# Involuntary Outpatient Commitment / 'Assisted Outpatient Treatment'

## What the Research Does & Doesn't Tell Us – Deeper Dive Part II

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# Involuntary Outpatient Commitment Recap

A legal mechanism compelling a person determined to be experiencing a “severe mental illness” to accept treatment while living in the community, with the threat of hospitalisation as the primary enforcement tool. Active AOT legislation in 48 U.S. states and 75+ jurisdictions worldwide.

## U.S. Terminology

- Assisted Outpatient Treatment (AOT)
- Involuntary Outpatient Commitment (IOC)
  - Court-ordered; judge signs the order
  - Kendra's Law (NY) is the most-studied program
  - In a few states, involuntary inpatient & outpatient orders are combined – same order used for combination of inpatient and outpatient

## International Terms

- Community Treatment Orders (CTOs)
- Compulsory Community Treatment (CCT)
- Mandated Outpatient Treatment (MOT)
  - Usually clinician-initiated (UK, Aus, NZ)
  - Often involves tribunals (=

# Evidence Base Used in this Presentation

| ~150 | 3 | 3 | 12+ |
|---|---|---|---|
| Sources | RCTs | Cochrane reviews | Countries represented |

### U.S. evidence concentrated in:

North Carolina RCT (late 1990s data)
New York Kendra's Law studies (1999–2011)
Ohio (Mark Munetz/ NEOMED group)
ASPE multi-site evaluation (2024, pre-post design)
N.B. Valasek et al identified 21 peer-reviewed U.S. articles published between 2009–2022; 84 papers reviewed for this presentation

### International evidence concentrated in:

Australia & NZ (large administrative data studies)
UK (OCTET RCT + qualitative studies)
Norway, Sweden, Netherlands (legal reform studies)
Nearly absent from low/middle-income countries
Large within-country variation unexplained by demographics
70 articles reviewed for this presentation

# Part 1: Effectiveness

“does compulsory community treatment work?”

# The Randomised Trial Evidence: Consistently Null

**NYC/Bellevue (Steadman 2001)**

n=142

No significant differences on ANY outcome. Both groups received enhanced services.

**North Carolina (Swartz 1999)**

n=331

No differences in direct comparisons. Post-hoc benefits only for orders >180 days + intensive services (length not randomized)

**OCTET / England (Burns 2013)**

n=336

No differences in any primary outcome or pre-planned sub group analysis

**2017 Cochrane Review conclusion (3 RCTs): No significant difference in any primary outcome expect low level evidence for reduced victimization. Number needed to treat to prevent 1 readmission = 142.**

# The Observational Evidence: A Different Picture

### Pre-post and uncontrolled studies generally show positive results on variables measured (hospitalization rates & days; adherence; violence)

Kendra's Law (NY): 25% reduction in hospitalisation. NZ national data (n=14,726): Reduced admissions during CTO periods. ASPE multi-site (2024): Improved adherence (+25.9%), reduced violence (-19%), reduced suicidal ideation (-24.7%). Canadian, Swiss, and Israeli studies also report reductions in hospitalisation.

### But controlled comparisons show no effect

The Barnett et al. (2018) meta-analysis makes this clear: pre-post comparisons showed large positive effects, controlled comparisons showed none. This pattern holds across both U.S. and international literature

## Why the difference? Primary explanations in the literature

### Regression to the mean

People are placed on CTOs/AOT during crises (and periods of instability leading up to crisis). After a crisis, most people improve regardless of treatment. Comparing before vs. after a crisis will almost always show improvement — this is not a treatment effect.

### Coercion–services - accountability confound

AOT/CTO recipients receive enhanced services (more contacts, prioritized resources, provider side mandates & accountability). In the one RCT where BOTH groups received enhanced services (NYC), no differences emerged. Benefits may come from the services, not the legal mandate.

# Additional Explanations

**Administrative Measure Validity Concerns**

- Harms are rarely measured, leading to similarity with matched services without the ability to identify potential negative effects of IOC/AOT in areas such as financial disempowerment; “institutionalization” in IMDs, group homes & supervised residential programs; medication side effects and iatrogenic conditions such as Parkinsonism, obesity and diabetes, cognitive decline; social defeat
- Some outcomes *are* a direct result of heightened coercion / confounded with the intervention itself (e.g. medication adherence while on an IOC order – but does this matter if it doesn’t lead to significant reduction in distressing symptoms?)

