An Examination of the Research on the Efficacy of Involuntary Outpatient Commitment in Jurisdictions Beyond Massachusetts and the Limitations of Such Research

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September 2023

Introduction

The Massachusetts Association for Mental Health opposes involuntary outpatient commitment (IOC).[1] As part of our careful consideration of legislation before the Massachusetts Joint Committee on the Judiciary, we examined the implementation of IOC laws in the 47 states that have them. The task was challenging given the limited number of peer reviewed studies and the weak comparability among them.

There are few published studies that evaluate the effectiveness of IOC laws in particular states, and analysis of IOC programs in just two states (New York and North Carolina) make up a disproportionate share of this research. Moreover, the very few studies that review all the existing research, and criticize much of it, have themselves been subject to scrutiny. All the studies have research shortcomings, some acknowledge as much.

Taking these conditions into account, we have concluded that the studies, whether flawed or not, do not offer support for IOC as an effective tool to serve persons with serious mental illness. The following report sets out what we have learned from our research.

Key observations regarding IOC and IOC research

Before turning to the question of how and why IOC has or has not worked in other states, it is helpful to review certain fundamental observations regarding IOC and the research regarding its use.

- Not every U.S. state has an active program of IOC.
- Even in U.S. states that have a program, it may be county, not state, based, with counties able to elect to adopt the program or forego adoption. In some of these states, programs may be limited to a single or small number of counties.

[1] This paper also uses other terms for IOC as different researchers use different terminology for this concept. These other terms include assisted outpatient treatment (AOT) and compulsory community treatment (CCT).

- IOC laws differ from one another (sometimes significantly) and from the model proposed for Massachusetts.
- It is difficult to know whether IOC in a particular state is implemented consistently with the statute and with legislative intent, as there is little analytic study of this.
- The analyses available regarding the success of IOC programs are not all comparable. Some articles report evidence-based studies of a single or multiple location, some are reviews of such studies, and some are commentary that is not based on any empirical evidence. There are also a number of letters written to clinical journals in response to previously published studies. Many of these letters, although apparently written by IOC supporters, criticize the studies' methods.
- The evidence-based studies of IOC seem to be concentrated in just a few states, often with the same researchers looking at a particular program several times over the course of a number of years.
- There have also been studies of IOC conducted outside the U.S. and some surveys of studies of IOC have included studies of commitment programs both inside and outside the U.S. (Studies from outside the U.S. have been excluded from this analysis as service availability, laws, social and other factors in other countries differ from those in the U.S., making comparisons less reliable.)
- Studies have examined various types of outcomes, including outcomes that may not have even been among those originally considered by proponents (or opponents) of IOC.
- Researchers and commentators have noted limitations of the studies. Among them are the following:

    - Studies are varied in design and quality.
    - None of the studies insures causal-certainty, that is, there is no certainty about what caused an outcome.
    - There are problems of reliability and validity throughout the research literature.
    - Most epidemiological studies use administrative data, and some rely on medical record information that may be less reliable than information gathered in designed-research.
    - Many studies are observational, with a non-randomized comparison of IOC with either a non-compulsory group or the time before admission to hospital, both of which are problematic for group comparability. sized controlled trials have attempted to overcome this problem, but few have been published, and difficulties regarding ethical considerations and problems with bias in selected samples that might not be representative of the target population remain a key shortcoming in the studies.
    - Insufficient data are available to do prespecified subgroup analyses to investigate outcomes of IOC for children, women, and ethnic groups.[2]
    - Additional variables such as diagnosis, ethnicity, comorbidities, country, and criminal convictions could also have a key role in the effect of IOC but remain largely unstudied.

- There does not appear to be an existing systematic structure among researchers for the study of IOC and it is not clear that one could even be developed, in light of many of the above considerations.

[2] Analyses in these populations have been specifically recommended by the National Institute for Health Research Lived Experience Working Group as a focus for future work.

Evidence-based clinical reviews of outpatient commitment, which have scanned a wide range of quantitative research often ultimately rely on very few clinical studies and, typically, few of these have been conducted in the U.S. In other words, upon careful examination, it is clear that the scope of reliable clinical research appears very limited.

