RESEARCH BRIEF

Involuntary Outpatient Commitment / Assisted Outpatient Treatment

What the Research Does and Does Not Tell Us Part II: Deeper Dive Including Methods Limitations, Discussion of Racial Disparities, Structural Racism & Measured & Unmeasured Harms

Nev Jones, PhD + PathLab

School of Social Work | University of Pittsburgh | March 2026

OVERVIEW

Involuntary outpatient commitment (IOC)—known in the United States as assisted outpatient treatment (AOT)—is a legal mechanism that compels a person determined to have a "severe mental illness" to accept treatment while living in the community. The primary enforcement tool is the threat of hospitalization. Active AOT legislation exists in 48 U.S. states and more than 75 jurisdictions worldwide. International equivalents include community treatment orders (CTOs), compulsory community treatment (CCT), and mandated outpatient treatment (MOT).

In the United States, AOT is court-ordered; a judge signs the order. New York's Kendra's Law is the most extensively studied U.S. program. Internationally, orders are usually clinician-initiated and often involve specialized tribunals. This brief synthesizes approximately 150 sources, including three RCTs, three Cochrane reviews, and research from more than 12 countries. U.S. evidence is concentrated in the North Carolina RCT (late 1990s data), New York Kendra's Law studies (1999–2011), Ohio-based research (NEOMED group), and the 2024 ASPE multi-site evaluation (pre-post design). International evidence draws heavily from Australia/NZ, the UK (OCTET RCT; Burns et al 2014), and legal reform studies from Scandinavia and the Netherlands.

SECTION 1: EFFECTIVENESS

Randomized Trial Evidence

Three RCTs have tested involuntary outpatient commitment. The NYC/Bellevue trial (Steadman, 2001; n=142) found no significant differences on any outcome; both groups received enhanced services. The North Carolina trial (Swartz, 1999; n=331) found no differences in direct comparisons; post-hoc benefits appeared only for orders >180 days with intensive services (length not randomized). The OCTET trial in England (Burns, 2013; n=336) found no differences in any primary outcome or pre-planned subgroup analysis.

The 2017 Cochrane Review (3 RCTs) concluded: no significant difference in any primary outcome except low-level evidence for reduced victimization. Number needed to treat to prevent one readmission: 142.

Observational Evidence

Pre-post and uncontrolled studies generally show positive results on hospitalization rates, adherence, and violence. The Duke Kendra's Law re-authorization study reported a 25% reduction in hospitalization; the 2024 ASPE evaluation reported improved adherence (+25.9%), reduced violence (−19%), and reduced suicidal ideation (−24.7%).

However, controlled comparisons consistently show no effect. The Barnett et al. (2018) meta-analysis is definitive: pre-post comparisons showed large positive effects; controlled comparisons showed none.

Why the Discrepancy?

Regression to the mean: People are placed on CTOs/AOT during crises. After a crisis, most improve regardless of treatment. The "look back" period before the crisis is almost always also often a period of heightened challenges precipitating the crisis.

Coercion–services–accountability confound: AOT/CTO recipients receive enhanced services, often including priority or automatic access to desired resources such as subsidized or supported housing. In addition, most IOC/AOT programs include provider-side accountability mandates, i.e. holding providers accountable for sustained support of individuals on AOT orders whil no such accountability exists for non-AOT clients even on the same caseload. In the one RCT where both groups received enhanced services (NYC; Steadman et al 2001), no differences emerged.

What is confounding?

A "confound" is a factor that is entangled with the thing you are trying to study, making it impossible to tell which one is actually driving the results. In AOT research, the court order almost always comes bundled with enhanced services, priority housing access, and stronger provider accountability. When outcomes improve after an AOT order, we cannot tell whether the improvement was caused by the legal mandate itself or by the additional resources and attention that came with it. This is the core confound in AOT research: the order and the services are not separate—they arrive together.

An analogy: Imagine a school assigns struggling students both a tutor and a mandatory study hall. If grades improve, was it the tutor or the study hall? You cannot know unless you test each one separately. Randomized controlled trials (RCTs) are designed to do exactly this, by randomly assigning people to receive the order or not while holding services constant. In the one RCT that did this (NYC/Bellevue), no differences were found.

This is why the divergence between observational and RCT findings matters so much: observational studies (which cannot untangle these factors) show positive results, while the RCTs (which can) do not.

