

Alternatives to Outpatient Commitment

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The killing of 26 students and teachers in Newtown, Connecticut last year was committed by a young man, Adam Lanza, who took his own life before police could apprehend him. Investigative news reports and articles have stated that Lanza had received a diagnosis of Asperger's syndrome with sensory integration disorder.¹ Even before significant investigation into Lanza's past was conducted, however, the tragedy at Newtown rekindled the debate on legal commitment to outpatient treatment (outpatient commitment) for persons with disabling psychiatric disorders who refuse voluntary treatment. In this editorial, I review both pro and con arguments regarding outpatient commitment and the research conducted on it and discuss alternative approaches to addressing the objectives of assuring public safety and providing care for persons at risk of violence to self or others who are not engaged in mental health treatment.

Outpatient Commitment as Public Policy and Practice

The concept and practice of outpatient commitment has been a divisive subject in mental health care in the United States for at least two decades. Currently, 44 of 50 states have laws that provide for some form of outpatient commitment.^{2,3} Mental health professionals and others have argued that the prac-

tice, including commitment to taking prescribed psychiatric medications, can:

Be an effective means of providing care to persons with mental illness who refuse mental health treatment,⁴ including those who lack insight into the fact that they have a mental illness.⁵

Spur efforts to identify persons at risk of violence against self or others and, by providing treatment to them, reduce acts of violence committed by members of this group.⁶

Reduce the risk of incarceration of mandated persons.⁷

Encourage persons who have previously refused treatment to enter treatment willingly.⁷ For example, a colleague worked with homeless persons in New York City when they were notified of their eligibility to receive mandated outpatient commitment after Kendra's Law went into effect. He stated that a female client, after receiving notification, began to take her prescribed medications immediately, and her thinking and functioning improved (personal communication from Charles Barber, February 7, 2013). (Kendra's Law, ironically, was passed in New York State after a man with mental illness, who had repeatedly sought treatment but was turned away, pushed a woman in front of an oncoming subway train in New York City.⁴)

Encourage clinicians to provide coordinated and attentive care to mandated clients.⁶

Provide a less restrictive alternative to inpatient commitment for those who refuse outpatient treatment,⁸ and help prevent episodes of deteri-

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oration and negative outcomes, such as arrest or violence.⁹

Other mental health experts and advocates oppose outpatient commitment laws and practices, arguing that they may:

Unfairly target persons with mental illnesses, as most of this group does not commit acts of violence,⁴ whereas a strong majority (80%) of mass or serial killings is committed by persons seeking revenge, not persons with histories of mental illness.¹⁰

Wrongly assess individuals as being, or not being, at imminent risk of violence toward others, as psychiatrists have poor track records of predicting violence in their patients.⁴

Drive people away from treatment.⁸ The colleague noted earlier (personal communication from Charles Barber, February 7, 2013), whose client began to take her prescribed medication after Kendra's Law was passed, observed different responses among his male shelter clients: when informed of their potential eligibility for outpatient commitment, almost all fled the shelter and were not seen again.^{7,11}

Draw attention and resources away from the most significant challenges of mental health care in the United States: lack of access to care due to stigma and misconceptions about mental illness and violence (including ignorance of the fact that persons with mental illness are far more likely to be victims of violence than to commit it)^{4,12} and underfunded systems of care.⁷

Target African Americans, who were overrepresented in New York State among recipients of outpatient commitment after passage of Kendra's Law.^{13–15} The possible role of bias in this regard is unclear, as African Americans are overrepresented among the target group for outpatient commitment. Even so, the coercive nature of mandated mental health treatment, considered in the context of African Americans' overrepresentation in U.S. jails and prisons,¹⁶ should give us pause. It would be ironic, to say the least, if addressing the inequity in receipt of mental health care among African Americans¹⁷ were to be accomplished, in part, through forcing some members of this population to accept outpatient treatment.

