Research Protocol for Involuntary Outpatient Commitment Laws

Prepared by the Policy Surveillance Program Staff

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Involuntary Outpatient Commitment Laws

I. **Date(s) of Protocol:** June 1, 2015, August 15, 2015, March 1, 2016

II. **Scope:** Compile state statutes and regulations governing involuntary outpatient commitment (“outpatient commitment”) and its impact on patients’ right to refuse medication, firearm possession, and mental health reporting. While this dataset was originally cross-sectional, in the March 2016 update it became longitudinal, and now captures all relevant laws in effect from January 1, 2000 through March 1, 2016.

This dataset includes coding questions on who can initiate outpatient commitment, the criteria for outpatient commitment, a patient’s right to refuse medication, discharge planning, whether jurisdictions require mental health reporting, and limitations on gun possession rights for individuals who are or have been in outpatient commitment.

III. **Primary Data Collection**

a. **Project Dates:** Legal research was conducted between June 1, 2015 and August 14, 2015.

b. **Dates Covered in the Dataset:** January 1, 1996 to August 1, 2015. Because the study is a cross-sectional dataset intended to capture present-day law, there may be laws within the individual entries that were enacted prior to January 1, 1996; however, these laws are all still effective. Thus, the “effective date” is the date of the most recent law within each entry.

c. **Data Collection Methods:** The LawAtlas Legal Team (“Team”) building this dataset consisted of two legal researchers (“Researchers”), two managers (“Managers”), and one supervisor (“Supervisor”). Secondary sources and a subject matter expert were also used to compare and contrast collected or missing state law.

d. **Databases Used:** Searches were conducted using WestlawNext or LexisAdvance and state-specific legislature websites. Full text versions of the laws were collected and pulled from state legislature websites. Other sites such as Google, GoogleScholar, and HeinOnline provided additional secondary and primary literature. Legal text was pulled from sources such as state legislative websites or Justia.
e. **Search Terms:** The following search terms were used to capture the laws coded in the dataset:

- “Outpatient”
- "Outpatient Treatment"
- "Assisted Outpatient Treatment"
- "Outpatient basis"
- "Outpatient therapy"
- "Involuntary Outpatient Commitment"
- "Involuntary Outpatient Commitment"
- "Involuntary Hospitalization"
- convalescent release
- convalesc!
- "mental illness" /p definition
- patient treatment rights /p mental
- mental!
- "adv: compulsive force! medication"
- "Informed consent right to refuse"
- "Patient treatment rights /p refuse"
- "Medication Administration"
- "Medication administration patient rights"
- "patient treatment rights /p mental"
- "patient treatment rights /p medication"
- medication administration patient rights "Firearm possession"
- “Firearm disability”
- “mental” within “firearm”
- "Firearm possession /p mental"
- "National Instant Criminal Background Check System"
- "patient treatment /s rights /p mental"
- "medication administration"
- "National Instant Criminal Background Check System"
- "informed consent patient rights"
- "firearm possession /p mental"
- “discharge plan”
- conditional discharge
- conditional release

The Researchers supplemented keyword searches by reviewing the table of contents for statutes or areas of law related to outpatient commitment, patient rights, firearm possession, and mental health reporting.
When searching outside of outpatient commitment laws, searches were restricted to the topic’s relationship to the outpatient commitment process.

f. Initial Returns and Additional Inclusion or Exclusion Criteria: In order to fully capture the scope of outpatient commitment laws, researchers included laws for the two methods that could result in involuntary outpatient care including:

- **Court-ordered outpatient commitment**: Decided by a judge or jury through a formal court adjudication process in which patients’ symptoms are evaluated to determine whether they qualify for outpatient commitment.
- **Conditional release outpatient commitment**: Decided by a physician and/or other medical professionals only after a patient was first involuntarily committed. A conditional release is contingent on patients demonstrating they are capable of following a less restrictive outpatient treatment regimen based on their symptoms.

The following variables were also researched while analyzing outpatient commitment laws:

- Criteria for outpatient commitment
- Who can initiate outpatient commitment
- Right to refuse medication
- Consequences for patients who fail to comply with treatment
- Initial duration of outpatient commitment
- Discharge planning
- Outpatient commitment limits on an individual’s right to possess a firearm
- National Instant Criminal Background Check System (NICS) state mental health reporting.

