Involuntary Outpatient Commitment*: The Evidence and the Controversy

Albert R. Alden Memorial Lecture

Marvin Swartz, MD
Department of Psychiatry and Behavioral Sciences
Duke University School of Medicine
email: marvin.swartz@duke.edu

* aka: Assisted Outpatient Treatment
Thanks to my longtime collaborators!

- Jeffrey Swanson
- Barbara Burns
- Linda George
- John Monahan
- Henry Steadman
- Pamela Robbins
- H. Ryan Wagner
- Richard Van Dorn
- Allison Robertson
- Virginia Hiday
- Tom McGuire
- Christine Wilder
- Lorna Moser
- MacArthur Research Network on Mandated Community Treatment
A court-ordered mental illness outpatient treatment program is at the heart of partisan conflict over a House mental health overhaul bill - even though the program has already been put in effect in 45 states and the District of Columbia.

The mandatory programs are intended to improve patient outcomes and keep them from shuffling through the revolving door of emergency rooms - and the criminal justice system. They are widely accepted in the mental health community, and in both liberal and conservative states, as a "last resort" for certain seriously ill patients - and there's some evidence that they do help.

But AOT laws are controversial because they mandate treatment - which opponents say infringes on patients' civil liberties. They are typically opposed by the same groups that take issue with involuntary in-patient hospitalization - which Murphy doesn't expand.

Backers point to studies that show that if states properly fund AOTs, they can improve patient outcome - and eventually save money.
Conditional release from hospital (40 states\(^1\))
   - Early 20\(^{th}\) century, started as trial release

Alternative to hospitalization for people meeting inpatient commitment criteria (33 states\(^1\))
   - Least restrictive alternative

Preventive outpatient commitment (10 states\(^1\))
   - Court-ordered treatment authorized at a lower threshold than inpatient commitment criteria with the purpose of preventing further deterioration

\(^1\) Melton et al., 2007
Availability of appropriate services with aggressive outreach might obviate the need

Should not be used as a substitute for inadequacies in service systems

Applying coercion to patient blames the victim for service deficiencies.

Systems of care should be held accountable for gaps in care.
Robert Bernstein, PhD
Bazelon Center for Mental Health Law
Opposes OPC

E. Fuller Torrey, MD
Treatment Advocacy Center
Favors OPC
“Civil libertarians have made it almost impossible to treat psychotic individuals who refuse care. These misguided activists have created a morass of legal obstacles that prevents us from helping many psychotic individuals until they have a finger on a trigger.... It's time to reverse course. Mandatory treatment for those too ill to recognize they need help is far more humane than our present mandatory nontreatment.”

--E. Fuller Torrey

E. Fuller Torrey, MD
Treatment Advocacy Center
Robert Bernstein, PhD  
Bazelon Center for MH Law

Opposes OPC

"The Bazelon Center opposes outpatient commitment. There is no evidence that it improves public safety....Failure to engage people with serious mental illnesses is a service problem, not a legal problem. Outpatient commitment is not a quick-fix that can overcome the inadequacies of under-resourced and under-performing mental health systems. Coercion, even with judicial sanction, is not a substitute for quality services."

-- Position statement on outpatient commitment, Judge David Bazelon Center for Mental Health Law
“The medication militia...have embarked on a deadly Chemical Crusade to forcibly inject many of us...with these powerful neurotoxins, sometimes for life...Involuntary Outpatient Commitment [OPC] is literally fascism...a profound violation of core values of liberty and freedom.”

— Support Coalition
“Today, the forced drugging common inside of institutions has climbed over the walls and is now out in our communities. Citizens in the USA & parts of the world, living peacefully at home, are now court ordered to take powerful psychiatric drugs against their will. Typically these are "neuroleptic drugs" that can cause structural brain damage and even kill.”

David Oaks
MindFreedom
“Laws change for a single reason, in reaction to highly publicized incidents of violence. People care about public safety. I am not saying it is right, I am saying this is the reality... So if you're changing [OPC] laws in your state, you have to understand that... You have to take the debate out of the mental health arena and put it in the criminal justice/public safety arena.”

— D. J. Jaffe
Criteria for OPC in N.C.