**Self-Report Validity & Reliability Concerns**

- Self report under conditions of coercion is always suspect – individuals facing consequences if they speak out, appear “non-adherent” etc likely to conceal concerns + behavior
- Clinician reported outcomes also suspect – IOC/AOT clinicians who are also judged / held accountable for outcomes likely to mis-report

# More on Methods Limitations: What We Can and Can't Conclude

### The RCTs are limited

Only 3 – all older; inherent limitations of recruitment, ethics and capacity to consent in the context of AOT

### Observational studies can't establish causation

Pre-post designs show improvement due to regression to the mean; matched comparisons depend on very limited variables -- neither can truly isolate the court order's effect

### In general, administrative data misses what arguably matters most (well-being, community integration)

Most large studies rely almost wholly on routinely collected administrative and/or clinical data: hospitalizations; bed-days; arrests; offending

### Follow-up is too short

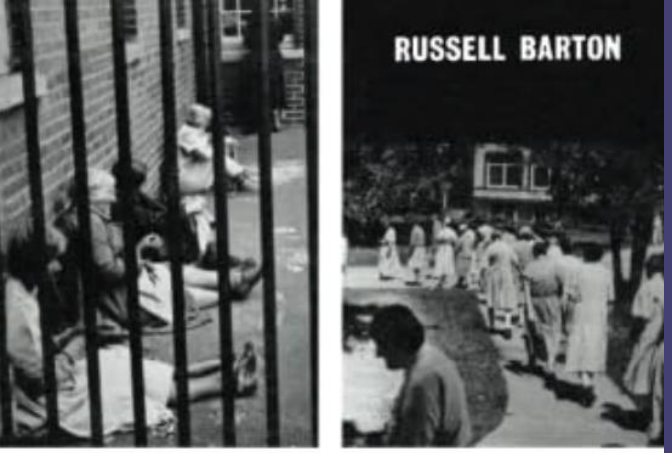
Most studies follow patients for 12 months; claims of benefit after 2+ years (e.g. Duke RCT; Kisely 2021) rest on observational data subject to survivorship bias — patients still on CTOs after 2 years are those who didn't drop out, die, or get discharged

# The Duration Question: Does Longer Compulsion Work Better?

**The claim:** Some studies suggest CTOs/AOT work if maintained long enough. The Duke (North Carolina) RCT found benefits only for orders sustained >180 days + intensive services. Kisely et al. (2021) meta-analysis found some evidence of benefit after 2+ years

### Limitations of the duration hypothesis

- Survivorship bias: patients still on CTOs at 2+ years are a selected group — those who died, were discharged, or disengaged are excluded
- Confounding by compliance: patients who accept long-term orders may be fundamentally different from those who don't (esp in countries in which escape from an AOT order only requires crossing a state or county line)
    - Confounds compounded by use of very limited admin/clinical outcomes -- & failure to measure social defeat
- Cossu et al. (2024) systematic review found adherence generally DOES NOT persist after CTOs end —calls into question whether compulsion produces lasting change in the way advocates desire it to
- No study has compared the effect of long-duration CTOs to long-duration enhanced voluntary services



RUSSELL BARTON



# INSTITUTIONAL NEUROSIS

SECOND EDITION

J. K. WING & G. W. BROWN

# Institutionalism and Schizophrenia

A COMPARATIVE STUDY OF THREE MENTAL HOSPITALS 1960-1968

CAMBRIDGE UNIVERSITY PRESS



# The New Asylums in the Communi

H. Richard Lamb, MD

• **One-hundred and one residents of a board-and-care home housing psychiatric patients were studied. Of these, 92% were diagnosed as psychotic; 42% have lived there five years or more; and 32% have overt major psychopathologic characteristics. Nine of ten have never lived alone or failed in their last attempt.**

**A relationship was found between use of a community social rehabilitation program and its distance and provision of transportation. Sixty-one percent have had contact with community vocational rehabilitation but only 12% are still involved. Half of them have no goals for changing anything in their lives; 95% use community facilities, mostly eating places and supermarkets.**

**Board-and-care homes offer an asylum from life's pressures, a degree of structure, and some treatment, especially medication supervision. For many long-term patients they have taken over the functions of the state hospital.**

**(*Arch Gen Psychiatry* 36:129-134, 1979)**

The controls and structure of the state hospital may have been necessary for many of the long-term mentally ill before the advent of modern psychoactive drugs. Unfortunately, the ways in which this structure was achieved and the everyday abuses of state hospital life have left scars on the mental health professions as much as on the patients. In any case, when the new drugs appeared[1,2] along with a new philosophy of social treatment,[3] the great majority of the chronic psychotic population was left in an environment that was no longer necessary or appropriate for them. But that didn't mean, as many first thought, that most were now ready to become well-functioning members of the community. There may now be less overt psychosis and less need for external controls, but the questions still remain: to what extent can

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From the Department of Psychiatry, University of Southern California School of Medicine, Los Angeles.

Reprint requests to Department of Psychiatry, University of Southern California School of Medicine, 1934 Hospital Pl, Los Angeles, CA 90033 (Dr Lamb).

the chronically ill cope with pre
interaction with others, and hav
dealing with their psychoses and
world? In particular, what has be
in board-and-care homes, those p
that have sprung up to fill the
emptying out of state hospital
medium-sized California county s
ly one third of the long-term ps
community younger than 65 yea
nosed as psychotic live in board-
extent are the lives of these pati
illnesses and by their environme
they been offered treatment and
have been the results? How do th
And what are their concerns?

