continue the person's detention; if the latter, a full hearing must be conducted within 30 days of the initial involuntary detention of the person (Ohio Rev. Code § 5122.14).

At a full hearing, at which a person has the right to counsel and other due process protections, the board generally presents the case that the person meets statutory criteria (Ohio Rev. Code § 5512.15(10)). If the court finds that the person meets the criteria, it can order the person into treatment for up to 90 days, and can order the person into a variety of settings. However, in general, the facility or practitioner designated by the court must consent to the designation for it to be valid (Ohio Rev. Code § 5512.15(15)(C)-(D)), and in most cases commitment is to the local board, which makes the actual treatment decision.¹⁰⁹ In making its order the court is to order the implementation of the least restrictive alternative available and consistent with treatment goals (Ohio Rev. Code § 5512.15(E)). If after 90 days the person still meets statutory criteria, the court shall hold another full hearing, and then at a minimum of two-year intervals after the initial 90-day commitment (Ohio Rev. Code § 5512.15(H)).

If during treatment it is determined by the treatment provider that the person can be treated in an available and appropriate less restrictive environment, the person is to be released (if hospitalized) and placed in the least restrictive environment available and consistent with the person's treatment goals (Ohio Rev. Code § 5512.15(F)).

¹⁰⁹ Defense attorney.

Ohio law also has a provision permitting trial visits, for periods not to exceed 90 days unless extended for additional periods of 90 days after evaluation of the person's condition (Ohio Rev. Code § 5122.22). The trial visit may be revoked by the chief clinical officer of the hospital from which the person has been released "if there is reason to believe that it is in the best interests of the patient to be returned to the hospital." In some of the interviews it was suggested that this provision is used disproportionately by a small number of counties, primarily as an effort to maintain some control over individuals who may present a risk to self or others if they fail to adhere to community-based care.¹¹⁰

The issue of medication compliance appears generally to be dealt with in separate proceedings from the issue of civil commitment and requires a judicial hearing.¹¹¹ The Ohio Supreme Court ruled in October, 2000 that a court may order a person to take medication over his or her objection if the person lacks capacity to make such decisions, and if the medication is in the person's best interest. It is not necessary that the person also be found to be a danger to self or others.¹¹²

The State of Ohio does not provide training on civil commitment.¹¹³ As noted at the beginning of this subsection, the responsibility given local boards is the predominant feature of the mental health system in Ohio; the linking of funding with the use of commitment has caused localities to create alternative services, for example, crisis services that make sense programmatically and are designed to enable the person to obtain treatment that might avoid commitment.¹¹⁴

Oregon

Oregon's civil commitment law:

- 1. Permits outpatient commitment in some circumstances;**
- 2. Includes a grave disability provision;**
- 3. Permits commitment if the person's condition is deteriorating and other conditions are met; and**
- 4. Permits revocation of trial visits for noncompliance with treatment conditions.**

¹¹⁰ Counsel to Ohio Department of Mental Health and defense attorney.

¹¹¹ Counsel to Ohio Department of Mental Health.

¹¹² *Steele v. Hamilton County Community Mental Health Board*, 90 Ohio St. 3d 176 (2000).

¹¹³ Counsel to Ohio Department of Mental Health and defense attorney.

¹¹⁴ Defense attorney.

For purposes of its commitment statute, Oregon defines “mentally ill person” as a person who because of mental disorder is one or more of the following:

1. dangerous to self or others;
2. unable to provide for basic personal needs and not receiving care necessary for health or safety (the equivalent of a “grave disability” criterion);
3. is chronically mentally ill; within the previous three years has been placed twice in a hospital or inpatient facility approved by the state Mental Health and Developmental Disability Services Division (hereafter, Division); is exhibiting symptoms or behaviors substantially similar to those that preceded and led to one or more of the previous inpatient placements; and unless treated, will continue, to a reasonable medical probability, to deteriorate physically or mentally until becoming either a danger to self or others or unable to provide for basic personal needs (Ore. Rev. Stat. Supp. § 426.005 (1)(d)).¹¹⁵

A person is “chronically mentally ill” and therefore eligible for the third criterion noted above if he or she is 18 years of age or older. The person must also have been diagnosed by a Division-certified psychiatrist, licensed clinical psychologist, or non-medical examiner as suffering from chronic schizophrenia, a chronic major affective disorder, a chronic paranoid disorder, or another chronic psychotic mental disorder other than those caused by substance abuse (Ore. Rev. Code § 426.495 (1)-(2)). In addition, the person must have impaired role functioning, consisting of at least two of the following:

1. Social role: An inability to function independently in the role of worker, student, or homemaker;
2. Daily living skills: An inability to engage independently in personal care (grooming, personal hygiene, etc.) or community living activities (handling personal finances, using community resources, performing household chores, etc.); or
3. Social acceptability: An inability to exhibit appropriate social behavior, which results in demand for intervention by the mental health and/or judicial system (Ore. Admin. R. § 309-032-0225(1)(b)).

There are a variety of ways that commitment may be initiated in Oregon. First, commitment may be initiated by notice given by “two persons,” the county health officer, or any magistrate. The notice is to be given the community mental health and developmental disabilities program director (hereafter, Director) where the allegedly

¹¹⁵ The citations to Oregon law are taken from the Oregon Revised Statutes (Butterworth 1987). When noted as Ore. Rev. Code Supp., the source is the 1998 Supplement.

mentally ill person resides. The Director must notify the court of receipt of the notice, notify the Division if it appears that commitment is proposed on the ground that the person is “chronically mentally ill” and initiate an investigation to determine whether there is probable cause to believe the person is a mentally ill person (which as noted above is defined to include the issues of risk and grave disability) (Ore. Rev. Stat. Supp. § 426.070).

Emergency detention can also be initiated by a police officer when the officer has probable cause to believe a person is imminently dangerous to self or another, or by the Director on similar grounds (Ore. Rev. Stat. § 426.228; 426.233). Similarly, a physician can initiate emergency commitment (Ore. Rev. Stat. Supp. § 426.232).

Upon initial detention, notice is given the court. The court in turn directs the Director to conduct an investigation into the person’s condition. The Director, during this pre-hearing period of detention, has three options. He or she can recommend to the court, in the investigation report, that the Director does not believe the person is a mentally ill person and that the court should not proceed. The Director can recommend that probable cause exists that the person is a mentally ill person and that the court should hold a hearing. The Director can also certify that he or she has probable cause to believe the person is a mentally ill person. If the Director also certifies that the county will pay for care and an approved facility is located that can provide the necessary care to meet the emergency psychiatric needs of the person, then the person can be detained for a 14-day period. The person and their counsel are notified of the Director’s decision and can either agree to the Director’s certification or ask for a court hearing (Ore. Rev. Stat. Supp. § 426.237).

If the court holds a hearing, it may discharge the person if not mentally ill. Alternatively, the court may dismiss the case if the person is mentally ill but agrees to treatment voluntarily and the court finds that the person “probably” will seek treatment. The court also has the option of committing the person to the Division for treatment. The court establishes the period of commitment (not to exceed 180 days) (Ore. Rev. Stat. Supp. § 426.130) and additional commitments for 180-day periods may be made subsequently (Ore. Rev. Stat. Supp. § 426.301).

The Division may place the person in outpatient commitment status only if an adequate treatment facility is available. In addition, the Director establishes conditions for outpatient commitment, including designating the service provider. Outpatient commitment is subject to revocation, discussed below, and the Director may modify the conditions of outpatient commitment when it is in the best interest of the person (Ore. Rev. Stat. Supp. § 426.127).

When a person is in inpatient care, trial visits may be granted under conditions established by the Division. Outpatient care may be required for the period left in the commitment order (Ore. Rev. Stat. § 426.273). Alternatively, a court may order conditional release. However, conditional release can occur only if the release is

requested by the person's legal guardian, relative or friend; the person requesting the release asks to be allowed to care for the person in a place satisfactory to the court; and the person requesting the release satisfies the court that he or she has the ability to care for the person and that adequate financial resources exist to provide care (Ore. Rev. Stat. Supp. § 426.125).

A person on outpatient commitment status, trial visit, or conditional release may have that status revoked for noncompliance with the conditions of placement (Ore. Rev. Stat. § 426.275). A court hearing is held on the subject of compliance, and the court can order the person back into inpatient care or can continue the person on the previous status. If the court directs the person to be rehospitized, it does not have to find that the person is mentally ill at the time of the hearing.¹¹⁶

Interview respondents suggested that outpatient commitment is used rarely in Oregon, and that trial visits from hospital are used much more frequently.¹¹⁷ One suggested that in part this is because resources to monitor people on outpatient commitment are scarce and that this affects its use.¹¹⁸ Another interview respondent observed that scarce community resources may place some people at risk for commitment; in her opinion if there were more resources to monitor and assist people in the community, fewer people might be returned to the hospital during a crisis.¹¹⁹ Some training is provided on the Oregon commitment laws, but there is still reported inconsistency, particularly between rural and urban counties, in the application of the statute.¹²⁰

Texas

Texas civil commitment law:

1. **Provides for a court order for outpatient commitment;**
2. **Uses the same processes for inpatient and outpatient civil commitment;**
3. **Provides some overlap in the criteria for inpatient and outpatient commitment (distress combined with deterioration of functioning and an inability to seek care voluntarily), but makes outpatient commitment unavailable if the individual represents a likely danger to self or others; and**
4. **Provides for the consideration of prior history of up to two years preceding the commitment hearing.**

¹¹⁶ *Oregon v. Bryant*, 871 P.2d 129 (Ore. App. 1994).

¹¹⁷ Administrator and Civil Commitment Specialist at Oregon Department of Mental Health.

¹¹⁸ Civil Commitment Specialist at Oregon Department of Mental Health.

¹¹⁹ Defense attorney with Public Defenders Office.

¹²⁰ Administrators at DMH and defense attorney.

The statute defines “mental illness” as an illness, disease, or condition, other than epilepsy, senility, alcoholism, or mental deficiency, that substantially impairs a person’s thought, perception of reality, emotional process, or judgment, or grossly impairs behavior as demonstrated by recent disturbed behavior (§ 571.003(14)).¹²¹ Other definitions, for example, of risk, are contained in the substantive provisions governing civil commitment, and are noted below as applicable.

A person may be held for emergency detention based on the order of a judge or magistrate. The court must find that the person evidences mental illness; a substantial risk of serious harm to self or others that is imminent unless the person is immediately restrained; and emergency detention is necessary to accomplish the necessary restraint (§ 573.012).

An application for court-ordered mental health services can be made by any adult; the application, unless filed by a county or district attorney must be accompanied by a certificate of medical examination (§ 574.001). Notice of the application is provided to the person and counsel, as well as to the guardian, if applicable. The court may order the person held for no longer than 72 hours until the court holds a probable cause hearing on the application.

The court cannot hold a hearing unless there are two certificates of medical examination on file with the court, prepared by different physicians each of whom has examined the person within the preceding 30 days (§ 574.009). The certificates must include identifying information regarding the examiner. In addition, they must include:

1. a diagnosis of the person’s mental and physical condition;
2. the period, if any, during which the person has been under the examiner’s care;
3. an accurate description of the mental health treatment given by the examiner;
4. the examiner’s opinion that the person is mentally ill and as a result
5. is likely to cause serious harm to self or others; or
6. is suffering severe and abnormal mental, emotional, or physical distress; experiencing substantial mental or physical deterioration of his ability to function independently, which is exhibited by the person’s inability, except for reasons of indigence, to provide for basic needs, including food, clothing, health, or safety; and is not able to make a rational and informed decision as to whether to submit to treatment (§ 574.011).

¹²¹ The citations to Texas law are taken from the Texas Code Annotation Health and Safety Code (Vernon 2000 Supplement).

In addition to the medical examinations, the Commissioner of Mental Health and Mental Retardation is to designate a facility or provider in the county to file with the court a recommendation for the most appropriate treatment for the person. If the recommendation is for outpatient treatment, the report must indicate whether the proposed services are available through the local mental health authority based on the inclusion of the person within the priority populations identified by the Department and that sufficient resources to provide services are available (§ 574.012).

The court then may hold a probable cause hearing to determine if there is probable cause to believe that the person presents a substantial risk of serious harm to self or others to the extent that he cannot be at liberty pending hearing, and that a physician has stated his opinion and reasons for the opinion that the person is mentally ill. The hearing must occur within 72 hours after the person's detention under a protective custody order (§ 574.025).

The hearing may be held at any suitable location within the county, though on request of the person or their counsel the hearing is to be held at the courthouse. Civil rules of evidence apply, and the hearing is open to the public, absent a request by the person or their counsel that it be closed (§ 574.031).

The court may order either inpatient or outpatient treatment at this probable cause hearing for a period not to exceed 90 days. The court may order inpatient treatment if the judge or jury finds from clear and convincing evidence that the person:

1. has a mental illness;
2. as a result of that illness is likely to cause serious harm to self or others, or is suffering severe and abnormal mental, emotional, or physical distress; experiencing substantial mental or physical deterioration of his or her ability to function independently, which is exhibited by his or her inability, except for reason of indigence, to provide for basic needs, including food, clothing, health, or safety; and
3. is unable to make a rational and informed decision as to whether to submit to treatment (§ 574.034(a)).

The statute provides that the court must specify which of these criteria are met and that the court can find clear and convincing evidence that these criteria are met only if the evidence includes expert testimony and, unless waived, evidence of a recent overt act or a continuing pattern of behavior that tends to confirm that a likelihood of serious harm exists or that the person is suffering from distress and deterioration of functioning (§ 574.034(c)-(d)).

The court may order *outpatient* treatment if it finds that the person:

1. has a mental illness that is severe and persistent;
2. because of the illness, if left untreated will continue to (i) suffer severe and abnormal mental, emotional, or physical distress; and (ii) experience deterioration of the ability to function independently to the extent that he or she will be unable to live safely in the community without court-ordered outpatient mental health services; and
3. is unable to participate effectively and voluntarily in outpatient treatment as demonstrated by (i) any of the patient's actions within the two-year period preceding the hearing, or (ii) specific characteristics of his or her clinical condition that make impossible a rational and informed decision whether to submit to voluntary outpatient treatment (§ 574.034(b)).

The court, when ordering outpatient care, must rely at least in part on expert evidence that “tends to confirm” the existence of the statutory criteria for outpatient commitment (§ 574.034(e)).

It should be noted that the criteria for outpatient and inpatient commitment are somewhat different. The latter focuses on severe distress combined with deterioration that will impact functioning, as well as an inability to voluntarily or effectively seek outpatient treatment. The inpatient criteria include this category, but also include the likelihood of serious harm to self or others, criteria not available as the basis for outpatient commitment.

A court after hearing may order the person treated as an inpatient or outpatient for a 12-month period. The substantive criteria for extended treatment are essentially the same as those for the 90-day order (§ 574.035). However, when ordering extended inpatient care, the court also must find that the person's condition is expected to continue for more than 90 days and that the person has received court-ordered inpatient mental health services under the civil commitment law or under a criminal commitment for at least 60 consecutive days during the preceding 12 months (§ 574.035(3)-(4)). The court, if ordering extended outpatient care, must make the same finding. In either situation, this finding is not required if the person is already on an extended-services order (§ 574.035(d)). Whether ordering 90-day or 12-month treatment the court “may advise, but may not compel” the person to take “psychoactive medication” as specified by an outpatient services plan, participate in counseling, and refrain from alcohol and drug use (§ 574.035(j)(1)-(3)). Treatment may be renewed for additional periods of 12 months, subject to the same criteria discussed here (§ 574.066).

After the judge or jury finds that the person is mentally ill and meets criteria for temporary or extended mental health services, the court may hear additional evidence related to alternative treatment. The court is to order services in the least restrictive

appropriate setting. The court may commit the person to an inpatient facility or to an outpatient provider (§ 574.036).

The person subject to outpatient treatment, or the treatment provider, or “any other interested person” may request the court to substantially modify the outpatient order. The court after hearing has the discretion whether or not to modify the order (§ 574.065).

Texas also provides for continuing-care for an individual who is to be furloughed or discharged from inpatient care. If the person is to be discharged rather than furloughed (the latter appearing to be similar to the trial visits used by other states) he or she may refuse continuing care services. If the person violates the conditions of a furlough (or pass), or the person’s condition has deteriorated to the point that his or her continued absence from the facility is “inappropriate,” the person may be returned to the facility by order of a magistrate (§ 574.083). There are no criteria that must be met before the magistrate issues such an order.

Medication

Texas law requires that persons are to be provided with information regarding prescribed medications (see e.g. § 571.0066). Separate statutory provisions address the topic of medicating persons under court-ordered mental health services. Medications cannot be administered over the person’s refusal in the absence of a medication-related emergency (defined in statute) or absent a court order (§ 574.103). The court can issue an order directing that a person be administered medication regardless of refusal if the person is under a court order for mental health services; the person lacks capacity (as defined in statute) regarding medication decisions; and treatment is in the person’s best interest. The court is also to consider the person’s expressed preferences regarding medication, the risks and benefits of the proposed medication, as well as alternatives (§ 574.106). If a court issues such an order, then the person’s consent is no longer valid, and the order expires when the order for mental health services in effect at the time of the medication order expires (§ 574.109-574.110).

Washington

The Washington civil commitment statute:

- 1. Provides explicitly for the use of prior history in making commitment decisions;**
- 2. Provides for different periods of commitment for inpatient care and for care provided under the least restrictive alternative section of the statute;**
- 3. Provides for commitment under a grave disability standard; and**

4. Provides a statutory provision establishing judicial decisionmaking for medication decisions.

Civil commitment law

The Washington legislature states that its legislative intent in the commitment law is to “encourage appropriate interventions at a point when there is the best opportunity to restore the person or maintain satisfactory functioning.” The legislature also notes that “for persons with a prior history or pattern of repeated hospitalizations or law enforcement interventions due to decompensation, the consideration of prior mental history is particularly relevant in determining whether the person would receive, if released, such care as is essential for his or her health or safety...a prior history of decompensation...should be given great weight in determining whether a new less restrictive alternative commitment should be ordered” (Rev. Code Wash. Supp. § 71.05.012).¹²²

The statute defines “mental disorder” broadly, as “any organic, mental or emotional impairment which has substantial adverse effects on an individual’s cognitive or volitional functions” (Rev. Code Wash. Supp. § 71.05.020 (15)). “Likelihood of serious harm” is defined as:

A substantial risk that: (i) physical harm will be inflicted by an individual upon his or her own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on oneself; (ii) physical harm will be inflicted by an individual upon another, as evidenced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm; or (iii) physical harm will be inflicted by an individual upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others; or the individual has threatened the physical safety of another and has a history of one or more violent acts (Rev. Code Wash. Supp. § 71.05.020 (14)(a)-(b)).

“Gravely disabled” is “a condition in which a person, as result of a mental disorder: (a) is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety; or (b) manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety” (Rev. Code Wash. Supp. § 71.05.020(9)).

Washington also relies on “county designated mental health professionals” to perform a variety of activities under the civil commitment statute. These individuals, for example,

¹²² The citations to Washington law are taken from the Revised Code of Washington (West 2000 Supplement).

have the authority to file with the court for the initial detention of an individual alleged to meet statutory criteria for commitment. This petition may result in judicially ordered detention of the person for evaluation and treatment on either an inpatient or outpatient basis for a period not to exceed 72 hours (Rev. Code Wash. Supp. § 71.05.150 (1)(a)-(c)). During this initial detention the person may refuse psychiatric medications, but not other medications prescribed by a licensed professional or emergency lifesaving treatment (Rev. Code Wash. Supp. § 71.05.210).

At the end of the initial 72-hour detention, a petition may be filed for 14 additional days of inpatient care, or for 90 days of a “less restrictive alternative” to “involuntary intensive treatment” if treatment staff believe the person meets statutory criteria and he or she will not volunteer for treatment (Rev. Code Wash. Supp. § 71.05.230). The court then holds a probable cause hearing on the petition for one of these forms of treatment, at which the person has full due process rights. If the court finds that the person meets statutory criteria, the court then determines whether 14 days of inpatient or 90 days of treatment in a less restrictive setting is appropriate (Rev. Code Wash. Supp. § 71.05.240). If at the end of this period of treatment the individual continues to meet statutory criteria, the court, after full hearing, may commit the person for either inpatient or less restrictive care for an additional period of 90 days (Rev. Code Wash. Supp. § 71.05.280; 71.05.320).

Interview respondents reported that commitment to a “less restrictive alternative” (LRA) was used frequently; one reason given was that the localities are financially responsible for providing care (pursuant to contracts with the state) and so there is an incentive to minimize the use of state hospitals. The LRA commitment also provides some measure of control over the individual.¹²³ It is generally used with individuals who have first been on a 72-hour hold in a hospital for evaluation.¹²⁴

In determining whether a person constitutes a likelihood of serious harm, the court is instructed by the statute to “give great weight” to any evidence before the court that the person has a recent history of violent acts or a recent history of one or more commitments under Washington law or the equivalent laws of another state. However, a history of prior violent acts or commitments cannot be the sole basis for commitment under the statute (Rev. Code Wash. Supp. § 71.05.245). One interview respondent believes that there is great variation across the state in the application of the “grave disability” and “threat to others” standards, particularly in interpreting what constitutes a threat sufficient to warrant commitment.¹²⁵

Washington also has a provision for conditional release worth noting. If the person is hospitalized, the hospital has discretion to place the person on conditional release, requiring the person to be treated as an outpatient for the amount of time left on the inpatient commitment. If the person fails to adhere to the terms and conditions of his or

¹²³ Assistant Attorney General, Chief of the Mental Health Section.

¹²⁴ Defense attorney with Department of Assigned Counsel.

¹²⁵ Defense attorney.

her release; has experienced substantial deterioration in functioning; there is evidence of substantial decompensation with a reasonable probability that further inpatient treatment can reverse the decompensation; or the person poses a likelihood of serious harm, then the person can be detained for up to five days, at which point a hearing must occur. If the court finds that the person has failed to comply with treatment and is experiencing decompensation or presents a likelihood of serious harm, the court may order the person hospitalized or continued on conditional release (Rev. Code Wash. Supp. § 71.05.340).

While the state does not provide training on civil commitment, it did develop, with the assistance of stakeholders from across the state, protocols to be used by individuals involved in the commitment process.¹²⁶ In addition, civil commitment is covered in bench books used by the courts conducting civil commitment hearings.¹²⁷

Noncompliance with medications

Washington permits administration of medication to a nonconsenting person in emergencies (where there is an “imminent likelihood of serious harm” and no medically acceptable alternatives exist) but in general the state must prove to a court that there is a compelling state interest in administering such medications in nonemergencies. The court may order medication in the case of competent adults if the state meets its burden. The court must make specific findings regarding the existence of a compelling state interest, the necessity and effectiveness of the proposed treatment, and the person’s wishes. If the person is not competent, the court is to attempt to make a decision the person would have made if competent (Rev. Code Wash. Supp. § 71.05.370).

Wisconsin

Wisconsin civil commitment law:

- 1. Provides for the commitment of an individual if deemed necessary to prevent probable deterioration;**
- 2. Contains a grave disability provision;**
- 3. Permits the use of medical records data in making a case for commitment;**
- 4. Permits a court to address medication issues at a probable cause hearing;**
- 5. Specifies what type of evidence does *not* constitute adequate proof that the individual meets statutory criteria for commitment; and**

¹²⁶ Assistant Attorney General.

¹²⁷ Defense attorney.

6. Provides for a “settlement agreement” that permits the postponement of a commitment hearing for up to 90 days while the person is treated in an outpatient setting.

A petition for examination under the civil commitment laws must allege that the individual is mentally ill, drug dependent or developmentally disabled and is a proper subject for treatment. The individual must also be alleged to be dangerous because “he or she does any of the following”:

1. evidences a substantial probability of physical harm to self as manifested by evidence of recent threats of or attempts at suicide or serious bodily harm.
2. evidences a substantial probability of physical harm to other individuals as manifested by evidence of recent homicidal or other violent behavior, or by evidence that others are placed in reasonable fear of violent behavior and serious physical harm, as evidenced by a recent overt act, attempt or threat.
3. evidences such impaired judgment, manifested by evidence of a pattern of recent acts or omissions, that there is a substantial probability of physical impairment or injury to self. The probability is *not* substantial if reasonable provision for the individual’s protection exists in the community and there is a reasonable probability the individual will avail himself or herself of those services. If a person other than a treatment facility provides the person with food, shelter, or other care and the person is substantially incapable of caring for self, such provision does not show a reasonable provision for the subject’s protection.
4. evidences behavior manifested by recent acts or omissions that, due to mental illness, he or she is unable to satisfy basic needs for nourishment, medical care, shelter, or safety without prompt and adequate treatment so that a substantial probability exists that death, serious physical injury, serious physical debilitation or serious physical disease will imminently ensue unless the individual receives prompt and adequate treatment for this mental illness. The provisos regarding substantial probability of harm and the provision of food, etc. by another noted in (3) above apply to this section as well.
5. for an individual, other than an individual alleged to be drug dependent or developmentally disabled, after the advantages and disadvantages of and alternatives to accepting a particular medication or treatment have been explained and because of mental illness, the person evidences either incapability of expressing an understanding of the advantages and disadvantages of treatment and the alternatives, or substantial incapability of applying an understanding of the advantages, disadvantages, and alternatives to his or her mental illness in order to make an informed choice as to whether to accept or refuse medication or treatment; and evidences a substantial

probability, as demonstrated by both the individual's treatment history and his or her recent acts or omissions, that the individual needs care or treatment to prevent further disability or deterioration and a substantial probability that he or she will, if left untreated, lack services necessary for his or her health or safety and suffer severe mental, emotional or physical harm that will result in the loss of the individual's ability to function independently in the community or the loss of cognitive or volitional control over his or her thoughts or actions. Again, the same provisos regarding substantial probability apply (WSA § 51.20).¹²⁸

This last section, known in Wisconsin as the "5th Standard," combines questions of capacity with the prospect of deterioration in the absence of treatment, and is unique among the state commitment laws examined for the purpose of this review. It also has a number of features that differ from the other criteria in Wisconsin law. For example, the Wisconsin Attorney General must approve petitions for commitment using this criteria.¹²⁹ In addition, as noted below, the period of commitment under this provision is shorter than that for the other criteria.

If the individual has been the subject of prior inpatient treatment or the subject of outpatient treatment immediately prior to commencement of a petition for commitment, the various statutory requirements regarding overt acts, threats, and attempts or recent behavior may be proved by showing a substantial likelihood, based on the person's treatment record, that the individual would be a proper subject for commitment if treatment were withdrawn (WSA § 51.20(am)). In addition, a person who has been an inpatient on voluntary status for no more than 30 days prior to the commitment proceedings may have recent acts or behavior demonstrated by acts or omissions occurring immediately previous to the voluntary admission.

The probable cause requirement may also be satisfied by finding probable cause that the person is mentally ill and a proper subject for treatment, and that he or she evidences such impaired judgment, manifested by evidence of a recent act or omission, that there is a substantial probability of physical impairment or injury to self (with the provisos noted earlier applying here as well) (WSA § 51.20(1m)).

Upon receipt of a petition for examination, the court may order detention if the court has cause to believe the person meets statutory criteria. If the person is detained, a probable cause hearing must be held within 72 hours of the time of arrival at the facility, excluding weekends and holidays (WSA § 51.20(2)). The person is entitled to "adversary counsel" (WSA § 51.20(3)) and the hearings must comply with due process (WSA § 51.20(5)).