Presence of a serious mental illness
Capacity to survive in the community with available supports
Clinical history indicating a need for treatment to prevent deterioration that would predictably result in dangerousness
Mental status that limits or negates the individual's ability to make informed decisions to seek or comply voluntarily with recommended treatment
Odds ratio for hospital readmission during any given month of a 1-year trial

<table>
<thead>
<tr>
<th>Group</th>
<th>Odds Ratio</th>
<th>95% CI</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control group</td>
<td>1.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OPC group</td>
<td>0.64</td>
<td>(0.46 – 0.88)</td>
<td>&lt;0.01</td>
</tr>
</tbody>
</table>

Odds ratio for hospital readmission during any given month of 1-year trial

<table>
<thead>
<tr>
<th>Odds Ratio</th>
<th>95% CI</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control group</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>OPC group</td>
<td>0.64 (0.46 – 0.88)</td>
<td>p&lt;0.01</td>
</tr>
</tbody>
</table>

Reduced odds of any violent behavior in 1 year associated with extended outpatient commitment (Duke Mental Health Study)

<table>
<thead>
<tr>
<th></th>
<th>Odd Ratio</th>
<th>95% CI</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Baseline history of violence</strong></td>
<td>1.915</td>
<td>(1.262 - 2.906)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td><strong>Outpatient commitment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>1.000</td>
<td>(1.000 - 1.000)</td>
<td></td>
</tr>
<tr>
<td>Brief (&lt;179 days)</td>
<td>0.986</td>
<td>(0.500 - 1.945)</td>
<td></td>
</tr>
<tr>
<td>Extended (180 days or more)</td>
<td>0.347</td>
<td>(0.152 - 0.792)</td>
<td>&lt;0.05</td>
</tr>
</tbody>
</table>

Note: logistic regression model controlled for demographic, social, and clinical characteristics including substance misuse.

Odd Ratio

Baseline history of violence 1.915 (1.262 - 2.906) <0.01
Outpatient commitment
   None 1.000 (1.000 - 1.000)
   Brief (<179 days) 0.986 (0.500 - 1.945)
   Extended (180 days or more) 0.347 (0.152 - 0.792) <0.05

95% CI

Reduced odds of any violent behavior in 1 year associated with extended outpatient commitment (Duke Mental Health Study)

Note: logistic regression model controlled for demographic, social, and clinical characteristics including substance misuse.

Percent who were crime victims in 12 months, by randomized study group assignment

New York City Pilot AOT Program Treatment Evaluation Study

- New York enacted a pilot statute to be tested in NYC
- Bellevue Hospital Study of pilot NYC Law (pre-Kendra’s Law)—by order of Legislature.
- Consumers randomly received AOT + Enhanced Services vs. Enhanced Services Alone.
- **Findings:** No differences between AOT vs. Enhanced Services
- **Limitations:** Law was in start-up and sample was small.
- Accompanied by fierce opposition the law was headed to sunset
March 23, 2000

“In an incident that has gnawed at New Yorkers' sense of security, Kendra Webdale was killed in January 1999 when Andrew Goldstein, a 30-year-old schizophrenic, picked her up on the platform of a 23rd Street subway station and threw her into the path of an oncoming train.”

New York passed AOT statute named “Kendra’s Law”
$32 million directly allocated yearly in support of the OPC program
- $15 million -- medication grant program
- $4.4 million -- prison and jail discharge managers
- $2.4 million -- oversight programs
- $9.55 million -- new case management slots
- $0.65 million -- drug monitoring

$125 million yearly for enhanced community services
- Used to increase ICM and ACT
- Used to develop Single Point of Access Program (SPOA)
New York State Assisted Outpatient Treatment (AOT) Evaluation Study

- Legislatively-mandated statewide assessment of “Kendra’s Law” using administrative data and case manager reports (Swartz et al., 2010)
- Study duration: 1999-2007
- Design: Observational study with multivariable analysis of time series data
  - Comparison: Both pre-post and propensity-matched comparison group
  - Participants: 3,576 AOT placements who had Medicaid
  - Outcomes: Hospital use, medications, receiving ACT/intensive case management/any case management
<table>
<thead>
<tr>
<th>Metric</th>
<th>First 180 days</th>
<th>181 days or more (renewed period)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receipt of ACT/ICM</td>
<td>242%</td>
<td>282%</td>
</tr>
<tr>
<td>Medication possession</td>
<td>47%</td>
<td>88%</td>
</tr>
<tr>
<td>Hospital admission</td>
<td>-23%</td>
<td>-41%</td>
</tr>
<tr>
<td>Days hospitalized</td>
<td>-10%</td>
<td>-16%</td>
</tr>
</tbody>
</table>
New York State Assisted Outpatient Treatment (AOT) Evaluation Study