To begin to answer these que
focused on 101 persons living i
about 2 miles from the downtown
primary method of study was i
views with each person, all done

## THE SETTI

Board-and-care home is a ter
describe a variety of facilities, m
numbers of psychiatric patients.
ranges from one to several hund
the State licensing agency, the m
Angeles are housed in facilitie
Board-and-care homes are unloc
room, three meals a day, supervi
minimal staff supervision.

A board-and-care home was so
following criteria: large enough
sample, licensed for younger th
board-and-care homes are licens
older, or younger than age 65),
would both permit and cooperate

way they are treated, both good and bad. To quote one of the more aware patients who had recently come from a board-and-care home now closed by the state licensing agency, "If you are housed in a dilapidated, poorly maintained building, fed poor-quality food, and treated impersonally by the staff, you cannot help but feel that you aren't worth much, for otherwise you would not be treated that way." It does immeasurable damage to the residents'

Half the persons (52%) living in this board-and-care home have no goals to change anything in their lives. And this lack of motivation is even greater in those older than 30 years of age and in those with a lifetime history of six months of hospitalization or more.

or convents. Many writers, however, have referred particularly to a form of behavioural reaction which is said to occur frequently among individuals who have remained for prolonged periods in certain types of segregated community. Bettelheim & Sylvester (1948), for example, described an institution in which a rigid, comprehensive and impersonal regime allowed no scope for individual decisions on the part of the inmate children and, demanding only their compliance, led to emotional apathy, lack of spontaneity, and an incapacity for active adjustment to events which were commonplace to non-institutionalized children. Similar terms have been used to describe the effects of prisons, tuberculosis sanatoria, mental hospitals, and homes for old people, and Titmuss (1958) has indicated the same tendencies in some general hospitals. The effects of prolonged incarceration in segregated communities have been described in detail in numerous novels and descriptive works, again with remarkable agreement on such details of the syndrome as apathy, resignation, dependence, depersonalization, and reliance on fantasy. It

# Alternatives To AOT: A Major Gap in our Understanding of Non-Coercive Approaches?

Maylea et al. (2025) searched specifically for successful CTO reduction programmes and found none with even a moderate evidence base: research on alternatives to outpatient compulsion tiny in comparison to the body of research on IOC

**What has been studied (briefly):**

### ACT without formal coercion

Stuen et al. (2018) found Norwegian ACT providers valued the model for building rapport but saw 'few alternatives to CTOs as long-term measures.' ; ACT model often used in IOC/AOT, but no study has rigorously compared randomization to ACT-with-CTO vs ACT-without-CTO.

### Supported decision-making

Brophy et al. (2019): SDM 'may contribute to reducing CTO use' but requires system-wide transformation; Wergeland et al. (2022) reports on Norway's capacity-based legislation documented major challenges in implementation.

### Advance directives / joint crisis plans

De Waardt et al. (2025): Dutch stakeholders emphasised advance dialogues and joint crisis plans as essential preconditions for any compulsory treatment but there is no associated empirical evaluation

### Enhanced voluntary services

Starkd et al (2020) and other CA evaluations document high rates of voluntary service agreement instead of IOC; nuy in the US, almost no

# Part 2: Racial, Ethnic and Cultural & Linguistic Minority Disparities

disproportionate coercion without disproportionate benefit

# The Numbers: Disproportionate Application Across Jurisdictions

**11x**

Black vs White CTO rates (England)

Kisely 2024

**3x**

Māori vs Caucasian CTO rates (New Zealand)

Lees et al. 2023

**40-66%**

Higher odds for CALD groups (Australia)

Kisely et al. 2021 (meta-analysis)

**2.8x**

Interpreter users' odds of CTO (Queensland)

Moss et al. 2019

**NO study finds that overrepresented groups derive additional or greater benefit from IOC**

Ahmad et al. (2025) scoping review: 43 studies included; only 9 directly focused on race/ethnicity & IOC (2001-2023; global review). Results were mixed and varied by design, population and jurisdiction – many with multiple limitations and a narrow conceptualization of ethnoracial disparitites/inequality

--Most of this research comes from Australia and New Zealand, focused on Mairi & Aboriginal communities

--Comparatively, US literature is markedly smaller and less developed

# Primary Framing of Racial Disparities in the IOC Literature

## U.S.: "Upstream" Framing

Swanson et al. (2009): Within the target eligible population (people with multiple involuntary hospitalisations), Black and White AOT rates are similar. The disparity is 'upstream' — in who enters the involuntary system

Galon (2012): No in-program racial bias in OPC application

## International: Population-Level Documentation

Multiple studies show CALD/Indigenous populations face higher CTO rates even after controlling for clinical variables:

- Kisely & Xiao 2018: Gradient by country of birth
- Kisely et al. 2019: Indigenous +45%, CALD +54%
- Moss et al. 2019: Interpreter use +176%
- Lees et al. 2023: Māori 3x+ rates, NOT explained by demographics

Neither approach adopts a deeper structural approach – examining how race, poverty, housing, policing, and service access interact to produce disproportionate coercion spanning pathways into & through IOC/ AOT

# Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites

Kelly M. Hoffman[a,1], Sophie Trawalter[a], Jordan R. Axt[a], and M. Norman Oliver[b,c]

[a]Department of Psychology, University of Virginia, Charlottesville, VA 22904; [b]Department of Family Medicine, University of Virginia, Charlottesville, VA 22908; and [c]Department of Public Health Sciences, University of Virginia, Charlottesville, VA 22908

Edited by Susan T. Fiske, Princeton University, Princeton, NJ, and approved March 1, 2016 (received for review August 18, 2015)

**Black Americans are systematically undertreated for pain relative to white Americans. We examine whether this racial bias is related to false beliefs about biological differences between blacks and whites (e.g., "black people's skin is thicker than white people's skin"). Study 1 documented these beliefs among white laypersons and revealed that participants who more strongly endorsed false beliefs about biological differences reported lower pain ratings for a black (vs. white) target. Study 2 extended these findings to the medical context and found that half of a sample of white medical students and residents endorsed these beliefs. Moreover, participants who endorsed these beliefs rated the black (vs. white) patient's pain as lower and made less accurate treatment recommendations. Participants who did not endorse these beliefs rated the black (vs. white) patient's pain as higher, but showed no bias in treatment recommendations. These findings suggest that individuals with at least some medical training hold and may use false beliefs about biological differences between blacks and whites to inform medical judgments, which may contribute to racial disparities in pain assessment and treatment.**

racial bias | pain perception | health care disparities | pain treatment

These disparities in pain treatment could reflect an overprescription of medications for white patients, underprescription of medications for black patients, or, more likely, both. Indeed, there is evidence that overprescription is an issue, but there is also clear evidence that the underprescription of pain medications for black patients is a real, documented phenomenon (1, 4). For example, a study examining pain management among pa-

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RESEARCH ARTICLE

# Racial Bias in Neural Empathic Responses to Pain

Luis Sebastian Contreras-Huerta, Katharine S. Baker, Katherine J. Reynolds, Luisa Batalha, Ross Cunnington

Published: December 23, 2013 • https://doi.org/10.1371/journal.pone.0084001

Article | Authors | Metrics | Comments | Media Coverage



## Abstract

Recent studies have shown that perceiving the pain of others activates brain regions in the observer associated with both somatosensory and affective-motivational aspects of pain, principally involving regions of the anterior cingulate and anterior insula cortex. The degree of these empathic neural responses is modulated by racial bias, such that stronger neural activation is elicited by observing pain in people of the same racial group compared with people of another racial group. The aim of the present study was to examine whether a more general social group category, other than race, could similarly modulate neural empathic responses and

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Volume 43, Issue 8, November 2017, Pages 789-812

https://doi.org/10.1177/0095798417690055

*Article*

# The Role of Racial Identity and Implicit Racial Bias in Self-Reported Racial Discrimination: Implications for Depression Among African American Men

**David H. Chae[1], Wizdom A. Powell[2], Amani M. Nuru-Jeter[3], Mia A. Smith-Bynum[4], Eleanor K. Seaton[5], Tyrone A. Forman[6], Rodman Turpin[4], and Robert Sellers[7]**

**Abstract**

Racial discrimination is conceptualized as a psycho
mental health. However, factors related to racial ide
are interpreted as instances of racial discriminatio
instruments, particularly given the ambiguous nat
dimensions of racial identity may moderate associ
health outcomes. This study examined relationshi
implicit racial bias, and depressive symptoms among
of age ($n$ = 95). Higher racial centrality was associ
while greater implicit anti-Black bias was associated with lower reports of racial discrimination. In models predicting elevated depressive symptoms, holding greater implicit anti-Black bias in tandem with reporting lower racial discrimination was associated with the highest risk. Results suggest that unconscious as well as conscious processes related to racial identity are important to consider in measuring racial discrimination, and should be integrated in studies of racial discrimination and mental health.

"In models predicting elevated depressive symptoms, holding greater implicit anti-Black bias in tandem with reporting lower racial discrimination was associated with the highest risk. "

# Black Americans and Schizophrenia: Racism as a Driver of Inequities in Psychosis Diagnosis, Assessment, and Treatment

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African American

Black Americans are 2.42 times more like
schizophrenia than their white counterparts
disparity that is generally attributed to the
structural racism (e.g., cumulative trauma,
discrimination (e.g., harassment by police), an
diagnostic process (Anglin et al., 2021; Eack et
Schwartz and Blankenship, 2014). Multifacete
also contributes to worse outcomes observed
schizophrenia, as indexed by incarceration,
ment, and psychiatric hospitalizations (Nage
et al., 2014; Rosenheck et al., 2006). Desp

RESEARCH & ANALYSIS

# Structural Racism and Inequities in Incidence, Course of Illness, and Treatment of Psychotic Disorders Among Black Americans

*Supriya Misra, ScD, Onisha S. Etkins, PhD, Lawrence H. Yang, PhD, and David R. Williams, PhD*

, schizophrenia, schizoaffective disorder) are a leading cause of
ortality and an overlooked health inequity in the United States.
uities in incidence, severity, and treatment of psychotic disorders,
munities, that appear to be primarily attributable to social
S narrative is that any observed differences are primarily a result
nosis.
ing the framework of structural racism will prompt European and
nd consider the multifaceted drivers of inequities in psychotic
Americans. In particular, we describe how historical and
(1) racialized policing and incarceration, and (2) economic
nt, which are already linked to other psychiatric disorders, likely
iences of psychotic disorders among Black Americans.

