

Position Statement of the International Association of Psychosocial Rehabilitation Services On Involuntary Outpatient Commitment (IOC)

Introduction

Public perceptions that violence is strongly associated with mental illness are fueled by graphic media reports of violent crimes and by an entertainment industry that frequently and incorrectly links violence with mental illness. While the actual number of crimes is much smaller than perceived by the public, those crimes that are committed by a person with mental illness are a terrible tragedy to the victims, those who committed them and their families. It is imperative that our communities take the steps necessary to ensure every person with mental illness has access to effective treatment and rehabilitation. And it is crucial that the safety of our communities be protected, including people with psychiatric disabilities, who are at higher risk of being victims of crimes than of committing them.

One solution which is being considered in many state legislatures, is the passage of broad involuntary outpatient commitment (IOC) laws which would require people with mental illness to take medications and participate in involuntary outpatient treatment programs against their will. While IAPSRS is strongly committed to both the public safety and the safety and welfare of every person with mental illness, the association feels the passage and the utilization of involuntary outpatient commitment laws will be ineffective, will abuse the rights of large numbers of people with mental illness, and will fail to address the core problem – poor access to effective services. ***We therefore oppose the passage of involuntary outpatient commitment laws.***

IAPSRS strongly opposes the use of images or language that are misleading and discriminate against people with mental illnesses. In an effort to foster support for involuntary outpatient commitment, some segments of the mental health community have been actively promoting linkages between mental illness and violence. Such stigma and discrimination stifles the voluntary seeking of services and makes it easier for communities to deny access to necessary services and supports. Stigma and discrimination makes it impossible to foster an environment of recovery and rehabilitation and makes it easier to infringe on the rights of people with mental illnesses.

What is Involuntary Outpatient Commitment?

Involuntary outpatient commitment laws vary from state to state, but generally they require the identified person with a psychiatric disorder to take medication and comply with involuntary outpatient treatment recommendations or risk being placed in an inpatient psychiatric hospital. The requirements for involuntary outpatient commitment may be defined very loosely (i.e. diagnosis of a major mental disorder and a history of treatment noncompliance) or very tightly (i.e. imminent risk of danger to self or others). IAPSRS believes the existing inpatient commitment; conditional release and guardianship laws in most states provide the protections needed for the small number of

persons who are truly dangerous to themselves or others. Broadening the scope of commitment laws to involuntary outpatient commitment is both unnecessary and unlikely to be effective.

Every state or province has statutes under which persons considered to have a mental disorder can be committed to inpatient treatment. The legal standard of commitment in the US requires a finding of a mental illness and overt or imminent dangerousness to self or others¹. The dangerousness standard is not absolutely clear, so in a few circumstances a standard lower than overt dangerousness is available, such as being so gravely ill and unable to care for oneself that a danger is present.

Moreover, almost every jurisdiction has some form of conditional release process. Conditional release allows the discharge of an individual from an institution such as a hospital or jail, with the understanding that compliance with the discharge plan is a requirement for continued community tenure. Another potential protection for those persons who are no longer able to be responsible for their own care is conservatorship or guardianship. Conservatorship or guardianship is a legal process that authorizes a third party to make decisions involving a potentially wide-range of issues on behalf of the individual.

While involuntary outpatient commitment laws require the presence of a mental illness they typically do not require the presence of imminent or overt dangerousness. Instead, these laws rely on past behavior as a predictor of future behavior or rely on a subjective assessment of current community functioning. Therefore, IOC differs significantly from both inpatient commitment and conditional release programs by dramatically broadening the potential number of people affected, and by significantly loosening the criteria that may lead to commitment.²

This new type of commitment law is being promoted by a small segment of the mental health treatment community who believe the extensive problems caused by the lack of a comprehensive, fully funded community-based mental health system can be solved by Involuntary outpatient commitment laws. However, involuntary outpatient commitment laws do not address the true problem confronting the mental health system – the lack of funding and support for effective, comprehensive community-based mental health services. Where the lack of funding for effective community mental services exists, IOC will prove ineffective; where effective services are fully funded then IOC laws will rarely if ever be used.

For the following reasons, the Board of the International Association of Psychosocial Rehabilitation Services opposes involuntary outpatient commitment laws and urges state, federal and provincial governments to address the true problems facing the mental health system.

Involuntary Outpatient Commitment Violates Rights

One of the most disturbing aspects of involuntary outpatient commitment is the potential violation of the rights of any person diagnosed with a mental illness. People diagnosed

with mental disorders are citizens of our communities, with the full rights and responsibilities of all citizens.