Research on Outpatient Commitment

Regarding research on outpatient commitment, two randomized controlled studies, one in New York and one in North Carolina, have been conducted in the United States. The New York study found no statistically significant differences in rehospitalization rates, arrests, homelessness, or other outcomes between participants randomized to receive involuntary outpatient care and those randomized to intensive outpatient care without outpatient commitment.¹⁸ The weaknesses of the study were small sample size, some differences in the two comparison groups, and problems with enforcement of court orders among the commitment group.¹⁹

In the North Carolina study, participants being discharged from psychiatric hospitalization were randomly assigned to outpatient commitment or standard release. Participants with outpatient commitment who also received intensive outpatient care had fewer hospital admissions and fewer days in the hospital, were more likely to adhere to community care, and were less likely to be violent or to be victimized than were participants in the standard release condition.²⁰ A weakness of this study is that the impact of outpatient commitment could not be distinguished from the impact of intensive outpatient care.¹⁹

Two systematic reviews of studies of outpatient commitment have been published by the Rand Corporation and the Cochrane Collaborative. The authors of the Rand report wrote of the findings in the North Carolina study: “[O]utcomes 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*” (Ref. 19, p 99; italics in original). A later Cochrane Collaborative review of outpatient commitment studies, including the New York and North Carolina studies and subsequent research, concluded: “The evidence found in this review suggests that compulsory community treatment may not be an effective alternative to standard care” (Ref. 21, p 2). The authors recommended further research on outpatient commitment and consideration of alternative approaches with stronger evidence of effectiveness.

Finally, a 2013 article in *The Lancet* reported on a randomized, controlled U.K. study of persons with psychosis discharged from psychiatric hospitalization under community treatment orders (CTOs) or

§ 17 leave. Participants randomized to CTO were subject to clinical monitoring and rapid recall assessment, whereas participants randomized to § 17 leave were subject to recall for assessment, but received significantly less extensive monitoring and for shorter times. Findings on the primary study outcome, rehospitalization over a 12-month period, were that there was no difference in readmission rates between the two groups. The authors concluded: "In well coordinated mental health services the imposition of compulsory supervision does not reduce the rate of readmission of psychosis patients. We found no support in terms of any reduction in overall hospital admission to justify curtailment of patients' personal liberty" (Ref. 22, p 1).

Alternatives to Outpatient Commitment

Coercive treatment should be undertaken with reluctance, with protections against abuse, and only when there is clear evidence of benefit to the individual, to society, or to both.^{23,24} Evidence of the effectiveness of outpatient commitment is not robust, even under the most generous reading. Evidence-based alternatives for engaging people with serious mental illness in care, which may be effective with the target group for outpatient commitment, are available. In the following sections, I will briefly discuss three alternatives that my colleagues and I have studied: peer engagement, mental health outreach to people who are homeless, and citizenship interventions.

Peer Engagement

In 2000, the Connecticut General Assembly, considering passage of an outpatient commitment law, responded positively to advocates' proposed alternative approach by allocating funds for a statewide community-based intervention, the Peer Engagement Specialist Project. For this program, peers (persons with lived experience of mental illness) were hired and trained to provide support and engagement services to persons who would have been subject to outpatient commitment had it been enacted in Connecticut. Included were persons with serious mental illnesses who had histories of violence or the threat of violence and who were not engaged in treatment. A randomized, controlled study of this four-site project compared persons receiving peer specialist services with persons receiving current community-based case management services. Findings were that participants in the peer engagement

condition had greater satisfaction with care and perceived higher positive regard, understanding, and acceptance from peer engagement specialists than did participants in the comparison condition from their case managers. In addition, positive regard from peer specialists in the early stages of enrollment was associated with participants' future motivation to receive care for psychiatric, alcohol, and drug use problems and attendance at Alcoholics and Narcotics Anonymous meetings.²⁵ Finally, for participants in the peer specialist condition, even negative feedback from their peer specialists regarding their behavior was linked to improved quality of life and fewer obstacles to recovery.²⁶ These findings suggest that peer providers can quickly forge therapeutic connections with and motivate to accept treatment those persons who are among the most disconnected from mental health care.²⁵

Citizenship Interventions

Citizenship-based approaches are designed to support the recovery of persons with serious mental illnesses through efforts to enhance their sense of belonging and attainment of valued roles in their communities. A citizenship-based intervention, including community-oriented classes, valued role and giving-back community projects, and wraparound peer support, was evaluated through a randomized, controlled trial. Participants with serious mental illness and criminal justice charges were randomized to the citizenship-based intervention plus current community mental health services or to current services. Citizenship intervention participants had statistically significant reductions in substance and alcohol use and increased quality of life on some subscales, compared with current service participants. In addition, arrests decreased significantly for both groups, perhaps suggesting that engagement in treatment, which occurred without outpatient commitment in this study, supported decreased criminal justice contacts for the target group.²⁷

