

Outpatient commitment: When it improves patient outcomes

1 year after Virginia Tech, many states' statutes remain ambiguous and ineffective

On April 16, 2007, Seung Hui Cho shot and killed 32 students and faculty on the Virginia Tech campus and wounded 25 others before killing himself. A judge had declared Cho mentally ill in 2005 and placed him on involuntary outpatient commitment (OPC). Cho apparently never sought treatment, and no one made sure that he did (*Box 1, page 26*).¹

Much second-guessing has occurred about whether enforcing Cho's OPC could have prevented the Virginia Tech tragedy. Most states authorize OPC, but few make much use of OPC statutes that require patients to adhere to prescribed treatment in the community. Virginia was typical; an OPC statute was on the books but rarely enforced.

This article discusses the evidence on OPC laws' effectiveness and offers recommendations on how to use these tools in psychiatric practice.

Mandating needed treatment

OPC—also called “assisted outpatient treatment” or “mandated outpatient treatment”—is a civil court procedure whereby a judge can order a noncompliant mentally ill patient to adhere to needed treatment. OPC statutes exist in 42 states and the District of Columbia, although judges use these powers erratically.^{2,3}

Most states have set identical thresholds for inpatient and outpatient commitment, such as when the patient is considered dangerous to self or others or (in some statutes) so gravely impaired that he is unable to



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Marvin S. Swartz, MD

Professor and head
Division of social and community psychiatry

Jeffrey W. Swanson, PhD

Professor

• • •

Department of psychiatry and behavioral sciences
Duke University Medical Center
Durham, NC



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Labeling a patient as 'ill enough' to be confined, then recommending his release to outpatient treatment feels like a liability risk

Box 1

Virginia's OPC statute: Inpatient criteria for outpatient cases

Virginia's commitment laws are in review because of the Virginia Tech shootings in April 2007. The state's existing OPC provisions are embedded in involuntary commitment law, which is mainly directed toward inpatients. As a result, Virginia's law:

- merely permits mandated outpatient treatment
- duplicates inpatient criteria for "imminent dangerousness" (although the state legislature is considering relaxing this criterion)
- provides no guidance on enforcement in the event of treatment nonadherence
- provides no administrative infrastructure to make the law work.

Virginia's statute is typical. It lacks a separate threshold for outpatient commitment, using the same high threshold of imminent threat to self or others that is required for inpatient commitment.

safely care for himself in the community. These high thresholds have dramatically reduced inpatient commitment eligibility and yet may flag the patient as too dangerous for outpatient commitment.

OPC orders usually cannot force medication. Periods of initial and subsequent commitment vary across states but not dramatically. In North Carolina, for example, initial OPC may be ≤ 90 days, after which a hearing must be held to renew the order for ≤ 180 days. Depending on individual states' statutes, OPC can be used as:

- an alternative to hospitalization for patients who meet inpatient commitment criteria
- a form of conditional release for patients completing an involuntary inpatient commitment
- an alternative to hospitalization for noncompliant patients at risk for relapse and involuntary inpatient commitment.²

Few states have lowered the threshold to the last variant, allowing OPC use to avert relapse and hospitalization. Newer statutes in New York, North Carolina, and elsewhere have incorporated these preventative outpatient commitment criteria.^{4,5}

Clinicians are uncomfortable using inpatient criteria for outpatient commitment. Labeling a patient as "ill enough" to be confined and then recommending that he or she be released to outpatient treatment feels like a liability risk.

Because the legislative intent in most state statutes was to set criteria and procedures for inpatient commitment, steps for implementing outpatient commitment are often ill-defined. An outpatient commitment process requires:

- notification to the responsible outpatient local mental health authority, clinicians, and local courts that the order is in place
- expectations regarding the order
- steps required to renew the order, if indicated.

States such as New York with fully operational outpatient commitment statutes have clear implementation processes.

Enforcement. Courts typically can request that law officers transport patients who fail to comply with OPC to a treatment facility. There, patients will be encouraged to comply with treatment or evaluated for inpatient commitment.² This relatively weak enforcement authority has led some to argue that OPC has no teeth.

Without clearly defined steps for implementation, an outpatient commitment order can be likened to a message in a bottle—a cry for help at risk for nondelivery. In the Virginia Tech case, the judge issued an outpatient commitment order for Cho, but how the local clinic understood its responsibilities and what resources and enforcement power it had were unclear.

Noncontrolled studies

Evidence from noncontrolled OPC studies is difficult to interpret because of:

- lack of comparable committed and noncommitted groups
- difficulty in comparing treatment across comparison groups
- selection effects, whereby clinicians and courts select patients for a predicted good outcome.²

Most noncontrolled studies have concluded that OPC improves treatment outcomes and decreases hospital readmission rates and lengths of stay under some circumstances.⁶⁻¹² The largest study reported on New York's initial 5 years' experience with more than 3,000 patients under its OPC statute, known as "Kendra's Law" (*Box 2, page 28*).¹² Under this law—the most intensively implemented OPC statute in the United States—the court's order specifies a detailed plan of medications and psychosocial treatment.