Additional Methodological Concerns

Harms are rarely measured and, when measured, measured in very limited ways. No study has utilized measures of serious medication side effects, financial disempowerment, family separation, learned helplessness, social defeat. Some outcomes touted as beneficial outcomes are confounded with the intervention itself (e.g., medication adherence under an IOC order) with null or no data on actual symptom effects. Self-report under coercion is always suspect as individuals under an order have strong disincentives to report outcomes other than satisfaction and compliance; similarly clinician-reported outcomes face incentive-driven misreporting risks.

The Duration and Intensity Hypothesis

A central claim in the AOT literature—originating from post-hoc analyses of the North Carolina RCT (Swartz et al., 1999)—is that IOC/AOT orders are effective, but only when they last long enough and are combined with intensive service engagement. This is sometimes called the "duration hypothesis," but it is more accurately described as a duration-and-intensity hypothesis: the claim is not simply that longer orders work better, but that sustained orders paired with high-frequency service contact (e.g., seven or more service events per month) are the necessary combination. This framing has been highly influential in shaping AOT policy, with advocates pointing to it as justification for longer initial orders and mandatory renewals.

However, there are several significant methodological problems with these claims. First, the finding is post-hoc—meaning it was not part of the original planned analysis, but emerged from subgroup exploration after the primary results showed no effect. Post-hoc subgroup analyses have a high risk of false positives and are generally considered hypothesis-generating rather than confirmatory. Second, the analysis suffers from survivorship bias: individuals who remain on orders for longer periods are, by definition, those who are compliant with the order—a characteristic that itself predicts better outcomes. Third, the duration-and-intensity combination reintroduces the core confound described above: individuals receiving both longer orders and more intensive services cannot tell us whether it was the legal mandate or the services producing any observed benefit. Finally, the finding that medication adherence does not persist after CTO expiration (Cossu et al., 2024) raises fundamental questions about whether the order produces lasting change or merely temporary compliance under legal pressure. No study compares long-duration orders with intensive services to long-duration enhanced voluntary services of equal intensity—the comparison that would be needed to isolate the effect of the mandate itself.

> *The RCTs are limited (only three, all older), observational studies cannot establish causation, administrative data misses what arguably matters most, and follow-up is typically too short.*

SECTION 2: RACIAL, ETHNIC & CULTURAL DISPARITIES

The Numbers

Racial and ethnic disproportionality in IOC/AOT is one of the most consistent findings in the literature—internationally and in the United States. In England, Black individuals face CTO rates 11x higher than White individuals (Kisely et al, 2024). In NZ, Māori face 3x rates (Lees et al., 2023). In Australia, CALD groups face 40–66% higher odds (Kisely et al., 2021); interpreter users face 2.8x odds (Moss et al., 2019). No study finds overrepresented groups derive additional benefit.

In the United States, the most detailed data come from New York's Kendra's Law program. Black New Yorkers constitute approximately 17.6% of the state's population but represent 38% of all individuals placed on AOT orders. Early analyses by Swanson et al. (2009) documented this disproportionality and noted that Black individuals were significantly more likely to be referred and ordered into AOT even after adjusting for clinical variables. The New York State Office of Mental Health's own program evaluations have consistently reported these patterns, and the 2024 New York State Comptroller's audit confirmed that racial disparities persist. Despite this, remarkably few peer-reviewed studies have made race their primary analytic focus: between 2009 and 2022, only two U.S. articles did so.

Ahmad et al. (2025) scoping review: 43 studies, only 9 on race/ethnicity and IOC (2001–2023). Most research from Australia/NZ; U.S. literature markedly smaller and less developed.

The Structural Pipeline

Racial disproportionality in AOT/IOC cannot be understood by looking at the court order in isolation. Instead, it must be understood as the product of a structural pipeline—a series of interconnected stages, each shaped by structural racism, that cumulatively funnel Black and Brown Americans into coercive treatment at far higher rates. Figure 1 below illustrates this pipeline. On the left side, the figure identifies seven sequential stages, divided into the broader structural pipeline (stages 1–4) and the AOT system specifically (stages 5–7).