Organization of this paper

This paper presents research on IOC implementation, organized in four sections.

The first section covers state-by-state IOC research produced up to 2014. This section focuses on the work of a group of researchers, led by Marcia Meldrum. In 2016, Meldrum and her colleagues published an article surveying the 45 U.S. states which the authors concluded were using IOC as of 2014.[3] They concluded that 20 states had active IOC programs, while the remaining 25 states had IOC but did not use it much. They grouped the states in these two categories and then reviewed and discussed prior studies of IOC. In this paper, rather than attempt to summarize the pre-2014 literature ourselves, we will present the conclusions of Meldrum's comprehensive literature survey.

Since the publication of the Meldrum article, there have been additional studies focused on IOC implementation in some individual states. (Forty-seven states now have IOC; MA, CT and MD do not.) The second section of this paper focuses on studies published from 2014 forward that review IOC programs in individual states.

There have also been, since 2014, some studies that were not focused on individual states but that offer some general guidance. The third section of this paper summarizes key findings of that broader post-2014 research.

The final section of this paper, offering a different type of information, reviews the experience of two states that have chosen not to adopt IOC, Connecticut and Maryland, to understand the considerations before those decisionmakers.

Studies up to 2014, as reviewed by Meldrum *et al.*

Meldrum and her colleagues conducted a national survey of states with IOC statutes to determine the extent to which IOC programs have been implemented in those states and to identify variations in implementation models. She found that the programs in the 20 states[4] with the most active IOC programs "varied considerably in style of implementation, criteria applied, agency responsible, use of treatment plan, monitoring procedures, and numbers of participants involved." So, for example, while statutory criteria were similar in these 20 states, the number of people placed under orders varied considerably, as did the methods of implementation. Again, while statutes were similar, criteria for referral of persons to IOC varied. The agency responsible for oversight varied – it was not always the state mental health department but might be a regional or local agency. The extent to which the

[3] Marcia L. Meldrum *et al.*, *Implementation Status of Assisted Outpatient Treatment Programs: A National Survey*, PSYCHIATRY ONLINE (June 2016), https://sci-hub.se/10.1176/appi.ps.201500073.
[4] These states are AZ, CA, DE, ID, IL, IN, IA, ME, MT, NE, NV, NH, NY, ND, OK, RI, SC, VT, WA, and WI.

treatment plan was formalized varied. Last, the effectiveness of participant monitoring and data tracking varied.

Meldrum and her colleagues also found a number of common problems including "inadequate resources, lack of enforcement power, inconsistent monitoring, and weakness of interagency collaboration." Notably, a full half of the states with more active programs cited inadequate resources – even though courts in almost all states were required to consider availability of resources and issue orders on the basis of advice from approved treatment teams. Further, respondents to the survey expressed concerns that voluntary mental health clients might face cutbacks as a result of the IOC program. Further, ten informants identified lack of interagency collaboration as a type of major problem. There was a resistance among local providers to accept the IOC patients, a resistance by local courts to accept IOC cases, inadequate monitoring, and basic lack of communication and coordination. Other informants complained about the lack of any real power of enforcement. Most states also claimed to have inadequate psychiatric bed capacity and preferred that patients remain in less expensive outpatient treatment settings. So, courts, when faced with noncompliance typically revised or extended the original order, "placing the responsibility back on the treatment provider to engage the participant." Last, fewer than half of the states had strong data tracking.

Meldrum concluded that many states had implemented IOC on a limited scale but with "minimal evaluation efforts." She and her colleagues issued strong guidance for future researchers:

> Evaluations of AOT performance must take into account differences in state statutes, such as whether criteria for inpatient or outpatient commitment are similar or distinct. Variations in implementation and inadequate resources have limited the development of a strong evidence base. … it is critical to develop and examine rigorous evidence on the operation and the impact of AOT programs in practice.

It is not clear, however, that subsequent researchers have followed this advice. Often the differences in state statutes have not been accounted for, variations in implementation and resources have not been addressed, and researchers have not always considered whether the evidence that supports their studies has been rigorously developed.