¹²⁸ The citations to Wisconsin law are taken from Wisconsin Statutes Annotated (1999 Supplement).

¹²⁹ Assistant Attorney General, Assistant Corporation Counsel for Dane County.

As noted, the probable cause hearing, if the person is detained, must occur within 72 hours of initial detention. It is worth noting that Wisconsin law provides that a person cannot be examined or treated under the civil commitment law unless the court first attempts to determine whether the person is enrolled in an HMO or other health plan and provides notice to the plan that the individual requires assessment or treatment under the statute (WSA § 51.20(7)(am)).

Upon a determination that probable cause exists, a full hearing must be scheduled within 14 days from the time of the detention. The patient or his counsel may waive the hearing for a period of 90 days based on an agreement by the patient to pursue treatment (WSA § 51.20(7)(c); (8)(bg)-(bm)). This option for a “settlement agreement” is discussed in more detail below.

One option the court has after hearing is to appoint a temporary guardian for the person for a period of up to 30 days. The court may also order psychotropic medication under this provision if the court finds the person incompetent to refuse medication and that the medication will have therapeutic value and not unreasonably impair the person’s ability to prepare for and participate in subsequent legal proceedings (WSA § 51.20(7)(d)). An individual is not competent under this provision to refuse medication if he or she is incapable of expressing an understanding of the advantages and disadvantages of accepting treatment, and the alternatives to accepting the particular treatment offered, after the advantages, disadvantages, and alternatives have been explained.

At or after the probable cause hearing, but prior to the final commitment order (except for an individual alleged to meet the criterion listed at (5) above), a court may also hold a hearing to determine whether there is probable cause to believe the individual is incompetent to refuse medication or treatment and whether it will have therapeutic value and not unreasonably impair the person’s ability to prepare for and participate in subsequent legal proceedings. If these findings are made, the court may order medication or treatment to be administered regardless of the person’s consent. The order applies to the period between the date of the order and any final order issued by the court after full hearing (WSA § 51.61(2)). The court may take similar steps at the final hearing as well.

The court also has a variety of other dispositional alternatives. If probable cause exists to find the person to be mentally ill and in need of treatment, the court may release the person to voluntary treatment, with conditions imposed by the court, pending full hearing. In such a case, full hearing must be held within 30 days of the order (WSA § 51.20(8)(a)). However, a person found incompetent to consent to medication cannot be released in this manner.

If the court finds probable cause to believe the allegations that the person meets statutory criteria for commitment, and if the person does not consent to 90 days of treatment (during which the court may hold hearings based on allegations of noncompliance (WSA § 51.20(bm)-(br))), the court shall appoint two psychiatrists or a psychiatrist and a psychologist or two physicians to examine the person. The person is to be advised prior

to exam that there is a right to remain silent and that their statements can be used against them¹³⁰ (WSA § 51.20(9)(a)). If the examiner determines the person is a proper subject for treatment, the examiner is to make a recommendation regarding the appropriate level of treatment, including the level of inpatient facility providing the least restrictive environment consistent with the person's needs (WSA § 51.20(9)(b)).

Prior to the final hearing, for individuals alleged to meet criterion (5) above, county officials are to provide the court and individual with an initial written recommended treatment plan containing the goals of treatment, the type of treatment to be provided, and expected treatment providers. The plan is to address a variety of things, including the person's need for inpatient care, residential services, community support services, case management, and medication (WSA § 51.20(10)(cm)).

At the conclusion of the hearing, the court can dismiss the petition, or if the court finds the person meets statutory criteria the person may be committed for treatment. The statute varies on whether the state or county is to provide treatment, though in general the county appears to carry the responsibility on most occasions.

If the court finds that the person's dangerousness is likely to be controlled by appropriate medication administered on an outpatient basis, the court may direct a conditional release of the person, with a condition being that the person take prescribed medication (WSA § 51.20(13)(dm)) and report to a particular outpatient treatment facility. In such a case, absent a court order to take medication based on a finding of incompetence (pursuant to WSA § 51.61 noted above), the person still retains the right to refuse medication. However, if the person fails to comply with the court's order, the person may be taken into custody—at such time, the person may still refuse medication absent a judicial hearing.

The court order generally lasts for 6 months, though there are some exceptions to this depending on the criteria under which the individual was committed. For example, if committed under criterion (5) noted above, hospitalization is limited to 30 continuous days initially and with subsequent hospitalizations, for example, if rehospitalized while on conditional release. If hospitalized under criterion (4) above (grave disability) hospitalization cannot exceed 45 consecutive days.¹³¹ While individuals subject to commitment do not have formal priority for services, at least two interview respondents agreed that the court order gives them a *de facto* priority.¹³²

If the person no longer meets the criteria for recommitment, the person is to be discharged (WSA § 51.35.(4)). Individuals may also be placed in the community from the hospital with conditions, including a requirement to take medications and to receive treatment. At the time of transfer the patient is to be informed of the consequences of

¹³⁰ Application of *Miranda* to civil commitment examinations is not usual.

¹³¹ Assistant Corporation Counsel for Dane County.

¹³² Assistant Attorney General, Assistant Corporation Counsel.

violating any conditions or terms for treatment, including possible transfer back to a facility imposing greater restrictions on the patient's freedom (WSA § 51.35.(1)(a)).

Criterion (5), the "5th Standard," has been used sparingly, and many counties have not used it at all.¹³³ One innovation in Wisconsin law that is used frequently, and that one interview respondent described as the best feature in the statute, is the "settlement agreement."¹³⁴ This option permits the subject of the commitment petition, or his or her counsel, to waive hearing if the person agrees to 90 days of treatment. This provision was praised as enabling the person to obtain treatment, while forgoing the stigma associated with inpatient civil commitment.¹³⁵

¹³³ Assistant Attorney General, Assistant Corporation Counsel.

¹³⁴ Assistant Corporation Counsel.

¹³⁵ Assistant Corporation Counsel and defense attorney (private bar).

VI. WHAT LESSONS HAVE BEEN LEARNED FROM THE EXPERIENCE OF OTHER STATES?

Beyond understanding the statutory criteria and commitment processes in other states, our interview protocol asked respondents to share “lessons learned” from their experiences in the day-to-day process of civil commitment in their states. Questions were included on implementation of civil commitment reforms; specifics about the operation of outpatient commitment programs; the consistency of implementation across jurisdictions, judges, and providers; and the impact of civil commitment reforms on patients, providers, treatment resources, and systems of care. In summing up, we asked respondents about advice they might offer California legislators if the legislature considers amending the Lanterman-Petris-Short Act. Our respondents expressed strong feelings on a number of the topics.

As mentioned in the Methods Section, it is important to emphasize that because of time and resource limitations we conducted only a total of 37 interviews across eight states. Given those limitations, we selected representatives of four groups we believed to be centrally involved in decisionmaking on involuntary treatment – prosecuting attorneys, defense attorneys, psychiatrists, and representatives of local behavioral health authorities. We were systematic in the way we chose representatives of each group across the eight states, but the findings we present must be understood in context. We did not have the resources to tap all relevant stakeholder groups in the eight states; for example we did not interview representatives of consumer/survivor groups, family organizations, advocacy organizations or many other interested parties. Additionally, we did not have the resources to conduct large-scale surveys that might have helped us determine the representativeness of the answers we were given, or might have indicated the extent to which there is variation of opinion within group in the eight states. Finally, we did not have resources to survey *all* of the states that have implemented outpatient commitment laws. Given those significant limitations, these interview data simply show the extent to which there are areas of consensus on some of the key issues across the eight states included in the analysis.

Perhaps the most important lesson drawn from this series of interviews is that making assumptions about the implementation of outpatient commitment based on statutory analysis alone is risky. A reading of what is *permissible* under a statute may not accurately reflect the experience in a state. Any discussion of differences across states must include an analysis of actual practice in each state as well as a review of statutory language as interpreted by the courts.

Some of our key findings on outpatient commitment from the interviews with key informants included the following:

- **There was widespread support among key informants for outpatient commitment, although quite a few expressed only qualified support for the practice in their own states.**

- **Three things were deemed critical to the success of outpatient commitment: having the infrastructure to support it; having the services to make it work for patients; and having a service system that can deliver those services rationally.**
- **The outpatient commitment laws are used infrequently in most states and are used primarily as a discharge-planning vehicle rather than an alternative to hospitalization.**
- **As a part of their commitment process, at least three states use mechanisms to involve the patient in development of a consensus plan for compliance with mental health treatment.**
- **There is disagreement as to whether the outpatient commitment order is “reciprocal” (i.e., commits the provider or mental health system to provide services as well as committing the patient to receive them).**
- **Provider liability is a concern but not an overwhelming one.**
- **Not all outpatient commitment orders are specific about which agency will provide services and what the specific treatment will be. Medication is not necessarily a part of the commitment order.**
- **In most states, forcible medication is not allowed under outpatient commitment orders.**
- **The burden of monitoring outpatient commitment orders most often falls to treatment providers, most of whom do not have the resources to provide high levels of supervision.**
- **States differ widely in the extent to which their outpatient commitment orders have “teeth” (i.e., are enforceable).**
- **Some key informants are so concerned about the lack of “leverage” in their outpatient commitment statutes that they are looking for alternatives to address the problem of noncompliance. Mental health courts figure prominently in those discussions.**
- **Most key informants report a lack of consistency across jurisdictions but say that little is being done to address the problem.**

The following are summaries of the views of the key informants, organized by topical areas related to the sections of the interview protocol.

Outpatient Commitment: Support for the Law but Qualified Support for the Practice

Almost without exception, the interview respondents supported the use of outpatient commitment to address the issues of noncompliance with community-based treatment. Descriptors used for outpatient commitment included “extremely useful and necessary;”¹³⁶ an “effective legal tool” to promote compliance with psychiatric treatment among severely ill patients in the community;¹³⁷ and “a welcome return to the *parens patriae*”¹³⁸ role for the state,¹³⁹ which some respondents felt had been abandoned under the dangerousness standard of civil commitment. In describing support for outpatient commitment in the face of a lack of support in the empirical literature, one of the respondents suggested that research at this point is not definitive. Research has neither proven outpatient commitment effective, nor proven that it is not effective in improving compliance and other outcomes. He suggested, “even when research is equivocal, there is little to suggest that the intervention is harmful – but it requires good community services and its coercive power is quite limited.”¹⁴⁰

He and other respondents cautioned, however, that while they view outpatient commitment as helpful, “it shouldn’t be overestimated.” One respondent, who conducted one of the first generation studies on outpatient commitment in Ohio, summarized the limits of involuntary outpatient treatment in this way,

It [outpatient commitment] doesn’t mean they have to comply with treatment – it doesn’t allow us to do anything other than continue to monitor them...[but] we can intervene with the probate court before they slide all the way down to meeting the emergency criteria.¹⁴¹

Even if respondents qualified their support of the law based on issues raised in the practice in their own states, most shared the view of one psychiatrist:

I wouldn’t throw out the law [because] people are clearly helped by it and it does affect some people to comply.¹⁴²

Respondents reported, however, that consumer/survivors in their states did not necessarily agree with the view that these laws are benign. Consumer/survivor organizations as well as advocacy groups have argued forcefully that these laws are not only repressive but also unnecessary.

¹³⁶ County behavioral health director, Michigan.

¹³⁷ Psychiatrist, New York.

¹³⁸ “Parent of the country,” referring to the role of the state as protector or guardian of the health, comfort and welfare of its citizens (Black’s Law Dictionary, 5th Edition, West 1983).

¹³⁹ Psychiatrist, Wisconsin.

¹⁴⁰ Psychiatrist, New York.

¹⁴¹ Psychiatrist, Ohio.

¹⁴² Psychiatrist, North Carolina.

In countering that argument, another psychiatrist maintained,

It's not enough to say, we wouldn't need it [involuntary treatment] if only we had the services available [then] people would take them voluntarily – compliance is a real issue because it's the illness creating noncompliance – it's not just a decision – it's lack of capacity to decide what's in your best interest.¹⁴³

Other respondents suggested that a balancing is required. Such a balance would provide the resources necessary to provide community treatment and due process for people brought into the system involuntarily – but would also allow for involuntary outpatient treatment where necessary.¹⁴⁴

In spite of the almost overwhelming support for outpatient commitment laws expressed by key informants in these eight states, significant problems were identified in the implementation of these laws. For example, the county behavioral health director in North Carolina cited problems in consistency across jurisdictions, the lack of tracking mechanisms to provide adequate clinical supervision in all communities, and a lack of funding for needed services. This respondent concluded that recent attempts at further reform of the commitment statute in North Carolina were stalled because “our outpatient commitment implementation is so broken that it didn't make sense to add a new component.” The county behavioral health director in Oregon reported his perception that the law in Oregon is not working as intended, is not used frequently, and that the people targeted are possibly not the people who might benefit most, (e.g., those who suffer from alcohol and drug problems in addition to mental illness). He reported that caseloads for case managers are too high (50-60 patients) for there to be adequate monitoring. One respondent from Texas summarized by suggesting that Texas has a “weak law” that has “no teeth.”¹⁴⁵

However, some of the respondents were either uncomfortable with the idea of court-ordered outpatient treatment or were concerned that the fears of consumer/survivors were not adequately addressed in their own states.¹⁴⁶ These respondents reported that some mental health consumer/survivors see outpatient commitment as a violation of their rights,¹⁴⁷ and believe that some mental health professionals might be applying the law in a punitive fashion.¹⁴⁸ The director in Washington was concerned that if these laws come to be viewed as innocuous, the state may be creating an “an institution without walls.”

¹⁴³ Psychiatrist, New York.

¹⁴⁴ Psychiatrist, Wisconsin.

¹⁴⁵ Psychiatrist, Texas.

¹⁴⁶ County behavioral health directors in North Carolina, Ohio and Washington.

¹⁴⁷ County behavioral health director, North Carolina.

¹⁴⁸ County behavioral health director, Ohio.

She suggested,

There is a danger that people feel OK about doing it because they [consumer/survivors] are put in a least restrictive alternative rather than putting people through the whole [commitment] process.

But, returning to a balancing view, the county behavioral health director in Ohio suggested,

Outpatient commitment is a failure of our system to intervene early and support fully” [it reflects] “an opportunity we missed to engage people in treatment on a voluntary basis” [but] “outpatient commitment is an important lever to encourage people into treatment and assist in recovery, but we want to use it sparingly and only for as long as needed.

To the extent that respondents reported that outpatient commitment is effective in their state, they attributed its success to two factors – the treatment associated with the commitment and the “external discipline” provided by providers¹⁴⁹ and by the courts.¹⁵⁰

The Treatment System Is Critical to the Success of Outpatient Commitment

There were three aspects of service provision deemed critical to the success of outpatient commitment. In the words of our respondents, these include:

- Having the infrastructure to handle outpatient commitment;
- Having the treatment services available; and
- Having a service system that can deliver the services rationally.

First, respondents emphasized the need to have some sort of infrastructure in each local community to handle petitions, receive court orders, track clients through the system (both the commitment system and the treatment system) and assure that people are not staying on commitment orders any longer than is justifiable. Most respondents reported that their communities do not do an adequate job of tracking.

One exemplary model is the pilot program at Bellevue Hospital Center in New York City that pioneered the use of multidisciplinary teams with legal support. These teams, which receive both clinical and legal supervision, are legal designees of the City Department of Mental Health (i.e., have delegated authority to initiate petitions) but are operated by the City’s Health and Hospitals Corporation. The Department of Mental Health contracts

¹⁴⁹ County behavioral health director, Michigan.

¹⁵⁰ Psychiatrist, Ohio.

with a large number of service agencies to provide mental health and other clinical and supportive services.

By contrast, the county behavioral health director in North Carolina reported variability in infrastructure development across the state, with some local behavioral health authorities “overwhelmed” by courts ordering outpatient commitment without consultation with the responsible local behavioral health authority or treatment provider.

Second, there was universal concern about outpatient commitment laws being enacted without adequate appropriations for treatment services. Respondents emphasized that *a sustained commitment to a high level of funding is required to provide adequate supervision, monitoring, and clinical services*. Some respondents advocated the development of particular types of services, such as assertive community treatment,¹⁵¹ intensive case management,¹⁵² and supported housing¹⁵³ as part of the outpatient commitment initiative. Others emphasized the need to supplement appropriations for a “straightforward array” of services with “wrap around funds” that can be used to purchase particular services on an *ad hoc* basis.¹⁵⁴ Respondents in Ohio and Washington focused on the need for access to the newer antidepressants and antipsychotic medications.¹⁵⁵ These respondents suggested that newer antipsychotic medications are critical to managing at-risk patients in the community; however, the introduction of managed care formularies (either restricting or discouraging the use of newer medications) and price increases are causing strains on the public mental health system. One Ohio respondent also emphasized that the chronic shortage of permanent, affordable housing is a perennial problem in helping maintain people with severe mental illnesses in the community.¹⁵⁶

Some respondents questioned whether implementing an outpatient commitment program created a right to treatment in the community, and, if so, what “breadth of services people should have a right to?”¹⁵⁷ Respondents in New York praised their legislature for sustaining funding for community services at a high level since the passage of Kendra’s Law in 1999, but expressed some concern about future funding because Kendra’s Law itself did not include a services appropriation.¹⁵⁸ They suggested that it would have been *very* difficult for counties to comply with the law in the absence of the infusion of significant new resources into the system. Such an infusion of resources was not evident in North Carolina and respondents there reported that not all communities can afford the

¹⁵¹ County behavioral health director, Michigan; psychiatrists in Michigan and New York.

¹⁵² Psychiatrist, New York.

¹⁵³ Psychiatrist, New York.

¹⁵⁴ Legal counsel to county behavioral health organization, New York.

¹⁵⁵ County behavioral health directors in Ohio and Washington.

¹⁵⁶ County behavioral health director, Ohio.

¹⁵⁷ Psychiatrist, Michigan.

¹⁵⁸ County behavioral health director, New York.

levels of intervention that were provided to patients in the Duke Study – raising questions about the generalizability of the Duke findings to the rest of North Carolina.¹⁵⁹

Respondents also stressed the need to improve the quality of routine clinical care in the public sector.¹⁶⁰ Beyond the need to increase the use of the newer medications and to ensure that prescribing practices conform to evidence-based practice guidelines, these respondents suggested that both additional funding and quality assurance efforts might be necessary to enhance the likelihood that California's public agencies are delivering psychosocial treatments that are evidence-based (such as those described in Section IV) and clinical services that conform to practice guidelines. High staff-to-client ratios were deemed necessary to ensure that adequate medical treatment¹⁶¹ and supervision¹⁶² are being provided.

Third, respondents emphasized the need to have service systems that can deliver care rationally. Psychiatrists in Michigan and New York characterized the issue as one of capability and sophistication at the local behavioral health authority level – both to build a system of care in the local community and to provide incentives to modify provider behavior. Rural areas and those local mental health systems administered under private-sector managed care raised particular concerns. For example, one respondent in North Carolina reported that in some rural areas case managers have over 200 patients on their caseloads.¹⁶³ One of the Michigan respondents expressed concern about the delegation of public responsibility for services to private managed care entities that may be as motivated by the “bottom line” as by the needs of patients.¹⁶⁴

Outpatient Commitment Is Used Infrequently and Primarily as a Discharge-Planning Vehicle

With only a few exceptions, respondents reported that few people are under outpatient commitment orders in their jurisdictions. In Michigan, the county behavioral health director reported that less than 10% of clients in the county were under outpatient commitment orders and the psychiatrist reported that outpatient commitment is “not routine, not extraordinary, somewhere in between.”

The county behavioral health official in New York reported that they had anticipated “a flood of commitments” after the passage of Kendra's Law. Officials in New York City had estimated that 7,000 individuals in New York City would potentially be affected. As of September 15, 2000, however, there were only 235 petitions (56 of which were brought by the State of New York). The initial estimates were based on a perceived widening of the commitment criteria under Kendra's Law (as opposed to the pilot), the

¹⁵⁹ County behavioral health director, North Carolina.

¹⁶⁰ Psychiatrist, New York.

¹⁶¹ Psychiatrist, New York.

¹⁶² Psychiatrist, Washington.

¹⁶³ County behavioral health director, North Carolina.

¹⁶⁴ Psychiatrist, Michigan.

fact that Kendra's Law allowed a broader range of people to petition, and officials' belief that risk managers at hospitals would use Kendra's Law as a discharge-planning mechanism.

Ohio respondents reported pockets of use but that no counties use outpatient commitment extensively.¹⁶⁵ They had no expectation that outpatient commitments would ever cover more than 10% of patients. The Oregon county behavioral health director also reported light use (with the exception of Portland and Salem) but suggested that there has been "no attempt to make it a priority" and attributed that to the lack of service support.

Washington respondents reported a mixed picture – with some counties using outpatient commitment (especially counties in which there were public mental hospitals) and other counties not using it at all. The reports from Wisconsin were mixed, with reports of high use of outpatient commitment in some counties, but lower use in others, and the so-called 5th Standard not used at all in some counties because of concerns that it might be unconstitutional.¹⁶⁶

To the extent that local behavioral health authorities were using outpatient commitment, most of the key informants reported that outpatient commitment was used primarily as a discharge-planning vehicle rather than as a community alternative (although there were some differences of opinion among respondents in Texas and Wisconsin and reports of variability across Ohio). The psychiatrist in Washington reported that a commitment directly to the community could happen in theory but is not a routine feature of community-based care.

Among the reasons reported for low rates of use, the respondents in North Carolina felt that rates of use were related to differences in the "culture" of communities as reflected by overall rates of commitment (i.e., local behavioral health authorities are no more likely to use outpatient commitment than they are to use inpatient commitment). Another respondent reported a reluctance on the part of community mental health providers to admit people on outpatient commitment because these patients were perceived to be high-risk patients in need of high levels of supervision, and many community-based programs lacked staffing for intensive services.¹⁶⁷ Service providers were also concerned about liability for the acts of people on commitment orders. Some felt that patients who were sick enough to meet commitment criteria needed to be stabilized in a protected environment like a hospital.¹⁶⁸

Finally, at least one respondent raised questions about the generalizability of the research on outpatient commitment.¹⁶⁹ He noted that the only two randomized clinical trials of

¹⁶⁵ Psychiatrist and county behavioral health director, Ohio.

¹⁶⁶ County behavioral health director and psychiatrist, Wisconsin.

¹⁶⁷ Psychiatrist and county behavioral health director, North Carolina.

¹⁶⁸ Psychiatrist, Oregon.

¹⁶⁹ Psychiatrist, New York.

outpatient commitment (the Duke Study in North Carolina and the Bellevue Study in New York City) involved patients being discharged from the hospital. He questioned the generalizability of those findings to communities planning to use outpatient commitment as an alternative to hospitalization.

Making the Outpatient Commitment Process More “Voluntary”

At least three of the states use mechanisms to involve the individual in the development of a consensus plan for compliance with his or her mental health treatment. In Michigan, a person being evaluated for commitment may voluntarily waive the full contested hearing if he or she agrees to voluntary compliance with the treatment plan. (One respondent suggested, however, that this procedure created “a kind of limbo status” where the patient was “not 100% committed.”)¹⁷⁰ In Wisconsin, at the time of the probable cause hearing, lawyers, the doctor, and the individual can agree to stipulate to probable cause if he or she agrees to comply with the treatment plan. The case is held open (usually 90 days) with promise of dismissal at some time certain. During that period of time a social worker monitors the person and the agreement can be enforced; however, when the agreement expires it cannot be extended.¹⁷¹ In New York, some counties have chosen to seek voluntary compliance agreements in an effort to divert focus from the legal to the clinical arena. New York City continues to prioritize the use of outpatient commitment.¹⁷²

Are Commitment Orders “Reciprocal”: Who Is Committed Under an Outpatient Commitment Order – the Patient, the Provider or Both?

Responses to this question varied, from key informants who suggested that the local behavioral health authority and the provider are “committed” by court order to provide treatment services¹⁷³ to others who suggested that the commitment order was not an order to treat but, in effect, a referral to the provider who would determine what, if any, services the patient needed and the system could provide.¹⁷⁴

Concerned with whether outpatient commitment might represent a “back door” for judges to assure that patients are going to get some treatment, the New York county behavioral health director commented,

Outpatient commitment is *not* a vehicle to create a right to treatment – if you want a right to treatment do that – but do it for everybody – don’t make everyone go through the court system to access care.

¹⁷⁰ County behavioral health director, Michigan.

¹⁷¹ Assistant Attorney General, Wisconsin.

¹⁷² Psychiatrist, New York.

¹⁷³ County behavioral health directors in New York, Ohio, and Washington; psychiatrists in Ohio and Wisconsin.

¹⁷⁴ Psychiatrist in North Carolina; county behavioral health director in Oregon.

The Issue of Provider Liability Doesn't Figure Prominently Among the List of Concerns People Have

Respondents reported some concern in their communities about issues of provider liability – whether liability for failing to petition for commitment,¹⁷⁵ for failure to monitor aggressively,¹⁷⁶ or failure to report noncompliance to the court.¹⁷⁷ No respondents suggested that fear of liability is a major factor in the behavior of service providers in regard to outpatient commitment. Most reported that public-sector agencies are at risk for all patients they are treating, whether or not they are under commitment orders. Some reported that neither courts nor mental health systems do much to hold providers accountable¹⁷⁸ but others reported that county behavioral health authorities use their contracting leverage to ensure that services are provided.¹⁷⁹

The Specificity of Outpatient Commitment Orders – Are Medications Included?

Some respondents expressed concern that the court orders not be too specific. These respondents questioned whether judges are in a position to be making clinical decisions, demanding specific treatments or that involuntary patients be prioritized over others, especially when treatment resources are scarce.¹⁸⁰ Others lamented a “disconnect with the capacity of the system to implement the orders” and the lack of information. In most cases these respondents observed little regular communication between the court and the treatment system with the result that judges have no idea whether patients are receiving the services the court intended.¹⁸¹

In some states, orders may mention medication without specifically dictating that the patient must take medication to be in compliance with the order.¹⁸² In Texas, the judge may “advise but not compel” the patient to take medication and any major changes to the treatment plan must go back to the court for approval.¹⁸³

In Oregon, the statute doesn't specify and written orders tend to vary in form and length – but typically include medication compliance, attending outpatient appointments, and may also require that a person refrain from alcohol and drug use and/or live at a particular address.¹⁸⁴ In Washington and Wisconsin the orders are specific on the issue of medication,¹⁸⁵ and, in Wisconsin, can also mention alcohol and drugs. (It should also be

¹⁷⁵ County behavioral health director, New York.

¹⁷⁶ County behavioral health director, Michigan; psychiatrist, Washington.

¹⁷⁷ County behavioral health director, New York.

¹⁷⁸ County behavioral health director, North Carolina.

¹⁷⁹ Psychiatrist, Wisconsin; county behavioral health director and psychiatrist, Washington.

¹⁸⁰ County behavioral health director, Michigan.

¹⁸¹ County behavioral health director, North Carolina.

¹⁸² Psychiatrist, Ohio.

¹⁸³ Psychiatrist, Texas.

¹⁸⁴ Psychiatrist, Oregon.

¹⁸⁵ Psychiatrist, Washington; county behavioral health director, Wisconsin.

noted that in Wisconsin the person is committed to the county behavioral health authority rather than to a facility or provider, but the order does identify the provider as well as any specific conditions).