The potential violation of rights is underscored by our inability to predict violent behavior. According to the American Psychiatric Association, "Psychiatrists have no special knowledge with which to predict dangerous behavior. Studies have shown that even for people with a history of violent acts, two out of three predictions of future violence will be wrong." (APA, 1983).

Involuntary Outpatient Commitment Is Not An Effective Policy

There is little evidence supporting the effectiveness of involuntary outpatient commitment. A recent study at Bellevue Hospital (Policy Research Associates, 1998) revealed that people under court ordered treatment did no better than people in the voluntary program. In every category: rehospitalizations, arrests, life and symptomology, and discontinued treatment, there was "no statistical difference" between the people under court order and those voluntarily receiving services. In fact, one of the conclusions of the study was that the court order had "no discernable added value in producing better outcomes." What did make a difference in outcomes were the enhanced services both groups received.

Mental Health Services are Overburdened and Under Funded

The biggest problem our communities face is the lack of accessible and appropriate services for people with mental illnesses. Public funding for treatment of mental illness is a third less, once adjusted for inflation, than it was in the 1950s according to the Bazelon Center for Mental Health Law. Managed care has dramatically reduced the availability of long term care for persons with serious mental illness. In the past 11 years, the value of behavioral healthcare benefits has declined every year, for a total loss of 54.7% of the value of the benefit. (Hay Group, 1999). In the two most publicized cases of violence, Andrew Goldstein, who pushed a woman in front of a New York subway train, had repeatedly requested services and repeatedly been discharged with minimal follow up, before the pushing incident (Winerip, 1999); and Russell Weston, the man who shot dead two police officers in the US Capitol, had been the victim of "Greyhound treatment" where a consumer is given a one way bus ticket and shuttled from one state to another. In this case a Montana state hospital discharged Weston then lost track of him. No mental health agency caught up with him until after the shooting (NEED CITATION).

Almost 40% of persons with serious mental illness have not seen a mental health professional in the last year and only 68.2% are receiving medication. (Barker et al, 1992). Of those who are receiving treatment, the vast majority are not receiving effective treatment. Only 29.1% of people with schizophrenia are receiving appropriate doses of medication over the long term, fewer than 25% of those who could benefit from employment services receive them, and only 2% of those at high risk of relapse are receiving intensive case management services. (Steinwach, Lehman, et al, 1997). It is no wonder that persons with mental illness end up on the front pages of our newspapers.

Court ordered involuntary outpatient commitment holds no promise of more or better care for anyone ---not for those committed or those seeking services voluntarily. IOC will do little to increase the availability of services where they do not exist or are inadequate. In fact, the passage of involuntary outpatient commitment laws will be a false panacea, which hides the real need --- appropriate funding for effective mental health services. Limited resources for community based mental health services and the continued unwillingness of most states to reallocate mental health resources out of institutions to community based programs means IOC will only result in shifting scarce resources from those who seek services on their own to those committed under IOC.

Involuntary Outpatient Commitment Causes Trauma

The effectiveness of medication, mental health treatment and rehabilitation depend on the willing participation of the consumer. The experience of most providers is that people with mental illness react negatively to coercion, and involuntary outpatient commitment seldom results in long-term positive outcomes. The process can be an intrusive and painful process, resulting in trauma for the person committed. It often fosters a distrust of the service system that leads to long-term avoidance of mental health treatment. In a California study of the perceptions of people with psychiatric disorders, 47 percent reported avoiding any traditional mental health services for fear of involuntary commitment (Campbell and Schraiber, 1989).

Gifted practitioners and a commitment process that is truly respectful of the rights and dignity of consumers may be able to overcome these obstacles. But it seldom happens. The Bellevue Study concluded, "A commitment process – attuned to the rights of patients, credible in the eyes of providers, and bringing new leverage to bear on the problems of non-compliance – each a goal of legislation, proved difficult to implement." The Bellevue report goes on to state that, " OCP court proceedings have become increasingly informal to the point that initial hearings are perfunctory and renewal orders most often occur without a formal hearing."

Violence and Mental Illness

In 1998, Dr. Bruce Link commented in the Archives of General Psychiatry. "To date nearly every modern study indicates that public fears are way out of proportion to the empirical reality. The magnitude of risk of violence associated with mental illness is comparable to that associated with age, education, and gender." (NEEDS CITATION)

- The MacArthur Violence Risk Assessment Study (Steadman et al, 1998) was designed to shed light (and scientific evidence) on this thorny issue. The study followed 1136 people with mental disorders as they were discharged from inpatient facilities and 519 people with no mental disorders living in the same neighborhoods. *The findings reveal that people with mental illness are no more violent than their neighbors who do not have a mental illness.*

Involuntary Outpatient Commitment Reinforces Discrimination and Stigma

IAPSRS strongly opposes any attempts to promote involuntary outpatient commitment by publicizing inaccurate and discriminatory portrayals of people with mental illness. Comments such as “these individuals commit nearly 1,000 homicides each year” (Treatment Advocacy Center website www.psychlaws.org) are incredibly damaging to the 10.2 million people with serious mental illnesses (SAMHSA 1999) in our country.