Excluded areas of law include:

- **Voluntary outpatient commitment laws.** The Team decided to scope out these laws because the provisions for voluntary outpatient commitment varied from standard laws on involuntary outpatient commitment. Since voluntary commitment laws also ultimately depend on a patient’s own decision to commit themselves, these laws were scoped out to avoid inconsistencies with the many legal requirements associated with the involuntary commitment process.
- **Impatient care laws, unless these laws were the exclusive method into outpatient treatment, such as states that have conditional release**
- **Laws related to the initial screening of individuals starting the outpatient commitment process, patient hearing, and other rights not related to medication refusal.** The Team decided to scope out these laws because
of the large volume and complexity of their requirements. A separate dataset would be needed to adequately capture the variation in these laws.

- Laws exclusively related to the commitment of sexual predators, criminals, and minors. The Team decided to scope these laws out because the provisions for the commitment of these specific classes varied significantly from standard laws on outpatient commitment. These variations were of particular complexity within relation to initiation, duration, and modification of outpatient commitment.

- References to the Diagnostic and Statistical Manual of Mental Disorders (DSM) for the classification of mental illnesses and disorders when determining whether an individual qualifies for outpatient commitment. These references were scoped out to avoid inconsistencies when selecting mental health criteria for jurisdictions that did not consider DSM classifications. Where a DSM classification was needed, Researchers selected the presence of mental illness generally.

- Homeless individuals were scoped out as an exempt outpatient commitment class because they only came up in the state of Oklahoma.

IV. Coding

a) Development of Coding Scheme: The team worked in collaboration to determine the focus of the research and the key questions to be coded. The Researchers also conducted background research on outpatient commitment and extensively reviewed secondary sources on the topic. The Managers and Researchers conceptualized coding questions, then circulated them for review by the Supervisor. When the questions were finalized, the Team entered the questions into the LawAtlas Workbench.

b) Coding Methods: The Team frequently met as a group to narrow the scope of the dataset to direct indicators of outpatient commitment. As necessary, the coding scheme was altered to accommodate newly identified features of the law and completed states were recoded accordingly.

In order to alert the user of variations in treatment procedures for jurisdictions that permit both court ordered and conditional release involuntary outpatient commitment, Researchers provided caution notes for each question where answers varied depending on the method that was used to commit the patient to outpatient.

Below are also specific rules used when coding questions and answer choices in the dataset:

**Question:** “What are the criteria for involuntary outpatient commitment of an individual?”
When possible, only those criteria explicitly required for an individual to qualify for outpatient commitment were selected. If outpatient commitment was only possible through conditional release, criteria explicitly required for both involuntary inpatient commitment and conditional release were selected.

Additionally, note that the coding for this question captures both required and permissive criteria. For example, in some states, all criteria coded must be met for an individual to qualify for outpatient commitment; whereas other states only require that some of the criteria listed be met to be committed.

Question responses were also conceptualized and/or consolidated as follows:

- **“Danger to self due to mental illness”:** Coded when law explicitly mentions danger to self and mental illness.
- **“Danger to others to mental illness”:** Coded when law explicitly mentions both danger to others and mental illness.
- **“Prevent future danger to self”:** Coded when law indicated that a patient was likely to deteriorate to a condition where they would become dangerous to themselves at some point in the future if they did not receive treatment.
- **“Prevent future danger to others”:** Coded when law indicated that a patient was likely to deteriorate to a condition where they would become dangerous to others at some point in the future if they did not receive treatment.
- **“Prevent future danger to self due to mental illness”:** Coded when law indicated that a patient was likely to deteriorate to a condition where they would become dangerous to themselves at some point in the future if they did not receive treatment, and the law explicitly mentioned mental illness as a criteria.
- **“Prevent future danger to others due to mental illness”:** Coded when law indicated that a patient was likely to deteriorate to a condition where they would become dangerous to others at some point in the future if they did not receive treatment, and the law explicitly mentioned mental illness as a criteria.
- **“Mental Illness”:** Mental illness was coded when it appeared in the law as a stand-alone criterion that triggered commitment of an individual. It was not coded when the response “danger to self due to mental illness” or “danger to other due to mental illness” were coded because in those instances, the danger to self or others requirements are tied to the presence of mental illness, and mental illness is not a stand-alone criterion.
- **“Treatment needed to prevent further deterioration”:** Coded where explicitly mentioned, where the danger element had yet to manifest. The individual, because of his condition, is likely to worsen in health at some point in the future. This element distinguishes individuals who are currently in poor health.
“Unable to Meet Basic Needs”: Coded where explicitly mentioned, where the inability to secure food, shelter, clothing, or other basic needs is referenced. Also selected where the law states an individual is unlikely to survive in the community with or without supervision and with or without clinical determination.