Most Key Informants Report That Forcible Medication Is Not Allowed

Key informants agreed that forcible medication is probably the most sensitive legal and practical issue they face. Some even questioned whether outpatient commitment is compatible with the idea of forced medication.¹⁸⁶ Michigan respondents reported that they are not allowed to forcibly medicate – even if the patient is in a hospital – without a court order.¹⁸⁷ Key informants from New York reported that forcible medication is prohibited as part of the outpatient commitment order but that a separate “medication order” may be obtained on a finding that the patient lacks the capacity to make treatment decisions; however, even community medication orders raise practical issues.¹⁸⁸

Under the pilot program at Bellevue Hospital Center (before the implementation of Kendra’s Law changed the policy regarding medication), the City’s Health and Hospitals Corporation developed pilot guidelines for forcible medication – but these guidelines could only be used with injectable medications. The policy stated that if patients physically resisted they could be transported to the emergency room; however, there was no provision in the statute for such transportation (and no appropriation to pay for it). One of the respondents, who was involved in the effort to develop the policy, concluded that it was very difficult to craft a reasonable approach and warned of the practical problem of legislating a process that will ultimately depend on the willingness of providers. He suggested, “the closer you get to the front line the less there is a desire to do this” because of very real concerns about relationships with patients, need for documentation, and liability.¹⁸⁹

Most respondents reported that their statutes did not allow forcible administration of medication under outpatient commitment orders and that, whether inpatient or outpatient, patients retained the right to refuse medication, absent a court order to the contrary. Counties and providers varied in the extent to which they sought those orders, although those who routinely sought them were able to obtain such orders.

¹⁸⁶ Psychiatrist, New York.

¹⁸⁷ County behavioral health director, Michigan.

¹⁸⁸ Psychiatrist and county behavioral health director, New York.

¹⁸⁹ Psychiatrist, New York.

The Burden of Monitoring Falls Mostly on the Treatment System – Which Has Implications for Treatment Resources

Key informants in Michigan and New York emphasized the need for model clinical programs that have small caseloads and intensive services to provide the kind of supervision and monitoring that is required.¹⁹⁰ Michigan utilizes ACT programs, including some teams that specialize in treating dual-diagnosis patients (patients with co-occurring mental and substance abuse disorders). In New York City, there are four outpatient commitment coordinating teams and patients receive either intensive case management or ACT to ensure a high level of monitoring.

Others reported that there are not necessarily any special programs for patients under outpatient commitment orders¹⁹¹ nor necessarily any special monitoring.¹⁹² One of our respondents in North Carolina reported,

People get the same access to treatment whether they are voluntary or involuntary – no one necessarily tracks people on outpatient commitment any differently than voluntary patients – the only difference comes if they fail to show.¹⁹³

However, the North Carolina county behavioral health official suggested that the “better programs” probably are prioritizing these clients, although she agreed that there are no special tracking mechanisms in most counties nor has there been consistent training on procedures for officials of the county behavioral health authorities.

Respondents in Ohio, Washington and Wisconsin reported that the local behavioral health authorities are involved in tracking individuals under outpatient commitment orders.¹⁹⁴ In Ohio, a statutory provision requires that people under commitment orders be seen a minimum of every 30 days to see if they continue to meet the commitment criteria; however, there is no periodic reporting to the court. In Washington, county-designated mental health providers keep records on all people committed and prompt service agencies when orders are about to expire. According to the county behavioral health director, “we case manage the providers.” In Wisconsin, our respondents reported that most counties designate an administrative staff person to be in charge of outpatient commitments and each person is also assigned a caseworker to carry out day-to-day management.¹⁹⁵

The county behavioral health director in Oregon expressed concern about the clinical implications of having providers be the monitors of compliance. She expressed a

¹⁹⁰ Psychiatrists in Michigan and New York.

¹⁹¹ County behavioral health director, North Carolina.

¹⁹² Psychiatrist, Texas.

¹⁹³ Psychiatrist, North Carolina.

¹⁹⁴ Psychiatrists in Ohio and Wisconsin and county behavioral health director in Washington.

¹⁹⁵ County behavioral health director, Wisconsin.

preference for separating the roles of “probation officer” and “provider” so that monitoring does not interfere with the development of the “treatment alliance” with patients, which she described as critical to successful treatment.

When questioned about the impact of outpatient commitment on treatment resources, the respondents had mixed views. In some states where local behavioral health authorities manage all or most of the state and local resources (e.g., Ohio, Wisconsin, Michigan), respondents reported having an incentive to monitor and provide services to people who need them because “we need to have a handle on them [those who refuse to comply] or they can become very expensive.”¹⁹⁶ Other respondents suggested that state funding for mental health services is shrinking over time, although some states (e.g., New York) require that priority for services be given to people on outpatient commitment orders.¹⁹⁷ All respondents agreed that additional monies would be needed to provide suitable intensive services and monitoring in the community; however, no one subscribed to the notion of “tying” service dollars to involuntary treatment. Respondents were concerned that limiting new service dollars to treatment associated with court orders would tend to “incentivize” providers to increase their use of outpatient commitment – perhaps unnecessarily.

States Differ Widely in the Extent to Which Commitment Laws and Practices Have “Teeth”

As is evident in our statutory analysis, states vary widely in the extent to which enforcement mechanisms are built into the statute. Our interviews suggested there is also variability in the ways localities have chosen to enforce commitment orders.

In several states, the commitment orders are actually ‘combination’ orders (including both inpatient and outpatient periods). For example one of our Michigan respondents reported that court orders cover both hospital and community treatment so that enforcement for noncompliance is “virtually automatic.”¹⁹⁸ People in Michigan who do not comply with treatment can be brought in for an evaluation and returned to hospital care for the maximum amount of hospitalization permitted under the order without an additional hearing. In Ohio, the county behavioral health authority can notify the court that the terms of the court order are not being met and the person can be taken into custody and returned to the hospital.¹⁹⁹ The person can request a hearing but a hearing is not automatic. Both Washington and Wisconsin respondents reported that the order can be revoked and the person sent back to the hospital.²⁰⁰

¹⁹⁶ County behavioral health director, Michigan.

¹⁹⁷ County behavioral health director, New York.

¹⁹⁸ Psychiatrist, Michigan.

¹⁹⁹ County behavioral health director, Ohio.

²⁰⁰ Psychiatrists in Wisconsin and Washington and county behavioral health director in Washington.

By contrast, according to one respondent, New York law “lends an imprimatur of enforcement when there isn’t really one.”²⁰¹ Under New York statute, the person who does not comply with an outpatient order can be transported for evaluation but cannot be hospitalized unless the inpatient commitment criteria apply. The county behavioral health director in New York suggested that another remedy is needed. He reported that there has been a policy debate about the possibility of contempt-of-court sanctions for noncompliance. The psychiatrist in North Carolina also lamented the lack of enforcement capability in their programs,

The problem with outpatient commitment is that we cannot force them to have treatment – if the person is really committed to not getting treatment there is not a whole lot you can do – even with outpatient commitment. There isn’t any legal means of getting them to accept it except for those who [comply because they] are afraid of authority.

He was also among the respondents who noted that local law enforcement agencies in many communities are reluctant to be involved in enforcement of orders because of the length and unpredictability of the process on a day-to-day basis.

Some States Are Already Looking for an Alternative Solution to the Problem of Noncompliance

Several of our respondents contrasted the lack of enforcement power in the outpatient commitment statute with the perceived leverage criminal courts have over criminal defendants. Respondents in three states mentioned that there have been policy debates in their states about the development of so-called mental health courts.²⁰² Although historically families of people with severe mental illness have been encouraged to intervene to get legal charges dropped and divert their adult children into the civil commitment system, more recently some family and physician groups in these states are showing a new interest in the “leverage” that might be obtained in the criminal justice system – whether through jail diversion programs, probation systems, or mental health courts.

Aspects of the mental health court model that respondents found appealing were close working relationships among law enforcement, mental health and substance abuse systems;²⁰³ the association of mental health courts with treatment models like assertive community treatment;²⁰⁴ and the individual attention provided to clients by the mental health and drug court judges.²⁰⁵ However, these respondents also recognized that mental

²⁰¹ Legal counsel to county behavioral health organization, New York.

²⁰² Goldkamp and Irons-Guynn, 2000.

²⁰³ County behavioral health director, North Carolina.

²⁰⁴ Psychiatrist, Ohio.

²⁰⁵ Psychiatrist, Washington.

health courts, like drug courts, require an infusion of new resources and that successful court programs are dependent on service dollars to provide treatment for offenders in the community.

Most Key Informants Report a Lack of Consistency Across Jurisdictions But Also Report That Little Is Being Done

Almost all respondents acknowledged a lack of consistency in some aspect of the commitment process across jurisdictions, judges, county behavioral health organizations, and providers. Reported explanations for such inconsistency included variations in familiarity with procedures;²⁰⁶ variations in patient population;²⁰⁷ variations in access to psychiatrists, especially in rural areas;²⁰⁸ the discretion inherent in case-by-case determinations;²⁰⁹ differences in the “culture” of local communities and providers;²¹⁰ and differences in the “proclivities” of judges.²¹¹

Respondents focused on the importance of leadership – suggesting that the state departments of mental health, the local behavioral health authorities, the bar and judicial organizations would need to focus their attention on this issue in order to improve practices within the state. Several respondents suggested that inconsistency across jurisdictions was mostly an unrecognized or unacknowledged problem and thus no priority had been given to addressing it on a systemic level. Among the most critical problems we identified was the widespread lack of management information systems that could identify trends across jurisdictions within a state.

Nevertheless some respondents reported benefit from a variety of *ad hoc* efforts, including standardized forms and data collection;²¹² shared protocols;²¹³ joint trainings with participation by judges and county behavioral health officials;²¹⁴ manuals and flow charts developed by state organizations of county behavioral health boards;²¹⁵ videotapes for mental health consumer/survivors²¹⁶ and professionals;²¹⁷ and a State Department of Mental Health information line for judges and mental health professionals.²¹⁸

²⁰⁶ County behavioral health director, Michigan.

²⁰⁷ County behavioral health director, New York.

²⁰⁸ Psychiatrists in North Carolina and Michigan.

²⁰⁹ County behavioral health director, New York.

²¹⁰ Psychiatrist and county behavioral health director, Ohio.

²¹¹ County behavioral health director, Ohio.

²¹² Psychiatrist, New York.

²¹³ Psychiatrist, Ohio.

²¹⁴ County behavioral health director, Ohio.

²¹⁵ Psychiatrist, Wisconsin; county behavioral health director, Ohio.

²¹⁶ County behavioral health director, Ohio.

²¹⁷ Psychiatrist, Texas.

²¹⁸ Psychiatrist, Texas.

In addition, some states have employed methods to centralize decisionmaking as one approach to improving consistency. For example, in Wisconsin, during the debate on the addition of the 5th Standard, some stakeholders were concerned that the standard itself was subjective and open to a wide variety of interpretations by local behavioral health authorities and physicians. To address that concern, the legislature required that all petitions under the 5th Standard be cleared by the state attorney general's office. According to our respondents, this process has been implemented without any significant problems.²¹⁹

“Closing Arguments”

When offered the opportunity to sum up their best advice to the California Senate, the respondents focused their attention on both the process of passing outpatient commitment legislation and the practicalities that would need to be addressed if an outpatient commitment statute were to be implemented in local communities.

On the process, respondents suggested that legislative debates tend to be heated and stakeholders often take extreme positions about the impact of proposed legislation. *Several respondents suggested that outpatient commitment is neither as effective a solution to the problem of compliance as its advocates claim nor, in its practical application, as repressive a law as consumer/survivors fear.* Another suggested that if the legislature decides to proceed with a bill, the members should spend at least as much time during the legislative process with “potential implementers” as with advocates. He suggested, “once the Senate has drafted the statute – stop listening to the advocacy groups and go to the implementers – ask them – if we do this what will you actually have to do in your county? In your facility? Could you do this? That should be the question at the end of the process – not should you but could you.”²²⁰

Other respondents focused more attention on implementation and suggested that a good statute would be simple, specific (“who, what, when, where, how”), and include criteria and standards that are unambiguous.²²¹ The implementation should be uniform across the state,²²² with a fixed point of accountability in every community and adequate training for all stakeholders.²²³

Respondents from New York suggested that California may want to consider following the New York example by first passing a pilot with an evaluation and/or including a “sunset” provision in the statute (Kendra’s Law sunsets in 2005). Concerns about the effect of outpatient commitment in the context of the California mental health system could be addressed by either a pilot or a time-limited statute.

²¹⁹ Psychiatrist and county behavioral health director, Wisconsin.

²²⁰ Psychiatrist, Michigan.

²²¹ Psychiatrist, New York.

²²² Psychiatrist, New York.

²²³ Psychiatrist, Wisconsin.

Conclusion

Interview respondents expressed support for outpatient commitment laws in spite of the lack of empirical evidence and in spite of their acknowledgment of problems in implementing outpatient commitment in their own jurisdictions. This support may be explained by the fact that all respondents agreed that lack of compliance with outpatient treatment is a real problem, resulting in relapse and rehospitalization for at least some proportion of people with serious mental illnesses. Most also subscribed to the notion that outpatient commitment probably is not harmful – at least when compared to inpatient commitment – because outpatient commitment results in placement in a less restrictive environment. To the extent that respondents were concerned about deprivation of liberty (and some did subscribe to more civil libertarian views on this matter), most argued for the balancing of the patient’s liberty interests with the state’s right to intervene. They told us that outpatient commitment was less restrictive of liberty and therefore less objectionable, especially when outpatient commitment statutes do not allow patients to be returned to the hospital without a hearing, and do not allow forcible medication. Most respondents reported that outpatient commitment was used primarily as a discharge-planning mechanism, which conforms with the notion that it provides the mechanism to get people with severe mental illness out of more restrictive care settings and into the community. These respondents subscribed to the notion that outpatient commitment orders provided some “leverage,” which they saw as useful in improving compliance – at least among those patients who respect the authority of the court. Among those who criticized the implementation of outpatient commitment laws in their own states, most criticized the programs because their states and communities were unable to deliver the promised treatment. Undoubtedly, had we interviewed consumer/survivors in the eight states we would have found less unanimity on these issues.

As to why outpatient commitment is used relatively infrequently, our informants suggested a wide variety of reasons, related to experiences in their own states. These concerns included infringement on civil liberties, provider liability, overly stringent commitment criteria, and lack of enforcement. Others expressed concern about lack of services and staffing. Still others made observations about the “culture” of some communities and providers or the civil libertarian views of some judges, prosecutors, and defense attorneys. Few respondents expressed concern about the constitutionality of outpatient commitment laws and none of the statutes in these eight states have been struck down by the courts.

In general, state outpatient commitment provisions have not been subject to much reported litigation. In addition, the courts that have reviewed commitment statutes have generally upheld grave disability criteria as well as other expansions of state civil commitment statutes. Whether the courts would uphold a pure “mental illness” commitment statute (one that permitted commitment solely on the grounds of mental illness with no behavioral criteria) is open to debate, but the courts do appear to generally endorse the broader standards for dangerousness embodied in recent state statutory revisions.

The one limiting factor that was emphasized in the majority of the interviews was the concern about inadequacies in the service system; however, we did not ask respondents to rank-order their concerns, so we can only speculate on which factors may be more important than others in lessening the use of outpatient commitment.

VII. INVOLUNTARY TREATMENT IN CALIFORNIA: WHO IS POTENTIALLY AFFECTED BY A CHANGE IN THE LANTERMAN-PETRIS-SHORT ACT?

California's civil commitment practice is governed by the Lanterman-Petris-Short Act, signed into law by Governor Ronald Reagan in 1967. This law, now over 30 years old, was revolutionary in its time. Many commentators, attorneys, and advocates regard the LPS Act as having significantly influenced mental health law in the United States by emphasizing voluntary treatment and moving away from indeterminate involuntary confinement. Under the LPS, decisions about who needs involuntary treatment are based on "behavioral criteria" (such as "dangerous to self or others" and "grave disability") rather than "need for treatment" justifications.²²⁴

In describing the LPS Act, Paul Appelbaum, one of the country's leading researchers and commentators on mental health law, suggested that the California statute, along with the Ervin Act in Washington, DC, was groundbreaking, in that the LPS Act

Reflected a view of the proper reach of state power that was to grow in popularity in the following two decades. It was based on the libertarian belief that the state is justified in infringing individual liberty only when one person's actions endanger others, and perhaps in a limited set of circumstances when people act irrationally to endanger themselves. Many commentators argued precisely this vision of liberty inspired our founding fathers, and that state actions that transcend these limits lack constitutional legitimacy.²²⁵

Noting that the arguments for restricting the scope of involuntary treatment "ranged from the philosophical to the fiscal to the clinical," Appelbaum suggested that, "the California experience, in particular, was watched carefully around the nation." The current debate about changes to the LPS will undoubtedly also attract national attention.

Involuntary Treatment Under the Lanterman-Petris-Short Act

The LPS Act, codified in the California Welfare and Institutions Code at § 5000 *et seq.*, has a number of important goals:

- To end the inappropriate, indefinite, and involuntary commitment of mentally disordered persons, developmentally disabled persons, and persons impaired by chronic alcoholism, and to eliminate legal disabilities;

²²⁴ See LPS Reform Task Force, March 1999; California Institute of Mental Health, March 2000; Little Hoover Commission, November 2000.

²²⁵ Appelbaum, 1994; pp. 26-27.

- To provide prompt evaluation and treatment of persons with serious mental disorders or impaired by chronic alcoholism;
- To guarantee and protect public safety;
- To safeguard individual rights through judicial review;
- To provide individualized treatment, supervision, and placement services by a conservatorship program for gravely disabled persons;
- To encourage the full use of all existing agencies, professional personnel and public funds to accomplish these objectives and to prevent duplication of services and unnecessary expenditures; and
- To protect mentally disordered persons and developmentally disabled persons from criminal acts (W & I C § 5001(a)-(g)).

Our emphasis in this report is on the criteria and processes for civil commitment of adults with mental illness.

Under the LPS Act, the legal criteria for confinement for evaluation and treatment is “probable cause to believe that the person is, as a result of mental disorder, a danger to others, or to himself or herself, or gravely disabled.” (W & I C § 5150). “Gravely disabled” is defined as “a condition in which a person, as a result of a mental disorder, is unable to provide for his or her basic personal needs for food, clothing or shelter.” (W & I C § 5008(h)(1)(A)).²²⁶

The Act allows detention for evaluation and treatment for people with mental illnesses under “successive periods of increasingly longer duration,”²²⁷ beginning with an initial 72-hour hold for evaluation and treatment.

72-hour hold. The statute authorizes an initial period of hospitalization in a designated facility; however, if, in the judgement of the facility medical staff the person does not meet the criteria or can be “properly served” without being detained, the statute authorizes the facility to provide “evaluation, crisis intervention, or other inpatient or outpatient services on a voluntary basis.” The hold for evaluation and treatment may be up to 72 hours but, if at any time during those 72 hours the person is found not to meet the criteria, he or she must be released. After the expiration of 72 hours, the facility must

²²⁶ The Act also states, however, that “a person is *not* gravely disabled if that person can survive safely without involuntary detention with the help of responsible family, friends or others who are both willing and able to provide for the person’s basic personal needs for food, clothing, or shelter” (W & IC § 5250(d)(1)) and the responsible family member, friend or other person specifically indicates their willingness in writing (W & I C § 5250(d)(2)).

²²⁷ California Jurisprudence, Third Edition (West 1997).

either release the individual, refer for voluntary treatment, certify for intensive treatment or begin the process of appointing a conservator (W & I C § 5150 *et seq.*).

14-day certification for intensive treatment. A person detained for 72 hours may be certified for up to 14 days of intensive treatment if the staff of the facility determine that the person “as a result of mental disorder or impairment by chronic alcoholism” is a danger to others, or to himself or herself, or gravely disabled and that the person is unwilling to accept treatment on a voluntary basis. The person may be held for up to 14 days, but must be released at any time he or she no longer meets the commitment criteria (W & I C § 5250 *et seq.*).

At the conclusion of the 14-day period, the person must be released, retained for further treatment on a voluntary basis, or held by the facility on one of four possible statuses:

- certified for additional intensive treatment (14-day) for *suicidal* persons (W & I C § 5250 *et seq.*)
- certified for additional intensive treatment (30-day) for *grave disability* (W & I C § 5270 *et seq.*)
- certified for additional intensive treatment (180-day) for *imminently dangerous* persons (W & I C § 5300 *et seq.*) or
- held under a temporary conservatorship (for gravely disabled persons) (W & I C § 5352 *et seq.*).

Additional 14-day intensive treatment of suicidal persons. Any person who, during the 72-hour or 14-day periods “threatened or attempted to take his own life or who was detained for evaluation and treatment because he threatened or attempted to take his own life and who continues to present an imminent threat of taking his own life” and has refused voluntary treatment may be confined for not more than an additional 14 days. At the end of the 14 days, the person must be released, retained for further treatment on a voluntary basis, or a petition can be filed for conservatorship (W & I C § 5250 *et seq.*).

*Additional 30-day intensive treatment of gravely disabled individuals.*²²⁸ A person may be held for an additional 30 days of involuntary treatment if the facility staff find that the person remains gravely disabled and “unwilling or unable to accept treatment voluntarily.” Treatment extends for not more than 30 days and at the end of the 30 days, the person must be released, retained for further treatment on a voluntary basis, certified for treatment as an imminently dangerous person, or a petition can be filed for conservatorship (W & I C § 5270 *et seq.*).

²²⁸ Only available in counties where the board of supervisors has specifically authorized the use of this mechanism.

Additional 180-day intensive treatment of imminently dangerous persons. At the expiration of the 14 days of intensive treatment, a person may be held for further treatment (not to exceed 180 days) if the person has “attempted, inflicted or made a serious threat of physical harm” on another person. These criteria apply if the person was either taken into custody because of having attempted or inflicted harm, attempted or inflicted harm while in custody, or made a serious threat within seven days of being taken into custody and currently “presents a demonstrated danger of inflicting substantial physical harm on others.” A person being held on a 180-day certification may be treated on an outpatient basis if the facility staff find that the person will no longer be a danger to the health and safety of others while on an outpatient basis and will benefit from outpatient status. At the end of the 180 days, the person shall be released unless a new petition for postcertification treatment is filed (on the grounds of threats, attempts or infliction of harm during the initial 180-day period) (W & I C § 5300 *et seq.*).

Temporary (30-day) and LPS (1-year) Conservatorship. Staff of facilities that are providing evaluation and treatment or intensive treatment may petition the court for appointment of a conservator for any person who is “gravely disabled as a result of mental disorder or impairment by chronic alcoholism.” The conservatorship may be temporary (30-day, typically the time involved in an investigation) or long-term (1 year and renewable). A conservatorship “involves a protective relationship in which a person is appointed by the court to act in the best interest of a gravely disabled individual to ensure that the basic needs of food, clothing, and shelter are met, and that if required, the individual receives needed psychiatric care and treatment.”²²⁹ Conservators are required to notify the court when the individual is no longer gravely disabled so that the court can terminate the conservatorship (W & I C § 5352 *et seq.*).

Figure F.1 in Appendix F illustrates the flow of individuals through the commitment system in California.

Data on Civil Commitment in California

As mentioned in the Methods Section, we obtained data from the California Department of Mental Health for secondary analyses to answer questions on the utilization of involuntary treatment in California. The Senate Office of Research requested descriptive analyses on the following:

- The population of persons subject to current involuntary treatment guidelines in California, by commitment category.
- The commitment history of a selected sample of patients, ranging from those referred for evaluation but never committed, to those subject to short-term but not long-term commitments, to those committed to long-term conservatorships. The profile included, to the extent possible,

²²⁹ California Institute of Mental Health, 2000.

information on diagnosis, grounds for commitment, demographic characteristics, living arrangements, treatment and commitment history, past utilization of services, and secondary diagnoses.

- Subcategories of persons at risk of commitment, or more lengthy commitment, under expanded commitment criteria and provisions.

To address these questions we analyzed data from the State of California's Client Data System (CDS) for the fiscal year 1997-98 (the most recent full year for which data are available). The CDS database contains service records for all persons served by county mental health contract agencies; however, mental health services paid for by private insurers and services delivered through Medi-Cal Inpatient Consolidation are not included in the CDS reporting system. *This is an important qualification because the Department of Mental Health suggests that possibly only half of all inpatient admissions in California are reported in the CDS.*²³⁰

The CDS contains demographic and descriptive information including clients' legal status, diagnosis, and GAF²³¹ scores at admission and discharge, as well as information about service use. For our analyses, we included records for all admissions in fiscal year 1997-98, only excluding records for which admission occurred prior to 1997 and for individuals under the age of 18.

Describing the Population Subject to Current Commitment Guidelines

Admission and discharge legal status are reported on the CDS according to the corresponding California Welfare and Institutions Code (W & I C) section numbers. We used admission and discharge legal status to categorize involuntary treatment into commitment categories by "restrictiveness" of commitment.²³² Table 1 below lists the types of commitment and the associated data elements in the CDS.

²³⁰ According to DMH, county mental health authorities authorize and pay for hospital stays for Medi-Cal patients but payment is made through Medi-Cal inpatient consolidation. DMH officials believe that the majority of these inpatient services are provided on an involuntary basis. Unfortunately, the Medi-Cal claims database does not include information on legal status, and admissions under Medi-Cal are not included in the CDS database, so we are unable to provide a complete picture of involuntary treatment in California.

²³¹ GAF refers to the Global Assessment of Functioning – Axis V of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (APA, 1994).

²³² By "restrictiveness" we mean the duration of the legal status (e.g., 72-hour hold, 14-day intensive treatment, etc.) It is important to note, however, that duration of legal status is not necessarily related to length of stay. Commitment status defines the outward limits of the legal confinement (i.e., a person cannot be held for over 72 hours on a 72-hour hold); however, the LPS Act requires that a person be released at any point that he or she no longer meets the commitment criteria. It is possible, then, to find very short lengths of stay under any of the commitment categories.

TABLE 1
COMMITMENT CATEGORIES IN THE
CALIFORNIA WELFARE AND INSTITUTIONS CODE

Commitment Type	California W & I Code
72-hour hold ²³³	W5150-W5157, W5200-W5213
14-day certification	W5250-W5260
2 nd 14-day certification	W5260-W268
Additional 30-day certification	W5270-W5271
Additional 180-day certification	W5300-W5309
Temporary conservatorship	W5352-5357
LPS conservatorship	W5358-W5371
Voluntary admission	W6000 and above
Other	All other W & I, Penal, Health & Safety Codes

Table E.1 in Appendix E summarizes admission legal status by discharge legal status for all episodes of care in 1997-98,²³⁴ providing information on how clients proceed through the involuntary treatment system.

In 1997-98 there were a total of 106,314 admissions under a 72-hour hold.²³⁵ Sixty-two percent of the admissions under a 72-hour hold were discharged under a 72-hour hold as well. An additional 8% of the admissions under a 72-hour hold were discharged under 14-day certifications. A small number of the 72-hour hold episodes resulted in discharges under more restrictive commitment categories. Nine admissions under a 72-hour hold were discharged under a 2nd 14-day certification, 370 were discharged under an additional 30-day certification, and 15 were discharged under an additional 180-day certification. In addition, a small number of the admissions under 72-hour holds resulted in discharges to temporary conservatorships (992) and LPS conservatorships (97). The remaining admissions for 72-hour holds were discharged on voluntary status (26%) or on other codes (3%).

²³³ Codes pertaining to 72-hour detention of inebriates for evaluation and treatment and court-ordered evaluation for persons impaired by chronic alcoholism or drug abuse were classified as "Other."