Beyond the limitations on research of IOC that Meldrum and her colleagues identified, psychiatrist and U. Mass. Medical School Professor Jeffrey Geller, questioned the possibility of even assessing IOC at a state level. Responding to the Meldrum article, Geller and Brian Stettin wrote:

> [W]e know from experience that it is much easier to find state mental health officials who think that they know the extent of AOT implementation in their state than it is to find anyone who actually does. The reason is that with a few notable exceptions, AOT programs are neither implemented on the state level nor monitored by state mental health agencies. AOT programs are typically established by city, county, and regional mental health systems in collaboration with local courts. They function under authority granted by state law, but there is no administrative role for state government. Which is to say that in seeking to discover "the ways in

> which individual *states* have utilized" AOT [emphasis added], we believe that Meldrum and colleagues started off by asking the wrong question.[5]

Geller and Stettin questioned certain of Meldrum's assignments of states to the "active" and "inactive" categories. Some states, they asserted, were wrongly categorized. This may be due to the fact, they suggested that, in some IOC states, state-level informants do not even have accurate information. In a number of states, activity might have been happening at the county and not the state level. Geller and Stettin conclude that, "To properly survey the implementation of AOT would require a county-by-county effort across the states with AOT laws, with independent verification of interviewees' claims."

Whatever the validity of Dr. Geller's criticism, it seems clear that Meldrum's survey is, at best, of questionable accuracy. Nevertheless, we use it as a starting point since, given the relative lack of any useful national surveys, it may be the best that is available.

Studies, beginning in 2014, focusing on individual states with involuntary outpatient commitment

In this section, we focus on states whose IOC programs have been studied from 2014 forward. Our research found that such state-specific research had only been published regarding New York. (We did not find any evidence-based, county-specific research for any U.S. county.)

The clinical research conducted in New York, one of the states that Meldrum (and Geller/Stettin) flagged as having a working program of IOC, is the most expansive. We find that, beginning in 2014, this research does not support the use of IOC as a treatment methodology.

2017 Schneeberger study

A 2017 study by Schneeberger and colleagues, commissioned by the New York State Office of Mental Health, evaluated 76 participants who received AOT and 108 who received non-compulsory treatment over the course of a year, looking at psychotic symptoms.[6] Schneeberger and his fellow researchers first reviewed the context in which they were conducting their work, specifically that AOT was successful when and because it was paired with overall investment in mental health resources:

> Positive effects of AOT may be mediated by an increased availability of healthcare resources or increased service use. This hypothesis is supported by research on the effectiveness of (intensive) case management. Furthermore, a meta-analysis demonstrated that the implementation of resource group assertive community treatment yielded positive effects, including reduced symptoms, increased subjective reports of wellbeing, and functioning on the basis of various clinical measures for people with psychotic disorders. Following this line of argument, [as] Swartz and Swanson [suggested in 2004] AOT can only be effective when more

[5] Jeffrey Geller, MD, MPH and Brian Stettin, JD, *Letter: Documenting AOT Implementation: Misinformed Informants?*, PSYCHIATRIC ONLINE (July 1, 2016), https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.670706.

[6] Andres R. Schneeberger *et al.*, *Effects of Assisted Outpatient Treatment and Health Care Services on Psychotic Symptoms*, 175 SOCIAL SCIENCE & MEDICINE 152 (Feb. 2017), https://www.sciencedirect.com/science/article/abs/pii/S0277953617300060.

> intensive services are provided, precluding its use as an inexpensive intervention. [Internal citations are omitted in this quote.]

They continued, noting the risk AOT poses to patient engagement in the system, with no corresponding benefit – questioning the overall value of AOT:

> There is a growing belief that AOT undermines the delivery of voluntary mental health services and drives consumers away from the mental health system. Some studies have not found any differences in outcomes between people with SMI who were enrolled in outpatient commitment and those who received different types of treatment. In addition, the question is raised if other forms of treatment engagement and the increased availability of healthcare service would be sufficient to improve treatment, questioning the need for AOT. [Internal citations are omitted in this quote.]