Mental Health Outreach

Mental health outreach was developed as a means of finding mentally ill homeless people who are not engaged in care, building their trust, and providing care, including mental health, housing, and rehabilitation services.^{28,29} Research on a nine-state, 18-site national study of services for this group found that mental health outreach engages the most severely

psychiatrically impaired among persons living on the streets and that those engaged through street outreach showed significant improvements in several domains.³⁰

These three interventions directly target persons who, otherwise, would be subject to outpatient commitment (peer engagement); persons who would be subject to outpatient commitment and others with serious mental illness and criminal justice charges (the citizenship intervention); or persons who are homeless and are equally marginalized and hard to reach (mental health outreach). In addition to these potential alternatives to outpatient commitment, initiatives involving coordination of care, ongoing assessment, stigma reduction, mental health public education activities, and ongoing consultation from experts in forensic psychiatry should be regarded as part of a comprehensive alternative approach to work with the target group for outpatient commitment.

Regarding coordination of care, an advance in community mental health care since the early 1980s has been the development of local mental health authorities (LMHAs) to oversee and provide quality assurance for integrated clinical care and rehabilitation services.³¹ In addition, enhanced coordination of care between mental health and criminal justice systems can be built on current initiatives and coordinating mechanisms related to the reentry of persons to their communities following incarceration.³²

Ongoing assessment can be accomplished by building on current evaluation structures in LMHAs and other service systems and through statewide reporting requirements for monitoring program outcomes. Stigma reduction and mental health public education activities to enhance early intervention efforts in mental illness and encourage individuals to seek care can support the alternative intervention approaches just described. Ongoing consultation from experts in forensic psychiatry is available in many local systems of care and should be enhanced in others for work with this target group. Specific objectives, action steps, and target dates for these recommended initiatives must be developed. The capacities and means for carrying these recommendations forward, however, are largely in place at present.

Conclusion

The topic of outpatient commitment engenders strong emotions on both sides of the debate. Those in favor express outrage over leaving to their own

devices persons with disabling psychiatric disorders who refuse treatment and who, they argue, represent a potential danger to the public. Those opposed express outrage over the threat to the civil rights of persons with mental illness who are highly unlikely to commit acts of violence and are already subject to coercive practices such as forced treatment compliance to remain in some housing programs and representative payees who control their money. Mental health policy-making, as with other public policy-making, must consider individual and societal needs, ethics-related and constitutional demands, and evidence. Outpatient commitment is likely to help some persons, such as the female client mentioned earlier who enrolled in treatment after being informed of her eligibility for outpatient commitment under Kendra's Law. This person, one might guess, would support the ethics component of Kendra's Law, at least in her own case, along with testifying to its practical benefit for her.

(As this editorial goes to press, a cost-effectiveness study of New York's Kendra's Law has been published. Costs of care for 634 persons enrolled in court-ordered outpatient treatment within 30 days of discharge from psychiatric hospitalization between January 2004 and December 2005 were compared for the year before and the first and second years after enrollment. The study found reduced psychiatric hospitalization and arrests, increased use of outpatient treatment and psychiatric medications, and overall significantly decreased mental health system and Medicaid costs for patients during the first year, with less dramatic but still decreased costs, during the second year after enrollment. Costs of care for a comparison group of persons enrolled voluntarily in intensive outpatient care also declined, but less significantly than for the court-ordered treatment group.³³ While this study warrants, and will no doubt foster, renewed discussion of the effectiveness and advisability of outpatient commitment, it lacks randomization or a true matched sample, and thus can offer only a qualified comparison to the New York and North Carolina studies discussed above. In addition, its findings do not address the argument in this editorial regarding the potential alternatives to outpatient commitment of peer engagement, citizenship interventions, and mental health outreach.)

On balance, after more than 20 years of mandates and programs, outpatient commitment remains a costly, coercive, and unproven approach. More

promising, and proven, practices are available. Through building on such practices and increasing the availability of services, effective mental health care can be provided to persons with serious mental illness who are not presently receiving care, including the very small percentage of those among this group who are at risk of violence toward others.

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