- Case manager data showing reduced hospitalization effect of adding AOT to ACT/ICM:
  - Monthly probability of hospitalization reduced 43% to 57% for participants receiving AOT plus intensive services (ACT team or intensive case manager) compared to participants receiving ACT or ICM alone (without AOT)
Overall Summary of NY AOT Evaluation Findings

• NYS’s AOT Program improves a range of important outcomes for its recipients.
• The increased services available under AOT clearly improve recipient outcomes,
• The AOT court order and its monitoring do appear to offer additional benefits in improving outcomes.
• The AOT order exerts a critical effect on service providers.
The Cost of Assisted Outpatient Treatment: Can It Save States Money?

Jeffrey W. Swanson, Ph.D.
Richard A. Van Dorn, Ph.D.
Marvin S. Swartz, M.D.
Pamela Clark Robbins, B.A.
Henry J. Steadman, Ph.D.
Thomas G. McGuire, Ph.D.
John Monahan, Ph.D.

Objective: The authors assessed state’s net costs for assisted outpatient treatment, a controversial court-ordered program of community-based mental health services designed to improve outcomes for persons with serious mental illness and a history of repeated hospitalizations attributable to nonadherence with outpatient treatment.

Method: A comprehensive cost analysis was conducted using 36 months of observational data for 634 assisted outpatient treatment participants and 255 voluntary recipients of intensive community-based treatment in New York City and in five counties elsewhere in New York State. Administrative, budgetary, and service claims data were used to calculate and summarize costs for program administration, legal and court services, mental health and other medical treatment, and criminal justice involvement. Adjusted effects of assisted outpatient treatment and voluntary intensive services on total service costs were examined using multivariate time-series regression analysis.

Results: In the New York City sample, net costs declined 43% in the first year after assisted outpatient treatment began and an additional 13% in the second year. In the five-county sample, costs declined 49% in the first year and an additional 27% in the second year. Psychotropic drug costs increased during the first year after initiation of assisted outpatient treatment, by 40% and 44% in the city and five-county samples, respectively. Regression analyses revealed significant declines in costs associated with both assisted outpatient treatment and voluntary participation in intensive services, although the cost declines associated with assisted outpatient treatment were about twice as large as those seen for voluntary services.

Conclusions: Assisted outpatient treatment requires a substantial investment of state resources but can reduce overall service costs for persons with serious mental illness. For those who do not qualify for assisted outpatient treatment, voluntary participation in intensive community-based services may also reduce overall service costs over time, depending on characteristics of the target population and local service system.

(Am J Psychiatry 2013; 170:1423–1432)
Cost of AOT, mental health and criminal justice services before and after AOT in NYC

- 12-month period before discharge on AOT: $104,753
- First 12-month period after discharge on AOT: $59,924
- Second 12-month period after discharge on AOT: $52,386

Legend:
- Orange: Criminal justice services
- Blue: Medical treatment
- Purple: Outpatient mental health treatment
- Green: Hospitalization (Medicaid)
- Red: Hospitalization (OMH)
- Teal: AOT legal assistance and program administration
Oxford Community Treatment Order Evaluation Trial (OCTET)

- Conducted in the UK--third randomized trial of AOT
- OCTET subjects (after involuntary hospitalization) randomly assigned to be released either to:
  - **Experimental condition**: community treatment order, the UK equivalent of involuntary outpatient commitment authorized under the 2007 Mental Health Act.
  - **Control condition**: authorized “leave of absence from hospital,” a form of conditional release authorized under Section 17 of UK’s 1983 Mental Health Act.
  - To achieve ‘legal equipoise’ OCTET investigators were prohibited from conducting a trial comparing compulsory and strictly voluntary treatment
Primary outcome was readmission to the hospital during the 12 month follow-up period.

Secondary outcomes included length of time to the first readmission, number of readmissions, total amount of time spent in hospital, clinical functioning, and social functioning.