Despite these serious limitations, Schneeberger *et al.* sought to fill a gap in the existing research about AOT: "To our knowledge, no study has specifically focused on how AOT, as a treatment modality, affects *psychotic* symptoms among SMI patients." (Italics added.)

At the conclusion of their study, Schneeberger and his fellow researchers found that their results had mirrored those of the earlier researchers they had cited. They concluded that their results suggested that the positive effect of AOT on psychotic symptoms is related to the availability of mental healthcare service use, supporting the 2004 research by Swartz and Swanson.

> *2019 Yanos* et al. *study*

Another study -- of persons in New York City -- by Yanos *et al*. evaluated thirty persons receiving Assertive Community Treatment[7] in NYC (15 AOT and 15 non-AOT), gathering qualitative and quantitative information to evaluate perceptions of the therapeutic relationship and associated factors.[8] In their 2019 paper on the study, the researchers reported that quantitative findings revealed no differences in measures between AOT and non-AOT participants, with the exception being perception of "negative pressures" in the referral process, which was higher in the AOT group. Qualitative findings were more mixed, with a notable subgroup of AOT-participants experiencing themes of paternalism and coercion in the referral and treatment decision-making process. The researchers concluded that "the impact of AOT-referral on perceptions of ACT services is complex, and that AOT referrals impact treatment relationships in a subset of clients." They concluded that AOT may adversely impact the therapeutic alliance.

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[7] Assertive Community Treatment (ACT) is known as PACT in Massachusetts. PACT uses a multidisciplinary team approach to provide acute and long-term support, community based psychiatric treatment, assertive outreach, and rehabilitation services in the natural environment of the person, and are available on a 24-hour, 7-day a week basis. Network of Care Massachusetts, Program for Assertive Community Treatment (PACT), Massachusetts Department of Mental Health (DMH), https://massachusetts.networkofcare.org/mh/services/agency.aspx?pid=MassachusettsDepartmentofMentalHealthDMHProgramforAssertiveCommunityTreatmentPACT_2_1632_0.

[8] Philip T. Yanos *et al.*, *Assisted Outpatient Treatment Orders and the Therapeutic Relationship in Assertive Community Treatment: A Mixed-methods Study*, PSYCHOSIS (2019), https://sci-hub.se/10.1080/17522439.2019.1670232.

Other reports

Finally, while not clinical studies, others have commented on New York State's IOC law.

In 2017, Stephen Eide presented a memo advocating for New York's IOC law to be made permanent. Before making his case for IOC, Eide acknowledged that, to avoid imposing an unfunded mandate, New York's state government has been obliged to provide local officials with resources to implement IOC.[9] Thus, the success of IOC is inextricable interwoven with these new services and supports. After reviewing prior studies, some of which were not randomized controlled trials (RCTs), Eide presented data for the period of 1999 to 2017 for people subject to AOT orders in New York. Comparing subjects' personal data regarding hospitalization, incarceration, homelessness, and medication acceptance while on the IOC order with their personal data on these measures prior to being on the IOC order, he argued that AOT was an effective practice. However, this approach lacks scientific rigor, as the analysis is not conducted in the context of a research study and, therefore, all potential confounders and potential sources of bias have not been removed. Eide then moved away from data entirely and argued that New York's law is necessary because: seriously mentally ill people are losing out in the competition for mental health services; limited knowledge of the causes of serious mental illness places people at risk of deterioration; and there is a "niche population" ill-suited for involuntary inpatient or voluntary outpatient care. Eide provides no support for these three premises (all of which one might reasonably question) or his conclusion that, for each, AOT is the needed response. Thus, Eide's argument is seriously marred both by his lax presentation of data and his unsupported policy arguments in support of AOT.

In 2021, Victoria M. Rodriguez-Roldan published a law review arguing that New York State's AOT program further marginalized and discriminated against New Yorkers of color.[10] The article presented data showing that while Black and Hispanic people make up 17.6% and 19.3% of New York's population, they comprise 38% and 27%, respectively, of those under outpatient commitment.

Notable non-state specific research on involuntary outpatient commitment from 2014 to the present

Given the paucity of state-specific evidence-based clinical research, we note below other evidence-based clinical research and related articles, including surveys of other studies, arranged chronologically from 2014 to the present.