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# The weaponization of medicine: Early psychosis in the Black community and the need for racially informed mental healthcare

Sonya C. Faber[1]*, Anjalika Khanna Roy[2], Timothy I. Michaels[3,4] and Monnica T. Williams[5]*

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There is a notable disparity between the observed prevalence of schizophrenia-spectrum disorders in racialized persons in the United States and Canada and White individuals in these same countries, with Black people being diagnosed at higher rates than other groups. The consequences thereof bring a progression of lifelong punitive societal implications, including reduced opportunities, substandard care, increased contact with the legal system, and criminalization. Other psychological conditions do not show such a wide racial gap as a schizophrenia-spectrum disorder diagnosis. New data show that the differences are not likely to be genetic, but rather societal in origin. Using real-life examples, we discuss how overdiagnoses are largely rooted in the racial biases of clinicians and compounded by higher rates of traumatizing stressors among Black people due to racism. The forgotten history of psychosis in psychology is highlighted to help explain disparities in light of the relevant historical context. We demonstrate how misunderstanding race confounds attempts to diagnose and treat schizophrenia-spectrum disorders in Black individuals. A lack of culturally informed clinicians exacerbates problems, and implicit biases prevent Black patients from

## Racial and Ethnic Inequities in Inpatient Psychiatric Civil Commitment

Timothy Shea, M.D., Samuel Dotson, M.D., Griffin Tyree, M.D., M.A.S., Lucy Ogbu-Nwobodo, M.D., M
Derri Shtasel, M.D., M.P.H.

**Objective:** Involuntary psychiatric treatment may parallel ethnoracial inequities present in the larger society. Prior studies have focused on restraint and seclusion, but less attention has been paid to the civil commitment system because of its diversity across jurisdictions. Using a generalizable framework
psychiatric commit

**Methods:** A prospe
admitted to an in
(2012–2018). Patien
out their admission
Sociodemographic
for confounding v
regression.

**Results:** Of the 4,
during the study pe
Black, 10% as prima

3% as another race or multiracial. In
involuntarily admitted, and court
were filed for 7%. Compared with W
White groups were more likely to be
and Black and Asian patients were m

## Understanding Involuntary Hospitalization Applications Submitted to an Urban Police Department

Kevin M. Simon, M.D., M.P.H., Jenna Savage, Ph.D., Lauryn Krebs, M.A., Trinity Wegiel, Melissa S. Morabito, Ph.D.

the application
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Boston, the au-
Police Depart-
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30, 2022. The
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data were based on police perceptions, and 21% of cases lacked race-ethnicity data. Seventy-six percent of applications were submitted without a direct clinical examination by petitioners, who did not justify the omission. The Boston PD completed 70% of the requested involuntary hospitalization orders.

**Conclusions:** This study identified substantial racial disparities in Section 12 applications, which disproportionately involved Black or African American individuals. The frequent absence of direct clinical examinations before application submissions and the lack of justification indicated a need for regulatory oversight and enhanced petitioner training. In-
demographic data underscored the need for
ata collection and reporting practices. These
hlight the need for reforms to ensure equitable,
and best practice–aligned involuntary hospi-
ocesses.

vices 2025; 76:120–125; doi: 10.1176/appi.ps.20230411

## Race, History of Abuse, and Homelessness Are Associated With Forced Medication Administration During Psychiatric Inpatient Care

TINA E. THOMAS, MBBS, MRCPsych
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RANIA M. ELKHATIB, MD
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TERESA A. PIGOTT, MD

***Objective:*** **Although previous research has suggested that racial disparities exist in the administration of forced medication (FM) in psychiatric inpatients, data remain scarce regarding other contributing variables. Therefore, this study examined sociodemographic and clinical variables associated with FM administration in psychiatric inpatients.**

***Methods:*** **Electr
patients admitt
hospital betwee
to identify pat
records indica
requested and
Patients were
they met the fo
18 years of
developmental
neurological co
nonpsychiatric
stance-induced
After data on th
final sample inc
(4.5% of the tot
istration of FM
The FM group was compared with a control group of 2569 patients matched in terms of age,**

***Discussion:*** **These results suggest that FM is more likely to be instituted in psychiatric inpatients who are of a minority race (African American), are in a homeless living situation, and/or have a history of abuse. Moreover, FM may be associated with poorer clinical outcomes at least as measured by the length of stay and higher readmission rates. We**

American population. Studies have found that African

"African American race, homelessness, and a history of trauma were [each] significantly associated with forced medication administration during inpatient hospitalization [controlling for other demographic characteristics]"

# Focus: Indigenous Perspectives — Māori in Aotearoa New Zealand

### The data (Beaglehole et al. 2024, Lees et al. 2023)

34% of CTO recipients were Māori (vs 17% of population). Māori are younger, spend longer under compulsion, more likely to have psychotic disorder diagnosis. 22% of Māori CTO recipients were under 18 (vs 12% non-Māori). Non-Māori received MORE depot antipsychotic medication on CTOs than Māori — raising questions about treatment equity. Mortality rate ratio during CTOs: 1.71 for Māori (vs 1.16 for non-Māori).

