APA Official Actions

Position Statement on Involuntary Outpatient Commitment and Related Programs of Assisted Outpatient Treatment[1]

Approved by the Board of Trustees, December 2015
Approved by the Assembly, November 2015

"Policy documents are approved by the APA Assembly and Board of Trustees. . . These are . . . position statements that define APA official policy on specific subjects. . ." – *APA Operations Manual*

APA Position:
The American Psychiatric Association recognizes that there is a substantial population of persons with severe mental illness whose complex treatment and human service needs go unmet by community mental health programs. For many persons so affected, their course is frequently complicated by non-adherence with treatment and as a result, they frequently relapse, are hospitalized or incarcerated. They also interact with a variety of human service agencies— substance use disorder treatment programs, civil and criminal courts, police, jails and prisons, emergency medical facilities, social welfare agencies, and public housing authorities. The pressing need to improve treatment adherence and patient outcomes, has led policymakers to consider court-ordered treatment as a way to improve treatment adherence. In this document the term 'involuntary outpatient commitment' is used to refer to outpatient treatment mandated under state involuntary commitment statutes.

Involuntary outpatient commitment is a civil court procedure wherein a judge orders a person with severe mental illness to adhere to an outpatient treatment plan designed to prevent relapse and dangerous deterioration. Persons appropriate for this intervention are those who need ongoing psychiatric care owing to severe illness but who are unable or unwilling to engage in ongoing, voluntary, outpatient care. It can be used on release from involuntary hospitalization, an alternative to involuntary hospitalization or as a preventive treatment for those who do not currently meet criteria for involuntary hospitalization. It should be used in each of these instances for patients who need treatment to prevent relapse or behaviors that are dangerous to self or others.

Involuntary outpatient commitment programs have demonstrated their effectiveness when *systematically implemented*, *linked to intensive outpatient services* and *prescribed for extended periods of time*. Based on empirical findings and on accumulating clinical experience, involuntary outpatient commitment can be a useful tool in the effort to treat patients with severe mental illness with clinical histories of relapse and re-hospitalization. It is important to emphasize, however, that all programs of involuntary outpatient commitment must include these elements of well-planned and executed implementation, intensive, individualized services and sustained periods of outpatient commitment to be effective. There is also clear evidence that involuntary outpatient commitment programs help focus the attention and effort of the providers on the treatment needs of the patients subject to involuntary outpatient commitment.

Involuntary outpatient treatment raises an ethical tension between the principles of autonomy and beneficence. Therefore states should make every effort to dedicate resources to voluntary outpatient treatment and only if such treatment fails resort to involuntary treatment. Psychiatrists must be aware of the conflict between the patient's interest in self-determination and promotion of the patient's medical best interest. In any system of treatment, including involuntary

[1] Outpatient court-ordered treatment may be referred to as 'assisted outpatient treatment', 'involuntary outpatient commitment', 'mandated community treatment', or 'community treatment orders'. Some regard the term 'assisted outpatient treatment' as a euphemistic term for treatment under coercion. In this document the term 'involuntary outpatient commitment' is used to refer to these programs.

outpatient treatment, principles of non-maleficence—doing no harm—and justice must be considered. Involuntary treatment, like any intervention, must not be discriminatory, and must be fairly applied and respectful of all persons.

The APA supports the following positions and principles regarding involuntary outpatient commitment.

1. Involuntary outpatient commitment, if systematically implemented and resourced, can be a useful tool to promote recovery through a program of intensive outpatient services designed to improve treatment adherence, reduce relapse and re-hospitalization, and decrease the likelihood of dangerous behavior or severe deterioration among a sub-population of patients with severe mental illness.

2. The goal of involuntary outpatient commitment is to mobilize appropriate treatment resources, enhance their effectiveness and improve an individual's adherence to the treatment plan. Involuntary outpatient commitment should not be considered as a primary tool to prevent acts of violence.