“Unwilling or unable to voluntarily accept treatment”: Coded where explicitly indicated and where the law suggests an individual cannot, under their own volition, obtain adequate and effective treatment.

**Question:** “What classes of people are exempt from outpatient commitment?”

Exempt classes are groups of people not eligible to qualify for outpatient commitment. Only those classes of individuals explicitly exempt from outpatient commitment were selected. In states where all elements of outpatient commitment—except for mental illness—can be established, an exception may have been made.

For more information on this, please consult the legal text for each jurisdiction.

Question responses were also conceptualized and/or consolidated as follows:

- “Chemical dependency”: Coded where drug and/or alcohol addiction or substance abuse are explicitly mentioned. This does not include temporary moments of drug or alcohol intoxication.
- “Temporary intoxication”: Coded for brief, temporary, momentary, or other time limited durations of drug and/or alcohol intoxication. This does not include general drug or alcohol addiction or substance abuse.
- “Disability resulting from old age”: Coded for mental or cognitive impairments related to aging, such as Alzheimer’s and dementia.
- “Developmental disabilities”: Includes the explicit reference to intellectual disabilities or terms referring to mental retardation, deficits, and other learning disabilities.
- “Physical disabilities”: Includes conditions such as organic injuries resulting in cognitive impairment, traumatic brain injury, epilepsy, seizure disorders, and other disabilities impacting one’s physical capabilities.
- “Antisocial behavior”: Coded where explicitly mentioned or law references personality or psychological disorders resulting in criminal behavior or social isolation.
- “No exemptions are explicitly indicated in the law”: Coded only where those classification of exempt classes are ambiguous or there was an absence of any classes mentioned in the law. The selection of this response does not represent the affirmative designation of no classes being exempt from treatment.
- “Spiritual Treatment”: Caution noted when states had an exemption for individuals being treated through spiritual means.
**Question:** “Who can initiate outpatient commitment?”

Only those individuals that can explicitly initiate a petition or request for outpatient commitment of a person were selected. Only adult petitioner or individuals over the age of eighteen were scoped. Those selected, do not represent the individuals charged with actually determining whether someone qualifies for treatment.

Responses selected, broadly capture a collection of the individuals that may initiate a petition or request. For this reason, answers do not differentiate between jurisdictions that require a request by more than one individual. For these jurisdictions, a caution note was added.

Question responses were also conceptualized and/or consolidated as follows:

- **“Police, probation, and parole officers:** Included when a statute made reference to law enforcement officers generally, or references only those authorized to make arrests.
- **“Relative”:** Coded when a specific relative was mentioned, such as a parent, sibling, cousin, or child of a respondent. This does not include a spouse for which a separate answer choice was created.
- **“Mental health professionals”:** Includes caretakers or other health care professionals that hold some experience or expertise in the mental health field or have a related title and are not certified as a physician, physician assistant, registered nurse, psychologist or psychiatrist.
- **“Medical directors”:** Includes supervisors, superintendents, facility administrators, and commissioners of major health organizations, agencies, institutions (including settings for inpatient and outpatient care), and their authorized designees.
- **“Public official”:** Includes anyone in a position of official authority that is conferred by the state, such as judges, legislators, or government administrators.
- **“Spouse”:** Includes husbands, wives, and the designation of a reciprocal beneficiary (only within Hawaii).
- **“Any interested person”:** Coded where explicitly indicated and where the law provides broad authority to anyone to initiate a request. If “interested person” was defined with an inclusive list of individuals, than those options were coded rather than this answer choice.