### The voices (Kirikiri et al. 2024 — led by a Māori researcher)

Five themes: CTOs as restrictive and stigmatising; poor information about CTO structures; CTOs as mechanism to circumvent consent; CTOs as mandating support; CTO status as unimportant. Participants described interpersonal and structural racism, lack of Māori mental health workers, and a system that did not prioritise culturally appropriate care. Novel finding: CTOs used to BYPASS informed consent requirements.

### The obligation

Te Tiriti O Waitangi principles require equity of health outcomes for Māori, active protection, and Māori self-determination in health service design. Authors call for Kaupapa Māori health services offering alternative treatment options.

# Racial Inequity in IOC/AOT

Excess force against Black Americans is likely at every stage of the service system pipeline

1. **Social Determinants** — Segregation, poverty, policing intensity
2. **Crisis Pathway & ED** — Emergency eval, MOO & restraint disparities
3. **Diagnostic Bias** — Racialized schizophrenia diagnosis
4. **Hospitalization Cycling** — Cumulative coercion each admission

IOC/AOT

5. **Referral Discretion** — Violence risk perception, implicit bias
6. **Court Order** — Authorizes future law enforcement force
7. **Enforcement & Experience** — Monitoring, pick-up orders, rehospitalization

● Bias or disproportionality documented directly or via known mechanism

● Structural pipeline (1–4) ● AOT system (5–7)

**38%** Black in NY AOT (vs. 17.6% pop.) **2** articles on race, 2009–2022

## Key Distinctions

**Referral racial bias in IOC/AOT**: is there discrimination at the referral decision? The literature finds inconclusive evidence (Swanson 2009 vs. Galon 2012).

**Racial inequity (re)produced through AOT**: does AOT, operating downstream of racially structured systems, concentrate coercive authority on a population that is disproportionately Black and Brown *as a result* of and further reinforcing those prior inequities and their ongoing sociostructural underpinnings?

**And is excess force applied at every stage?** Evidence consistently suggests yes, providing mechanisms at all key junctures

### ● Emergency evaluation

Black race associated with physical and chemical restraint — controlling for clinical presentation.

*Eswaran et al 2023; Smith et al 2022; Schnitzer et al 2020; Thomas et al 2020*

### ● Commitment enforcement

Law enforcement kill Black Americans with perceived mental illness at significantly greater rates. IOC court orders authorize police transport for non-adherence.

*Shadravan et al 2021; Saleh et al 2018; Watson & El-Sabahi 2023; Thomas et al 2021*

### Why those impacted may not explicitly identify this as racism

Force is administered by personnel following institutional protocols & often experienced as standard procedure not racial targeting. Standard clinical framing tends to render excess force (MOO, restraints, police removals) invisible as racial force, even as it is applied disproportionately. Oppressive conditions tend to be internalized (documented across the Globe & central to many theories of collective consciousness raising). This is precisely how structural racism functions.

*Studies that 'control for' diagnosis, hospitalization history, and clinical severity are controlling for the very pathways through which structural racism — including racially disparate force — operates.*

# Summary and Recap: U.S. Racial Equity - What We Do & Don't Know

**The U.S. literature's engagement with race is limited and largely defensive**

No study examines whether AOT — as actually practised across diverse jurisdictions — disproportionately subjects Black, Latinx, and Indigenous individuals to state coercion, including disparate determinations of "non-compliance" during an IOC order, disparate police involvement & use of force in police "removals", commitment & medication-over-objection while on IOC

- Swanson 2009 is the **only** detailed U.S. analysis of racial composition — from a single programme (Kendra's Law)
- Galon 2012 examined one site (n=154) — too small to detect meaningful differences
- Gonzales 2015 found no measurable differences between those referred to AOT and those NOT referred — suggesting at least some degree of arbitrariness in selection (and a set-up for racial bias to play out)
- Wahbi 2022 provides one of the only US –based structural/abolitionist analysis — but theoretical work, not empirical
- **No U.S. study examines differential health outcomes by race under AOT; how AOT intersects with policing, housing, and poverty; experiences of Black, Latinx, Indigenous, or immigrant AOT recipients; whether AOT deterrs voluntary help-seeking differentially by race**
- Higher perceived coercion among African Americans under OPC (Swartz 2002) has **never been followed up** with in-depth qualitative or mixed methods work necessary to tease out underlying mechanisms and effects

**This "don't know" / haven't investigated it" is structural racism too**

# Part 3: Harms

single most prominent and systemic blind spot in the evidence base

# Harms: What's Measured, What's Not

*"Any possible harms were under-researched, particularly in quantitative designs" — Kisely et al. 2024; Umbrella Review*

### Mortality

Beaglehole 2023: 29% higher mortality during CTO periods (rate ratio 1.29). Accidents/assaults: 73% higher (RR 1.73). Māori mortality on CTOs: 1.71 HIGHER. No comparable U.S. studies. Morandi 2024: 13% of Swiss CTO patients died during the study period (but no control group).