The constant media depiction of a person with mental illness as violent, deranged, and dangerous is not only inaccurate, but it does great harm to all persons who live with a mental illness every day. This stigma permeates our society --- the media, employers, neighbors, health care providers and even family members. In a recent study of mental health consumers and stigma, 95 percent of the respondents reported a lasting and negative impact from stigma (Wahl, 1999). Some of the results of living with stigma were lowered self-esteem and self-confidence, avoidance of social contact, reduced likelihood of returning to school or job, and unwillingness to share information about mental illness with others. Consumers report anger, hurt, sadness and discouragement as reactions to stigmatizing situations. The pervasive stigma in our society is one of the major reasons people do not seek treatment. Discrimination in school, on the job, and in the community is rampant. Recovering from stigma and discrimination can be more difficult than recovery from the mental illness.

Where Do We Go from Here?

If involuntary outpatient commitment is not the answer, what can we do to reach out to this high-risk population? There are many things every community can and should do. IAPSRS members strongly believe in the three R's: Rehabilitation, Recovery and Rights, in helping people with mental illnesses. These three principles form the foundation upon which IAPSRS provides services in the community.

Mental health advocates have a responsibility to propose solutions that work and ensure that people receive the treatment they need, when they need it. In almost every jurisdiction, some effective community based mental health services can be found. But all too often the allocation of resources has not followed people into the community and consequently the availability of services is far from adequate. IAPSRS recommends the following actions be promoted in every community.

- Communities must demand the funds necessary for the development of integrated systems of mental health services predicated on the goal of rehabilitation and recovery, and which emphasizes working collaboratively with the consumer to maximize their ability to develop and sustain a satisfying life.
- Every state and/or locality should fully implement effective discharge plans for people with serious mental illness coming out of hospitals and prisons. Community programs should be required to provide assertive outreach to any new referrals from these institutions. States and localities should be held financially liable for the adverse consequences of failing to provide a discharge plan and outreach services.

- Communities need to demand the integration of substance abuse and mental health treatment for all persons who are diagnosed with both disorders. Practitioners who are cross-trained in both disciplines should provide this treatment.
- The mental health community should promote the use of relapse prevention plans and advance directives in which persons with mental illness can proactively plan with mental health practitioners for the interventions and care needed at the very earliest signs of relapse.
- Jail diversion programs, effective mental health treatment programs in jails and prisons, and community treatment programs for persons released from jail are an absolute necessity. As much as possible we need to eliminate prisons and jails as a venue for serving people with psychiatric disabilities.

The inadequate funding and fragmentation of a comprehensive community mental health system is revealed every time a person with a mental illness commits suicide, dies in a police shooting, is a victim of crime, ends up in jail because treatment is not available, or, in those rare circumstances, commits a crime. This agenda is both more complicated and will be more difficult to attain than the passage of involuntary outpatient commitment laws. But the long term impact of these recommendations is far more likely to both protect the public safety and improve the services for people with serious mental illnesses, without alienating large numbers of people with psychiatric disabilities from services and without violating the constitutional rights of a significant portion of our citizens.

¹ The United States Supreme Court has determined that involuntary commitment to a psychiatric hospital is "a massive curtailment of liberty (*Humphrey v. Cady*, 405 U.S. 504, 509 1972)." The court has also emphasized "involuntary commitment to a mental hospital, like involuntary confinement of an individual for any reason, is a deprivation of liberty which the State cannot accomplish without due process of law (*Specht v. Patterson*, 386 U.S. 605, 608 (1967))." Moreover, the court has clearly stated that there is "no Constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom (*O'Connor v. Donaldson*, 422 U.S. 563,574 (1975))." "[T]he mere presence of mental illness," the court found, "does not disqualify a person from preferring his home to the comforts of an institution (*Id.*)"

² With this new form of IOC the legal standard of imminent or overt dangerousness is absent. IOC laws substitute this standard with predictions of individual behavior, predictions that Supreme Court says must be viewed with suspicion. (*Lessard v. Schmidt*, 349 F. Supp. 1078, 1093; 1972)

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