**Question:** “Can a patient refuse medication once in treatment?”

For this question, “medication” was defined as any medication, including psychotropic medication and drugs, which results in a chemical alteration of the patient for the purposes of treating the committing illness.

General references to treatment were not included unless a jurisdiction definition for treatment explicitly delineated that treatment included the use of medication.
The Researchers coded “no” where the law explicitly prohibited a patient from refusing medication, the law was vague, or where it did not mention a patient's right to refuse medication. Where the law provided an affirmative prohibition a citation was provided.

The Researchers coded “yes” only when a statute explicitly indicated one or all of the following:

- Specifically stated a patient possessed the affirmative right to refuse medicine.
- The law stated or suggested a physician must obtain informed consent before administering medication to a patient.
- The law indicated a treatment facility or hospital staff could not administer medicine without a patient’s approval.

**Question:** “Are there exceptions to a patient’s right to refuse medication?”

Researchers coded answer choices based on which authority had the general ability to override a patient’s right to refuse medication rather than who may object to their right.

For example, if a physician could administer medication when he or she deemed it necessary, but a patient could request a hearing before a court to evaluate the appropriateness of the treatment, the physician’s decision was coded as an exception. If the court hearing; however, was required and a physician could only make a recommendation, the court’s order was coded as the exception.

The question does not include emergency exceptions (i.e. life-threatening or extremely dangerous situations which do not require prior approval) in the answer choices. The scope of this question only includes non-emergent conditions, where there must be showing of a probability of harm in the near future if a patient is not administered medication.

Question responses were also conceptualized and/or consolidated as follows:

- “Yes, with an administrative order”: Coded when a state administrative agency, official, or board is permitted to overrule an individual’s right to refuse medicine.
- “Yes, if deemed necessary by a qualified medical professional”: Coded when an individual who is not a physician, but works in the medical field, may overrule a patient’s right to refuse medication. This answer choice includes chief medical officers, hospital or treatment facility personnel, providers, and clinicians.

**Question:** “Are there consequences for patients who fail to comply with treatment?”

Researchers coded answer choices only where the law explicitly discussed consequences for a patient’s non-compliance or violation of their treatment plan.
Researchers only selected consequences which were explicitly stated in the collected outpatient commitment statutes and regulations. A no to this question can indicate that the state defaults to contempt of court when the patient fails to comply with a treatment order.

Question responses were also conceptualized and/or consolidated as follows:

- “Short-term hold”: Coded when explicitly stated or when a patient is detained within a restrictive setting or facility for a short period of time. The Researchers define a more restrictive setting as any specific setting that is more restrictive than placement within a standard treatment facility or hospital.
- “Modification of treatment plan”: Coded when explicitly stated, when a patient’s treatment plan is modified or altered to reach compliance, the status of a patient is changed, or when a new medication is administered to patient that is outside their standard treatment plan.
- “Return to treatment facility”: Coded only when explicitly indicated and there is no language demonstrating a patient is being taken to a facility that is more restrictive than a standard treatment facility or hospital.

**Question: What is the initial duration of outpatient commitment?**

The answer choices for this question were added as they appeared in statutes. All time periods were based on a maximum length of initial duration that a court can legally order even though the court may fluctuate the actual period ordered on a case-by-case situation. The minimum durations were also scoped out. When the duration differed under conditional release it was caution noted.

The answer choices were all converted to days as the unit for uniformity and consistency unless the answer was over one year. For the conversion, one month is equivalent to thirty days, two months to 60 days, etc.

Any ambiguous and/or indefinite periods were coded to use the first required periodic review date as the length of duration.

**Question: “Can the duration be modified?”**

The Researchers coded this question as “yes” whenever it was possible to either shorten or lengthen (early discharge or commitment extension) the initial duration ordered by the court or when an inpatient commitment can be ordered for noncompliance and the inpatient commitment could result in a change in commitment duration (ex. Mississippi).

The Researchers also coded the question as “yes” when alternative maximum durations existed for prior commitments or convictions.

**Question: “What conditions can lead to a duration modification?”**

The Researchers only coded administrative orders and court orders if the duration modification required a hearing. The hearing could be initiated by the physician,
medical professionals, the patient, or any other third party that had an interest in the commitment order.

Researchers coded answer choices based on which authority had the general ability to modify the treatment duration rather than who may object.