### Perceived coercion (measured but not foregrounded)

Consistently increased by CTOs/AOT (Swartz 2002, Elbogen 2003). Munetz 2014: IOC/AOT participants perceive significantly MORE coercion than AOT recipients and more hopelessness after (Munetz) - but literature often treats coercion as a trade-off, not a harm in its own right

### Experiential harms (qualitative only)

Khalil 2025: CTOs described as punitive, potentially contributing to trauma. Kirikiri 2024: CTOs used to bypass consent. Brophy 2019: Medication side effects a primary source of distress. Macgregor 2022: Tribunal participation experienced as tokenistic

### What is virtually unmeasured

Metabolic/physical health effects of compulsory medication & iatrogenic health conditions; damage to future help-seeking & self-determination; social exclusion, stigma & social defeat; “institutionalization” and long-term identity impacts; cumulative burden of repeated orders over a lifetime

# Unmeasured Structural Harms

- Further coupling of dangerousness, risk & ‘serious mental illness’ (administrators, legal system, general public)
- Force/coercion communicated as primary strategies of “treatment,” branded as compassion
- Workforce de-skilling (someone doesn’t ‘comply’ – threaten or force them as the solution)
- Civil rights deprivation as justification for provider-side accountability (and this gets normalized)
- Monetary & social/political disinvestment in true social integration / recovery oriented / trauma informed continuum of support & care

# Part 4: Direct Experience and Participatory Research

whose perspectives shape the existing evidence base?

# The Qualitative Evidence Gap

*"Who's talking about us without us?" — Brosnan (2018), survivor researcher*

### U.S.: Near-total absence

Only 1 substantial qualitative study with AOT recipients (Yanos 2019, small NYC sample). Player 2015 captures attorney perspectives, not client voices. Coercion studies (Swartz 2002, Elbogen 2003) use standardised instruments that measure perceptions but cannot capture meaning, context or internalized low expectations/adaptive processes/internalization. Corring 2017 systematic review: 22 qualitative studies, mostly from UK/Australia/NZ — NOT the U.S.

### International: Richer but still limited

~20+ qualitative studies across UK, Australia, NZ, Canada, Norway, Netherlands. Multi-perspective studies include patients, carers, clinicians. But: most involve small samples. None use longitudinal qualitative methods. Meaningful service user/survivor involvement in research design is the rare exception, not the rule.

### What direct recipients consistently say (across ALL jurisdictions)

Ambivalence: compulsion may have helped during crises BUT experienced as coercive. Prefer community compulsion to hospitalisation, but both are coercive. Medication is the perceived primary purpose; side effects are a major source of distress. Trust is central — and often damaged by clinician's dual role as therapist/enforcer. Third-person effect: CTO patients more optimistic about CTOs helping OTHERS than themselves (Nakhost 2019).

# Lived Exp Involvement in Research: Rhetoric vs Reality

## What's missing

The entire foundational evidence base — 5 RCTs, 3 Cochrane reviews, Kendra's Law evaluation, ASPE report, all major meta-analyses — was produced without documented consumer involvement in research design, conduct, or interpretation. Outcome measures reflect PROFESSIONAL priorities (readmissions, bed-days, arrests) not what CONSUMERS say matters (dignity, autonomy, trust, side effects, housing, social inclusion).

## Exceptions in the international literature

Brophy et al. (2018, 2019): Consumer researchers on team
Maylea et al. (2025): Consumer academics as co-authors
Kirikiri et al. (2024): Māori researcher leading Māori-focused study using Kaupapa Māori principles
Brosnan (2018): Survivor researcher perspective / critical commentary
Brophy (2013): Articulation of emancipatory social work values guiding IOC/AOT research

## Virtually absent in U.S. literature

No U.S. AOT study reports lived exp co-design or co-production of research
No survivor-led research on AOT in the U.S.
The ASPE evaluation was designed by RTI International, PRA, and Duke — no lived exp representation documented (or even noted as a limitation)
This matters: a genuinely co-produced research agenda would likely ask very different questions and measure very different outcomes

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

# Part 5: Legal Oversight and Reform

safeguard or rubber stamp?

