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.