

**Committee for Persons in Recovery  
U.S. Psychiatric Rehabilitation Association**

**Position Paper on Involuntary Outpatient Commitment**

**Approved by the Board of Directors  
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**Developed by the People in Recovery Committee with assistance from the Multi-  
Cultural Committee of USPRA  
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In the *Final Report* of the President's New Freedom Mental Health Commission issued in 2003, recognized experts in the field of mental health services, psychiatric rehabilitation, and recovery detailed the critical need for mental health care to be consumer and family-driven as a primary goal for the transformation of systems of care. Similarly, published reports from the Institute of Medicine (2006) contend that mental health services must be "patient-centered," meaning that care must be "respectful of and responsive to individual patient preferences, needs, and values." Despite the fact that these evidence-based reports clearly support the need to reduce and potentially eliminate coercive treatments among mental health consumers, such as Involuntary Outpatient Commitment (IOC) and the use of seclusion and restraint, these practices continue in many mental health settings. Procedures such as IOC and seclusion and restraint should no longer be recognized as treatment options, but should be seen as treatment failures.

Involuntary Outpatient Commitment, known euphemistically as "Assisted Outpatient Treatment," is a process by which individuals' options regarding the conduct of their lives are constricted, narrowing their opportunities for growth. Although IOC laws vary from state to state, generally they require individuals with psychiatric diagnoses to take medication and comply with involuntary outpatient treatment recommendations, or risk being placed in inpatient psychiatric hospitals. Currently, the requirements for IOC 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). Overall, however, there is little standardization, and few specific guidelines, for recommending IOC. Typically, laws and procedures rely on past behavior as a predictor of future behavior or rely on a subjective assessment of current community functioning (Bazelon Center for Mental Health Law, 2006). IOC is not a clinical process but, rather, a legal one; it is derived from political principles, not from recovery principles.

The United States Psychiatric Rehabilitation Association (USPRA) objects to the use of Involuntary Outpatient Commitment in any form. The Association finds that the application of IOC: (1) fundamentally violates the constitutional right to privacy and due process among individuals in recovery from psychiatric disabilities; (2) has been historically overused in urban areas and disproportionately applied to people of color; and (3) represents an abject failure of the public mental health system, coercing and forcing treatment as a substitute for poor public funding and systems transformation to use of evidence-based practices (EBPs). As noted below, each of these three issues is discussed, documenting empirical evidence from numerous research and program evaluation studies. As noted in the literature, IOC represents a form of treatment contrary to principles of recovery and the promotion of community integration and self-determination.

## **1. IOC is a Discriminatory Practice and Violates the Civil Rights of People with Psychiatric Disabilities**

Involuntary Outpatient Commitment, as problematic as it is on multiple levels, is always presented to community stakeholders as a solution to treatment non-adherence. Why don't people with a diagnosis of a mental illness follow doctors' orders? Largely for some of the same reasons that people with chronic medical conditions, such as heart disease, cancer, diabetes, or any other ailments, fail to adhere to treatment: because they don't want to perceive themselves as patients; because they perceive the side effects of medication as being worse than the illness itself; because they simply forget; and a variety of other reasons common to all patient groups (Neutel & Smith, 2003; Pumilia, 2002; Schroy, 2002). People in recovery from mental illness differ in their rationale for non-adherence. Major factors include the extreme stigma, prejudice, and discrimination they have suffered for being diagnosed with a mental illness, a prejudice which is only reinforced by the existence of restrictive practices such as IOC.

Despite the many normalized reasons for not taking medication that are cited above, advocates for Involuntary Outpatient Commitment routinely invoke cognitive disruptions related to the symptoms of mental illnesses as the sole reason for non-adherence, perhaps in an attempt to justify why people with diagnoses of a mental illness are treated differently from other groups. However, there are people who smoke, overeat, take medication incorrectly (or not at all), or otherwise act in ways that are contrary to their own health interests. Yet no laws exist compelling these non-adherent populations to do otherwise. In fact, one-third of all prescriptions are never filled, and over half of prescriptions that are filled are incorrectly administered, leading to an estimated 125,000 deaths per year (Peterson et al., 2003). Additionally, in accordance with their mission, USPRA asserts that different cultural groups may exhibit specific cultural patterns, which can appear problematic, "abnormal," or non-adherent in our society, but are normal and common cultural patterns in that particular group. Culturally competent practitioners have knowledge of these factors and incorporate strategies to address them into services (Rogers et. al., 2006).

Involuntary outpatient commitment is predicated not on the illegality of past actions, but rather on the unreliable prediction that persons with psychiatric diagnoses are likely to be both non-adherent in the future and that anticipated non-adherence will lead to dire consequences, either for the individual or the community. It is for that reason that IOC is at odds with the Constitutional protections that all citizens enjoy, and is itself more evidence that people with diagnoses of mental illness experience wide-spread institutionalized discrimination. In particular, IOC of law-abiding people is a violation of constitutionally guaranteed, substantive due process. It is contrary to the most important American values and those for which other democracies claim to stand. In recognition of these rights and the inconsistencies that IOC represents, USPRA stands in opposition to IOC as a matter of law and practice.