2015 Kisely and Campbell review of "all relevant randomized controlled clinical trials"

A 2015 Kisely and Campbell review evaluated all relevant randomized controlled clinical trials (RCTs) of compulsory community treatment (CCT) compared with "standard care" for people with Serious Mental

[9] Stephen Eide, *Assisted Outpatient Treatment in New York State: The Case for Making Kendra's Law Permanent*, MANHATTAN INSTITUTE (Apr. 2017), https://media4.manhattan-institute.org/sites/default/files/R-SE-0417.pdf.

[10] Victoria M. Rodríguez-Roldán, *The Racially Disparate Impacts of Coercive Outpatient Mental Health Treatment: The Case of Assisted Outpatient Treatment in New York State*, DREXEL L. REV. (2021), https://drexel.edu/~/media/Files/law/law%20review/v13-4/945_rodriguez-roldan.ashx.

Illness (mainly schizophrenia and schizophrenia-like disorders, bipolar disorder, or depression with psychotic features). Standard care could be voluntary treatment in the community or another preexisting form of compulsory community treatment such as supervised discharge. The study looked at programs in the U.S. and England. The researchers concluded that the evidence indicating that AOT reduces hospital admissions or length of stay was "very limited." While people receiving CCT were less likely to be victims of violent or nonviolent crime, CCT resulted in "no significant difference in service use, social functioning or quality of life compared with standard voluntary care."[11]

2016 Barnes and Badre article on use of antipsychotics and implications for compulsory use

While not a clinical study, in 2016, Shawn Barnes and Nicolas Badre published an article in PSYCHIATRIC SERVICES examining the rationale and evidence for long-term use of antipsychotics, noting the pervasive belief within the psychiatric community that psychotic illness, especially schizophrenia, requires lifelong medication. They argue that although antipsychotics are clearly indicated for patients in the acute phase of psychotic illness, the evidence for long-term use is less convincing and may not justify compulsory long-term use, such as through IOC orders.[12]

The authors conclude:

> As clinicians who treat severe mental illness on a daily basis, we encourage continued academic and public discourse on how to best assist patients with severe mental illness. AOT offers mental health clinicians immense power to affect the lives and outcomes of people with severe mental illness. However, with this power comes an immense responsibility to engage in the most ethical and evidence-based treatment, especially considering that noncompliance may have legal ramifications for patients. We argue that the involuntary use of long-term antipsychotic treatment for relapse prevention for an asymptomatic patient with severe mental illness is rarely justifiable.

2017 Kisely review of three studies

In 2017, Steve Kisely and his colleagues published another review, this time of three studies, two in the U.S. and one in England, totaling 749 individuals.[13] The researchers concluded that the review data showed compulsory community treatment resulted in "no clear difference in service use, social functioning or quality of life compared with voluntary care or brief supervised discharge." Again, people receiving CCT were, however, less likely to be victims of violent or non-violent crime. The researchers noted that it was unclear whether this benefit was due to the intensity of treatment or its compulsory

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[11] Steve R. Kisely & Leslie A. Campbell, *Compulsory Community and Involuntary Outpatient Treatment for People With Severe Mental Disorders,* 41 SCHIZOPHRENIA BULLETIN, 542 (Mar. 2015), https://sci-hub.se/10.1093/schbul/sbv021.

[12] Shawn Barnes, MD and Nicolas Badre, MD, *Is the Evidence Strong Enough to Warrant Long-Term Antipsychotic Use in Compulsory Outpatient Treatment?,* PSYCHIATRIC ONLINE (Mar. 15, 2016), https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201500408.

[13] Steve R. Kisely *et al.*, *Compulsory Community and Involuntary Outpatient Treatment for People with Severe Mental Disorders*, COCHRANE DATABASE OF SYSTEMATIC REVIEWS (MAR. 17, 2017), https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD004408.pub5/full

nature. In conclusion, they wrote, "Short periods of conditional leave may be as effective (or non-effective) as formal compulsory treatment in the community."