The first four stages precede AOT but shape who enters it: (1) social determinants such as residential segregation, concentrated poverty, and disproportionate policing; (2) crisis pathways, where Black individuals are more likely to encounter the mental health system through emergency departments and law enforcement rather than outpatient care, and face documented disparities in restraint use; (3) diagnostic bias, including the well-documented overdiagnosis of schizophrenia in Black men; and (4) hospitalization cycling, where each involuntary admission adds to the record used to justify future coercion. Once in the AOT system, disparities continue through (5) referral discretion, shaped by clinician perceptions of violence risk and implicit bias; (6) the court order itself, which authorizes law enforcement involvement; and (7) enforcement and experience, including monitoring, pick-up orders, and rehospitalization.

The right side of the figure highlights two domains where disparate force is documented with citations: emergency evaluation (where Black race is associated with physical and chemical restraint even after controlling for clinical presentation) and commitment enforcement (where law enforcement kills Black Americans with perceived mental illness at significantly higher rates, and IOC court orders authorize police transport for non-adherence). The figure also draws attention to a critical methodological point: many studies that claim to "control for" race by adjusting for diagnosis, hospitalization history, and clinical severity are actually controlling for the very pathways through which structural racism operates. These variables are not neutral confounders—they are themselves products of the racialized system, and adjusting for them can mask the true extent of racial inequity (see callout box below).

What is structural racism, and why does it matter here?

Structural racism refers to the ways that historical and contemporary policies, institutional practices, and social conditions interact across systems to produce and sustain racial inequities—even in the absence of overtly racist intent by any individual actor. In the context of AOT, this means that racial disproportionality is not primarily about whether a given clinician or judge is personally biased. Rather, it is about how interconnected systems—housing, policing, emergency services, diagnostic practices, insurance, and the legal system—channel Black and Brown individuals into coercive psychiatric intervention at every stage.

This distinction has direct methodological implications. Researchers who include individual-level race as a control variable in AOT outcome models—asking, for example, "does race predict AOT referral after adjusting for diagnosis and hospitalization history?"—may inadvertently "adjust away" the very disparities they should be examining. If Black Americans receive more schizophrenia diagnoses due to diagnostic bias, and more involuntary hospitalizations due to racialized crisis pathways, then statistically controlling for these factors removes the signal of structural racism from the analysis. This is sometimes called "overadjustment bias." To meaningfully study racial equity in AOT, research must attend to structural-level processes—not just individual-level race variables—and must avoid treating the downstream products of racism as though they are race-neutral covariates.