No significant differences were found across any of the outcomes at the 12 month follow-up.
Seemed to provide evidence of the lack of benefit of AOT—‘the tie-breaker’

Critics of this study argue that it was not a clear replication of the previously conducted RCTs

Lacked a true ‘voluntary’ treatment arm and had high rates of drop outs
Stakeholders Views of Mandated Treatment

- How do representative stakeholders evaluate the evidence regarding OPC?
- What importance do they give to the outcomes?
- Are the inherent trade-offs in mandates acceptable?
Vignette Example:

Upon discharge from the hospital, a judge ordered Mr. Smith to go to the mental health center for treatment for the next six months. If he doesn’t keep his appointments and take prescribed medications, the police will take him to treatment. After getting out of the hospital, he argues a lot with his family, friends, and other people. He becomes upset and suddenly hits a stranger on the street who he thinks might hurt him. His symptoms worsen and he is again admitted involuntarily to the psychiatric hospital for a week or more.
Regression utility weights (subjective preferences) for outcomes in vignettes about OPC

Utility weights represent the change in subjects’ rating of the outcome vignette that is attributable to endorsement of a positive outcome. Positive coefficients denote a positive utility for the outcome.
Montgomery County

GENERAL DISTRICT COURT

In re: SEUNG-HUI CHO

CERTIFICATION AND ORDER FOR IN Voluntary ADMISSION TO A PUBLIC OR LICENSED PRIVATE FACILITY

COMMONWEALTH OF VIRGINIA

City: Montgomery

To the sheriff or other authorized officer of said county or city and to the director of

Paul M. Barnett
Special Justice
P.O. Box 5029
Christiansburg, VA 24073

WHEREAS, I, Judge or Special Justice of said county or city have observed the person named in the foregoing petition, alleged to be in need of care and treatment in a hospital, and have reviewed the medical certifications and statement of facts upon which such certifications are based and have this day found that the person named in the foregoing petition:

1. Presents an imminent danger to himself as a result of mental illness.
2. Presents an imminent danger to others as a result of mental illness.

Furthermore: (check one and complete)

A. The alternatives to involuntary hospitalization and treatment were investigated and were deemed suitable. I have found that there is a less restrictive alternative to involuntary hospitalization and treatment in this case. I, therefore, direct that the person named in the foregoing petition receive treatment in accord with the following order:

COURT-ORDERED TO FOLLOW AN RECOMMENDED TREATMENT
Is OPC a Remedy for Acts of Severe Violence—like Colorado, Arizona or VT?

- Data available indicate OPC can reduce minor acts of violence
- Acts of serious violence are far too infrequent to study accurately
- Might infer that improving treatment adherence may reduce serious violence—but there is no evidence.
- OPC law should be considered on merits of improving treatment adherence and reducing relapse not as violence prevention per se.
What Has Happened to OPC in NC?

• Funding tied to OPC cases ($2,000/case/yr) until mid-1990s, but ended in mid-90s with change in state funding.
• Even in 1990’s was used inconsistently across the state.
• Modal OPC was from state hospital to area program.
• Many area programs had OPC coordinators.
• NC Mental Health Reform/privatization has misaligned incentives for OPC between LME/MCOs and privatized providers with no additional reimbursement for complex OPC cases.
• Diffusion of responsibility/lack of point of accountability
Turning Point?

• Rising awareness of poor access to high quality treatment

• High rates of ED boarding and incarceration
  – renewed national interest in OPC.
  – rising interest in implementation and in effective policies.
Rather than asking whether OPC is effective we should ask: Can OPC be effective and for whom?

- OPC is a complex community-based intervention, not easily evaluated in a randomized trial design
  - (e.g., Drug A v. Drug B)

- OPC can be effective if there is:
  - Systematic and effective implementation
  - Provision of intensive community-based services
  - Adequate duration of the court order
RESOURCE DOCUMENT ON INVOLUNTARY OUTPATIENT COMMITMENT AND RELATED PROGRAMS OF ASSISTED OUTPATIENT TREATMENT

Authors: Marvin S. Swartz, M.D. Steven K Hoge, M.D., Debra A. Pinals, M.D., Eugene Lee, M.D., Li-Wen Lee, M.D., Mardoche Sidor, M.D., Tiffani Bell, M.D., Elizabeth Ford, M.D., R. Scott Johnson, M.D.

"The findings, opinions, and conclusions of this report do not necessarily represent the views of the officers, trustees, or all members of the American Psychiatric Association. Views expressed are those of the authors." -- APA Operations Manual.

Approved by the Board of Trustees

Prepared by the Council on Psychiatry and Law.