For example, if a physician could modify a treatment's duration when he or she deemed it necessary, but a patient could request a hearing before a court to evaluate the appropriateness of the modification, the physician’s decision was coded as the individual that could modify the treatment duration. If the court hearing, however, was required and a physician could only make a recommendation, the court’s order was coded as the exception.

Question responses were also conceptualized and/or consolidated as follows:

- “Administrative order”: Coded when a state administrative agency, official, or board is permitted to modify duration.
- Any qualified medical professional”: Coded when an individual who is not a physician, but works in the medical field, may modify duration. This answer choice includes superintendents, directors, administrators, heads of treatment facilities, programs, hospitals, treatment teams, and any other qualified mental health professionals.
- “Prior convictions” and “Prior commitment”: Coded if the patient’s previous convictions and commitment could alter the duration initially ordered by a court or if they could result in a modification to the duration during the treatment.

**Question:** “Is a discharge plan required prior to discharge?”

For this question, the criteria for discharge were scoped out. The Researchers coded “yes” when a discharge plan was specifically required or discharge planning mandated specific modes of treatment or services.

The Researchers coded “no” when the statute only made a simple reference to discharging the patient or when the discharge plan was only required for inpatients who were being conditionally released into outpatient care.

**Question:** “Does outpatient commitment limit an individual’s right to possess a firearm?”

This question captured three types of jurisdictions with firearm regulations:

- Jurisdictions with their own law about firearm possession,
- Jurisdictions that adopt federal law, and
- Jurisdictions that reference federal law, but also create a state interpretation about possession.

For all three types of laws, prohibition is coded generally and included any statutory language which could result in a restriction for an individual, no matter the degree or limit of such restriction.
The Researchers coded “yes” when possession was prohibited explicitly or there was a reference accepting federal law prohibiting possession. In those states with conditional release as a method for reaching outpatient, researchers coded yes if there was a reference to federal/state laws restricting an inpatient commitment patient’s possession rights.

The Researchers coded “no” when a state law referenced the federal law prohibiting possession in a disagreement, no law exists, or when it was explicitly stated that no restriction exists. When patients in institutions, hospitals, and asylums are specifically restricted, the restriction was coded as only a restriction on inpatients and was therefore coded as “no” unless conditional release existed in the state.

**Question: “Can firearm rights be restored?”**

The Researchers coded “yes” when a state broadly references the federal law and adopts it generally, a state refers to the specific section of the federal law that allows for relief from possession disability, when a state allows for expunging of records, and when a state has its own explicit law allowing for relief.

**Question: “Does the state mandate reporting of outpatient commitment history to the FBI for the NICS database?”**

The Researchers coded “yes” when the state law requires collection and reporting of information related to outpatient commitment to the NICS (either explicitly or in reference to federal law) or when this information must be reported to state agencies, which then have a duty to report to federal agencies or the NICS.

The Researchers coded “no” when the NICS is optional or when a state may report.

V. Quality Control

Quality control consisted of the Supervisor exporting the data into a Microsoft Excel document each day the Researchers coded to examine the data for any missing entries, citations, and caution notes. 100% of the records were redundantly coded throughout the life of the project (51 of 51). The Supervisor assigned 100% redundant coding of the first 10 jurisdictions. The rate of divergence was 18.9%. The Supervisor assigned the next 10 jurisdictions for redundant coding and the rate of divergence fell to 12.3%. The Supervisor assigned the next set of jurisdictions for redundant coding and the rate of divergence again fell to 11.8%. The Supervisor assigned the next set of jurisdictions for redundant coding and the rate of divergence again fell to 11.5%. The Supervisor assigned the last set of jurisdictions for redundant coding and the rate of divergence rose slightly to 14.4%, requiring extra quality control. The Team discussed all divergences throughout the process and re-coded as necessary.

A naïve coder coded 20% of the total number of records (10 of 51). The rate of divergence was 16.88%. The Supervisor conducted a coding review of the naïve coding and assigned recoding as necessary. This was completed and the final rate of divergence was 0%.

Prior to publication, the Supervisor downloaded all coding data into Microsoft Excel to do a final review of coding answers, statutory and regulatory citations, and caution notes.
All unnecessary caution notes were deleted and all necessary caution notes were edited for publication.