²³⁴ Only episodes involving admissions under the W & I Codes listed in Table 1 are included in this analysis. Episodes were constructed using the CDS episode code to aggregate services that were related to a single episode of care.

²³⁵ It is important to note that being on a 72-hour hold does not necessarily mean that these individuals were hospitalized. As will be discussed later, many people admitted on a 72-hour hold are admitted to emergency or crisis services, rather than to a hospital, and may have been released without an overnight stay. In addition, a person may be admitted more than once in a single day under W & I Code 5150. For example, an individual could have been admitted to an emergency room for evaluation, discharged from the emergency room, and admitted to a 24-hour facility for treatment on the same day. The legal status for both admissions would be W & I Code 5150.

The majority of commitments involved admission to 72-hour holds. There were, however, 1,544 episodes involving admissions directly into 14-day certification, 27 episodes involving admissions directly into a 2nd 14-day certification, 27 episodes involving admissions directly into 30-day certification, and 62 episodes involving admissions directly into 180-day certification. These admissions could have been transfers from other facilities or individuals discharged under a 72-hour hold and admitted under another commitment code (e.g., 14-day certification) in the same facility on the same day.

There were 10,479 admissions directly into temporary conservatorships and 4,421 admissions directly into LPS conservatorships. Episodes of care associated with temporary conservatorship admission legal status tended to end with discharge on temporary conservatorship status (37%), voluntary status (14%), or on other codes (49%). Episodes of care that began with LPS conservatorship legal status tended to conclude with LPS conservatorship status (46%) and other discharge legal statuses (53%), but not voluntary discharge legal statuses (1%).

Unfortunately, we cannot provide a more complete picture of the flow through involuntary treatment categories because of some limitations in the data. CDS does not provide information about changes in legal status that occur between an admission and discharge; therefore, if there were changes in status within an episode of care within a facility, we would not have that information. In addition, as mentioned previously, some individuals may have more than one admission under a single code on a single day or a discharge under one code and an admission under another code on a single day. Finally, the CDS does not include data on involuntary treatment delivered through Medi-Cal managed care plans, so those episodes are missing entirely.

The preceding analysis examined episodes of care to describe the flow of people through the involuntary treatment process. We were also interested in describing or creating “profiles” of the people being evaluated and treated in each part of the system (i.e., 72-hour holds, short-term commitments, long-term commitments, etc.). For the next analysis, we aggregated to the individual level and categorized individuals according to the legal status of their most restrictive commitment episode in 1997-98.

In order to develop category profiles, we created a few decision rules to sort individuals into mutually exclusive legal categories. First, a number of people were admitted involuntarily but were discharged as voluntary. We categorized these episodes of care according to the involuntary legal status. Only if patients were coded as voluntary at both admission and discharge were they considered “true” voluntary patients.

Second, because admission legal status and discharge legal status were often not the same, in cases where the legal status was different, we categorized the episode of care according to the most restrictive legal status. (For example, if someone was admitted under a 72-hour hold and discharged under a 14-day certification, that episode would be classified as a 14-day certification).

Third, there were also many individuals who had more than one episode of care within the fiscal year. We categorized the episodes of care for these individuals according to the legal status code representing the most restrictive of their various episodes. For example, if someone had one episode of care under a 14-day certification and another episode of care under a 30-day certification, that person would be categorized in the 30-day certification group. If a person had more than one commitment at the most restrictive level, we chose the commitment associated with the most recent episode.

In a similar fashion, we also created a separate category to indicate whether a person was subject to a temporary or LPS conservatorship. For example, if an individual was admitted under a temporary conservatorship and discharged under an LPS conservatorship, for this analysis that individual was placed in the LPS conservatorship category. If a person had one episode of care under a temporary conservatorship and another episode of care under an LPS conservatorship, that individual was placed in the LPS conservatorship category. Since conservatorship could be invoked at any number of points along the commitment pathway, this categorization was not dependent on other legal status categories.

Some individual characteristics (e.g., diagnosis, GAF scores) could vary across episodes. We therefore used the individual characteristics associated with the most restrictive episode in this analysis. If an individual had more than one episode within the most restrictive commitment category, we looked at individual characteristics from the most recent episode.

Profiling People in Involuntary Treatment in California in 1997-98

In 1997-98, there were 58,439 individuals in the CDS database who were admitted under an involuntary legal status. For 88% of those individuals (51,932), a 72-hour hold was the most restrictive commitment.²³⁶ For an additional 12% (6,744), a 14-day certification was the most restrictive commitment. Of the remaining individuals, only 29 were certified for a 2nd 14-day commitment, 165 individuals were certified for an additional 30-day commitment, and 79 individuals were certified for an additional 180-day commitment.

Tables E.2 and E.3 in Appendix E profile the characteristics of the individuals categorized according to their legal status. There is a combined total of only 273 people in the last three categories (2nd 14-day, 30-day and 180-day certifications), so we have combined the three categories.²³⁷

²³⁶ It is important to note that being on a 72-hour hold does not necessarily mean that these individuals were hospitalized for 72 hours. The statute requires that an individual be released at any point that he or she no longer meet the commitment criteria. As will be discussed later, many people admitted on a 72-hour hold were admitted to emergency or crisis services, rather than to a hospital, and may have been released without an overnight stay.

²³⁷ We combined these categories because together they represented a small number of individuals and otherwise there would have been a large number of empty cells in the table.

Starting with individuals who were admitted only on a *voluntary* legal status, this subgroup of individuals was 52% female, 57% white, 17% Hispanic, 16% African-American and 10% of other or unknown ethnicity. The mean age of this group was 39. Fifty-eight percent of this group had 12 years of education or less and they were as likely to be unemployed (31%) as out of the labor force (31%). Forty-eight percent of these individuals were never married and 27% were widowed, divorced, or separated. At the time of admission, 42% reported living with a family member and 18% reported living on their own. Six percent reported being homeless at admission, but less than 1% of the individuals in this group reported living in a hospital at the time of admission. Twenty-one percent of the people in this category had a primary diagnosis²³⁸ of psychosis or schizophrenia, 42% had a primary diagnosis of mood disorders, and 8% had a secondary diagnosis of substance abuse. As a group, their average GAF score²³⁹ was 46, indicating serious symptoms or serious impairment in some area of functioning (e.g., social, occupational, school, etc.).

Individuals whose most restrictive commitment was a *72-hour hold* were 45% female, 58% white, 15% Hispanic, 16% African-American and 11% of other or unknown ethnicity. The mean age of this group was 38. Fifty-two percent of this group had 12 years of education or less and they were predominantly out of the labor force (27%) or of an unknown working status (47%). Fifty-four percent of these individuals were never married and 19% were widowed, divorced, or separated. At the time of admission, 34% reported living with a family member and 20% reported living on their own. Nine percent reported being homeless and only 3% in this group reported living in a hospital at the time of admission. Thirty-four percent of people in this category had a primary diagnosis of psychosis or schizophrenia and 30% were diagnosed with mood disorders. Six percent of the people in this group had a secondary diagnosis of substance abuse. As a group, their average GAF score was 36, indicating some impairment in reality testing or communications or major impairment in several areas of functioning.

Individuals whose most restrictive commitment was a *14-day certification* were 45% female, 54% white, 13% Hispanic, 22% African-American, and 11% of other or unknown ethnicity. The mean age of this group was 38. Sixty-three percent of this group had 12 years of education or less and they were predominantly out of the labor force (40%) or of an unknown working status (46%). Fifty-four percent were never married and 20% were widowed, divorced, or separated. At the time of admission, 26% reported living with a family member and 14% reported living on their own. Nine percent reported being homeless, and only 9% reported living in a hospital at the time of admission. Fifty-eight percent of the people in this category had a primary diagnosis of psychosis or

²³⁸ In Tables E.2 and E.3 we report discharge diagnosis rather than admission diagnosis when the two diagnoses differ because discharge diagnoses tend to be more accurate. The "Other" category includes other diagnoses as well as no mental disorders, deferred, unknown, and invalid codes. For secondary diagnoses, underreporting is very common – suggesting that the rates of co-occurring substance abuse reported here probably greatly underestimate the problem.

²³⁹ GAF scores were available at both admission and discharge. We reported admission GAF scores as discharge GAF scores may be affected by length of hospitalization.

schizophrenia and 29% were diagnosed with mood disorders. Six percent had a secondary diagnosis of substance abuse. As a group, their average GAF score was 37, indicating some impairment in reality testing or communications or major impairment in several areas of functioning.

Individuals whose most restrictive commitment was either an *additional 14-day certification, 30-day certification or 180-day certifications* were 47% female, 66% white, 10% Hispanic, 17% African-American and 7% of other or unknown ethnicity. The mean age of this group was 43. Fifty-three percent of this group had 12 years of education or less. They were predominantly out of the labor force (38%) or with an unknown working status (45%). Sixty percent were never married and 24% were widowed, divorced, or separated. At the time of admission, 44% of the individuals in this group reported living in a hospital, 14% reported living with a family member, 9% reported living on their own, and 8% reported being homeless. The primary diagnosis was psychosis or schizophrenia for 64% the people in this category, and 24% were diagnosed with mood disorders. Just under 3% of the people in this category had a secondary substance abuse diagnosis. As a group, their average GAF score was 35, indicating some impairment in reality testing or communications or major impairment in several areas of functioning.

Individuals who were subject to a *temporary conservatorship* were 46% female, 61% white, 10% Hispanic, 18% African-American and 11% of other or unknown ethnicity. The mean age of this group was 46. Fifty-eight percent of this group had 12 years of education or less. Twenty-nine percent were unemployed, 48% were out of the labor force, and 18% had an unknown labor force status. Fifty-eight percent were never married and 24% were widowed, divorced, or separated. Forty-one percent of the individuals in this group reported living in a hospital at the time of admission and 19% reported living in a community facility, while 9% reported living with a family member, 8% reported living on their own, and 6% reported being homeless at the time of admission. Seventy-four percent of the people in this category had a primary diagnosis of psychosis or schizophrenia and 16% were diagnosed with mood disorders. As a group, their average GAF score was 33, indicating some impairment in reality testing or communications or major impairment in several areas of functioning.

Individuals who were subject to *LPS conservatorship* were 41% female, 52% white, 15% Hispanic and 24% African-American. The mean age of this group was 44. Forty-seven percent of this group had 12 years of education or less. Seventy-three percent were unemployed and 16% were out of the labor force. Seventy-nine percent were never married and 16% were widowed, divorced, or separated. Fifty-six percent of the individuals in this group reported living in a hospital at the time of admission and 24% reported living in a community facility, while 7% reported living with a family member, 4% reported being homeless at the time of admission, and 3% reported living on their own. Seventy-seven percent of the people in this category had a primary diagnosis of psychosis or schizophrenia and 10% were diagnosed with mood disorders. As a group, their average GAF score was 35, indicating some impairment in reality testing or communications or major impairment in several areas of functioning.

Significance tests (chi-square test of association and f-tests for the continuous variables) indicate that all of the differences are statistically significant. This is not surprising due to the fact that we are examining a very large population. In this situation, very small differences tend to be statistically significant. Therefore, we will only discuss differences of substantive interest.

All of the groups look similar in terms of demographic characteristics. It appears that individuals who are committed under the most restrictive commitment codes are more severely ill. Twenty-one percent of the voluntary patients have primary diagnoses of schizophrenia or other psychotic disorders but the proportions are substantially higher among those receiving involuntary treatment. The proportion of individuals with a primary diagnosis of psychosis increases as the length of commitment increases – from 34% of individuals on 72-hour holds, to 58% of individuals on 14-day certifications, to 65% of those held under the most restrictive commitment categories. The proportion of voluntary patients with mood disorders is 42% as compared to 30% for those on 72-hour holds and 24% for patients held under the more restrictive commitment categories. Rates of secondary diagnosis of substance abuse did not vary across groups, however. Admission GAF scores provide a clinical indicator of functioning. GAF scores for involuntary patients are lower than for voluntary patients (indicating poorer functioning among involuntary patients). Among those on conservatorships, the vast majority were diagnosed with schizophrenia or other psychotic disorders and GAF scores indicate some impairment in reality testing or communications or major functional impairments in several areas (such as family relations, work, school or judgment, thinking or mood).

There is some other evidence in the CDS data that individuals who have been subject to more restrictive commitment were not functioning as well in the community as those who received treatment voluntarily and those who were committed for shorter periods. Individuals who received treatment voluntarily were more likely to be living with family and with non-relatives than those who were treated involuntarily. (By contrast, those who were on 72-hour holds were more likely to report living alone prior to admission.) Those committed were also a bit more likely to have been homeless at admission than were voluntary patients. Employment is another indicator of overall functioning. Just under 10% of those who received voluntary care and those who were committed under 72-hour holds in the past year were in the competitive labor market, while only 3% of those who were held on a 14-day certification and 0% of those who were committed for more than 14 days were in the competitive labor market. A greater percentage of the individuals who were receiving voluntary care were unemployed but looking for work (31%) than those who have been treated involuntarily (the percentage looking for work ranges from 9% to 15% for those who have been treated involuntarily).

Service Use and Commitment History

Table E.4 in Appendix E summarizes information about the patterns of service utilization by commitment category, including the percentage of people in each commitment category who accessed services and the mean and median of service use for each commitment group.²⁴⁰ This table includes information on all individuals in the CDS database who received involuntary treatment in 1997-98 and reports on their service use for the prior 12 months. Table 2 below summarizes the service use categories included in the analysis.

Table 2
Service Use Categories from the Client Data System

24 Hour ²⁴¹	Hospital inpatient, administrative hospital days, psychiatric health facilities (PHFs), skilled nursing facilities (SNFs), and institutions for mental disease (IMDs) – both “basic” and “patch”
Day Care	Crisis stabilization, vocational services, socialization, SNF augmentation, day treatment (intensive and rehabilitative, full and half days)
Outpatient & Service Coordination	Case management/brokerage, collateral, mental health services, medication support, crisis intervention

Only 6% of voluntary patients accessed any *24-hour hospital care* (as defined in Table 2 above) in the prior 12 months. Thirty-nine percent of those whose most restrictive commitment was a 72-hour hold received 24-hour hospital care over the prior 12 months. The majority of the individuals committed for between 14 days and 30 days also accessed 24 hour services (94% for the 14-day category, 72% for the 2nd 14-day certification category and 96% for the 30-day certification category). Only 58% of the people for whom the most restrictive commitment was 180-day certification had inpatient care in the prior 12 months.

Access to *day services* tended to be high across the commitment categories; however, individuals committed to a 2nd 14-day certification and 180-day certification had somewhat lower rates of access than individuals in other commitment categories.

For *outpatient services*, access was highest among voluntary patients (95% of voluntary patients accessed outpatient services) as compared to any of the commitment groups; however, access was relatively high for some groups (ranging from 53% to 86%).

²⁴⁰ The service use reported includes the commitment on which the individual was classified.

²⁴¹ We included hospitals and nursing facilities but did *not* include non-hospital, 24-hour facilities including residential programs (adult, adult-crisis, other), inpatient units in jail, psychosocial rehabilitation centers, or independent or semi supervised living centers.

Table E.4 in Appendix E also reports on the mean and median service use by commitment category. Among those who used *24-hour hospital care* in the prior 12 months, individuals in the most restrictive commitment categories (30-day and 180-day) used more hospital days over the preceding 12 months than those in the less restrictive commitment categories. Hospital service utilization was highest for the 180-day group (median of 92 days). Voluntary patients and those in the 72-hour group had the lowest hospital use (median of 6 days in the prior 12 months).

Median use of various types of *ambulatory services* tended to be lower than use of hospitalization for each of the commitment groups, with the exception of people on 2nd 14-day certifications, whose mean use of *outpatient services* (at 21 encounters in the prior 12 months) was about the same as their use of hospital days. In general, these ambulatory care data do not support the assumption that individuals were entering the involuntary treatment system because they were not able to access outpatient services. Rates of access were generally (although not uniformly) high. However, while rates of access were generally high, median service use was generally low. This may mean that people were not able to access the intensity of services they needed. For example, median outpatient service use was 4 units in the prior 12 months for voluntary patients and 3 units in the prior 12 months for people whose most restrictive commitment was a 72-hour hold. People in other commitment categories had higher median outpatient service use (a median range of 5 to 21 units of service in the prior 12 months). Day service use was uniformly low, with median use of 1 or 2 days per year across the groups.

Table E.5 in Appendix E summarizes information about the patterns of involuntary treatment by commitment category. For this analysis we grouped individuals into commitment groups based on their most restrictive commitment in 1997-98. Using that most restrictive commitment as the index commitment, we then looked back at their commitment experience in the prior 12 months.²⁴² Of the individuals whose most restrictive commitment in 1997-98 was a 72-hour hold (51,392 individuals), 32% had at least one other 72-hour hold in the prior 12 months. Only 1% of those same individuals had at least one 14-day certification in the prior 12 months. Among those whose most restrictive commitment was a 14-day hold (6,774), slightly over 50% had a 72-hour hold and 29% had a 14-day certification in the prior 12 months. Some of the highest rates of commitment were among the longer-term commitment groups. Sixty-five percent of those in the 2nd 14-day certification group had at least one prior 72-hour hold, 59% of those in the 30-day certification group had at least one prior 180-day certification, and among the 180-day certification group, there were high rates of both 72-hour holds (40%) and 14-day certifications (28%). High percentages of individuals on both temporary and LPS conservatorships had involuntary treatment episodes (72-hour holds and 14-day certifications) in the prior 12 months.

²⁴² Categorization was based on the most restrictive commitment for that individual in fiscal year 1997-98; however, because we are reporting on commitments in the 12 months prior to the index commitment, we may be reporting on some commitments in the prior fiscal year (which may, in fact, be more restrictive than the index commitment).

Table E.5 also reports on mean and median use of involuntary treatment over the prior 12 months. These data suggest that among those people who experienced an involuntary treatment episode in the prior 12 months, most had between one and three episodes of equal or lesser restrictiveness.

Identifying Subcategories of At-Risk Individuals Under Expansions of LPS

In order to identify individuals who might be affected by proposed changes in the Lanterman-Petris-Short Act (such as an expansion of the grave disability criteria or the addition of outpatient commitment), we looked at a single high-risk group in two different ways.

First, we looked at the experience of people whose most restrictive commitment in fiscal year 1997-98 was a 72-hour hold, focusing on their use of hospital and ambulatory services in the 12 months leading up to their 72-hour hold. We did this to develop some crude estimates of the numbers of people who might be considered “revolving door” involuntary patients.

Summarizing what we have already reported, this group is the largest of the commitment groups (51,392 individuals), representing 88% of all individuals in the commitment system in California. Just over 34% (17,600) have serious mental illnesses (i.e., diagnosis of schizophrenia or other psychosis). While many are receiving ambulatory services, 38% (19,528) had no outpatient service use in the 12 months prior to their commitment and 40% had no day services. This group also had relatively low rates of access to hospitalization (62% had no hospital days in the prior 12 months). It appears that the intensity of services they did receive, on average, may not have been adequate to address their clinical needs because 32% (16,445) had a prior 72-hour hold in the 12 month period (with a median of 2 holds).²⁴³ Those individuals who have not accessed outpatient services but have more than one episode of involuntary treatment in a single 12-month period could represent a group that might be the target of a commitment program designed to provide an alternative to inpatient commitment

In order to estimate the number of persons who might be at highest risk, we looked at the service use and commitment histories of the 17,600 individuals who had a 72-hour hold and also had a diagnosis of schizophrenia or other psychosis. Of these individuals with severe mental illness, 7,388 had at least one other episode of involuntary treatment in the prior 12 months and 3,140 had no outpatient service use in the prior 12 months. There were 2,735 individuals with severe mental illness who evidenced both risk factors (i.e., prior involuntary treatment and no outpatient treatment in the prior 12 months).

²⁴³ Among those whose most restrictive commitments were 14-day certifications, the CDS data also show that 30% had no prior outpatient service use in the prior 12 months, and, among users, the median number of units was 5 in the previous 12 months. Thirty-four percent had no prior day services (with a median among users of 1 day). Rates of prior commitment were high in this group: 51% had at least one 72-hour hold (with a median of 2) and 30% had at least one prior 14-day certification in the prior 12 months (with a median of 1).

These data do suggest that there are a significant number of people with severe mental illness (7,388) who might be characterized as experiencing “revolving door” involuntary treatment (i.e., at least two episodes of involuntary treatment in a single 12 month period). Approximately 37% of these individuals also had no outpatient service use in that same time period. *What we cannot tell from administrative data is whether the lack of service use is a compliance issue or simply an inability to access appropriate community-based services because of a lack of service availability.*

Second, among those whose most restrictive commitment was a 72-hour hold, we sought to distinguish those who were admitted to crisis settings for evaluation and treatment but were not admitted to a 24-hour hospital setting. We think this latter group might include people who were brought in for emergency evaluation but were not found to meet the commitment criteria and were released. These are people who might potentially be affected by an expanded definition of grave disability.²⁴⁴

We identified individuals who were admitted to either crisis stabilization (day services) or crisis intervention (outpatient services) settings or received any mental health services within the day services or outpatient services mode that was associated with a 72-hour hold.²⁴⁵ We then compared this group to individuals who were admitted under a 72-hour hold to a 24-hour hospital facility.²⁴⁶ Table E.6 in Appendix E summarizes these data. In 1997-98 there were 51,932 individuals admitted on a 72-hour hold. Of those individuals, 18,430 were admitted to a 24-hour hospital facility. An even larger group of individuals (32,221) were evaluated and treated in an emergency or crisis setting.

The demographic characteristics of the people on 72-hour holds who were treated in a hospital setting were very similar to those who were *not* hospitalized, with the exception of employment status (58% of those hospitalized were either unemployed or not in the labor force versus 41% of those *not* hospitalized). People on 72-hour holds who were hospitalized were also more likely to have a primary diagnosis of psychosis or schizophrenia (43% versus 28%), more likely to be diagnosed with a mood disorder (36% versus 29%) and less likely to have a primary diagnosis of substance abuse disorder (6% versus 16%) than those who were *not* hospitalized. Both groups were reported to have admission GAF scores indicating major functional impairment.

²⁴⁴ We should also note that the implementation experience of the other states suggests that the addition of an outpatient commitment alternative in California may be more likely to affect people at discharge from commitment rather than those entering commitment, because it has been used more frequently as a discharge-planning vehicle. Our analyses, however, focused on the service use in the 12 months *prior to* an index commitment.

²⁴⁵ Individuals who received outpatient or day services and were also admitted to a 24-hour facility within the same episode of care are counted in the 24-hour facility category.

²⁴⁶ These were individuals who had a 72-hour hold in a hospital, PHF, SNF or IMD and no other involuntary treatment. Individuals admitted to 24-hour facilities other than hospitals, PHFs, SNFs and IMDs were excluded from this analysis.

In order to estimate the number of these individuals who might be at highest risk, we again looked at those who evidenced multiple risk factors. Of the 32,221 individuals who were admitted on a 72-hour hold to crisis settings rather than to 24-hour hospital care, 28% (9,094) had a primary diagnosis of schizophrenia or other psychotic disorders. Of those with severe mental illness, about 10% had *no* outpatient service use in the prior 12 months. A much larger number of people with severe mental illness (2,463) had at least one other involuntary treatment episode in the prior 12 months. Only 710 people with severe mental illness evidenced both additional risk factors (i.e., prior involuntary treatment but no outpatient service use in the prior 12 months). These data indicate that the vast majority of individuals with severe mental illness who were evaluated and/or treated in a crisis or emergency setting on a 72-hour hold had been receiving at least some outpatient treatment in the prior year and yet 27% (2,463) also had at least one prior episode of involuntary treatment in that same year.

It is difficult to speculate on whether these individuals would be affected by an expansion of the commitment criteria, because we do not know *why* they were not admitted to 24-hour hospital care. We cannot tell from administrative data. It may be that the clinical crisis precipitating the 72-hour hold was resolved quickly and hospitalization was deemed unnecessary. On the other hand, it may be that the treating staff felt these individuals did not meet the commitment criteria and released them, as they are required to do under the LPS Act. To the extent that a significant number of these individuals were found to be in need of treatment but not to meet the commitment criteria for grave disability, an expansion of the commitment criteria might have an impact, although the potential magnitude is largely unknowable from these data. A study that includes medical record review, on the other hand, might shed more light on this important issue.

Conclusion

Among the most striking findings is the small percentage of people who continue in the involuntary treatment system beyond an initial 14-day certification. Of the 58,439 individuals who were involuntarily treated in California (and whose care was reported in the CDS), less than 1% continued in the commitment system after an initial 14-day certification. In fact, of those who experienced a 72-hour hold, only 12% moved on to any other commitment category. These data also suggest that while the more restrictive categories were not used very often, they were, in fact, used more often for those with more severe illnesses and lower functioning. These findings, taken together, seem to suggest that there were many people in California whose illnesses were severe enough to bring them to the attention of authorities for intervention (at least for evaluation and preliminary treatment in either an emergency or crisis facility or a 24-hour facility) but either their illnesses were not severe enough to warrant continuing their treatment involuntarily or facilities were successful at getting these clients to agree to remain in treatment voluntarily. The CDS data indicated that about 26% of all 72-hour hold admissions were discharged on voluntary status.

Estimates of the impact of the introduction of outpatient commitment and/or the widening of commitment criteria are very difficult to make with the available data. The CDS data indicate that there were 16,445 people who experienced more than one 72-hour hold in California in 1997-98. Of these “revolving door” individuals, 7,388 were people with schizophrenia or other psychotic disorders. A significant number of these individuals received *no* outpatient services in the prior 12 months (2,735) and the data suggest there may be a significant number of others who were not being adequately served by the ambulatory treatment system. We cannot tell from administrative data whether lack of compliance or problems in access to community-based services (or both) are the explanatory factors.

Another analysis indicates there were 9,094 severely mentally ill individuals who were evaluated and treated on a 72-hour hold but not hospitalized, perhaps because they did not meet the current commitment criteria. Most of these individuals had accessed outpatient services in the prior 12 months, but 27% (2,463) had prior involuntary treatment as well. We cannot tell anything more from administrative data about why these individuals were released from emergency or crisis settings without hospitalization or whether expanding the current commitment criteria would have an impact on the rate of involuntary treatment in California.

The experience of other states suggests that we should be very conservative in estimating the potential impact of changes in commitment statutes. As reported in Section VI, New York City officials, responding to a perceived widening of the commitment criteria and the addition of outpatient commitment under Kendra’s Law, originally estimated that the law would potentially effect 7,000 individuals in New York City alone. As of September 2000, however, there were only 235 outpatient commitment petitions in New York City. Similarly, Wisconsin respondents reported that the 5th Standard (which broadened the commitment criteria) has been used only sparingly in some counties and not at all in others. Among our eight states, most respondents reported many fewer outpatient commitments than originally anticipated.

We should note several other qualifications about the CDS data. As mentioned previously, the CDS database does not include all inpatient admissions in California. According to the Department of Mental Health, admissions under Medi-Cal Inpatient Consolidation are not reported in the CDS and the Medi-Cal claims database does not include legal status as a data element. *This effectively means that there is no way to obtain a complete picture of involuntary treatment in California with existing databases.* There were also problems of missing data in the CDS, some question about the consistency of coding data elements, and a lack of detail that is characteristic of most administrative datasets. In particular, the underreporting of secondary diagnosis was high, limiting our ability to understand how the phenomena of dual diagnosis may be affecting involuntary treatment. Nevertheless, the CDS does provide a useful, if limited, look at the involuntary treatment system in California. However, other methods of study (such as medical record review of a sample of clients) would greatly enhance the knowledge base for making policy decisions on involuntary treatment.