Central to USPRA's mission of recovery from psychiatric disabilities is the integration of persons diagnosed with mental illnesses into the community and self-determination. With whose voice does the community speak when it invokes involuntary outpatient commitment? It speaks with the voice of the judge and the prosecutor, as well as individuals who fear mental illness as a result of stigma and misinformation. The IOC

process values the perceived safety of the community over the rights of individuals to find their path to recovery. Persons who are apt to feel themselves judged merely for having the diagnosis of a mental illness experience the unhappy reality of institutional judgment. Equally damaging, IOC conjoins the system of treatment services with the criminal justice system, validating for our most hesitant and suspicious potential treatment participants the idea that the therapeutic community is somehow in league with authoritarian elements, because, in fact, it is. This is not to say that sanctions should not exist for people who have committed crimes; members of the community, with or without a mental illness, who have been afforded the due process protections of law and are determined to be guilty of criminal behaviors, can and should be held accountable for their actions.

## **2. Use of Involuntary Outpatient Commitment Discriminates Against People of Color**

USPRA endorses multicultural diversity principles as the foundation for providing effective multicultural psychiatric rehabilitation services. These multicultural principles endorse that every person's gender, ethnicity, sexual orientation, level of ability/disability, age, and socioeconomic status, uniquely define his or her needs and recovery. Sadly, the anecdotal and historical data collected to date indicates that the mental health system fails people of color. Implementing, enforcing or expanding Involuntary Outpatient Commitment, in effect, further denies people of color access to the most helpful services and perpetuates cultural paranoia, which in and of itself, can lead to misdiagnoses.

The use and application of IOC is often based on the social fears and biases, not on sound recovery based psychosocial practices (Thomas & Sillen, 1972). For example, according to New York State Office of Mental Health's Final Report on Kendra's Law (2005), 63% of people being court-mandated under Kendra's Law are identified as African American or Hispanic. So while less than one-half of New York State's total population is comprised of African American and Hispanic individuals, two out of every three court-mandated orders have been levied at people of color (Finley & Pernell-Arnold, 1996). As demonstrated by this example, IOC laws are not being equally applied, and are disproportionately employed against persons of color. Is this to suggest that people of color are more violent than the general public? Or do people of color have a greater incidence of mental illnesses than the general population? Or is it possible that mental health systems have completely and utterly failed people of color? The effects of stigma, social isolation and rejection, and discrimination must be addressed as violations of basic human rights, as well as barriers to recovery and self-determination.

## **3. Use of IOC Represents the Failure of the Public Mental Health System**

USPRA believes Involuntary Outpatient Commitment represents a complete treatment failure and should not be a standard treatment practice. As such, USPRA seeks to identify and implement compassionate and person-centered means of reaching those persons that experience cognitive impairments and other symptoms of mental illness. USPRA is dedicated to the principle that people can be reached in ways that do not damage their sense of self-esteem or purpose in life. For example, early intervention

teams have been successfully used to help individuals who are in the early stages of an acute episode of psychosis avoid hospitalization and remain in the community without the use of coercion (Malla & Norman, 2002; Melle, et al., 2004). With care and understanding, the benefits of psychiatric rehabilitation – notably services tailored to the needs, wants, and experiences of each person in recovery – can be better understood, and embraced through a process of collaboration, which is itself a hallmark of recovery. Psychiatric rehabilitation principles embrace the concepts of person centered and self-directed treatment planning and service delivery. In contrast, Involuntary Outpatient Commitment minimizes, if not eliminates, these integral approaches to treatment. Recovery is much less attractive when presented as force, coercion, and/or a criminal justice sanction; thus IOC has the net effect of driving people, especially people of color, away from recovery, rather than toward recovery.

USPRA believes people who are subjected to Involuntary Outpatient Commitment subsequently receive enhanced services only because of perceived regional liabilities. Ironically, many events that lead to IOC are due to one or more failures of the mental health system overall. Improvement of service coordination should already be the goal of a system, which can support its members without the use of force or coercion. On the other hand, prioritizing IOC above other services burdens other resources necessary in comprehensive mental health systems. For example, when housing is scarce, emphasizing IOC acts as a disincentive to recovery. It may result in persons in long-term recovery being denied an opportunity to utilize community resources for which they are appropriate and ideal candidates. As stated earlier, improvements in service delivery and coordination should already be a goal, one that is achievable in the absence of IOC.

### **Summary**

The core values of the United States Psychiatric Rehabilitation Association state that all people have the capacity to learn and grow, and that a diagnosis of mental illness does not nullify this potential. USPRA believes that people have the right to make choices and live with the consequences of those choices, both good and bad. People in recovery from psychiatric disabilities will, with guidance and understanding, learn as much or more by making their own life choices compared to having those choices made for them. People in recovery understand and embrace a process of collaboration tailored to their individual needs, wants, and experiences. This is the foundation of self-determination and recovery. Involuntary Outpatient Commitment destroys this collaborative relationship by introducing force, coercion, and broken confidentiality, making recovery all the more difficult. It is antithetical to the idea of recovery to decide, in advance, that a person will act self-destructively; then, on the basis of that assumption, deny him/her the right of free choice. Psychiatric rehabilitation practitioners recognize the importance of developing partnerships with persons served so that the input and feedback can be exchanged in a systematic and on going basis (Rogers et. al., 2006). It is to this collaborative mission and the further promotion of self-determination and recovery that USPRA is firmly committed.

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