2017 paper by Marvin S. Swartz and eight others representing the Council on Psychiatry and Law of the American Psychiatric Association

A 2017 paper by Marvin S. Swartz and eight other medical doctors constituting the America Psychiatric Association Council on Psychiatry and Law reviewed "several generations of studies, evaluations, legislative and systematic reviews of the evidence for involuntary outpatient commitment."[14] They concluded that there was

> no clear consensus about [IOC's] effectiveness across different jurisdictions … The evidence on the effectiveness is mixed, with effectiveness largely a function of systematic and effective implementation, the availability of intensive community-based services and the duration of the court order.

The researchers continued, stating that despite an interest in IOC as a means to reduce violence, "rigorous empirical evidence to employ it on that basis is slim." Noting that while New York's reports of substantial reductions in violence in its AOT program may be persuasive, considering both NY and NC, "the paucity of empirical evidence is marked if the goal is reduction of larger scale acts of extreme violence."

2018 Phoebe Barnett et al. systemic review and meta-analysis

A 2018 systemic review and meta-analysis by Phoebe Barnett *et al.* found no consistent evidence that compulsory community treatment reduces hospital readmission or length of inpatient stay, although it might have some benefit in enforcing use of outpatient treatment or increasing service provision, or both.[15] Interestingly, while the researchers identified 1931 studies for consideration, only 41 met inclusion criteria and of those 41, only 5 were dated 2014 or after and none of those studies were of U.S. programs.

2021 Steven P. Segal review of quantitative studies

Steven P. Segal's 2021 review of quantitative studies from inside and outside the U.S. found that when IOC is associated with Assertive Community Treatment or some form of aggressive case management, it will be associated with reducing re-hospitalization numbers, but when outpatient services are more limited, IOC is associated with rapid return to hospital (and therefore increased "total-hospital-days and

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[14] Marvin S. Swartz, MD *et al., Resource Document on Involuntary Outpatient Commitment and Related Programs of Assisted Outpatient Treatment*, AMERICAN PSYCHIATRIC ASSOCIATION (approved by the Joint Reference Committee Oct. 2015), https://www.psychiatry.org/File%20Library/Psychiatrists/Directories/Library-and-Archive/resource_documents/resource-2015-involuntary-outpatient-commitment.pdf.

[15] Phoebe Barnett *et al.*, *Compulsory Community Treatment to Reduce Readmission to Hospital and Increase Engagement with Community Care in People with Mental Illness: A Systematic Review and Meta-Analysis*, LANCET PSYCHIATRY (Dec. 2018), https://sci-hub.se/10.1016/S2215-0366(18)30382-1.

readmissions when compared to a comparison group). The study cites other examples of mixed results as well.[16]

2022 Steven P. Segal review of quantitative studies

In another review of quantitative studies (again, not limited to the U.S.), Segal concludes that while studies confirm beneficial associations between outpatient civil commitment and direct measures of the amelioration of imminent threats to health and safety, it is "not a great solution." He continues, explaining that it may be disempowering for the individual during the period of high risk.[17] Notably, Segal's review includes no 2014 or later study conducted on a U.S. jurisdiction. Thus, the applicability of the results to present day use of IOC in U.S. locations is uncertain.

The experience of two states that have rejected involuntary outpatient commitment

In addition to reviewing the experience of states which have adopted IOC, it is illuminating to consider the history of states that have debated and rejected IOC legislation.[18]

Connecticut

The Connecticut Legislature has considered and rejected IOC in 1988, 1996, 2000, 2012, 2015, 2016, 2020, 2021, and 2023. Moreover, the last time IOC legislation was proposed and *received a hearing* before the Connecticut Legislature was 2020. In that year, testimony was submitted to the Connecticut Legislature *against IOC legislation* by NAMI-Connecticut, ACLU-Connecticut, the Connecticut Chapter of the National Association of Social Workers, the Connecticut Cross Disability Lifespan Alliance, the Connecticut Legal Rights Project, Inc., Mental Health Connecticut, and the Connecticut Department of Mental Health and Addiction Services, among other organizations, state agencies, and individuals.[19]