3. Involuntary outpatient commitment should be available in a preventive form and should not be exclusively reserved for patients who meet the criteria for involuntary hospitalization. The preventive form should be available to help prevent relapse or deterioration for patients who currently may not be dangerous to themselves or others (and therefore are not committable to inpatient treatment) but whose relapse would likely lead to severe deterioration and/or dangerousness.

4. Assessment of the likelihood of relapse, deterioration, and/or future dangerousness to self or others should be based on a clearly delineated clinical history of such episodes in the past several years based on available clinical information.

5. Involuntary outpatient commitment should be available to assist patients who, as a result of their mental illness, are unlikely to seek or voluntarily adhere to needed treatment.

6. Studies have shown that involuntary outpatient commitment is most effective when it includes a range of medication management and psychosocial services equivalent in intensity to those provided in assertive community treatment or intensive case management programs. States adopting involuntary outpatient commitment statutes should assure that adequate resources are available to provide such intensive treatment to those under commitment.

7. States authorizing involuntary outpatient commitment should provide due process protections equivalent to those afforded patients subject to involuntary hospitalization.

8. Data have shown that involuntary outpatient commitment is likely to be most successful when it is provided for a sustained period of time. Statutes authorizing involuntary outpatient commitment should consider authorizing initial commitment periods of 180 days, permitting extensions of the commitment period based on specified criteria to be demonstrated at regularly scheduled hearings. Based on clinical judgement, such orders may be terminated prior to the end of a commitment period as deemed appropriate.

9. A thorough psychiatric and physical examination should be a required component of involuntary outpatient commitment, because many patients needing mandated psychiatric treatment also suffer from other medical illnesses and substance use disorders that may be causally related to their symptoms and may impede recovery. Clinical judgment should be employed in determining when, where and how these examinations are carried out.

10. Clinicians who are expected to provide the court-ordered treatment must be involved in decision-making processes to assure that they are able and willing to execute the proposed treatment plan. Before treatment is ordered, the court should be satisfied that the recommended course of treatment is available through the proposed providers.

11. Efforts to engage patients and, where appropriate, their families in treatment should be a cornerstone of treatment, even though court-ordered. Patients and their families should be consulted about their treatment preferences and should be provided with a copy of the involuntary outpatient commitment plan, so that they will be aware of the conditions to which

the patient will be expected to adhere.

12. Involuntary outpatient commitment statutes should contain specific procedures to be followed in the event of patient non-adherence and should ensure maximum efforts to engage patients in adhering to treatment plans. In the event of treatment non-adherence, provisions to assist with adherence may include empowering law enforcement officers to assume custody of non-adherent patients to bring them to the treatment facility for evaluation. In all cases there should be specific provisions for a court hearing when providers recommend involuntary hospitalization or a substantial change in the court order.

13. Psychotropic medication is an essential part of treatment for most patients under involuntary outpatient commitment. The expectation that a patient take such medication should be clearly stated in the patient's treatment plan when medication is indicated. However, involuntary administration of medication should not be authorized as part of the involuntary commitment order without separate review and approval consistent with the state's process for authorizing involuntary administration of medication on an outpatient basis.

14. Implementation of a program of involuntary outpatient commitment requires critical clinical and administrative resources and accountability. These include administrative oversight of and accountability for involuntary outpatient commitment program operations, the ability to monitor patient and provider adherence with treatment plans, the ability to track involuntary outpatient commitment orders and to report program outcomes.

15. There is limited research to evaluate the possible disproportionate use of involuntary outpatient commitment among minority and disenfranchised groups. As a result, independent evaluation of involuntary outpatient commitment programs should be conducted at regular intervals and reported for public comment and legislative review, especially in view of concerns about its appropriate use. Among several outcomes that should be assessed is any evidence of disproportionate use of involuntary outpatient commitment among minority groups and disenfranchised groups, inadequate due process protections and the diversion of clinical resources from patients seeking treatment voluntarily. Any indications of findings in these areas should be followed by program improvement plans and corrective action.