# Legal Oversight: Consistent Cross-Jurisdictional Concerns

**99%** of Swedish court decisions agreed with treating psychiatrists — courts failed to meet standards of procedural fairness (Zetterberg 2014)

**12%** of Scottish CTO applications met the minimum standard for documenting the key legal criterion (SIDMA) (Martin 2021)

**20%** of Victorian tribunal hearings resulted in shorter orders — linked to patient/support person attendance (Taylor-Sands 2021)

U.S. parallel: Player (2015) found defense attorneys face significant barriers in AOT hearings; judges defer heavily to clinical testimony — 'more rubber stamp than genuine adjudication'

**Legislative reform consistently disappoints**

Queensland's CRPD-influenced legislation INCREASED CTO rates (Gill 2020); Victoria's 2014 Act reduced CTOs but increased inpatient conversions (Vine 2019).

# Unexplained Regional Variation: Supply-Side Drivers

## The pattern

NZ: Nearly 4-fold variation across DHBs (53–184 per 100,000) NOT explained by demographics (Lees 2023). Australia: 66–113 per 100,000 across states (Kisely 2024). England: CTO use varies 1.1%–20.2% of patients across trusts (Lei 2019). U.S.: 48 states authorise AOT but many rarely use it; NY's programme is exceptionally well-resourced and even then huge variation across counties (from ultra-minimal use to extensive implementation). Involuntary inpatient use also hugely variable across US (Lee & Cohen 2021).

## What this tells us

Variation driven by clinical cultures, local resources, and practitioner preferences — NOT patient need / justification. Nyttingnes et al. (2023): Norwegian areas with LOWER involuntary care levels showed NO worse patient outcomes. Stuen et al. (2018): Norwegian ACT teams varied from 6% to 52% of patients on CTOs — reflecting team culture, not patient characteristics

## Implication

If areas with lower compulsion do not show worse outcomes, then higher-use areas may be subjecting patients to unnecessary harm Understanding what enables some services to function with lower coercion — and supporting others to learn from them — may be the most productive path forward

# What the Combined Evidence Tells Us

- Controlled evidence does not support effectiveness on standard outcomes — across all jurisdictions and legal frameworks
- Marginalised populations are disproportionately subject to orders without additional benefit — consistent with structural discrimination
- Harms are systematically under-measured, creating a fundamental imbalance in the evidence base
- Consumer experiences are remarkably consistent across countries: ambivalence, coercion, narrow medication compliance focus, damaged trust
- Legal oversight frequently fails to provide genuine protection — courts and tribunals defer to clinicians
- IOC/AOT rates are high, rising in many countries, and seemingly driven more by clinical culture than patient need
- Alternatives to compulsory treatment remain unevaluated — including ACT without formal coercion
- Duration claims rest on observational data with survivorship bias, and adherence does not persist post-CTO

# What We Still Don't Know

- Does compulsory community treatment CAUSE mortality — or merely correlate with greater severity?
- What specific mechanisms drive any observed outcomes — legal leverage, service intensity, compulsory medication adherence, clinical monitoring, social defeat / institutionalized apathy/compliance?
- Do harms outweigh benefits when BOTH are comprehensively measured?
- Why do some clinicians and services rely heavily on compulsion while others do not?
- What would happen to patients currently on CTOs/AOT if systematically offered enhanced voluntary services that were truly “high quality” (person centered trauma informed) instead?
    - And what if we prevented harm upstream through services that from first point of contact ensured authentically humanizing, trauma informed, non-coercive support?
- Should the consistent null RCT findings be dismissed as readily as they have been in the US?
- How does compulsory treatment interact with race, poverty, housing, policing, and service access?
- How do people subject to long-term / repeat IOC experience its effects on identity, relationships, and recovery over time?
- Can ACT, intensive community supports, supported decision-making, or peer-led services such as INSET achieve equivalent or better outcomes without the legal mandate?

# Research Priorities Going Forward

## Measure harm with equal rigor

Prospective studies with validated instruments — mortality, trauma, metabolic effects, social exclusion, help-seeking deterrence. Hofstad (2023) Norwegian protocol provides a potential template for one valuable approach (= “By using the natural variation in health providers' preference for compulsory care as a source of quasi-randomization we will estimate causal effects of compulsory care on short- and long-term trajectories.”

## Center lived experience

Co-produced research designs, survivor-led studies, outcome measures reflecting what matters to people under orders; especially needed in the U.S., which has almost no qualitative data

## Address the coercion–services--provider accountability confound

Natural experiments, instrumental variable approaches (Hofstad 2023), stepped-wedge designs exploiting policy variation. Compare ACT-with-IOC to ACT-without-IOC

## Examine structural inequity

Intersectional analyses of how race, poverty, housing, and policing produce disproportionate reliance on compulsion; move beyond 'upstream' framing to examine AOT/CTOs as mechanisms operating within (and reinforcing) systems of inequality

## Evaluate alternatives with equal investment

Supported decision-making, advance directives, peer-led outreach and support services, enhanced voluntary community care — tested with the same rigour (and financial resources) applied to compulsory approaches

# Closing (rhetorical?) question: Should the burden of proof should rest with those who advocate for maintaining compulsory community treatment rather than those who question its use?

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

Interested in access to AOT/IOC Research Articles? Future Research and Evaluation Reports? Advocacy Resources? Fill out this form!