As Attorney Kathleen Flaherty, Executive Director of the Connecticut Legal Rights Project, Inc., has explained in testimony submitted to the Massachusetts Joint Committee on the Judiciary this session, the Connecticut Legislature has carefully considered, and ultimately rejected, IOC legislation repeatedly over twenty-five years. As she explains, a task force created by the Legislature to study IOC issued a 1997 report that did not recommend either adoption or dismissal of the concept of involuntary

[16] Steven P. Segal, *Hospital Utilization Outcomes Following Assignment to Outpatient Commitment*, 48 ADM. POLICY MENTAL HEALTH 942 (Nov. 2021), https://sci-hub.se/10.1007/s10488-021-01112-y.
[17] Steven P. Segal, *Protecting Health and Safety with Needed-Treatment: The Effectiveness of Outpatient Commitment*, 93 PSYCHIATRY Q. 55 (Mar. 2022), https://sci-hub.se/10.1007/s11126-020-09876-6.
[18] While beyond the scope of this paper, another important review would survey the many states that have an IOC statute, but are now pursuing other, voluntary options in search of better success rates. One example is the Intensive and Sustained Engagement Team (INSET) program, which has recently announced its expansion to four more sites in New York State.
[19] For links to all testimony submitted for and against Connecticut's IOC legislation in 2020, see https://www.cga.ct.gov/aspx/CGADisplayTestimonies/CGADisplayTestimony.aspx?bill=SB-00428&doc_year=2020.

commitment.[20] In 2000, two IOC bills died in the Appropriations Committee. In 2012, the Judiciary Committee held a public hearing on an IOC bill and declined to report it out. In 2013, a Young Adult Behavioral Task Force issued a report that only recommended "further study" of IOC. A 2015 Sandy Hook Advisory Commission Final Report concluded that it was "unable to arrive at a recommendation concerning adopting IOC as an option short of involuntary hospitalization in Connecticut." Again in 2016, the Judiciary Committee heard an IOC bill but declined to report it out. In 2020, the Public Safety & Security Committee held a public hearing on a bill, but it died when the 2020 session ended due to the COVID-19 pandemic. In addition, the Connecticut Legislature has requested three research reports from the Office of Legislative Research: in 2001, 2011, and 2013 on what other states do regarding IOC. In light of all this review and research, the Connecticut Legislature has refused to adopt IOC legislation.

Maryland

Like Connecticut, Maryland does not have a state statute authorizing IOC, despite the fact that the state legislature has heard such bills since 2001.[21] There is a bill pending this legislative session, SB. 480. Maryland's Department of Legislative Services has prepared a fiscal and policy note on that bill.[22] As the bill calls for implementation of AOT at the county level, the state executive office anticipated needing

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[20] TASK FORCE TO STUDY ISSUES RELATING TO INVOLUNTARY OUTPATIENT COMMITMENT AND ALTERNATIVES, TASK FORCE REPORT: OUTPATIENT COMMITMENT & ALTERNATIVES (CONNECTICUT): ISSUES RELATING TO INVOLUNTARY OUTPATIENT COMMITMENT AND ALTERNATIVES (Jan. 1, 1997), http://www.narpa.org/reference/task.force.report.

[21] Baltimore does have an Outpatient Civil Commitment program, piloted in FY2018 with funding from the Maryland Department of Health Behavioral Health Administration. This is not IOC, but a conditional release program which permits mandated community treatment as a condition of discharge for persons who have been involuntarily admitted on an inpatient basis. People with mental illness who are currently hospitalized, can be referred to the OCC program either involuntarily or voluntarily. Peers with lived experience provide persistent support to individuals for six months, starting from before their discharge from the hospital. There is no court system involvement. The proponents of this model note, while comparing their model to AOT:

> Publicly available data on civil commitment is inconsistent, making it difficult to draw a strong conclusion that one type of AOT model is more effective than another. What is clear from the research is that involuntary commitment to outpatient treatment has not proven to reduce the rate of readmission to the hospital for people with severe mental illness.