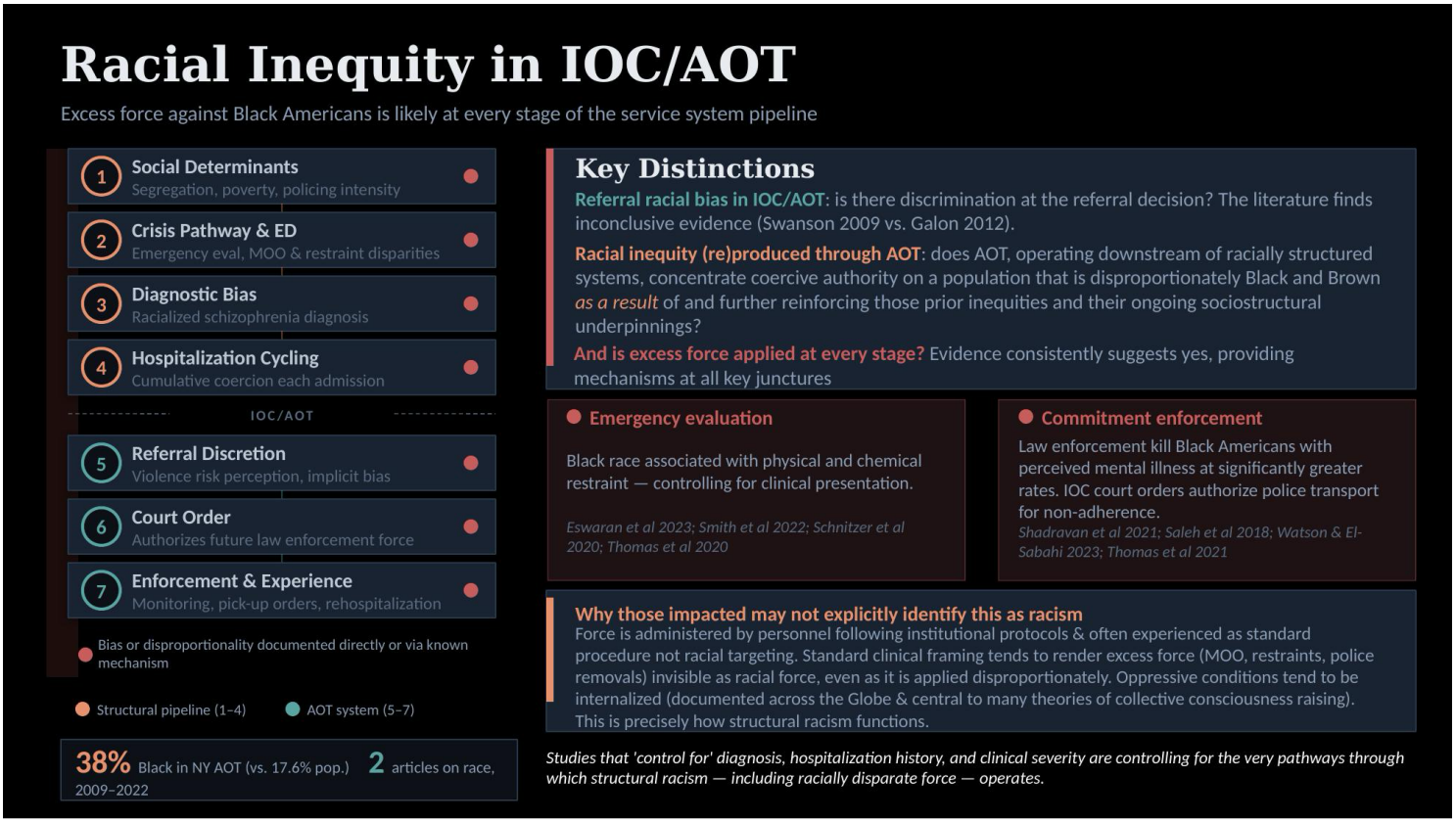

Figure 1. Racial Inequity in IOC/AOT: The Structural Pipeline

In New York, the disproportionality highlighted in the figure is not a single-point failure but the cumulative product of each pipeline stage. Black New Yorkers are more likely to live in neighborhoods with intensive policing and limited outpatient access; more likely to enter the system through emergency departments rather than voluntary care; more likely to receive schizophrenia diagnoses; and more likely to accumulate the hospitalization history that triggers AOT eligibility criteria. By the time a referral reaches the court, the racial disparity is already deeply embedded in the clinical record. The figure's bottom line—that studies statistically "controlling for" diagnosis, hospitalization history, and clinical severity are controlling for the very pathways through which structural racism operates—is essential to interpreting the existing literature. Much of what appears to be race-neutral analysis is, in practice, obscuring the structural processes that produce racial disproportionality in the first place.

Indigenous Perspectives: Māori in Aotearoa NZ

Māori constitute 34% of CTO recipients (vs. 17% population). Māori are younger, spend longer under compulsion, with a mortality rate ratio of 1.71 during CTOs (vs. 1.16 non-Māori). Qualitative research (Kirikiri et al., 2024) found CTOs restrictive, stigmatizing, and used to circumvent consent.

No U.S. study examines differential health outcomes by race under AOT; how AOT intersects with policing, housing, and poverty; or whether AOT deters voluntary help-seeking differentially by race.

SECTION 3: MEASURED & UNMEASURED HARMS

Mortality

Beaglehole et al (2024): 29% higher mortality during CTO periods (RR 1.29); accidents/assaults 73% higher (RR 1.73). Māori CTO mortality: 1.71x. No comparable U.S. studies.

Medication-Related Harms

AOT orders in practice overwhelmingly center on medication compliance, and the medications involved—primarily antipsychotics, often at high doses and in combination (polypharmacy)—carry serious and well-documented medical risks. Long-term and high-dose antipsychotic use is associated with metabolic syndrome, Type II diabetes, significant weight gain, cardiovascular disease (including prolonged QTc interval and elevated risk of sudden cardiac death), hyperlipidemia, and hyperprolactinemia (Opio et al., 2020; Pillinger et al., 2020; Salari et al., 2024).. Second-generation antipsychotics such as clozapine and olanzapine carry particularly high metabolic risk. Extrapyramidal side effects, including drug-induced Parkinsonism, akathisia, and tardive dyskinesia, remain common, especially with long-acting injectable formulations frequently used in AOT contexts. Emerging evidence also links prolonged antipsychotic use to cognitive decline and early onset dementia, though these findings remain under investigation (Haddad et al., 2023; Joshi et al., 2021; Mancini et al., 2015).