VIII. CONCLUSION

In this Report, we have addressed three specific questions:

- How effective is involuntary treatment compared to other types of intervention and treatment?
- What has been the experience of other states with implementation of involuntary treatment laws and programs?
- Who is potentially impacted by a change in the involuntary treatment criteria in California?

Based on our analysis of the empirical literature, statute and case law, experience of stakeholders in eight states, and California CDS data, we are now in a position to draw some conclusions.

The Comparative Effectiveness of Involuntary Treatment

There are two generations of research on the effectiveness of involuntary outpatient treatment. The first generation of studies mostly found limited positive results from involuntary outpatient treatment; however, these studies were plagued by significant methodological limitations. These limitations reduce the confidence we can place in their findings. In addition, this body of research did not specify for whom, how, or under what circumstances court-ordered outpatient treatment may work.

Data from a second generation of research, which builds on the foundation of earlier studies, are just beginning to accrue. There have been only two randomized clinical trials of involuntary outpatient treatment, and these studies came to conflicting conclusions. The investigators in New York found no statistically significant differences in rates of rehospitalization, arrests, quality of life, psychiatric symptoms, homelessness, or other outcomes between the involuntary outpatient treatment group and those who received intensive services but without a commitment order. However, a number of limitations in the New York study (e.g., small sample size, non-equivalent comparison groups, lack of enforcement of court orders), may have affected the findings and make it difficult to draw definitive conclusions.

In contrast to the New York study, the Duke University study suggests that a sustained outpatient commitment order (180+ days), *when combined with intensive mental health services*, may increase treatment adherence and reduce the risk of negative outcomes such as relapse, violent behavior, victimization, and arrest. According to the study, the two most salient factors associated with reduced recidivism and improved outcomes among people with severe mental illness appear to be intensive mental health treatment and enhanced monitoring for a sustained period of time. In the Duke Study, outcomes were only improved for those under court order who received intensive mental health

services. *Whether court orders without intensive treatment have any effect is an unanswered question.* If the policy objective is to reduce episodes of relapse and dangerousness, there may be no simple solution to be found in legally mandating patients to comply with outpatient treatment. There is no evidence that simply amending the commitment statute to add an outpatient commitment program will make benefits accrue to people with severe mental illness.

In contrast to the paucity of studies on involuntary outpatient treatment, our analysis of evidence-based reviews found clear evidence that some intensive community treatments produce good outcomes for people with severe mental illness. The best evidence from randomized clinical trials supports the use of assertive community treatment programs – which involve the delivery of community-based care by multidisciplinary teams of highly trained mental health professionals with high staff-to-client ratios. Because these interventions are staff-intensive, they are also more expensive to implement than traditional community-based mental health services. It may be necessary, then, to target assertive community treatment on those people at highest risk for negative outcomes. There is additional evidence, albeit weaker, for some of the other popular community-based mental health interventions. Some of the lesser-studied interventions, such as supported housing and supported employment, are regarded by researchers as “promising” although unproven at this time. More research is critically needed on interventions deployed in the “real world” of routine clinical practice in the public mental health sector. More attention to quality improvement is also needed.

There are no empirical data that allow us to assess the policy tradeoffs between involuntary outpatient treatment and alternatives such as assertive community treatment. The Duke study did *not* achieve outcomes that were superior to outcomes achieved in studies of assertive community treatment. The investigators did attempt, however, to identify some subgroups for whom involuntary outpatient treatment was especially effective in reducing hospital readmissions and shortening lengths of stay. Their findings suggest that people with psychotic disorders and those at highest risk for bad outcomes benefit from intensive mental health services provided in concert with a sustained outpatient commitment order. The precise *cause* of the effect, however, remains unknown. In sum, the Duke study does *not* prove that treatment works better in the presence of coercion or that treatment will not work in the absence of coercion – and other evidence-based reviews prove that alternative interventions such as assertive community treatment have similar positive effects.

The Experience of Other States

The eight states we studied have statutory provisions that permit outpatient commitment (although not all states have separate outpatient commitment sections), reflecting the growing popularity of these kinds of provisions nationally. These statutes have faced little challenge in the courts and none has been overturned. Many of the states explicitly permit the use of a person’s prior treatment or behavioral history in determining whether the person meets commitment standards, representing a major shift from laws that for the

last two decades had focused on contemporaneous behavior. However, in states like Wisconsin, where a separate standard (the 5th Standard) combines the question of competency with the prospect of deterioration in the absence of treatment, the 5th Standard is reported to have been used sparingly. In general, forcible medication (and competency to refuse medication) are handled separately from commitment.

We were surprised to find a trend to use outpatient commitment as a discharge-planning mechanism rather than as a community-initiated alternative to hospitalization. By and large, rather than creating a new class of patients for whom the community is the staging ground for commitment, these states are employing outpatient commitment at the time of discharge to extend close supervision and monitoring into the community.

It also appears that these states are handling the issues around commitment in a more nuanced manner than in the past. There are a variety of ways states are attempting to apply commitment law to minimize overt coercion while continuing to acknowledge the importance of protecting the public safety. For example, in Wisconsin, a “settlement agreement” permits the person who is the subject of a commitment petition to waive a hearing if he or she agrees to 90 days of treatment. This provision was praised as enabling a person with mental illness to obtain treatment while foregoing the stigma attached to commitment. Similarly, in New York, behavioral health officials in some counties have chosen to use “voluntary compliance agreements” rather than pursue court orders for involuntary outpatient treatment.

Among the attorneys, behavioral health officials, and psychiatrists we interviewed, there was widespread support for involuntary outpatient treatment in spite of the fact that empirical support from the second generation of effectiveness studies is only now beginning to accrue. This support may be explained, in part, by a consensus of opinion that noncompliance with treatment is a significant problem for at least some proportion of people with severe mental illness. There was a difference of opinion among our respondents about whether outpatient commitment is benign. Most argued for a balancing of the liberty interests of the patient with the state’s right to intervene, and most found outpatient commitment less objectionable than inpatient commitment, especially when statutes do *not* allow automatic rehospitalization for noncompliance or forcible medication without a separate finding of incompetency. It is critical to note, however, that the views of consumer/survivors – the people who would be most directly affected by a change in the commitment law – were missing from our study.

Although there was support for outpatient commitment laws, there was also some skepticism and uncertainty about the practical application of such laws. Many respondents expressed concern about inadequacies in the service systems in their own communities. They emphasized that outpatient commitment is not a “silver bullet” and that it simply cannot work in the absence of intensive clinical services and mechanisms for enforcement of court orders.

The Effect of LPS Changes on People with Mental Illness in California

Among the most interesting findings from the analysis of the Department of Mental Health's Client Data System (CDS) is that only 1% of people who are involuntarily treated continue in the commitment system after an initial 14-day commitment. Longer commitments are rare but they are used more often for people with more severe illness and lower functioning. Among those who are held for evaluation and treatment (72-hour hold), most are treated in crisis or emergency settings rather than hospital settings, and at least one-quarter are discharged as voluntary patients.

It is difficult to estimate from existing data how many people may be affected by a change in California's Lanterman-Petris-Short Act. In order to identify individuals who might be affected by the changes proposed under AB 1800, we looked at a high-risk group in two different ways.

First, we looked at the experience of people whose most restrictive commitment in fiscal year 1997-98 was a 72-hour hold. These are people who were involuntarily detained for evaluation and/or short-term treatment without further confinement. This group (51,392 individuals) represents 88% of all individuals in the commitment system in California. We analyzed their service utilization and involuntary treatment history in the 12 months prior to their 72-hour hold. We did this to develop some crude estimates of the numbers of people who might be considered "revolving door" commitment patients and therefore candidates for involuntary outpatient treatment.

CDS data show that 38% of these individuals (19,528) had no outpatient service use, 40% had no day service use, and 62% had no days of hospitalization in the prior 12 months. In addition, 32% of these individuals had at least one other involuntary treatment episode in the prior 12 months.

Within this group, there were over 17,600 Californians with a diagnosis of schizophrenia or other psychotic disorder. *Of these individuals with severe mental illness, 3,140 had no prior outpatient service use in the previous 12 months and 7,388 had at least one other episode of involuntary treatment in the prior 12 months.* These severely mentally ill individuals who have not accessed any outpatient services but have more than one episode of involuntary treatment within a single year (2,735 individuals) might be the target of an involuntary outpatient treatment provision. Unfortunately, we cannot tell from administrative data whether lack of compliance or problems in accessing community-based services (or both) explain the patterns we see.

We also tried to estimate the number of people who might potentially be affected by an expanded definition of grave disability (i.e., the addition of a *preventive* criteria) by looking at a subgroup of individuals whose most restrictive commitment in 1997-98 was a 72-hour hold. These were individuals who were held for 72 hours or less in a community setting for an emergency evaluation but were not admitted to a hospital. We identified individuals who were admitted to crisis stabilization or crisis intervention

settings and compared them to individuals who were admitted to 24-hour hospital settings. While most of the people with severe mental illnesses were evaluated and treated in hospital settings, there were 9,094 individuals who received their care in community-based crisis settings. Most of these individuals had accessed outpatient services in the prior 12 months, but 27% (2,463) had prior involuntary treatment as well.

Unfortunately, we simply cannot tell from administrative data why these individuals were released within 72 hours. We do not know, for example, what proportion of these individuals were released because the facility staff did not believe they met the LPS commitment criteria for grave disability (but might have been held under a more expanded commitment criteria) and what proportion received treatment that resolved their clinical crisis quickly and did not require further treatment. Further research, including a medical records analysis, would allow us to refine these numbers considerably.

In any event, the experience of other states suggests that we should be circumspect about estimating the potential impact of changes in commitment criteria or processes. The experience of New York is illustrative. New York City officials estimated that the passage of Kendra's Law in 1999 would result in 7,000 individuals being placed on outpatient commitment orders. As of September 2000, there were only 235 involuntary outpatient commitment petitions, although the number appears to be growing. The experience of the eight states also suggests that involuntary outpatient commitment will be used primarily as a discharge-planning vehicle. In this case the numbers of people entering the involuntary treatment system may not increase at all.

In closing, while there is some evidence that the combination of outpatient commitment and intensive treatment has salutary effects on the outcomes in which policymakers are keenly interested (e.g., reducing rates of hospitalization, violent behavior, and arrests), there is no evidence to suggest that simply amending the statutory language is likely to produce the desired results. Investments would need to be made in developing and sustaining an infrastructure for implementation of involuntary outpatient treatment – including intensive clinical services and supports, tracking systems for supervision and monitoring, and effective enforcement mechanisms.

Unfortunately, there are no cost-effectiveness studies that would provide policy guidance on the relative return on investment for developing an involuntary outpatient treatment system as opposed to focusing all of the available resources on developing a state-of-the-art community-based mental health treatment system in every California community. Clearly, either approach will require a sustained administrative and financial commitment by the legislative and executive branches of government.

REFERENCES

- American Psychiatric Association (1999). *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*. 4th Edition. Washington, D.C.
- American Psychiatric Association (1999). *Resource Document on Mandatory Outpatient Treatment*. Washington, D.C.
- Appelbaum, P. (1994). *Almost a Revolution: Mental Health Law and the Limits of Change*. Oxford University Press.
- Barbarto, A., & D'Avanzo, B. (2000). Family interventions in schizophrenia & related disorders: A critical review of clinical trials. *Acta Psychiatr Scand*, 102(2), 81-97.
- Blanch, A., & Parrish, J. (1992). *Proceedings of Roundtable Discussion on the Use of Involuntary Interventions: Multiple Perspectives*. Rockville, MD: Center for Mental Health Services.
- Bond, G. R., Drake, R. E., Mueser, K. T., & Becker, D. R. (1997). An update on supported employment for people with severe mental illness. *Psychiatr Serv*, 48(3), 335-346.
- Bursten, B. (1986). Posthospital mandatory outpatient treatment. *Am J Psychiatry*, 143(10), 1255-1258.
- California Institute of Mental Health (2000). *Involuntary Treatment of People with Severe Mental Illness: A Resource Guide*. Sacramento, CA.
- Campbell, J., & Shraiber, R. (1989). *In Pursuit of Wellness: The Well-Being Project*. Sacramento: California Department of Mental Health.
- Cook, D., Mulrow, C., & Haynes, R. B. (1997). Systematic reviews: Synthesis of best evidence for clinical decisions. *Ann Intern Med*, 126(5), 376-380.
- Cooper, H., & Hedges, L. V. (Eds.). (1994). *The Handbook of Research Synthesis*. New York: Russell Sage.
- Dixon, L. B., & Lehman, A. F. (1995). Family interventions for schizophrenia. *Schizophr Bull*, 21(4), 631-643.
- Drake, R. E., Mercer-McFadden, C., Mueser, K. T., & Becker, D. R. (1998). A review of integrated mental health & substance abuse treatment for patients with dual disorders. *Schizophr Bull*, 24, 589-608.

Fernandez, G. A., & Nygard, S. (1990). Impact of involuntary outpatient commitment on the revolving-door syndrome in North Carolina. *Hosp Community Psychiatry*, 41(9), 1001-1004.

Frank, R., & McGuire, T. (1996). Introduction to the economics of mental health payment systems. In B. L. Levin & J. Pettila (Eds.), *Mental Health Services: A Public Health Perspective* (pp. 23-37). New York, NY: Oxford University Press.

Garcia, S. A., & Keilitz, I. (1991). Involuntary civil commitment of drug-dependent persons with special reference to pregnant women. *Ment Phys Disabil Law Rep*, 15, 418-426.

Geller, J., Grudzinskas, A. J., Jr., McDermeit, M., Fisher, W. H., & Lawlor, T. (1998). The efficacy of involuntary outpatient treatment in Massachusetts. *Adm Policy Ment Health*, 25(3), 271-285.

Goldkamp, J. & Irons-Guynn, C. (2000). *Emerging Judicial Strategies for the Mentally Ill in the Criminal Caseload: Mental Health Courts in Fort Lauderdale, Seattle, San Bernadino and Anchorage*. Philadelphia, PA: Crime and Justice Research Institute.

Greeman, M., & McClellan, T. (1985). The impact of a more stringent commitment code in Minnesota. *Hosp Community Psychiatry*, 360, 990-992.

Hiday, V. A. (1987). An assessment of outpatient commitment in North Carolina. *Ed & Self Mgmt Psych Pt*, 1(4), 4-7.

Hiday, V. A. (1992). Coercion in civil commitment: Process, preferences and outcome. *Int J Law Psychiatry*, 15, 359-378.

Hiday, V. A., & Goodman, R. (1982). The least restrictive alternative to involuntary hospitalization, outpatient commitment: Its use and effectiveness. *Journal of Psychiatry and Law*, 10 (Spring), 81-96.

Hiday, V. A., & Scheid-Cook, T. L. (1987). The North Carolina experience with outpatient commitment: A critical appraisal. *Int J Law Psychiatry*, 10(3), 215-232.

Hiday, V. A., & Scheid-Cook, T. L. (1989). A follow-up of chronic patients committed to outpatient treatment. *Hosp Community Psychiatry*, 40(1), 52-59.

Hiday, V. A., & Scheid-Cook, T. L. (1991). Outpatient commitment for "revolving door" patients: Compliance and treatment. *J Nerv Ment Dis*, 179(2), 83-88.

Hiday, V. A., Swartz, M. S., Swanson, J. W., & Borum, R. (under review). Coercion in mental health care.

Huxley, N. A., Parikh, S. V., & Baldessarini, R. J. (2000). Effectiveness of psychosocial treatments in bipolar disorder: State of the evidence. *Harv Rev Psychiatry*, 8(3), 126-140.

Johnstone, P., & Zolese, G. (2000). Length of hospitalisation for people with severe mental illness (Cochrane Review). In *The Cochrane Library*. Issue 2, CD001087. Oxford: Update Software.

Joy, C. B., Adams, C. E., & Rice, K. (2000). Crisis intervention for people with severe mental illnesses (Cochrane Review). In *The Cochrane Library*. Issue 2, CD001087. Oxford: Update Software.

Keilitz, I. (1990). Empirical studies of involuntary outpatient civil commitment: Is it working? *Ment Phys Disabil Law Rep*, 14(4), 368-379.

Keilitz, I., & Hall, T. (1985). State statutes governing involuntary outpatient civil commitment. *Ment Phys Disabil Law Rep*, 9, 378-397.

Latimer, E. A. (1999). Economic impacts of assertive community treatment: A review of the literature. *Can J Psychiatry*, 44(5), 443-454.

Lehman, A. F. (1995). Vocational rehabilitation in schizophrenia. *Schizophr Bull*, 21(4), 645-656.

Ley, A., Jeffrey, D. P., McLaren, S., & Siegfried, N. (2000). Treatment programmes for people with severe mental illness and substance misuse (Cochrane Review). In *The Cochrane Library*. Issue 2, CD001088. Oxford: Update Software.

Lidz, C. (1998). Coercion in psychiatric care: What have we learned from research? *J Am Acad Psychiatry Law*, 26, 631-637.

Lindenmayer, J. P. (2000). Treatment refractory schizophrenia. *Psychiatr Q*, 71(4), 373-384.

Little Hoover Commission (2000). *Being There: Making a Commitment to Mental Health*. Available at <http://www.lhc.ca.gov/lhc.html> accessed January 17, 2001.

LPS Reform Task Force (1999). *A New Vision for Mental Health Treatment Laws: A Report by the LPS Reform Task Force*. Available at <http://www.psychlaws.org/StateActivity/California/LPSwhitepaper.html> accessed January 17, 2001.

Maloy, K. A. (1992). *Critiquing the Empirical Evidence: Does Involuntary Outpatient Commitment Work?* Washington, DC: Mental Health Policy Resource Center.

Marshall, M., Gray, A., Lockwood, A., & Green, R. (2000). Case management for people with severe mental disorders (Cochrane Review). In *The Cochrane Library*. Issue 2, CD0000050. Oxford: Update Software.

Marshall, M., & Lockwood, A. (2000). Assertive community treatment for people with severe mental disorders (Cochrane Review). In *The Cochrane Library*. Issue 2, CD0001089. Oxford: Update Software.

McCafferty, G., & Dooley, J. (1990). Involuntary outpatient commitment: An update. *Ment Phys Disabil Law Rep*, 14, 277-287.

Mental Health Weekly. (1995). U.S. Senate panel proposes involuntary commitment measure, 5(1),6.

Merinder, L. B. (2000). Patient education in schizophrenia: A review. *Acta Psychiatr Scand*, 102(2), 98-106.

Miller, R. (1985). Commitment to outpatient treatment: A national survey. *Hosp Community Psychiatry*, 36(3), 265-267.

Miller, R. (1988). Outpatient civil commitment of the mentally ill: An overview and update. *Behavioral Sciences and the Law*, 6, 99-118.

Miller, R., & Fiddleman, P. B. (1982). Involuntary civil commitment in North Carolina: The result of the 1979 statutory changes. *North Carolina Law Review*, 60, 985-1026.

Miller, R. D., & Fiddleman, P. B. (1984). Outpatient commitment: Treatment in the least restrictive environment? *Hosp Community Psychiatry*, 35(2), 147-151.

Monahan, J., Bonnie, R., Appelbaum, P. S., Hyde, P. S., Steadman, H. J., & Swartz, M. (under review) Mandated community treatment: Beyond outpatient commitment (October 19, 2000)

Mulvey, E. P., Geller, J. L., & Roth, L. H. (1987). The promise and peril of involuntary outpatient commitment. *Am Psychol*, 42(6), 571-584.

Munetz, M. R., Grande, T., Kleist, J., & Peterson, G. A. (1996). The effectiveness of outpatient civil commitment. *Psychiatr Serv*, 47(11), 1251-1253.

Newman, S. J. (2000). *Housing and Serious Mental Illness: A Critical Review of the Literature*. Baltimore: Johns Hopkins University, Institute for Policy Studies.

Nicol, M. M., Robertson, L., & Connaughton, J. A. (2000). Life skills programmes for chronic mental illness (Cochrane Review). In *The Cochrane Library*. Issue 2, CD000381. Oxford: Update Software.

O'Keefe, C., Potenza, D. P., & Mueser, K. T. (1997). Treatment outcomes for severely mentally ill patients on conditional discharge to community-based treatment. *J Nerv Ment Dis*, 185(6), 409-411.

Pekkala, E., & Merinder, L. (2000). Psychoeducation for schizophrenia (Cochrane Review). In *The Cochrane Library*. Issue 4, CD002381. Oxford: Update Software.

Pharoah, F. M., Mari, J. J., & Streiner, D. (2000). Family intervention for schizophrenia (Cochrane Review). In *The Cochrane Library*. Issue 4, CD000088. Oxford: Update Software.

Rohland, B. M. (1998). *The Role of Outpatient Commitment in the Management of Persons with Schizophrenia*. Des Moines, IA: Iowa Consortium for Mental Health.

Rosenheck, R. (2000). Cost-effectiveness of services for mentally ill homeless people: The application of research to policy and practice. *Am J Psychiatry*, 157(10), 1563-1570.

Schwartz, S. J., & Costanzo, C. E. (1987). Compelling treatment in the community: Distorted doctrines and violated values. *Loyola of Los Angeles Law Review*, 20, 1329-1429.

Scott, J. E., & Dixon, L. B. (1995a). Assertive community treatment and case management for schizophrenia. *Schizophr Bull*, 21(4), 657-668.

Scott, J. E., & Dixon, L. B. (1995b). Psychological interventions for schizophrenia. *Schizophr Bull*, 21(4), 621-630.

Steadman, H. J. (1998). *Research Study of the New York City Involuntary Outpatient Commitment Pilot Program: Prepared for New York City Department of Mental Health*. Delmar, NY: Policy Research Associates, Inc.

Steadman, H. J., Gounis, K., Dennis, D., Hopper, K., Roche, B., & Swartz, M. S. (in press). *Outcomes of Participants in the New York City Involuntary Outpatient Commitment Pilot Program: New York City*.

Stefan, S. (1987). Preventive commitment: The concept and its pitfalls. *Ment Phys Disabil Law Rep*, 11, 288-302.

Swanson, J. W., Borum, R., Swartz, M. S., Hiday, V. A., Wagner, H. R., & Burns, B. J. (under review). Can involuntary outpatient commitment reduce arrests among persons with severe mental illness?

Swanson, J. W., Swartz, M. S., Borum, R., Hiday, V. A., Wagner, H. R., & Burns, B. J. (2000). Involuntary out-patient commitment and reduction of violent behaviour in persons with severe mental illness. *Br J Psychiatry*, 176, 324-331.

Swanson, J. W., Swartz, M. S., George, L. K., Burns, B. J., Hiday, V. A., Borum, R., & Wagner, H. R. (1997). Interpreting the effectiveness of involuntary outpatient commitment: A conceptual model. *J Am Acad Psychiatry Law*, 25(1), 5-16.

Swartz, M., Hiday, V. A., Swanson, J. W., Wagner, H. R., Borum, R., & Burns, B. J. (1999). Measuring coercion under involuntary outpatient commitment: Initial findings from a randomized controlled trial. In J. P. Morrissey & J. Monahan (Eds.), *Research in Community and Mental Health* (Vol. 10, pp. 57-77). Stamford, Connecticut: JAI Press Inc.

Swartz, M. S., Burns, B. J., George, L. K., Swanson, J., Hiday, V. A., Borum, R., & Wagner, H. R. (1997). The ethical challenges of a randomized controlled trial of involuntary outpatient commitment. *J Ment Health Adm*, 24(1), 35-43.

Swartz, M. S., Burns, B. J., Hiday, V. A., George, L. K., Swanson, J., & Wagner, H. R. (1995). New directions in research on involuntary outpatient commitment. *Psychiatr Serv*, 46(4), 381-385.

Swartz, M. S., Swanson, J. W., Hiday, V. A., Wagner, H. R., Burns, B. J., & Borum, R. (under review). A randomized controlled trial of outpatient commitment in North Carolina.

Swartz, M. S., Swanson, J. W., Wagner, H. R., Burns, B. J., Hiday, V. A., & Borum, R. (1999). Can involuntary outpatient commitment reduce hospital recidivism? Findings from a randomized trial with severely mentally ill individuals. *Am J Psychiatry*, 156(12), 1968-1975.

Taube, C. A., Goldman, H. H., & Salkever, D. (1990). Medicaid coverage for mental illness. *Health Aff*, 9, 5-18.

Telson, H., Glickstein, R., & Trujillo, M. (1999). *Report of the Bellevue Hospital Center Outpatient Commitment Pilot Program*. New York: Bellevue Department of Psychiatry.

Torrey, E. F., & Kaplan, R. J. (1995). A national survey of the use of outpatient commitment. *Psychiatr Serv*, 46, 778-784.

Tuunainen, A., Wahlbeck, K., & Gilbody, S. M. (2000). Newer atypical antipsychotic medication versus clozapine for schizophrenia (Cochrane Review). In *The Cochrane Library*. Issue 2, CD000096. Oxford: Update Software.

Tyrer, P., Coid, J., Simmonds, S., Joseph, P., & Marriott, S. (2000). Community mental health teams (CMHTs) for people with severe mental illnesses and disordered personality (Cochrane Review). In *The Cochrane Library*. Issue 2, CD00270. Oxford: Update Software.

Van Putten, R. A., Santiago, J. M., & Berren, M. R. (1988). Involuntary outpatient commitment in Arizona: A retrospective study. *Hosp Community Psychiatry*, 39(9), 953-958.

Van Tosh, L. (1993). *Working for a Change: Employment of Consumer/Survivors in the Design and Provision of Services for Persons Who are Homeless and Mentally Disabled*. Rockville, MD: Center for Mental Health Services.

Weiner, B. A., & Wettstein, R. W. (1993). *Legal Issues in Mental Health Care*. New York: Plenum.

Zanni, G., & deVeau, L. (1986). Inpatient stays before and after outpatient commitment. *Hosp Community Psychiatry*, 37(9), 941-942.