Behavioral Health System Baltimore, Policy Brief: Involuntary Commitment for Mental Illness Must Be an Option of Last Resort, https://mgaleg.maryland.gov/cmte_testimony/2023/hgo/15167_03162023_105651-482.pdf.

Two years after the commencement of the Baltimore program, in fall 2019, only nine individuals were enrolled, six of them voluntarily. MDEdge, Baltimore's Pilot Project in Outpatient Civil Commitment: Novel Program Has Gotten Off to a Rough Start (Sept. 23, 2019), https://www.mdedge.com/psychiatry/article/208602/schizophrenia-other-psychotic-disorders/baltimores-pilot-project.

[22] Department of Legislative Services, Maryland General Assembly, 2023 Session, Fiscal and Policy Note, First Reader, SB.480, https://mgaleg.maryland.gov/2023RS/fnotes/bil_0000/sb0480.pdf.

just one state level program administrator to implement the program. However, analysts concluded that local expenditures would increase "to the extent that a local jurisdiction… establishes an AOT program" and that some costs would not be reimbursable. Further, the judiciary expected the need for $123K for FY24 alone and the Office of the Public Defender expected the need for $3.6M for the first full FY to provide legal defense, plus additional costs. (Legislative Services agreed that legal representation would be a necessary cost but noted that a set of unknowns made a precise prediction of cost difficult.) Finally, analysts did not expect savings from diversion from hospital admissions given the ongoing high demand for such services.

Regarding the pending legislation, Maryland disability rights advocates have argued that the U.S. Department of Justice's 2016 finding that Baltimore police used unreasonable force when escorting individuals to hospitals for mental health evaluations under emergency petitions and made "little, if any, effort to de-escalate or engage peaceably" suggests that a plan to have police respond to noncompliance with AOT places people with disabilities at risk of trauma, physical harm, and even death. It would also place people at higher risk of criminal justice system involvement. They raise concerns with misplaced resources: "Increasing availability of outpatient community mental health services, as well as resources like housing, transportation and case management, could better prevent the hospitalizations and incarcerations that this bill cites as reasons to commit an individual to AOT, and would better achieve the goals of this bill." Finally, they state that the AOT program would disproportionately impact Black and Brown Marylanders, both with respect to risk in the course of police interactions and with respect to commitment rates. With respect to the latter concern, they caution: "Maryland's Office of the Public Defender has similarly identified that Black and Hispanic individuals are involuntarily committed at significantly disproportionate rates."[23]

Conclusion

Involuntary outpatient commitment has an uneven implementation history across the U.S. To a large extent, IOC programs have not been fully operational, even where they have been authorized. Most programs are county, not state, based, and evaluation of these programs has been extremely limited. In the absence of research, it is nearly impossible to report on state-by-state implementation of IOC legislation. The very few attempts to do so have been subject to criticism from both proponents and opponents of IOC.

Thus, despite a frequent suggestion that the evidence to support IOC is abundant, there are actually few rigorous examinations of IOC in the U.S. Relatedly, many of the studies have serious limitations, as concluded by several reviewers. Upon careful examination, it is clear that the scope of reliable clinical research is extremely limited. It appears that state laws have been enacted without useful research to justify them.

[23] Disability Rights Maryland, Position Paper on House Bill 823 – Mental Health Law – Assisted Outpatient Treatment Programs Health and Government Operations Committee (Mar. 14, 2023), https://mgaleg.maryland.gov/cmte_testimony/2023/hgo/1FYQYHORPptJoUGaLDGZQvS5vZg1YBPpC.pdf#:~:text=House%20Bill%20823%20would%20authorize%20counties%20to%20establish,people%20of%20color%20and%20those%20living%20in%20poverty.

The debate regarding IOC in Connecticut and Maryland, two states without IOC legislation, is further instructive. In both states, as in Massachusetts, IOC proposals have been vetted over multiple years. And, in both states, thoughtful advocates and analysts have noted serious potential impacts, financial and otherwise, of IOC implementation. These arguments have been persuasive for policymakers and legislators in Connecticut and Maryland, who have repeatedly declined to adopt AOT.

The experiences in states with and without IOC offers strong confirmation that Massachusetts should be extremely wary of IOC.