Polypharmacy—the concurrent use of multiple psychiatric medications—compounds these risks. Individuals on AOT orders frequently receive combinations of antipsychotics, mood stabilizers, and anxiolytics, with side effects that interact and accumulate (in PathLab's research, for example, we have found that over 60% of those prescribed antipsychotics in one large state system are prescribed 2 or more; half of those are prescribed 3 or more). The compounding burden of sedation, metabolic disruption, and movement disorders can severely impair daily functioning, employment capacity, and quality of life. Critically, no AOT outcome study in the United States has systematically measured or reported on these medication-related harms as outcomes, creating a significant blind spot in the evidence base. The absence of monitoring data is itself a form of harm, as it means individuals under de facto compulsory medication orders lack the evidentiary infrastructure that would normally accompany mandated medical intervention in inpatient or other institutional settings.

Perceived Coercion

Multiple studies document increases in perceived coercion under CTOs/AOT (Swartz et al, 2002; Elbogen et al, 2003). In the only study to examine differences between experiences of a mental health diversion court versus IOC/AOT, the IOC/AOT participants perceived more coercion, less procedural justice (on every single item metric) and more hopelessness following discharge than the mental health court participants (Munetz et al, 2014). Qualitative research from outside the US has begun to document the ways in which the impacts of perceived coercion can undermine trust in the system and self-directed motivation (Corring et al., 2017; 2019). Overall, however, even perceived coercion is under-measured and the literature often treats coercion as a trade-off, not a serious harm in and of itself.

Experiential Harms

In the qualitative literature, AOT/IOC/CTOs have been described as punitive and traumatic (Khalil et al, 2025) and used to bypass consent among minoritized cultural and linguistic groups (Kirikiri et al, 2024). Medication side effects are often experiences as a primary source of distress (Brophy et al, 2019), IOC/AOT as biomedically reductionistic and non-recovery oriented (i.e. focusing primarily on medications; Corring et al., 2017; 2019) and tribunal participation as tokenistic (MacGregor et al, 2022). As we note below, there is only a single US study with a qualitative component exploring relational coercion in the context of AOT, and no qualitative research published to date that explores service users' own experiences of harm and/or benefit.

Housing and Community Conditions

AOT is frequently described as enabling individuals to "live in the community," but the actual community conditions AOT recipients experience deserve scrutiny. In practice, the housing placements available to individuals on AOT orders—including supervised residential facilities, adult homes, and congregate care settings—are often located in high-disadvantage neighborhoods with limited access to nutritious food options, green space, and exercise facilities (cf Chhabra et al., 2020; Klienman et al., 2026; Knight et al., 2014). The residential settings themselves may be highly restrictive, with imposed curfews, limits on visitors, restrictions on leaving the premises, mandatory medication observation, random drug testing and other features more characteristic of institutional care than genuine community living (Boyd et al., 2016). For many AOT recipients, "community placement" represents a transfer from one controlled environment to another rather than meaningful reintegration into community life. And in some states, housing is unavailable even to individuals on AOT orders and there is literally no change in housing status – AOT service teams will visit them on the street and in shelters.

These conditions interact with and compound the medication-related harms described above: metabolic side effects such as weight gain and diabetes risk are worsened by environments with poor nutritional options and limited opportunities for physical activity. Socially impoverished environments further contribute to cognitive decline. The resulting combination—compulsory high-dose medication plus sedentary, nutritionally impoverished living conditions—creates a health environment that may actively undermine physical and mental wellbeing even as it is framed as "treatment."

Virtually Unmeasured

Beyond the specific harms called out above, entire categories of potential harm remain virtually unmeasured in the AOT literature: the extent to which IOC/AOT prescribing conforms to evidence based guidelines; responses to and system responsibility for serious chronic health conditions linked to psychiatric medications; the actual living conditions of individuals on AOT orders mapped out (access to green space or exercise facilities; neighborhood crime and risk indicators; poverty). Long-term identity impacts have never been studied in any country, nor the cumulative burden of repeated orders as they impact identity and sense of self.