TABLE OF APPENDICES

APPENDIX A:

- Search Methodology
- Screening Form
- Abstraction Form

APPENDIX B:

- Project Description
- Project Team
- Interview Protocol
- List of Interview Respondents

APPENDIX C:

- Table C.1: First Generation Outpatient Commitment Studies
- Table C.2: Second Generation Outpatient Commitment Studies

APPENDIX D:

- Table D.1: Assertive Community Treatment and Case Management
- Table D.2: Psychological and Psychosocial Interventions
- Table D.3: Homelessness, Housing, Vocational Rehabilitation, Employment
- Table D.4: Community Interventions for Co-Occurring Disorders
- Table D.5: Hospitalization and Recent Advances In Psychopharmacology

APPENDIX E:

- Table E.1: Admission/Discharge Legal Status For Episodes Of Care
- Table E.2: Characteristics Of Individuals By Legal Status
- Table E.3: Characteristics Of Individuals By Conservatorship Status
- Table E.4: Service Use By Legal Status
- Table E.5: Prior Involuntary Treatment by Legal Status
- Table E.6: 72-Hour Hold Characteristics Of Individuals By Treatment Setting

APPENDIX F:

- Figure F.1: Flow Chart of The Involuntary Commitment Process in California

SEARCH METHODOLOGY

TIME PERIOD COVERED: 1980-2000

LANGUAGE QUALIFICATION: English only

SEARCH #1:

DATABASES SEARCHED:

MEDLINE
HealthSTAR
PsycINFO
Sociological Abstracts

SEARCH STRATEGY:

COMMITMENT OF MENTALLY ILL FROM MEDLINE, HEALTHSTAR

OR

(MENTALLY DISABLED PERSONS OR MENTAL DISORDERS!) AND (LEGAL GUARDIANS OR AMBULATORY CARE OR AMBULATORY CARE FACILITIES!) FROM MEDLINE, HEALTHSTAR

OR

COMMITMENT (PSYCHIATRIC) FROM PSYCINFO

OR

INSTITUTIONALIZATION AND (MENTAL ILLNESS OR PSYCHOSIS OR SCHIZOPHRENIA) FROM SOCIOLOGICAL ABSTRACTS

AND

CIVIL- OR INVOLUNTAR- OR COERC- OR COMPULSORY OR FORC- OR ENFORC- OR MANDAT-

SEARCH #2:

DATABASE SEARCHED:

PsycINFO

SEARCH STRATEGY:

OUTPATIENT COMMITMENT OR INVOLUTARY TREATMENT OR (ADVANCE DIRECTIVES AND PSYCHIATR-)

SEARCH #3:

DATABASE SEARCHED: Social SciSearch

SEARCH STRATEGY:

[(MENTAL- ILL- OR MENTAL- DISORDER- OR PSYCHIATR- OR PSYCHOSIS OR PSYCHOTIC OR SCHIZOPHRENI-) AND (TREAT- OR THERAP- OR COMMIT- OR HOSPITALI- OR MEDICAT- OR ADMISSION- OR ADMIT-) AND (OUTPATIENT- OR CIVIL- OR INVOLUNTAR- OR COERC- OR COMPULSORY OR FORC- OR ENFORC- OR MANDAT-)] IN TITLE, SUBJECT HEADING FIELDS

SEARCH METHODOLOGY

SEARCH #4:

DATABASE SEARCHED:

Mental Health Abstracts

SEARCH STRATEGY:

(TREAT- OR THERAP- OR COMMIT- OR HOSPITALI- OR MEDICAT- OR ADMISSION- OR ADMIT-) AND
(OUTPATIENT- OR CIVIL- OR INVOLUNTAR- OR COERC- OR COMPULSORY OR FORC- OR ENFORC-
OR MANDAT-)] IN TITLE, SUBJECT HEADING FIELDS

SEARCH #5:

DATABASES SEARCHED:

MEDLINE
HealthSTAR
PsycINFO
Mental Health Abstracts
Sociological Abstracts
Social SciSearch

SEARCH STRATEGY:

PERCEIV- COERC- OR PSYCHIATR- DIRECTIVE- OR ASSISTED OUTPATIENT- OR CONDITIONAL
RELEASE- OR CONDITIONAL DISCHARG- OR COMPETEN- DETERMIN- OR COMMUNITY TREATMENT
ORDER- OR GRAV- DISAB- OR [(MENTAL- ILL- OR MENTAL- DISORDER- OR PSYCHIATR- OR
PSYCHOSIS OR PSYCHOTIC OR SCHIZOPHRENI-) AND (CONSERVATOR- OR GUARDIAN-)]

TOTAL NUMBER OF ITEMS RETRIEVED (FOR ALL SEARCHES): 6719

NOTES:

A dash (-) after a term indicates truncation – e.g. “mental-“ will search “mental” and “mentally”

An exclamation point after a term indicates that the term is being searched hierarchically (“exploded”) – i.e. the broader term and specified narrower terms in the hierarchy will be searched. This feature is used in Medline and HealthSTAR.

RAND

STUDY ON INVOLUNTARY TREATMENT FOR PEOPLE WITH MENTAL ILLNESS

Screening Form

Abstract Number:

First Author (last name):

Title (first several words):

Reviewer:

Inclusion Determination

- | | | | |
|----|---|---|---|
| 1. | Does the article pertain to the policy issues of interest
(i.e., effectiveness of involuntary outpatient treatment) | Y | N |
| 2. | Was the study reported in the article conducted in either the U.S.,
Canada or Britain? | Y | N |
| 3. | Does the article report data from an empirical study?
(i.e., reporting outcomes in addition to any legal analysis or commentary) | Y | N |
| 4. | At a minimum, does the study design include a comparison or control
condition or employ a pre/post design? | Y | N |

**If the answer is "No" to any of items 1 – 4,
circle "Exclude Manuscript" and DO NOT
ABSTRACT FURTHER**

EXCLUDE MANUSCRIPT

RAND

STUDY ON INVOLUNTARY TREATMENT FOR PEOPLE WITH MENTAL ILLNESS

Article Abstraction Form

Abstract Number:

First Author (last name):

Title (first several words):

Reviewer:

1. Is the article best classified as:

- ☐ published article (peer-reviewed journal)
- ☐ published article (non-peer-reviewed)
- ☐ book chapter
- ☐ an unpublished report
- ☐ other _____

2. Is the article best classified as:

- ☐ review article
- ☐ article reporting primary data collection and analysis
- ☐ article reporting secondary data analysis

3. Is the unit of analysis the community (*e.g., measurement at the community level such as aggregate commitment rates*) or individuals (*e.g., outcomes of people who have received services under an outpatient commitment demonstration program*)?

- ☐ individual
- ☐ community

4. Please provide a brief written description of the intervention or policy change being studied:

5. Which best describes the study type:

- ☐ cross sectional comparison of experimental and comparison groups
- ☐ pre-post comparison of experimental group without comparison group
- ☐ pre-post comparison of experimental group with comparison group
- ☐ randomized controlled trial
- ☐ other _____

6. Over what period of time was the study conducted? (mark X if not reported)

Intervention or policy change being observed _____ years _____ months

Post-intervention/policy-change follow-up _____ years _____ months

The complete study _____ years _____ months

7. What was the geographic setting within which the study was conducted?

- ☐ urban area
- ☐ rural area
- ☐ both urban and rural
- ☐ not reported

Specify state(s) _____

8. What best describes the sampling frame?

- ☐ entire eligible population
- ☐ probability sample
- ☐ convenience or self-selected sample
- ☐ not reported

9. Did the sample include the following age groups?

children (0-17)	Y	N
adults (18-64)	Y	N
elders (65+)	Y	N
<input type="checkbox"/> not reported		

10. Did the sample include:

men	Y	N
women	Y	N
<input type="checkbox"/> not reported		

11. Did the sample include:

Caucasian	Y	N
African-American	Y	N
Hispanic/Latino	Y	N
Asian/South Asian/Pacific Islanders	Y	N
<input type="checkbox"/> not reported		

12. Did the study make comparisons across groups that differed on the basis of at least one important characteristic (e.g., geographic location, age, diagnosis, whether or not they received an intervention)?

Y	N
---	---

If yes, briefly describe each group (*Group 1 should be the main comparison/control group*)

Group 1 _____

Group 2 _____

Group 3 _____

Group 4 _____

13. Please indicate the number of subjects who completed the study in each group:

Group 1 _____

Group 2 _____

Group 3 _____

Group 4 _____

14. What outcomes were measured (*e.g., changes in symptoms or mental status, changes in hospitalization rates, days, time to readmission, etc*)?

15. How was the analysis performed?

- ☐ qualitative description
- ☐ quantitatively without significance testing
- ☐ quantitatively with significance testing
- ☐ (for non-experimental designs) comparison across groups controlled for initial differences using multivariate analysis

16. Were any of the results statistically significant? Y N

17. Was any cost-effectiveness/benefit analysis done? Y N

18. Assessment of the overall quality of the study on a scale from 1-5
(*with 1 being poor and 5 being excellent; mark X if unable to rate*)

Adequacy of the sample size	_____
Attrition bias	_____
Selection bias	_____
Relevance of outcome measures	_____
Differential exposure to intervention	_____
Appropriateness of data analytic techniques	_____
Extent to which conclusions follow from the evidence presented	_____
Generalizability of the findings	_____

RAND Study on Involuntary Treatment for People with Mental Illness

Project Description

September 2000

In the current era of cost containment, policy makers and mental health providers have focused attention on providing appropriate community based mental health care while decreasing the expensive "revolving door" use of psychiatric hospitals, emergency services, detoxification units, and jails. The visibility of homeless people in major urban centers has also focused attention on those who refuse to use mental health services, especially people who are visibly suffering from co-occurring substance abuse problems. In recent years there has been a growing public outcry concerning homelessness, resulting in panhandling ordinances and "quality of life" arrests. Acts of violence by mentally ill individuals have caused newspaper editorials to question the wisdom of current commitment criteria. What is not clear is whether these phenomena are a cause or an effect of the dramatic changes in mental health care over the last three decades. What does seem clear is the increasing need to engage and retain people in treatment, as well as control utilization (and therefore cost), has created an environment conducive to change in the public provision of mental health services.

In the last decade, involuntary commitment has expanded rapidly into the community. There is a small but growing body of research on involuntary outpatient commitment. While some advocates claim that outpatient commitment is a useful method for increasing participation in outpatient care, others argue that empirical studies have not been able to disentangle the effects of treatment from the effects of commitment. And, as many consumers argue, if people with severe mental illnesses were offered treatment that addressed their needs and preferences, would involuntary commitment be necessary?

This year the California Legislature will be considering proposals to amend the existing involuntary treatment statute, the Lanterman-Petris-Short Act. In order to assist the California Senate, RAND is conducting a study that will provide a fresh and objective look at the experiences of other states and a more "evidence-based" review of the empirical literature on issues of public policy interest in the upcoming debate. The RAND study focuses on three research questions: (1) how effective is involuntary treatment compared to other types of intervention and treatment? (2) what has been the experience of other states with implementation of involuntary treatment laws and programs? and (3) who is potentially impacted by a change in the involuntary treatment criteria in California?

The project involves statutory and case law analysis, in-depth interviewing of stakeholders involved in the civil commitment process in eight states, an evidence-based review of the empirical literature on involuntary commitment, and an analysis of California Department of Mental Health data. A final report will be delivered to the Senate on January 31, 2001.

The project is being conducted by RAND in cooperation with the California Senate Office of Research and on behalf of the California Senate Committee on Rules. RAND is a non-profit research institution in Santa Monica, California that helps improve policy through research and analysis. Information on our research, publications, and other background is available from our website at www.rand.org. The principal investigators for this study are M. Susan Ridgely, J.D., a RAND senior policy analyst, and John Petrila, J.D., L.L.M., and Randy Borum, Ph.D., senior consultants to RAND.

Study on Involuntary Treatment for People with Mental Illness

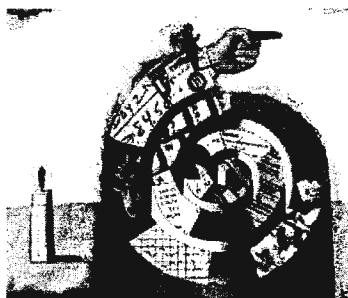
RAND Project Team

September 2000

M. Susan Ridgely (J.D., University of Maryland, 1995) is a health attorney with extensive experience in the organization and financing of behavioral health services in the public sector. Ms. Ridgely is currently Co-Principal Investigator of the evaluation of Florida's Medicaid Prepaid Mental Health Plan. This project is one of 21 in SAMHSA's national multi-site study of Managed Behavioral Healthcare in the Public Sector. She is also a principal in the UCLA/RAND Research Center on Managed Care and Psychiatric Disorders and the Center's RWJ Healthcare for Communities (HCC) Project, which is designed to track changes in health policy and behavioral health care delivery in 60 representative U.S. communities. Her work in the last 10 years has focused on the evaluation of public behavioral health service delivery. During the 1980s Ms. Ridgely was Chief of Social Services for the D.C. Public Defender Service – Mental Health Division which represents mentally ill individuals in the civil commitment process at St. Elizabeths Hospital in the District of Columbia. During the late 1980s she was a public policy analyst specializing in mental illness and disability rights and also served as the Staff Director of the National Commission on the Insanity Defense. Ms. Ridgely has published extensively in the behavioral health field and is on the editorial board of the *Journal of Behavioral Health Services and Research*.

John Petrila (J.D., University of Virginia, 1976; L.L.M., University of Virginia, 1977) is Chair and Professor in the Department of Mental Health Law & Policy at the Florida Mental Health Institute. He also holds joint appointments as Professor in the USF College of Public Health as well as Adjunct Professor of Law at Stetson University College of Law. Mr. Petrila received his law degree and an advanced degree in mental health law from the University of Virginia School of Law. He was the first Director of Forensic Services in the Missouri Department of Mental Hygiene and in the 1980s and early 90s he was General Counsel and Deputy Counsel for Litigation to the New York State Office of Mental Health. Mr. Petrila is a nationally recognized expert on mental health law. He consults frequently to states involved in complex litigation involving mental health and correctional systems. Mr. Petrila is co-author of three books, including *Psychological Evaluations for the Courts*; *Mental Health Services: A Public Health Perspective*; and *Mental Health Law, Florida*, and has authored more than 50 other articles, monographs, and book chapters on mental disability law and policy.

Randy Borum (Psy. D., Florida Institute of Technology, 1992) is Associate Professor in the Department of Mental Health Law & Policy at the Florida Mental Health Institute. He is Board-Certified (ABPP) and fellowship-trained in Forensic Psychology, and has completed an NIMH Research Fellowship in the Mental Health Services Research Program jointly sponsored by UNC-Chapel Hill and Duke University Medical Center. Prior to coming to USF, Dr. Borum was Assistant Professor at Duke University Medical Center where he was a co-investigator on a randomized study of involuntary outpatient commitment. He is currently Co-Principal Investigator in SAMHSA's multi-site Criminal Justice Diversion Initiative for Individuals with Co-Occurring Mental Illness and Substance Abuse Disorders. Dr. Borum regularly consults with state and county mental health agencies on forensic mental health policy and provides training and policy consultation relating to the assessment and management of people at risk for violence. He has authored over 50 publications and currently serves on the editorial boards of *Law and Human Behavior* and the *Journal of Threat Assessment*.



RAND Study on Involuntary Treatment for People with Mental Illness

RAND Health
RAND Institute for Civil Justice

September 2000

Description of Interviews with Stakeholders

A bill has been introduced in the California legislature that would make a number of substantive changes to California's Lanterman-Petris-Short Act. In an effort to understand the potential impact of changing California's commitment law, the California Senate has asked RAND to undertake this study.

Together with the study sponsors, we have identified your state as one of eight in our study of the implementation of changes in civil commitment. We have chosen states that meet one or more of the following criteria: (1) states that have recently substantially changed their commitment statute; (2) states that have commitment criteria similar to those proposed in California's bill; (3) states that have an outpatient commitment statute and where studies on outpatient commitment have been conducted; and/or (4) large states with a decentralized public mental health system whose experience with civil commitment might most closely mirror California's.

We are currently reviewing your state statutes and case law, as well as any empirical studies that have been published. In addition to a "paper" review, however, we would like to understand the experience from the point of view of key stakeholders involved in the involuntary commitment process. In order to have a complete picture of the experience in your state, we need to have responses from representatives of important stakeholders including state mental health attorneys, defense attorneys, and mental health service providers. We are asking for your help.

We are providing this copy of the survey questions so you can consider them in advance of our request for an interview. We would like to have your responses to all of the questions, however, if you are uncomfortable with any question you may skip it in the interview. We estimate that the interview will take about 60 minutes.

Your responses, along with those from three other interview respondents in your state, will be summarized in a report that will be submitted to the California Senate. In some cases we may wish to attribute a specific quotation to you.

Because of the interest many parties have in this legislation, the Senate has asked that we identify the interview respondents. With your permission, we will be including your name and affiliation in that report. If you do not wish to be identified, please let us know. Findings from the study will also be shared with all participants.

The following are the kinds of issues we would like to discuss in the interviews (this is a general list for all respondents – not all questions will necessarily apply to your state or to you as a respondent):

Issues in Implementation of Commitment Reforms

- When was the last significant statutory change to the state's commitment law?
- Have there been successful legal challenges to any of the aspects of commitment reform? (e.g., definitions of dangerousness or grave disability)
- Has there been consistency in legal interpretation of the statute?
- What has been the impact, if any, of legal rulings on the implementation of commitment reforms?
- What has been the reaction of key stakeholders to commitment reform (including providers, consumers, advocates, state mental health attorneys and defense bar)?

Outpatient commitment

- Is there an explicit outpatient commitment statute? A provision within the commitment statute for outpatient commitment?
- Is there a specific target group for the statute (e.g., people with severe mental illness)?
- Are there different commitment criteria, length of commitment and/or due process requirements for outpatient commitment (as compared to inpatient commitment)?
- Can an outpatient commitment petition be initiated when the patient is in the community or only after hospitalization?
- Who gets notice of the petition?
- Is there a written order? Who receives copies (e.g., the patient? their family? the service provider?)
- What treatment is permitted? How is the treatment funded?
- What is the role/responsibility of the treatment provider? What is the impact, if any, on provider liability?
- Does (or can) the written order specify that the patient must take medication?
- What is the process for monitoring outpatient commitment orders?
- Are patients automatically placed in an inpatient facility in the event that they don't abide by the terms of the outpatient commitment order? What are the procedures? Does the patient have a right to a hearing? A right to appointed counsel?
- Please describe the actual practice of enforcement for non-compliance. Who is involved in enforcement (e.g., peace officers, service providers)?

- Would you say that outpatient commitment is frequently used, infrequently used or almost never used in your state? If use has been greater or lower than expected, why do you think that is?
- In your experience, what factors are most likely to prompt initiation of a petition for outpatient commitment for a particular patient? What criteria prompt providers to initiate a petition in lieu of offering voluntary treatment?

State Efforts to Ensure Consistency of Commitment Determinations

- Is it your perception that statutory commitment criteria are clear to stakeholders in the commitment process (judges, attorneys, providers, consumers)?
- Do you think consistency across jurisdictions is a problem? Across judges? Across providers?
- Has there been any monitoring of the consistency of commitment determinations in your state? Are there data bases that would allow for such monitoring?
- Does the state mandate or provide training for judges, prosecutors, etc. to enhance the likelihood of consistency of commitment determinations at the local level? If so, what type of training?
- Does the state employ other methods to increase consistency (such as providing manuals, etc.)?

Commitment Reform and Treatment Resources

- Has reform of the state's civil commitment statute affected the availability of treatment resources in your state?
- Have changes impacted the nature or volume of the patient population? The patterns of service use?
- Do involuntary patients have priority for community based services?
- Has there been any attempt to tie commitment to treatment resources (e.g., for example by increasing funds to local agencies based on the number of people placed on outpatient commitment in their catchment area)?
- Have resource constraints (e.g., in acute care resources, in community resources) had an impact on implementation of civil commitment reforms?

Based on all of your experience,

- What have been the positive consequences, if any, of changing the law? Negative consequences? Unintended consequences?
- What are the keys to successful implementation of changes in commitment law?
- What are the most important lessons for California to learn from your experiences?

APPENDIX B: INTERVIEW RESPONDENTS

MI	Oliver G.	Cameron	M.D., Ph.D.	Professor of Psychiatry	University of Michigan Medical Center
MI	Mark A.	Cody	J.D.	Attorney	Michigan Protection and Advocacy Service, Inc.
MI	Gerald	Goffin	M.S.W.	Supervisor, Community Support Services	CEI CMH Board
NC	Beth	Melcher	Ph.D.	Director, Government Relations	NAMI, North Carolina
NC	Richard	Slipsky	J.D.	Assistant Attorney General	North Carolina Department of Justice
NC	Rob	Stranahan	J.D.	Special Counsel	Office of Special Counsel Dorothea Dix Hospital
NC	John	Wagnitz	M.D., M.S.	Medical/ Clinical Director	Sandhills Center for MH/DD/SA Services
NY	Marvin	Bernstein	J.D.	Director	Mental Hygiene Legal Service, First Judicial Department
NY	Emmett J.	Creahan	J.D., M.P.A.	Director	Mental Hygiene Legal Service, Fourth Judicial Department
NY	Bruce S.	Dix	J.D.	Director	Mental Hygiene Legal Service, Third Judicial Department
NY	Dennis	Feld	J.D.	Deputy Chief Attorney	Mental Hygiene Legal Service, Second Judicial Department
NY	Peter R.	Freed	J.D.	Counsel	New York State Conference of Local Mental Hygiene Directors, Inc.
NY	David M.	LeVine	J.D.	Deputy Director	Mental Hygiene Legal Service, Third Judicial Department
NY	William	Martin	M.A., J.D.	General Counsel	City of New York, Department of Mental Health, Mental Retardation, and Alcoholism Services
NY	Christine	Morton	J.D.	Attorney	Mental Hygiene Legal Service, Second Judicial Department
NY	John	Tauriello	J.D.	Deputy Commissioner and Counsel	New York State Office of Mental Health
NY	Howard	Telson	M.D.	Psychiatrist	New York State Psychiatric Association
OH	Debra	Belinky	J.D.	Legal Counsel to the Director	Ohio Department of Mental Health
OH	William P.	Harper	M.A., M.S.W.	Executive Director	Recovery Services of Warren/Clinton Counties

APPENDIX B: INTERVIEW RESPONDENTS

OH	Michael	Kirkman	J.D.	Legal Director	Ohio Legal Rights Services
OH	Mark	Munetz	M.D.	Chief Clinical Officer	Summit County ADM Board
OR	Sharon	Maynard	J.D.	Staff Attorney	Metropolitan Public Defender
OR	Gene	Minard	M.D., M.P.H.	Forensic Psychiatrist	Retired
OR	Madeline	Olson	B.A.	Assistant Administrator	Oregon Department of Mental Health & Developmental Disabilities Services Division
OR	Richard	Templeton	Ph.D.	Civil Commitment Specialist	Office of Mental Health Services
OR	Paul	Wagner	M.Ed.	Supervisor, Crisis & Commitment Services	Marion County Health Department
TX	Spencer	Bayles	M.D.	Psychiatrist	Texas Society of Psychiatric Physicians
TX	Melinda	Brents	J.D.	Senior Assistant County Attorney	Harris County Attorney's Office
WA	Christos	Dagadakis	M.D., M.P.H.	Psychiatrist	Harborview Hospital Outpatient Psychiatry
WA	Fran	Lewis	M.A.	Director	Pierce County Human Services; also Pierce County Regional Service Network (Mental Health)
WA	Mary	Opgenorth	J.D.	Attorney	Department of Assigned Counsel
WA	Terrance	Ryan	J.D.	Assistant Attorney General	Office of the Attorney General
WI	Paul	Harris	J.D.	Attorney	Department of Health and Family Services
WI	Alan	Hart	J.D.	Attorney	Knoll, Hart & Greller
WI	Galen	Strebe	J.D.	Assistant Corporation Counsel for Dane County	Dane County, Wisconsin
WI	Darold	Treffert	M.D.	Behavioral Health Services	St. Agnes Hospital
WI	Timothy	Wiedel	M.D.	Clinical Program Director	Milwaukee County Mental Health Division

TABLE C.1
SUMMARY OF FIRST GENERATION OUTPATIENT COMMITMENT STUDIES

STUDY	SUBJECTS	DESIGN	DESIGN LIMITATIONS	RESULTS
Bursten, B. (1986). Posthospital mandatory outpatient treatment. <i>Am J Psychiatry</i> , 143(10), 1255-8.	221 patients between July 1, 1981 and March 31, 1983.	Compared rates of inpatient readmission of outpatient commitment patients with control groups of patients in hospitals that did not participate in outpatient commitment programs.	<ul style="list-style-type: none"> ▪ Important and unaccounted-for differences between MOT groups and comparison control groups ▪ No additional data presented to clarify and support interpretations ▪ Selection bias 	Data do not support effectiveness of outpatient commitment. Reductions in readmissions after outpatient commitment program were not attributable to outpatient commitment programs.
Fernandez, G., & Nygard, S. (1990). Impact of involuntary outpatient commitment on the revolving-door syndrome in North Carolina. <i>Hosp Community Psychiatry</i> , 41(9), 1001-4.	4,179 subjects committed under outpatient commitment in North Carolina from July 1985-June 1988.	Demographic, clinical, and hospitalization data were gathered from a N.C. database of mental health patients. Average numbers of inpatient admissions and hospital days were computed before and after outpatient commitment for each client (standardized to a rate per 1,000 days).	<ul style="list-style-type: none"> ▪ No comparison controls ▪ No contextual information about relevant trends in NC ▪ Selection bias ▪ Statistical analysis blurs potentially informative differences between the pre- and post-test groups 	Outpatient commitment appeared to reduce admissions per 1,000 by 82.2% and length of stay by 33.3%. Average number of admissions decreased from 3.69 before commitment to .66 after commitment.
Geller, J., Grudzinskas, A., et al. (1998). The efficacy of involuntary outpatient treatment in Massachusetts. <i>Admin Policy Ment Health</i> , 25, 271-285.	19 patients under court-ordered treatment via guardianship (IOT).	IOT subjects compared to matched comparison group on demographic and clinical factors, and on prior hospital days and admissions. Compared changes in hospital days and admissions in the 6 months before and after IOT order.	<ul style="list-style-type: none"> ▪ Selection bias ▪ Small sample 	Patients on IOT showed significantly greater reductions in the number of admissions (1.05 vs. .105) and in the number of hospital days (decrease of 68.4 vs. 3.7) than the matched control subjects during the 6 month follow-up period.
Greeman, M., & McClellan, T. (1985). The impact of a more stringent commitment code in Minnesota. <i>Hosp Community Psychiatry</i> , 36(9), 990-92.	153 patients admitted to VA medical center's inpatient service between August 1, 1981 and July 31, 1983.	Quarterly follow-up data on each patient's post-hospital adjustment in the community.	<ul style="list-style-type: none"> ▪ Selection bias ▪ Nonequivalent comparison groups 	Six (24%) out of 25 outpatient commitment patients and 11 (14%) of the 80 patients who were released after emergency holds without further coercive intervention were doing well in the community.

TABLE C.1
SUMMARY OF FIRST GENERATION OUTPATIENT COMMITMENT STUDIES

STUDY	SUBJECTS	DESIGN	DESIGN LIMITATIONS	RESULTS
<p>Hiday, V., & Scheid-Cook, T. (1987). The North Carolina experience with outpatient commitment: a critical appraisal. <i>Int J Law Psychiatry</i>, 10(3), 215-32.</p> <p>Hiday, V. A. (1987). An Assessment of Outpatient Commitment in North Carolina. <i>Ed & Self Mgmt Psych Pt</i>, 1(4), 4-7.</p>	740 mentally ill adults who had civil commitment hearings in July 1984 and June 1985, 161 of whom were ordered to outpatient commitment.	Comparisons of outpatient commitment patients with those released and those involuntarily hospitalized. Basic demographic, health, and "dangerousness" information was collected from court records on all 740 subjects.	<ul style="list-style-type: none"> ▪ No pre-test measures ▪ Comparison controls are nonequivalent with limited contextual data ▪ Subjective measures for outcomes in the community and variable definitions ▪ Selection bias in the creation of the study population ▪ No data linking IOC status with treatment compliance with performance in the community 	More outpatient commitment patients lived at home after discharge than either released or involuntarily hospitalized patients; they were less likely to use community mental centers, more likely to comply with treatment programs, and less likely to refuse medication.
<p>Hiday, V., & Scheid-Cook, T. (1989). A follow-up of chronic patients committed to outpatient treatment. <i>Hosp Community Psychiatry</i>, 40(1), 52-9.</p> <p>Hiday, V. A., & Scheid-Cook, T. L. (1991). Outpatient commitment for "revolving door" patients: Compliance and treatment. <i>J Nerv Ment Dis</i>, 179(2), 83-88.</p>	A group of 168 chronic psychiatric patients including 69 outpatient commitment patients, 84 involuntarily hospitalized patients, and 12 released patients.	Using mental health records, comparison of compliance and attendance of outpatient commitment patients over a 6-month period with those released outright and those hospitalized involuntarily.	<ul style="list-style-type: none"> ▪ No pretest measures ▪ Comparison controls are nonequivalent with limited contextual data ▪ Subjective measures for outcomes in the community, inconsistent data collection ▪ Selection bias in the creation of the study population ▪ No demonstrated link among IOC status, treatment compliance & community success 	Outpatient commitment patients were more likely than released or involuntarily hospitalized patients to utilize aftercare service and to continue in treatment. Differences in rehospitalization among the three groups were not statistically different.