Most of New York's OPC recipients stayed in assisted outpatient treatment longer than the court-mandated 6 months (average 16 months). The incidence of hospitalizations, homelessness, arrests, and incarcerations was far lower while patients participated in OPC, compared with the previous 3 years of their lives (*Table, page 34*). Medication adherence improved from 34% before OPC to 69% after commitment, and engagement with treatment improved from 41% to 62%, respectively.¹²

Conflicting controlled trials

Duke Mental Health Study. In the first controlled study of OPC, the Duke Mental Health Study (DMHS) enrolled 331 seriously mentally ill inpatients being discharged from involuntarily hospitalization to court-ordered outpatient treatment between 1993 and 1996. Patients with a history of violent behavior in the previous year were placed in a nonrandomized comparison group and remained on OPC for at least 90 days. The remaining 264 patients were randomly assigned to:

- an experimental group that received OPC for ≤ 90 days (could be renewed for ≤ 180 days) plus consistent community mental health services
- a control group that was released from OPC but received the same community mental health services as the experimental group.¹³

Community services included psychiatric appointments and case management. During 12-month follow-up, researchers interviewed patients, families, and clinicians to gather data on OPC's effectiveness.

Patients ordered to OPC had fewer hospital readmissions and spent fewer days in the hospital only if they received OPC plus consistent community services for ≥ 6 months.¹⁴ Patients who received this model of care were:

- less likely to be homeless,¹⁵ criminally victimized,¹⁶ arrested if they had past arrests,¹⁷ or violent¹⁸
- more likely than the control group to comply with recommended treatment.¹⁹

Patients received no benefit from OPC < 6 months—even if combined with consistent, frequent mental health services—or OPC of any length without consistent, frequent mental health services.

Study limitations. Length of time on OPC could not be randomly assigned, even though this was a key variable in the intervention. If lower-risk subjects had been selected for longer periods of commitment, positive findings could have been overstated. Legal criteria for renewing OPC also prevented us from selecting lower-risk subjects for longer exposure to court-ordered treatment. Higher-risk subjects appeared in preliminary analyses to have received longer periods of commitment, but unknown selection factors could have affected OPC duration.

Outpatient service intensity was not controlled but varied according to clinical need and other unknown factors. As a result, selectively providing services could have influenced outcomes, although other analyses argue that this factor was not important.⁴

New York. In 1994, the state legislature established a 3-year pilot program to evaluate OPC in New York City's Bellevue Hospital as a first step toward considering permanent OPC legislation.²⁰ The randomized, controlled study compared a court-ordered group (N=78) and a control group (N=64) during 1 year after hospital discharge. Both groups received enhanced outpatient services, such as psychiatrist appointments, intensive case management, and treatment for co-occurring substance abuse as needed.

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Hospitalizations, homelessness, and arrests were far lower while patients participated in OPC than in the previous 3 years of their lives



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Patients ordered to OPC benefited only if they received consistent community services for at least 6 months

Box 2

'Kendra's Law': A legacy of assisted outpatient treatment

Andrew Goldstein and Kendra Webdale were strangers standing on a New York City subway platform as a train arrived on January 3, 1999. She was an aspiring journalist and he a troubled man with schizophrenia who had stopped taking his medication. Goldstein later admitted in court that he placed his hands on the back of her shoulders and pushed her into the train's path.

"Kendra's law"—first enacted in 1999 and renewed for 5 years in 2005—provides assisted outpatient treatment (AOT) for persons age ≥ 18 with mental illness who—in view of their treatment history—are unlikely to survive safely in the community without supervision. The patient also must:

- have a history of treatment noncompliance
- be unlikely to voluntarily participate in treatment

- need assisted outpatient treatment to prevent a deterioration that would likely result in a substantial risk of physical harm to himself or others

- be likely to benefit from assisted outpatient treatment.

Implementation starts with a petition to the court, asking that a person be evaluated for AOT suitability. Petitions can be filed by psychiatrists, psychologists, social workers, family members, adult roommates, hospital directors, mental health or social services directors, and parole or probation officers. The petition is followed by an investigation by local authorities and a court hearing.

If the patient is found to be eligible for AOT, the court orders a highly specific treatment plan. Initial orders for 6 months can be renewed at subsequent court hearings.

Control and experimental groups showed no statistically significant differences in hospitalizations, arrests, quality of life, symptoms, homelessness, or other outcomes. The authors interpreted these findings to suggest that in this study intensive services—and not OPC court orders—reduced hospital recidivism and other poor outcomes in seriously mentally ill patients.