Equally notable is what the AOT evidence base does not examine on the putatively positive side. There has been almost no documentation of whether AOT in the United States facilitates access to robust psychosocial rehabilitation—such as supported employment, educational programming, social skills development, or peer support—as opposed to narrowly medication-centered compliance. No U.S. study has examined whether AOT leads to deeper community integration, meaningful social connection, or socioeconomic mobility. The outcome measures used in existing research (hospitalizations, arrests, medication adherence) capture system-level utilization, not whether individuals are actually building lives they value. Until the field measures both harms and meaningful recovery outcomes with equal rigor, the evidence base will remain fundamentally incomplete.

SECTION 4: DIRECT EXPERIENCE & PARTICIPATORY RESEARCH

In the U.S., there is a near-total absence of qualitative research with AOT recipients (Valasek et al. 2025). Only one substantial study, mixed methods rather than fully qualitative, exists and the sample was small (Yanos et al, 2019). The entire foundational evidence base for AOT in the US has been produced without documented lived experience involvement in research design, conduct, or interpretation. Outcome measures reflect professional priorities (readmissions, bed-days, arrests)—not what lived experience/users/survivors often say matters most (dignity, autonomy, trust, side effects, housing, social inclusion).

Recipients consistently describe ambivalence; medication as the narrow primary purpose of the order; side effects as a major source of distress; and trust damaged by the clinician's dual role as therapist/enforcer (Corring et al., 2017). A "third-person effect" has been identified: CTO patients more optimistic about CTOs helping others than themselves (Nakhost et al, 2019).

> *A research field about coercion that does not meaningfully include the voices of those coerced has fundamental bias and legitimacy concerns.*

SECTION 5: LEGAL OVERSIGHT & REFORM

99% of Swedish court decisions agreed with treating psychiatrists (Zetterberg et al, 2014). Only 12% of Scottish CTO applications met minimum documentation standards (Martin et al, 2021). In the U.S., defense attorneys face significant barriers; judges defer heavily to clinical testimony (Player, 2015). Legislative reform has consistently disappointed: Queensland's Committee on the Rights of Persons with Disabilities (CRPD)-influenced law actually increased CTO rates (Gill, 2020); Victoria's 2014 Act reduced CTOs but increased inpatient conversions (Vine et al, 2016).

Unexplained Regional Variation

IOC/AOT rates vary dramatically and are not explained by patient characteristics. NZ shows 4-fold variation across districts. Norwegian areas with lower compulsion show no worse outcomes (Nyttingnes et al., 2023). Norwegian ACT teams varied from 6–52% CTO use, reflecting team culture, not patient characteristics (Stuen et al., 2018). Even in New York State, utilization varies substantially by county, as does use of voluntary service agreements in lieu of AOT (heavily utilized in some counties, never used used in others).

SECTION 6: ALTERNATIVES TO AOT

Maylea et al. (2025) found no research on CTO reduction programs with even a moderate evidence base. ACT without formal coercion, supported decision-making, advance directives, peer led intensive community based support and enhanced voluntary services remain minimally studied.

SYNTHESIS

→ Randomized controlled trial evidence does not support effectiveness—across all jurisdictions studied

→ Marginalized populations face disproportionate coercion without additional benefit

→ Harms are systematically under-measured

→ Consumer experiences are consistent: ambivalence, coercion, often damaged trust

→ Legal oversight and due process frequently fails or falls short — courts defer to clinicians

→ When we look at the degree of regional variation, unexplained by client level factors, IOC/AOT rates driven more by clinical culture than patient need

→ Alternatives remain largely unevaluated

→ Duration claims rest on survivorship-biased observational data

RESEARCH PRIORITIES

Measure harms with equal rigor. Prospective studies addressing mortality, trauma, metabolic effects, social exclusion, social defeat and learned helplessness, help-seeking deterrence and de facto neighborhood segregation and unsafe living conditions.

Center lived experience. Co-produced designs, survivor-led studies, user/survivor-defined outcome measures—especially needed in the U.S.

Address the coercion–services-provider accountability confound. Natural experiments, instrumental variables, ACT-with-IOC vs. ACT-without-IOC comparisons.

Examine structural inequity. Move beyond "upstream" framing; intersectional analyses of race, poverty, housing, and policing as they impact the full pipeline from first contact to AOT or post-AOT services.

Evaluate alternatives with equal investment. Supported decision-making, advance directives, peer-led services, enhanced voluntary care.

The current evidence does not demonstrate that the benefits of compulsory community treatment outweigh its harms and liberty costs.

Should the burden of proof rest with those who advocate for maintaining compulsory community treatment rather than those who question its use?

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