TABLE C.1
SUMMARY OF FIRST GENERATION OUTPATIENT COMMITMENT STUDIES

STUDY	SUBJECTS	DESIGN	DESIGN LIMITATIONS	RESULTS
<p>Miller, R., & Fiddleman, P. (1982). Involuntary civil commitment in North Carolina: The result of the 1979 statutory changes. <i>North Carolina Law Review</i>, 60, 985-1026.</p> <p>Miller, R., & Fiddleman, P. (1984). Outpatient commitment: treatment in the least restrictive environment? <i>Hosp Community Psychiatry</i>, 35(2), 147-51.</p>	67 patients admitted involuntarily to a North Carolina hospital during 6-month periods before and after October 1, 1979 (the date the new NC statutes went into effect).	Examination of the court dockets, patients' hospital charts; examination of data from a 1-year follow-up; interviews with CMHC staff; questionnaires mailed to staff at the clinics and hospital and to legal participants in the commitment process.	<ul style="list-style-type: none"> ▪ No comparison controls ▪ Limited, small study sample (one hospital) ▪ Short follow-up period 	The number of patients who remained in treatment for the length of the commitment period decreased from 77% before to 50% afterward. CMHC staff evaluated outpatient commitment effective in 46% of the cases both before and after statutory change.
Munetz, M. R., Grande, T., Kleist, J., & Peterson, G. A. (1996). The effectiveness of outpatient civil commitment. <i>Psych Serv</i> 47(11), 1251-3.	20 patients with serious mental illnesses and a history of noncompliance and recurrent hospitalizations, but good treatment response.	Changes were examined in the patients' patterns of service use in the year prior to and following assignment to outpatient commitment.	<ul style="list-style-type: none"> ▪ Retrospective study design ▪ Small sample size ▪ No comparison control group 	Significant reductions were found in visits to the psychiatric emergency service, hospital admissions, and lengths of stay.
O'Keefe, C., Potenza, D. P., & Mueser, K. T. (1997). Treatment outcomes for severely mentally ill patients on conditional discharge to community-based treatment. <i>J Nerv Ment Dis</i> 185(6), 409-11.	26 patients discharged from the hospital under the condition that they receive community-based treatment.	Using retrospective file review, examined hospital days, medication compliance, substance abuse, violence, employment, and housing stability in the year prior to their conditional release and compared them to the two-year period after their conditional release.	<ul style="list-style-type: none"> ▪ Extremely small sample ▪ No comparison control group ▪ Selection bias 	Patients on conditional discharge showed improvements during the first year for days in the hospital, number of moves per year, and months of employment, and for first <u>and</u> second years in medication compliance, substance abuse, and violence.

TABLE C.1
SUMMARY OF FIRST GENERATION OUTPATIENT COMMITMENT STUDIES

STUDY	SUBJECTS	DESIGN	DESIGN LIMITATIONS	RESULTS
Rohland, B. M. (1998). The Role of Outpatient Commitment in the Management of Persons with Schizophrenia, Iowa Consortium for Mental Health, 1-11.	39 adult patients with severe mental illness who were committed to outpatient treatment under Iowa's outpatient commitment statute.	Outpatient commitment subjects were compared to a control group who had an inpatient admission at some point in the study period.	<ul style="list-style-type: none"> ▪ Selection bias ▪ Small sample size ▪ Poorly matched comparison group 	Positive results included improved treatment compliance in approximately 80% of outpatient commitment patients, and reductions in hospital and emergency room use.
Van Putten, R., Santiago, J., & Berren, M. (1988). Involuntary outpatient commitment in Arizona: a retrospective study. <i>Hosp Community Psychiatry</i> , 39(9), 953-8.	384 patients for whom outpatient commitment was sought at a hospital between February 7, 1983 and August 6, 1984.	Comparison of outpatient commitment patients with committed inpatients through retrospective review of medical, clinical, and court records.	<ul style="list-style-type: none"> ▪ No comparison controls ▪ No contextual data ▪ Small sample size ▪ Selection bias ▪ Short follow-up period 	The median number of days of hospitalization after the court hearing was lower when the order applied outpatient commitment than when it applied inpatient treatment (10 days compared to 19 days.)
Zanni, G., & deVeau, L. (1986). Inpatient stays before and after outpatient commitment. <i>Hosp Community Psychiatry</i> , 37(9), 941-42.	42 patients at a Washington, DC hospital whose status changed from voluntary to committed outpatient during 1983.	Compared for each patient the average inpatient length of stay, total number of inpatient hospitalizations, and inpatient days for the year before outpatient commitment and the year following it.	<ul style="list-style-type: none"> ▪ No comparison controls ▪ Selection bias ▪ No contextual data to clarify interpretations ▪ Small sample size 	Shortened inpatient stays and reduction in number of inpatient admissions. Average number of inpatient admissions in the year before outpatient commitment was 1.81 and 0.95 in the year following outpatient commitment, a statistically significant difference. Inpatient stays following outpatient commitment was shorter (38 days) than before outpatient commitment (55 days). This difference is not statistically significant but researchers concluded this "clearly support[s] the effectiveness of outpatient commitment."

TABLE C.2
SUMMARY OF SECOND GENERATION OUTPATIENT COMMITMENT STUDIES

STUDY	SUBJECTS	DESIGN	DESIGN LIMITATIONS	RESULTS
<p>Swanson, J. W., Borum, R., Swartz, M. S., Hiday, V. A., Wagner, H. R., & Burns, B. J. (under review). Can involuntary outpatient commitment reduce arrests among persons with severe mental illness?</p> <p>Swanson, J. W., Swartz, M. S., Borum, R., Hiday, V. A., Wagner, H. R., & Burns, B. J. (2000). Involuntary out-patient commitment and reduction of violent behaviour in persons with severe mental illness. <i>Br J Psychiatry</i>, 176, 324-331.</p> <p>Swartz, M., Hiday, V. A., Swanson, J. W., Wagner, H. R., Borum, R., & Burns, B. J. (1999). Measuring Coercion Under Involuntary Outpatient Commitment: Initial findings from a Randomized Controlled Trial. In J. P. Morrissey & J. Monahan (Eds.), <i>Research in Community and Mental Health</i> (Vol. 10, pp. 57-77). Stamford, Connecticut: JAI Press Inc.</p> <p>Swartz, M. S., Swanson, J. W., Hiday, V. A., Wagner, H. R., Burns, B. J., & Borum, R. (under review). A Randomized Controlled Trial of Outpatient Commitment in North Carolina.</p>	<p>Patients identified during hospitalization were randomly assigned to either an outpatient commitment with case management group or a case services alone group. An additional group of patients with a recent history of serious violence were placed in a nonrandomized comparison group and were placed in outpatient commitment.</p>	<p>Each group was followed by periodic interview for 16 months and by record for 2 years.</p>	<ul style="list-style-type: none"> ▪ Patients with history of serious violence could not be randomized. ▪ No one blind to study assignment. ▪ Renewals of outpatient commitment orders could not be randomized for patients who no longer met legal criteria. ▪ Only studied outpatient commitment in persons discharged from hospital. 	<p>Patients who underwent sustained periods of outpatient commitment beyond the initial court order (which is only for up to 90 days) had 57% fewer admissions and 20 fewer hospital days over the study period compared to controls. Sustained outpatient commitment is particularly effective for patients suffering from non-affective psychotic disorders (72% decrease in readmissions and 28 fewer hospital days). However, sustained outpatient commitment reduced hospitalization only when combined with a higher intensity of patient services (averaging 7 services/month). Analysis of mandatory outpatient treatment on violent behavior yielded similar results.</p>

TABLE C.2
SUMMARY OF SECOND GENERATION OUTPATIENT COMMITMENT STUDIES

STUDY	SUBJECTS	DESIGN	DESIGN LIMITATIONS	RESULTS
<p>Swartz, M. S., Swanson, J. W., Wagner, H. R., Burns, B. J., Hiday, V. A., & Borum, R. (1999). Can involuntary outpatient commitment reduce hospital recidivism?: Findings from a randomized trial with severely mentally ill individuals. <i>Am J Psychiatry</i>, 156(12), 1968-1975.</p>				
<p>Steadman, H. J. (1998). <i>Research Study of the New York City Involuntary Outpatient Commitment Pilot Program</i>. Prepared for New York City Department of Mental Health, Submitted by Policy Research Associates, Inc.</p> <p>Steadman, H. J., Gounis, K., et al. (in press). Outcomes of Participants in the New York City Involuntary Outpatient Commitment Pilot Program in New York City.</p>	<p>During an 11-month period, inpatients at a New York City hospital who were deemed appropriate for outpatient commitment were randomized to receive either intensive community treatment with a court order or intensive community treatment alone.</p>	<p>The program provided for a range of intensive outpatient treatment and included involuntary medication, but only for those patients found by the court to lack the capacity to give informed consent for treatment.</p>	<ul style="list-style-type: none"> ▪ The operative difference between experimental and control conditions (judicial orders) was misunderstood by patients and providers. ▪ More patients with co-occurring substance abuse in the AOT than in comparison group. ▪ Only studied outpatient commitment in persons discharged from hospital. 	<p>There is no statistical difference between the outpatient commitment and control groups for rehospitalization or hospital days during the study period. However, both groups experienced a significantly smaller rehospitalization rate during the study period than during the year preceding the target admission (from 87.1% to 51.4% for outpatient commitments and from 80.0% to 41.6% for controls). Also, non-substance abusing psychotic patients in the outpatient commitment group were rehospitalized far less frequently (25%) than those in the control group (45%).</p>

TABLE D.1
SUMMARY OF EVIDENCE-BASED REVIEWS ON EFFECTIVENESS OF MENTAL HEALTH TREATMENTS
FOR PEOPLE WITH SEVERE MENTAL ILLNESS
(Assertive Community Treatment and Case Management)

REFERENCE	INTERVENTION	ASSESSMENT	RESULTS	CONCLUSIONS
Latimer, E. A. (1999). Economic impacts of assertive community treatment: a review of the literature. <i>Can J Psychiatry</i> , 44(5), 443-454.	Assertive community treatment—economic impacts	Search terms are not described, however selection criteria are described. Findings included from both RTC and non-randomized studies. A small number of studies provided data on fidelity of implementation and only 3 studies included “comprehensive economic analyses.”	Reviewer finds that reduction in hospital days is related to implementation of the program (with “high fidelity” programs superior to other programs). The effect on housing costs is “ambiguous” and effects on use of other resources is inconsistent across studies. The 3 studies that involved the most sophisticated economic analyses found no statistically significant differences between ACT and the control condition, although trends favored ACT.	The reviewer concludes, “the most reliable cost offset to ACT treatment costs appears to be reduced hospital use. Using Quebec costs, an ACT program must enroll people with prior hospital use of about 50 days yearly, on average, to break even. As care systems evolve to reduce their reliance on hospitalization as a care modality with or without ACT, this threshold will become increasingly difficult to achieve.”
Marshall, M., & Lockwood, A. (2000). Assertive community treatment for people with severe mental disorders (<i>Cochrane Review</i>). In: <i>The Cochrane Library</i> . Issue 2, CD0001089. Oxford: Update Software.	Assertive community treatment	Evidence-based review that describes search terms and methods. Review included RCTs that compared ACT for people with severe mental illness to standard community care, hospital-based rehabilitation, or case management. (Studies of ACT as an alternative to admission or hospital diversion were excluded).	People receiving ACT were more likely to remain in contact with services, less likely to be admitted to a hospital, and spent less time in the hospital than people receiving standard community care. Significant differences were found in favor of ACT clients on accommodation status, employment and patient satisfaction. There were no differences on mental state or social functioning. When compared to people receiving hospital-based rehabilitation, the only difference was in readmission rates and LOS in the hospital. ACT clients were significantly more likely to be living on their own but there were no significant differences in clinical or other social outcomes. In comparison to case management, people in ACT consistently spent fewer days in the hospital but there were insufficient data to address other outcomes. ACT did not have a clear cost advantage.	Reviewers conclude that ACT is “a clinically effective approach to managing the care of severely mentally ill people in the community” and recommend that policy makers support the development of ACT teams.

TABLE D.1
SUMMARY OF EVIDENCE-BASED REVIEWS ON EFFECTIVENESS OF MENTAL HEALTH TREATMENTS
FOR PEOPLE WITH SEVERE MENTAL ILLNESS
(Assertive Community Treatment and Case Management)

REFERENCE	INTERVENTION	ASSESSMENT	RESULTS	CONCLUSIONS
Scott, J. E., & Dixon, L. B. (1995). Assertive community treatment and case management for schizophrenia. <i>Schizophr Bull</i> , 21(4), 657-668.	Assertive community treatment	Evidence-based review that describes search terms and methods. Review include RCTs and some quasi-experimental studies.	Reviewers conclude that "ACT consistently reduces the rate and duration of psychiatric inpatient care, increases program retention, and may be less costly over the short- and mid-range compared with other approaches to organizing and delivering services (e.g., community mental health centers or hospital-based aftercare." Evidence to support an effect on clinical and social outcomes has been mixed – some evidence supports the conclusion that ACT programs reduce psychiatric symptomatology, improve social functioning, and promote independence and residential stability – although the evidence is stronger for some program models than others and longer exposure to the intervention may be necessary. There is at least some evidence, in addition, that treatment gains may be lost if the treatment is withdrawn or discontinued.	The reviewers conclude that the evidence for the efficacy of ACT is strong while noting that the "border" between ACT and case management is not always clear. They argue for attention to the fidelity of the implementation of ACT programs.
Marshall, M., Gray, A., Lockwood, A., & Green, R. (2000). Case management for people with severe mental disorders (<i>Cochrane Review</i>). In: <i>The Cochrane Library</i> . Issue 2, CD0000050. Oxford: Update Software.	Case management	Evidence-based review that describes search terms and methods. Review included RCTs that compared case management to standard community care.	Case management increased the numbers of people remaining in contact with services and doubled the numbers admitted to psychiatric hospital. However, according to reviewers, "except for a positive finding on compliance, from one study, case management showed no significant advantages over standard care on any psychiatric or social variable." Cost data were insufficient to draw conclusions.	Reviewers conclude that case management does appear to increase contact with the mental health system but one result is increased hospital admission rates and possibly increased lengths of stay. CM has not been shown to produce clinically significant improvements in mental health, social functioning, or quality of life. The reviewer therefore conclude that "case management is an intervention of questionable value, to the extent that it is doubtful whether it should be offered by community psychiatric services" much less be considered 'the cornerstone' of community mental health care.

TABLE D.2
SUMMARY OF EVIDENCE-BASED REVIEWS ON EFFECTIVENESS OF MENTAL HEALTH TREATMENTS
FOR PEOPLE WITH SEVERE MENTAL ILLNESS
(Psychological and Psychosocial Interventions)

REFERENCE	INTERVENTION	ASSESSMENT	RESULTS	CONCLUSIONS
Scott, J. E., & Dixon, L. B. (1995). Psychological interventions for schizophrenia. <i>Schizophr Bull</i> , 21(4), 621-630.	Dynamic and supportive psychotherapies (both individual and group) and psychosocial skills training for people with schizophrenia	Evidence-based review that describes search terms and methods, however non-controlled as well as RCT studies were included in the review. There are relatively few controlled trials of psychotherapy for people with schizophrenia, all of the studies are at least 10 years old and are of limited quality. Other studies suffer from significant methodological weaknesses. There have been a number of controlled trials of psychosocial skills training but the RCTs share significant limitations.	Reviewers conclude that "there appears to be no evidence for the efficacy of dynamic, insight-oriented psychotherapies (either individual or group) for patients with schizophrenia," however, suggestive and tentative findings, suggest that supportive psychotherapy may reduce symptomatology and relapse as well as improve social and vocational adjustment for some sub-groups of patients. Results with regard to skills training suggest that training does lead to the acquisition of the targeted skills, that these skills persist after the training ends, but evidence for the generalizability of skills to settings outside of the training setting is far weaker.	Reviewers conclude that flaws in methodology, including significant flaws in the RCTs on skills training, has the "cumulative effect" of diminishing the confidence that can be placed in the findings and expectations for generalizability. Reviewers also note that evidence is conflicting or absent on whether other domains (e.g., relapse, psychopathology, social functioning, and quality of life) are impacted.
Huxley, N. A., Parikh, S. V., & Baldessarini, R. J. (2000). Effectiveness of psychosocial treatments in bipolar disorder: State of the evidence. <i>Harv Rev Psychiatry</i> , 8(3), 126-140.	Psychotherapy (group, family, individual) for people with bipolar disorder	Evidence-based review that describes search terms and methods. Review included RCTs (13) and non-randomized studies (19).	No available studies allow direct comparisons based on randomization of bipolar patients to alternative psychosocial modalities. However, available evidence suggests that group, family and individual psychotherapy are "feasible" in bipolar patients due to major improvements in pharmacological management of illness. Reviewers note that "documentation of specific clinical gains from adding psychosocial treatments to standard care with long-term mood-stabilizing medication was uneven in the studies reviewed." While noting significant methodological problems in the research, the reviewers reported clinical benefits such as reductions in morbidity and improved social and vocational functioning.	Reviewers note that "the most striking finding of this search was that formal research on psychosocial interventions in bipolar disorder has been remarkably limited." Reviewers caution that the studies are few and "vary in their scientific rigor" and encourage further research to "specify the benefits, limitation, risks and costs of particular interventions."

TABLE D.2
SUMMARY OF EVIDENCE-BASED REVIEWS ON EFFECTIVENESS OF MENTAL HEALTH TREATMENTS
FOR PEOPLE WITH SEVERE MENTAL ILLNESS
(Psychological and Psychosocial Interventions)

REFERENCE	INTERVENTION	ASSESSMENT	RESULTS	CONCLUSIONS
Nicol, M. M., Robertson, L., & Connaughton, J. A. (2000). Life skills programmes for chronic mental illness (<i>Cochrane Review</i>). In: <i>The Cochrane Library</i> . Issue 2, CD000381. Oxford: Update Software.	Any group or individual program involving independent functioning in daily living—these could include managing money, organizing a home, domestic skills and personal care	Evidence-based review that describes search terms and methods. Two RCTs were included in the analysis.	The two RCTs included only a total of 38 participants. No clear effects were demonstrated.	Reviewers conclude that “if life skills training is to continue as part of rehabilitation programmes, a large, well designed, conducted, and reported pragmatic randomized trial is an urgent necessity.”
Joy, C. B., Adams, C. E., & Rice, K. (2000). Crisis intervention for people with severe mental illnesses (<i>Cochrane Review</i>). In: <i>The Cochrane Library</i> . Issue 2, CD001087. Oxford: Update Software.	Crisis intervention	Evidence-based review that describes search terms and methods. Review included RCTs that compared crisis intervention to standard community care. In each of the 5 studies, crisis intervention was embedded in a form of home care so that none investigated crisis intervention “in a pure form.”	Forty-five percent of the home care group were readmitted to the hospital during the treatment period, however, home care was “slightly superior” in avoiding repeated admission. Other findings suggest that home care reduces loss to follow-up, reduces family burden, and achieves better patient satisfaction for patients and their families. No differences were found in mental state, loss or death. No data on differences in compliance with medication and number of relapses were available.	Reviewers find it difficult to draw any definitive conclusions about crisis intervention from this review, however, “the review suggests that home care crisis treatment, coupled with an ongoing home care package, is a viable and acceptable way of treating people with severe mental illnesses.” Other forms of crisis intervention need to be studied more systematically.
Pharoah, F. M., Mari, J. J., & Streiner, D. (2000). Family intervention for schizophrenia (<i>Cochrane Review</i>). In: <i>The Cochrane Library</i> . Issue 4, CD000088. Oxford: Update Software.	Family psychosocial interventions designed to reduce levels of expressed emotions	Evidence-based review that describes search terms and methods. Review included RCTs that compared to standard care.	Family intervention may decrease the frequency of relapse, may decrease hospitalization, and encourage compliance with medication but “the data are few and equivocal.” The reviewers did not find evidence that family intervention affects the drop out rates.	Reviewers state that “clinicians, researchers, policy makers and recipient of care cannot be confident of the effects of family intervention from the findings of this review.” The reviewers call for more clinical trials and attention in those trials to the issue of generalizability to routine care.

TABLE D.2
SUMMARY OF EVIDENCE-BASED REVIEWS ON EFFECTIVENESS OF MENTAL HEALTH TREATMENTS
FOR PEOPLE WITH SEVERE MENTAL ILLNESS
(Psychological and Psychosocial Interventions)

REFERENCE	INTERVENTION	ASSESSMENT	RESULTS	CONCLUSIONS
Dixon, L. B., & Lehman, A. F. (1995). Family interventions for schizophrenia. <i>Schizophr Bull</i> , 21(4), 631-643.	Family psychoeducational interventions	Evidence-based review that describes search terms and methods. Review includes RCTs and quasi-experimental studies. A number of high quality controlled trials are available, methodological problems include small sample sizes, and limited inclusion criteria and limited follow-up.	Reviewers report there is substantial evidence that family psychoeducational interventions reduce the rate of patient relapse and that there is "suggestive, though not conclusive" evidence that these interventions also improve patient functioning and family well-being.	Reviewers conclude that more research is needed to identify the critical elements of family interventions—although there is some evidence to suggest that brief psychoeducation alone is inferior to family interventions that use combinations of "engagement, support and problem solving."
Barbarto, A., & D'Avanzo, B. (2000). Family interventions in schizophrenia & related disorders: a critical review of clinical trials. <i>Acta Psychiatr Scand</i> , 102(2), 81-97.	Family intervention	Evidence-based review that describes search terms and methods. Review included RCTs that compared to standard care or alternative treatments. Reviewers note wide range in "methodological soundness" across studies.	Based on the evidence, reviewers conclude that "the addition of family intervention to standard treatment for schizophrenia has a positive impact on outcome to a moderate extent." The interventions appear to be effective in "reducing the short-term risk of clinical relapse after remission from an acute episode" but there is little evidence of an effect on mental state, social functioning or any family-related variables. No evidence of relative efficacy of different models is available.	The reviewers conclude that research on family interventions is "still in its infancy" and that future research must employ higher quality designs, with larger unselected samples, and more adequate outcome measures.

TABLE D.2
SUMMARY OF EVIDENCE-BASED REVIEWS ON EFFECTIVENESS OF MENTAL HEALTH TREATMENTS
FOR PEOPLE WITH SEVERE MENTAL ILLNESS
(Psychological and Psychosocial Interventions)

REFERENCE	INTERVENTION	ASSESSMENT	RESULTS	CONCLUSIONS
Pekkala, E., & Merinder, L. (2000). Psychoeducation for schizophrenia (Cochrane Review). In: <i>The Cochrane Library</i> . Issue 4, CD002381. Oxford: Update Software.	Psychoeducation to increase patients' awareness of their illness and its treatment	Evidence-based review that describes search terms and methods. Review included RCTs that compared to standard levels of "knowledge provision." Ten studies were included in the review.	Reviewers note that "compliance with medication was significantly improved in a single study using brief group intervention (at one year) but other studies produced equivocal or skewed data. Any kind of psychoeducational intervention significantly decreased relapse or readmission rates at 9 to 18 months follow-up compared with standard care." The reviewers concluded that psychoeducation may have a positive effect on patients' well being but no impact was found on insight, medication related attitudes or satisfaction with services.	Reviewers concluded that evidence suggests that psychoeducational approaches are useful and their brevity and inexpensiveness should make them attractive. More randomized trials are needed, however, to determine which formats are most effective.
Merinder, L. B. (2000). Patient education in schizophrenia: a review. <i>Acta Psychiatr Scand</i> , 102(2), 98-106.	Patient education	Evidence based review describes search terms and inclusion criteria. RCT and non-randomized studies were included.	The reviewers conclude that most of the studies demonstrate that knowledge and compliance can be improved by patient education but only a few studies also indicate that symptomatology and relapse can also be influenced under some circumstances. Data on other outcomes such as insight, social functioning, quality of life and satisfaction is too limited to draw conclusions.	The reviewers conclude that patient education has an impact on knowledge and that programs that employ "behavioral elements" show some efficacy in influencing compliance. However, "due to methodological limitation and insufficient reporting the results of available studies on patient education in schizophrenia are far from conclusive." They call for further research that is "methodologically homogeneous" and "better reported."

TABLE D.3
SUMMARY OF EVIDENCE-BASED REVIEWS ON EFFECTIVENESS OF MENTAL HEALTH TREATMENTS
FOR PEOPLE WITH SEVERE MENTAL ILLNESS
(Homelessness, Supported Housing, Vocational Rehabilitation, Supported Employment)

REFERENCE	INTERVENTION	ASSESSMENT	RESULTS	CONCLUSIONS
Rosenheck, R. (2000). Cost-effectiveness of services for mentally ill homeless people: The application of research to policy and practice [In Process Citation]. <i>Am J Psychiatry</i> , 157(10), 1563-1570.	Service interventions for seriously mentally ill homeless people, including outreach, assertive community treatment and housing placement	Search terms and search methods are not described. Findings included from both RCTs and "observational outcome studies." (Only 3 of 8 total studies are experimental studies.)	The single experimental study of outreach (NYC) found that over the 2-year follow-up the recipients of outreach services had greater access to basic resources, had improved psychiatric symptomatology, improved quality of life, and reduced nights sleeping on the streets. The experimental program clients incurred increased costs for care. Questions were raised about the generalizability of findings of cost effectiveness of ACT. The reviewers noted that "the total cost impact of an expensive intervention can be profoundly affected by the overall level of service use and costs among study participants" and noted that "there program are likely to achieve cost neutrality for only a small segment of the total target population. For housing programs, the reviewers report higher costs associated with "modestly better" outcomes.	The reviewer suggests that "innovative programs for homeless people with mental illness are modestly more effective than standard care, but they may also be more expensive. Furthermore, the reviewer suggests that in the transition from research to practice, these program must incur additional costs to increase the available pool of housing subsidies and income supports." The reviewer also suggests that decisions on whether these types of programs should be implemented depend on whether the value of their benefit equals the additional costs.