Study limitations. Statute implementation and OPC enforcement were haphazard, and in most cases sanctions for noncompliance—such as orders to law enforcement to detain noncompliant patients—were not put into effect. Patients and providers often did not clearly distinguish between the control and experimental groups. And finally, the study likely was too small to demonstrate a positive effect for OPC. Nevertheless, the findings suggest that OPC might provide no added benefit if persons with serious mental illnesses have access to enhanced outpatient services.⁴

Do OPC laws prevent violence?

The North Carolina and New York controlled studies of OPC yielded contradictory findings and are difficult to compare.

Even within North Carolina—where OPC has been shown most consistently to be effective—OPC orders' duration (the "dose") varies widely, as do the services patients receive.

No further randomized, controlled trials of OPC are underway. Our group is participating in a study supported by the MacArthur Foundation Research Network on Mandated Community Treatment and New York State Office of Mental Health to intensively review patient outcomes under New York's OPC statute.

Rare, violent acts such as Seung Hui Cho's rampage at Virginia Tech have motivated many states to propose OPC statutes. OPC statutes are designed more to improve treatment adherence and reduce rehospitalization than to prevent violence, however. Although the North Carolina study suggests OPC can prevent relatively minor acts of violence,¹⁸ the desired benefit of preventing potentially lethal violence is exceedingly difficult to realize or document.

Given that most states permit OPC, attempts to standardize and implement OPC are needed. To make OPC effective, evidence indicates that states also must provide intensive community services to keep patients in treatment.



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Combining OPC with depot antipsychotics may be more effective than oral agents for ensuring adherence and improving function

Table

Change in adverse events among OPC patients in New York

Event	Incidence during 3 years prior to OPC*	Incidence during OPC treatment	Rate of decline
Incarceration	23%	3%	87%
Arrest	30%	5%	83%
Psychiatric hospitalization	97%	22%	77%
Homelessness	19%	5%	74%

* Adverse events reported as occurring at least once
 OPC: outpatient commitment
 Source: Reprinted from reference 12, table 10

Strategies for using OPC

OPC is controversial in society and among clinicians. Some mental health organizations oppose outpatient commitment orders as coercive and intrusive, and some mental health professionals have concerns about legal or malpractice liability, increased paperwork, and administrative burden. Others may view OPC as:

- ineffective—providing weak sanctions that are impractical to enforce
- detrimental to the therapeutic alliance
- a less-desirable substitute for making high-quality voluntary treatment more widely available for the seriously mentally ill.

Reach a consensus. If your team is considering OPC for a patient, you must all agree on its use. Because most court orders are initiated on an inpatient unit as part of a discharge plan, clinicians across inpatient and outpatient settings must agree on how you will apply OPC to this patient.

Select appropriate candidates. Our group's experience suggests that patients with severe mental illness—especially schizophrenia spectrum disorders—are those most likely to benefit from OPC. There is no evidence that outpatient commitment helps patients with personality disorders or substance abuse without comorbid severe mental illness.

Maximize effectiveness. Evidence from the North Carolina studies suggests keeping OPC in place for ≥ 6 months and pro-

viding relatively intensive outpatient services. For schizophrenia-spectrum patients, combining OPC with depot antipsychotics may be more effective than oral agents for ensuring adherence and improving function.¹⁹

Plan enforcement. To enforce OPC orders, you need a mechanism to plan and coordinate law enforcement transport of patients to treatment in cases of nonadherence. Because transport can be a burden to law enforcement officers, at least one North Carolina county developed a legal agreement to allow its mental health clinicians to enforce orders and pick up patients.

Decide when to terminate. OPC orders probably should last at least 6 months, but little evidence exists to guide discontinuing an order after 6 months. This dilemma is similar to deciding when a depot antipsychotic can or should be converted to an oral agent in previously nonadherent patients.

Our approach is to consider terminating the order in patients with restored insight who have ≥ 6 months of consistent treatment compliance without a need for or threat of OPC enforcement. In some cases, other leverage may preempt the need for continuing an order, such as:

- financial contingencies from family or others
- treatment required as a condition of probation or parole
- housing conditioned on treatment adherence.

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Related Resources

- Treatment Advocacy Center. Nonprofit organization dedicated to eliminating barriers to timely, effective treatment of severe mental illnesses. www.psychclaws.org.
- MacArthur Foundation Research Network on Mandated Community Treatment. www.macarthur.virginia.edu/researchnetwork.html.

Disclosure

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Criteria for ending an OPC order may include restored insight and ≥ 6 months' adherence, without a need for enforcement

Bottom Line

For seriously mentally ill patients, use outpatient commitment (OPC) judiciously where it is available and can be implemented responsibly. For the greatest likelihood of improving treatment adherence and reducing rehospitalization, continue OPC at least 6 months and combine with consistent, frequent case management services. Share your experiences to help other clinicians understand for whom, under what circumstances, and at what cost OPC is effective.