TABLE D.3
SUMMARY OF EVIDENCE-BASED REVIEWS ON EFFECTIVENESS OF MENTAL HEALTH TREATMENTS
FOR PEOPLE WITH SEVERE MENTAL ILLNESS
(Homelessness, Supported Housing, Vocational Rehabilitation, Supported Employment)

REFERENCE	INTERVENTION	ASSESSMENT	RESULTS	CONCLUSIONS
Newman, S. J. (2000). Housing and serious mental illness: A critical review of the literature. Baltimore: Johns Hopkins University, Institute for Policy Studies.	Housing associated with service supports	Search terms, search methods, and criteria for inclusion are described. Review includes both RCTs and non-RCTs. 33 studies met criteria for inclusion, however, reviewer notes that the majority of studies suffer from one or more significant methodological weaknesses. Most studies rely on correlational analysis which cannot establish causation.	The research taken together cannot answer the following questions: (1) what attributes are critical to a capacity to live independently; (2) what types of residential alternatives are most effective; (3) what attributes are systematically associated with or predict the types of residential settings that will be best for a particular individual. In addition, there is no agreement reflected in this body of work about how to conceptualize and measure the effectiveness of housing as an intervention. One of the strongest findings from one of the best studies is that living in independent housing is associated with greater satisfaction with housing and neighborhood. On the other hand, only two studies addressed whether housing has a therapeutic benefit that operates independent of the services provided. The findings were mixed. The reviewer suggests that additional research is needed to understand the relationship between independent housing, satisfaction, and mental health outcomes.	"The two key policy questions that are arguably key in this topic area—the relative effects of housing and services on mental health outcomes, and the effectiveness of different housing-and-services bundles on mental health outcomes—pose significant methodological challenges. The reviewer believes there is a "critical need for a coherent research agenda built around key hypotheses."

TABLE D.3
SUMMARY OF EVIDENCE-BASED REVIEWS ON EFFECTIVENESS OF MENTAL HEALTH TREATMENTS
FOR PEOPLE WITH SEVERE MENTAL ILLNESS
(Homelessness, Supported Housing, Vocational Rehabilitation, Supported Employment)

REFERENCE	INTERVENTION	ASSESSMENT	RESULTS	CONCLUSIONS
Bond, G. R., Drake, R. E., Mueser, K. T., & Becker, D. R. (1997). An update on supported employment for people with severe mental illness. <i>Psychiatr Serv</i> , 48(3), 335-346.	Supported employment (e.g., job coaches, ACT, individual placement and support, day treatment, prevocational, clubhouse, skills training, sheltered workshop)	Search terms and methods are described. Review includes both RCTs and non-RCTs. Eleven studies in all, of which only 5 were RCTs. (Limited to studies completed by 1995.)	The reviewers find the results of the studies "encouraging." Among the experimental studies, "the unweighted mean rate of clients' obtaining competitive employment was 58%, with a range from 32 to 78%. The corresponding rate for the control groups was 21%, with a range from 6 to 40%." The reviewers caution, however, that significant methodological weaknesses in the studies are "tempering these optimistic findings." Reviewers suggest that the initial findings indicate the importance of particular program factors including "an explicit focus on competitive employment outcomes," and the need for integration of employment and clinical strategies.	Supported employment appears to be a "promising approach" for people with severe mental illness but more experimental studies are needed. Future studies should define the intervention programs more clearly, pay attention to program implementation, and include long-term follow-up.

TABLE D.3
SUMMARY OF EVIDENCE-BASED REVIEWS ON EFFECTIVENESS OF MENTAL HEALTH TREATMENTS
FOR PEOPLE WITH SEVERE MENTAL ILLNESS
(Homelessness, Supported Housing, Vocational Rehabilitation, Supported Employment)

REFERENCE	INTERVENTION	ASSESSMENT	RESULTS	CONCLUSIONS
Lehman, A. F. (1995). Vocational rehabilitation in schizophrenia. <i>Schizophr Bull</i> , 21(4), 645-656.	Interventions to enhance the vocational capacity of people with schizophrenia	Evidence-based review that describes search terms and methods. Review include RCTs and some quasi-experimental studies. Reviewers report on a limited number of controlled trials and suggest that these are of limited quality.	Many different types of vocational interventions have been developed and studied. According to reviewers, "no definitive conclusion can be offered as to whether vocational rehabilitation interventions enhance the vocational outcomes of persons with schizophrenia. We can state with moderate confidence that vocational programs by definition enhance the vocational activities of persons with psychiatric disabilities while patients are in these programs, but that they do not have significant effects on rates of competitive employment after leaving the programs." There is not enough information available from these studies to draw conclusions about the capacity of vocational rehabilitation interventions to enhance other outcomes, although the reviewer notes that there is "a trend that improvements in vocational functioning are correlated with" outcomes such as reduced symptoms and reduced relapse (without implying that there is a causal relationship).	The reviewer notes that more recent studies on supported employment "show more promise" on the issue of competitive employment and suggests that future research, that takes into account the new advances in other clinical technologies, especially improvements in psychopharmacology, should examine the impact of rehabilitation interventions when combined with alternative clinical treatments.

TABLE D.4

**SUMMARY OF EVIDENCE-BASED REVIEWS ON EFFECTIVENESS OF MENTAL HEALTH TREATMENTS
FOR PEOPLE WITH SEVERE MENTAL ILLNESS
(Community Interventions for Co-Occurring Disorders)**

REFERENCE	INTERVENTION	ASSESSMENT	RESULTS	CONCLUSIONS
Drake, R. E., Mercer-McFadden, C., Mueser, K. T., & Becker, D. R. (1998). A review of integrated mental health & substance abuse treatment for patients with dual disorders. <i>Schizophr Bull</i> , 24, 589-608.	Treatment programs within psychiatric care for people with co-occurring serious mental illness and substance use disorders	Not a systematic review—includes both RCTs (6 studies) and non-RCT studies (30 studies) employing a wide variety of research methods.	The reviewers conclude that 10 studies provide “encouraging evidence regarding the potential these programs have to engage dually diagnosed patients in services and to help them reduce substance abuse and attain remission. Outcomes related to hospital use, psychiatric symptoms, and other domains are less consistent.” In terms of approach, the review favors the ACT model (which the reviewers developed), however, subsequent reporting of data from their studies showed no cost-effectiveness differences.	While acknowledging the significant limitations of most of the research to date, the reviewers have argued that the weight of the evidence is in favor of integrated treatment. While encouraging, these findings do not provide compelling evidence of the cost effectiveness of integrated treatment at this point.
Ley, A., Jeffrey, D. P., McLaren, S., & Siegfried, N. (2000). Treatment programmes for people with severe mental illness and substance misuse (<i>Cochrane Review</i>). In: <i>The Cochrane Library</i> . Issue 2, CD001088. Oxford: Update Software.	Treatment programs within psychiatric care for people with co-occurring serious mental illness and substance use disorders	Evidence-based review that describes search terms and methods. Review included six RCTs. Reviewers site methodological issues such as small sample sizes (4 of the studies) and problems in the quality of study design and reporting of clinically relevant outcomes.	“There is no clear evidence, for the limited number of outcomes presented, than any substance misuse treatment programme within psychiatric care produced different outcomes to standard psychiatric care alone.” Explanations include concerns about whether experimental subjects received an appropriate “dose” of the intervention (e.g., did not attend or complete treatment) and concerns that control subjects may have also received assistance with substance abuse issues. Other concerns included high drop out rates in comparisons among different types of programs, and limited range of services or fidelity of implementation. Reviewers note that “an alternative explanation may be that there is no real effect at all.”	Reviewers state that “there is no clear evidence supporting an advantage of any type of substance misuse programme for those with serious mental illness over the value of standard care. No one programme is clearly superior to another.” Well-designed and controlled RCTs are necessary to establish an evidence base for integrated programs. The reviewers warn that “the current interest in specialist integrated programmes based on the New Hampshire approach [integrated ACT model] should be accompanied by rigorous service evaluation, preferably in controlled trials.”

TABLE D.4
SUMMARY OF EVIDENCE-BASED REVIEWS ON EFFECTIVENESS OF MENTAL HEALTH TREATMENTS
FOR PEOPLE WITH SEVERE MENTAL ILLNESS
(Community Interventions for Co-Occurring Disorders)

REFERENCE	INTERVENTION	ASSESSMENT	RESULTS	CONCLUSIONS
Tyrer, P., Coid, J., Simmonds, S., Joseph, P., & Marriott, S. (2000). Community mental health teams (CMHTs) for people with severe mental illnesses and disordered personality (<i>Cochrane Review</i>). In: <i>The Cochrane Library</i> . Issue 2, CD00270. Oxford: Update Software.	Community mental health team treatment for people with severe mental illness and personality disorder	Evidence-based review that describes search terms and methods. Review included only RCTs. (ACT trials were excluded).	Treatment team management is associated with fewer deaths by suicide, deaths "in suspicious circumstances" and attrition from the studies. Team treatment was also positively associated with satisfaction with care. No clear differences were found for other outcomes, including admission rates, duration of hospital treatment and "overall clinical outcomes." There may be problems in generalizing from these studies, however, as these teams were all linked to research programs.	Reviewers conclude that "community mental health team management is not inferior to non-team standard care in any important respects and is superior in promoting greater acceptance of treatment. It may also be superior in reducing hospital admission and avoiding death by suicide." The review gives some support for establishing teams however further research is necessary to establish the effect of provision of team-based care on important clinical outcomes.

TABLE D.5
SUMMARY OF EVIDENCE-BASED REVIEWS ON EFFECTIVENESS OF MENTAL HEALTH TREATMENTS
FOR PEOPLE WITH SEVERE MENTAL ILLNESS
(Hospitalization and Recent Advances in Psychopharmacology)

REFERENCE	INTERVENTION	ASSESSMENT	RESULTS	CONCLUSIONS
Johnstone, P., & Zolese, G. (2000). Length of hospitalization for people with severe mental illness (<i>Cochrane Review</i>). In: <i>The Cochrane Library</i> . Issue 2, CD001087. Oxford: Update Software.	Effects of brief (or short stay) admissions versus standard (or longer stay) admissions	Evidence-based review that describes search terms and methods. Only five RCTs met criteria to be included in the analysis.	Patients receiving brief admissions experienced no more re-admission, no more losses to follow-up, and were more successfully discharged than patients receiving standard/long stay care. Data on other outcomes were either difficult to interpret (due to methodological problems) or lacking.	Reviewers conclude that short stays are not encouraging a "revolving door" but suggest that more large, well-designed studies are needed (all of these trials were published in the 1970s). Questions about the effect of brief hospitalization on other important outcomes (e.g., mental, social, family, patient satisfaction, death, violence, criminal behavior, cost) remain unanswered.
Lindenmayer, J. P. (2000). Treatment refractory schizophrenia [In Process Citation]. <i>Psychiatr Q</i> , 71(4), 373-384.	Effects of atypical antipsychotics (clozapine, olanzapine, risperidone, quetiapine) as compared to typicals	Search terms and search methods are not described. Findings included from double-blind RCTs.	Evidence from the studies of atypical antipsychotics (when compared with typicals) indicate that atypicals can "offer significant advantages" over typical agents in the treatment of treatment-refractory patients but some patients still do not respond. Other factors need to be addressed such as compliance and co-morbidities.	There are no head-to-head double-blind studies of atypical antipsychotics in "treatment refractory" patients using sound methodological designs so relative efficacy cannot be established.
Tuunainen, A., Wahlbeck, K., & Gilbody, S. M. (2000). Newer atypical antipsychotic medication versus clozapine for schizophrenia (<i>Cochrane Review</i>). In: <i>The Cochrane Library</i> . Issue 2, CD000096. Oxford: Update Software.	Whether atypical antipsychotics share the superior effectiveness of clozapine without subjecting patients to the significant risks of clozapine use	Evidence-based review that describes search terms and methods. Eight studies were included—however only one study was of more than 12 weeks duration.	Newer atypicals seem to be similar to clozapine but these results were derived from a relatively small number of studies and patients. The impact of these drugs on quality of life, service use, hospital admission, and costs were not measured.	Reviewers note that "the equal effectiveness and tolerability of new atypical drugs in comparison with clozapine is not yet demonstrated." RCTs with larger numbers of patients, of longer duration, measuring additional outcomes are needed.

TABLE E.1

ADMISSION/DISCHARGE LEGAL STATUS FOR EPISODES OF CARE

ADMISSION STATUS	DISCHARGE STATUS									
Row Pct	72-Hours Hold	14-Day Certification	2 nd 14-day Certification	Additional 30-day Certification	Additional 180-day Certification	Temporary Conservatorship	LPS Conservatorship	Voluntary	Others	Total
72-Hours Hold	62.20	7.46	0.01	0.35	0.01	0.93	0.09	26.36	2.59	
14-Day Certification	1.04	60.88	0.13	0.65	0.00	628	0.19	16.77	14.05	
2nd 14-day Certification	0.00	0.00	33.33	0.00	0.00	0.00	0.00	7.41	59.26	
Additional 30-day Certification	0.00	3.70	0.00	81.48	0.00	0.00	0.00	7.41	7.41	
Additional 180-day Certification	0.00	6.45	0.00	0.00	66.13	0.00	0.00	1.61	25.81	
Temporary Conservatorship	0.10	0.02	0.00	0.01	0.03	37.40	0.34	13.57	48.53	
LPS Conservatorship	0.02	0.00	0.00	0.00	0.02	0.11	45.65	1.33	52.86	
Voluntary	1.87	0.24	0.00	0.03	0.01	0.06	0.02	62.20	35.58	
Others	0.49	1.18	0.00	0.03	0.25	1.64	0.03	6.36	90.02	
Total	70,667	9,494	21	465	83	5,215	2,208	179,335	99,363	366,851

TABLE E.2

CHARACTERISTICS OF INDIVIDUALS BY LEGAL STATUS

		Voluntary (N = 78,486)	72 hours (N = 51,392)	14 days (N = 6,774)	Longer-term commitment (N = 273)
GENDER					
	Female	52.1	45.2	45.1	47.3
	Male	47.9	54.8	54.9	52.8
RACE					
	White	56.6	57.7	54.4	66.3
	Hispanic	17.2	15.5	12.6	10.3
	African American	15.7	16.1	21.9	16.9
	Others	5.5	6.5	8.8	5.5
	Unknown	5.0	4.3	2.4	1.1
AGE					
		39	38	38	43
EMPLOYMENT					
	In Competitive Market	9.3	8.9	3.3	0.4
	In Non-Competitive Market	3.7	1.9	1.4	1.5
	Unemployed/Looking for Job	31.1	15.2	9.2	15.0
	Not in Labor Force	31.0	26.7	40.5	37.7
	Unknown	24.8	47.3	45.7	45.4
MARITAL STATUS					
	Never Married	47.9	53.5	54.3	60.4
	Now Married	16.1	14.6	10.1	10.3
	Widowed/Divorced/Separated	27.0	18.8	20.0	24.2
	Unknown	9.0	13.1	15.6	5.1
EDUCATION					
	0-11	29.8	27.1	34.6	24.5
	12	28.4	25.3	28.9	28.6
	13-15	13.0	10.2	12.2	17.6
	16	3.3	3.0	3.5	7.0
	17+	1.8	1.5	1.7	2.9
	Missing	23.8	32.9	19.2	19.4

TABLE E.2

CHARACTERISTICS OF INDIVIDUALS BY LEGAL STATUS (continued...)

		Voluntary (N = 78,486)	72 hours (N = 51,392)	14 days (N = 6,774)	Longer-term commitment (N = 273)
ADMISSION LIVING ARRANGEMENT					
	Lives Alone	17.9	19.7	14.4	8.8
	Lives with Family	42.4	34.3	26.2	14.3
	Lives with Non-related	8.8	6.4	2.6	1.1
	Community Facility	5.6	3.5	4.4	11.8
	Hospital	0.9	2.5	9.3	44.1
	Justice	2.5	0.4	2.3	2.9
	Other	16.4	24.0	32.1	8.5
	Homeless	5.6	9.2	8.8	8.5
DISCHARGE PRIMARY DIAGNOSIS					
	Cognitive	1.5	2.0	1.3	3.7
	Substance Related	7.2	13.2	6.1	2.6
	Schizophrenia\Psychotic	20.5	34.3	57.9	64.5
	Mood Disorders	41.8	30.2	29.2	23.8
	Anxiety Disorders	5.9	0.9	0.5	0.4
	Others	23.1	19.6	5.0	5.1
DISCHARGE SECONDARY DIAGNOSIS					
	Cognitive	0.1	0.1	0.1	0.0
	Substance Related	8.2	5.8	6.0	2.6
	Schizophrenia\Psychotic	0.4	0.6	0.9	0.0
	Mood Disorders	2.0	1.1	0.8	0.7
	Anxiety Disorders	1.8	0.4	0.1	0.4
	Others	87.4	92.1	92.2	96.3
GAF		46	36	37	35

TABLE E.3

CHARACTERISTICS OF INDIVIDUALS BY CONSERVATORSHIP STATUS

		Temporary Conservatorship (N = 6,841)	LPS Conservatorship (N - 2,626)
GENDER			
	Female	46.3	41.1
	Male	53.7	58.9
RACE			
	White	61.0	51.8
	Hispanic	9.9	14.6
	African American	18.3	24.1
	Others	7.9	5.3
	Unknown	2.9	4.2
AGE		46	44
EMPLOYMENT			
	In Competitive Market	0.5	0.5
	In Non-Competitive Market	3.2	0.4
	Unemployed/Looking for Job	29.2	72.6
	Not in Labor Force	48.8	15.7
	Unknown	18.3	10.9
MARITAL			
	Never Married	57.8	79.2
	Now Married	8.4	3.2
	Widowed/Divorced/Separated	24.0	15.7
	Unknown	9.8	1.9
EDUCATION			
	0-11	32.9	22.2
	12	24.8	25.9
	13-15	10.8	8.9
	16	3.4	2.6
	17+	2.2	1.3
	Missing	25.9	39.2

TABLE E.3

CHARACTERISTICS OF INDIVIDUALS BY CONSERVATORSHIP STATUS (continued...)

		Temporary	LPS
		Conservatorship	Conservatorship
		(N = 6,841)	(N = 2,626)
ADMISSION LIVING ARRANGEMENT			
	Lives Alone	7.8	2.6
	Lives with Family	9.4	7.2
	Lives with Non-related	2.3	0.8
	Community Facility	19.2	24.1
	Hospital	41.1	55.9
	Justice	0.7	0.7
	Other	13.9	5.0
	Homeless	5.5	3.7
DISCHARGE PRIMARY DIAGNOSIS			
	Cognitive	5.3	2.0
	Substance Related	1.3	0.9
	Schizophrenia\Psychotic	74.1	77.5
	Mood Disorders	16.3	10.2
	Anxiety Disorders	0.2	0.2
	Others	2.8	9.3
DISCHARGE SECONDARY DIAGNOSIS			
	Cognitive	0.7	0.3
	Substance Related	3.7	5.8
	Schizophrenia\Psychotic	0.8	0.5
	Mood Disorders	0.6	0.5
	Anxiety Disorders	0.1	0.2
	Others	94.2	92.8
GAF		33	35

TABLE E.4

PRIOR SERVICE USE BY LEGAL STATUS

Percent Accessing Services by Commitment Type							
		Voluntary	72-hour	14-Day	2nd 14-day	30-day	180-day
		(N = 78,486)	(N = 51,392)	(N=6,774)	(N = 29)	(N = 165)	(N = 79)
24-Hour Services		6.1	38.5	93.8	72	96.4	58.2
Day Services		14.5	60.6	65.6	44.8	81.8	36.7
Outpatient Services		94.5	62.8	69.1	86.2	52.7	84.8
Mean/Median Service Use Among Users							
		Voluntary	72-hour	14-Day	2nd 14-day	30-day	180-day
		(N = 78,486)	(N = 51,392)	(N=6,774)	(N = 29)	(N = 165)	(N = 79)
24-hour service		26.8/6	16.4/6	35.1/9	39.6/23	45.3/32	116.2/92
Day Services		17.2/1	3.3/1	4.1/1	12.7/1	3.6/2	3.3/2
Outpatient Services		12.8/4	13.6/3	19.8/5	43.1/21	19.6/6	53.2/15

TABLE E.5

PRIOR INVOLUNTARY TREATMENT BY LEGAL STATUS

Involuntary Holds in the Past 365 Days By Most Restrictive Legal Status								
		72-Hour	14-Day	2nd 14-day	30-Day	180-Day	Temp Con	LPS Con
		(N = 51,392)	(N = 6,774)	(N = 29)	(N = 165)	(N = 79)	(N = 6,481)	(N = 2,626)
72-Hour Hold		32.2	51.3	65.5	30.3	40.5	49.0	36.7
14-Day		1.0	29.5	13.8	10.3	27.8	16.4	3.3
2nd 14-Day		0.0	0.0	17.2	0.0	0.0	0.1	0.0
30-Day		0.0	0.0	0.0	58.8	0.0	0.2	0.3
180-Day		0.0	0.0	0.0	0.0	16.5	0.2	0.3
Mean/Median Number of Commitments in Past Year								
		72-Hour	14-Day	2nd 14-day	30-Day	180-Day	Temp Con	LPS Con
		(N = 51,392)	(N = 6,774)	(N = 29)	(N = 165)	(N = 79)	(N = 6,481)	(N = 2,626)
72-Hour Hold		2.35/2	2.84/2	2.11/2	3.4/2	2.69/2	2.98/2	2.75/2
14-Day		1.37/1	1.98/1	1/1	2.12/1	2/1	1.81/1	1.42/1
2nd 14-Day		1/1	1/1	1.4/1	NA.	NA.	1.5/1.5	1/1
30-Day		1.5/1.5	2/2	NA.	3.34/2	NA.	1.36/1	1.29/1
180-Day		2/2	NA.	NA.	NA.	2.38/1	1.55/1	2.75/1.5

TABLE E.6

**72-HOUR HOLD CHARACTERISTICS OF INDIVIDUALS
BY TREATMENT SETTING**

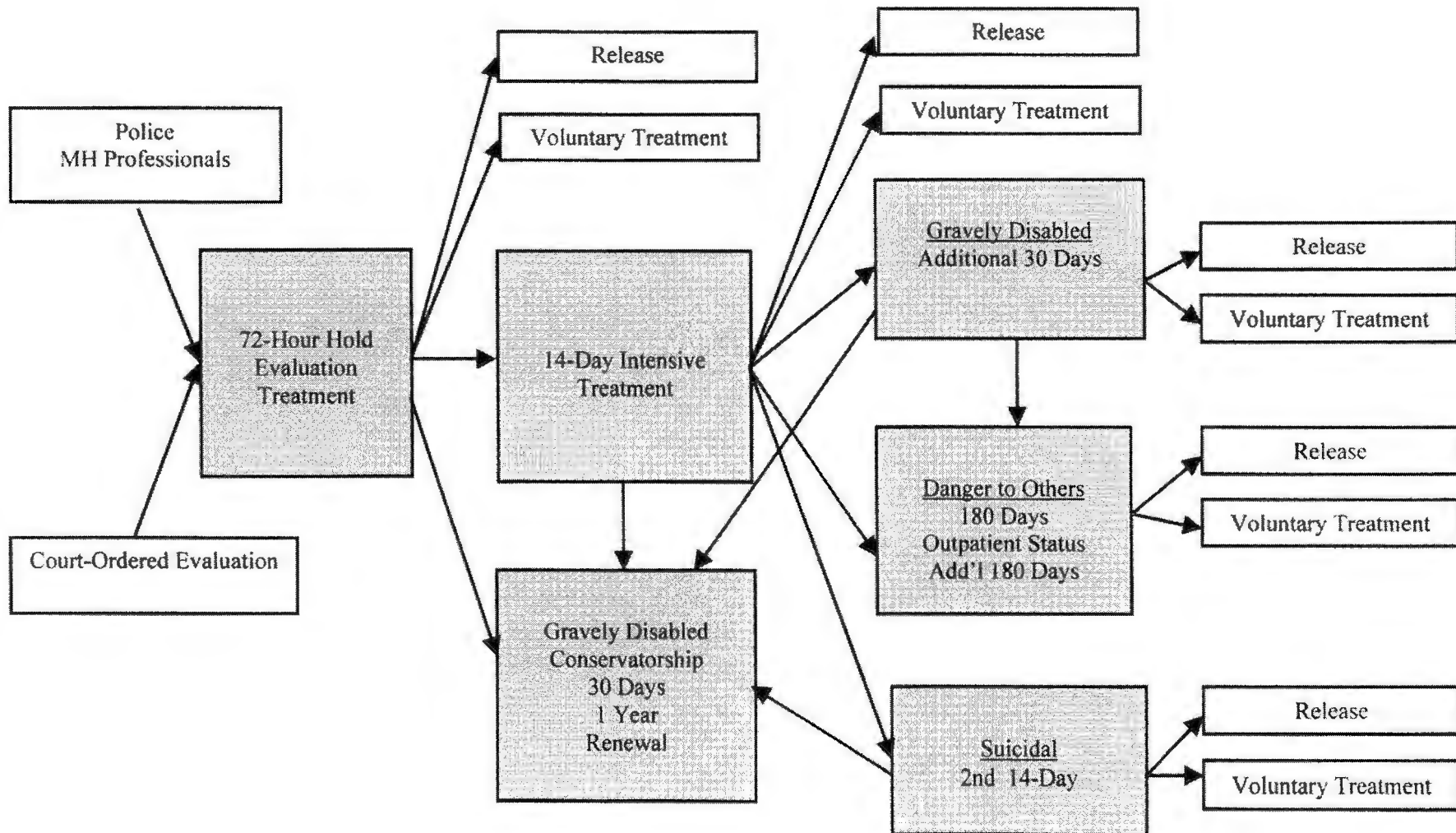
		24-hour (N = 18,430)	Day or Outpatient (N = 32,221)
GENDER			
	Female	45.3	45.5
	Male	54.7	54.5
RACE			
	White	55.8	59.0
	Hispanic	18.3	13.7
	African American	15.8	16.2
	Others	6.9	6.2
	Unknown	3.2	5.0
AGE		37	38
EMPLOYMENT			
	In Competitive Market	6.0	10.8
	In NonCompetitive Market	1.5	2.2
	Unemployed/Looking for Job	26.7	15.5
	Not in Labor Force	31.8	25.9
	Unknown	34.0	45.7
MARITAL STATUS			
	Never Married	56.1	51.5
	Now Married	13.5	15.1
	Widowed/Divorced/Separated	20.9	18.4
	Unknown	9.5	15.0
EDUCATION			
	0-11	28.3	25.8
	12	27.2	24.5
	13-15	11.1	10.0
	16	2.9	3.1
	17+	1.5	1.6
	Missing	29.0	35.0

TABLE E.6

**72-HOUR HOLD CHARACTERISTICS OF INDIVIDUALS
BY TREATMENT SETTING (Continued...)**

		24-hour	Day or Outpatient
		(N = 18,430)	(N = 32,221)
ADMISSION	LIVING ARRANGEMENT		
	Lives Alone	17.1	18.2
	Lives with Family	33.5	35.3
	Lives with Non-related	5.5	7.1
	Community Facility	6.5	4.4
	Hospital	6.5	1.7
	Justice	0.8	0.8
	Other	21.8	23.4
	Homeless	8.4	9.2
DISCHARGE	PRIMARY DIAGNOSIS		
	Cognitive	1.0	2.5
	Substance Related	6.3	16.4
	Schizophrenia\Psychotic	42.9	28.2
	Mood Disorders	35.7	29.2
	Anxiety Disorders	1.0	1.2
	Others	13.1	22.5
DISCHARGE	SECONDARY DIAGNOSIS		
	Cognitive	0.1	0.2
	Substance Related	7.9	6.1
	Schizophrenia\Psychotic	0.7	0.6
	Mood Disorders	1.1	1.1
	Anxiety Disorders	0.6	0.4
	Others	89.7	91.7
GAF		33	39

Figure 1
The Involuntary Commitment Process in California



MR-1340-CSCR

ISBN 0-8330-2980-0



5 1 5 0 0

9 780833 029805