VI. Updated (March 2016)

a. **Scope:** This dataset originally began as a cross-sectional dataset capturing laws effective as of August 1, 2015. During the March 2016 update, the dataset became longitudinal and now captures all relevant laws in effect from January 1, 2000 through March 1, 2016.

b. **Data collection methods:** One update Supervisor and three Researchers checked all existing legal citations on Westlaw and legislative tracking websites for previous amendments between January 1, 2000 and August 1, 2015, as well as pending, proposed, and enacted legislation since August 1, 2015. The Team collected the relevant laws for the 47 jurisdictions that have outpatient commitment. In addition, the search terms used in section III(e) were used to search for any new laws that had been enacted since the last data collection phase. This process was completed in three batches, rather than five, because there was a larger team of researchers working on the project than usual. This allowed each researcher to collect laws in 5-6 jurisdictions at a time. Batch 1: Missouri, Nebraska, North Carolina, Oregon, South Dakota, California, Mississippi, Montana, New York, Vermont, Arizona, Delaware, New Jersey, Texas, Utah. Batch 2: Idaho, Maine, Minnesota, North Dakota, Oklahoma, Rhode Island, Florida, Georgia, Hawaii, Illinois, Indiana, Michigan, Alaska, Colorado, Louisiana, Nevada, Ohio, West Virginia. Batch 3: New Mexico, Tennessee, Washington, Wisconsin, Wyoming, Massachusetts, Virginia, District of Columbia, Kentucky, New Hampshire, South Carolina, Arkansas, Maryland, Alabama, Connecticut, Iowa, Kansas, Pennsylvania.

The Researchers created new records with updated legal text for states with new laws or changes to existing laws that affected answer choices. Researchers cloned records and updated the legal text for states with changes that did not affect answer choices.

c. **Coding Updated Findings:** During the March 2016 update, the Team added records for all jurisdictions that had Involuntary Outpatient Commitment laws, going back to January 1, 2000. In addition, found that only one state, Vermont, had substantive changes to its law since the previous data collection phase that affected an answer choice and required coding. One Researcher coded the updates for this state. The other Researcher redundantly coded this state. The Supervisor reviewed the coding. All divergences were discussed and resolved. The Team also found that 8 jurisdictions: California, Missouri, North Carolina, Oklahoma, Oregon, Nevada, New York, and Wisconsin had non-substantive changes to the law, meaning these changes did not affect an answer choice. Because the changes did not affect an
answer choice, these records were cloned and not coded or redundantly coded. Once these records were cloned, the legal text for each record was updated with the new law.

i. **Coding methods:** For the question: “What are the criteria for involuntary outpatient commitment of an individual?” the Researchers decided that answer choice “treatment needed to prevent further deterioration” includes “serious physical or mental debilitation” when referring to a patient’s welfare. For example, in Arizona, when a person lacks that capacity, they may be subjected to involuntary outpatient commitment. Also for this question, Researchers decided to code short term civil commitment criteria in order to maintain consistency across all states.

Within how many hours?” the Researchers decided that the answer choice “on arrival” includes terms such as “without unnecessary delay,” “as soon as possible,” and “immediately” when no other timeframe is provided in the law. For example, Hawaii requires an emergency examination to be conducted “without unnecessary delay” following short-term emergency commitment. In that instance, the Researchers selected “on arrival” as the most appropriate answer choice.

d. **Quality Control:** The Supervisor downloaded records into Excel and ran divergence calculations on the redundantly coded records. 20% of all records were redundantly coded, with at least one record being redundantly coded in each jurisdiction. Divergences that occurred in one record for a jurisdiction were resolved for all records corresponding to that jurisdiction. The Supervisor also compared newly coded entries to previously coded entries for consistency. The Researchers researched and coded the states in batches of 15, 18, and then 18 states (5 to 7 states for each Researcher). In batch 1, the divergence rate was 16.55%. In batch 2, the divergence rate was 11.67%. In Batch 3, the divergence rate was 16.71%. All divergences were discussed and resolved. Researchers re-coded as necessary after divergences were resolved.

The supervisor performed a final data check before publishing the dataset. This consisted of using the search terms to identify whether any jurisdictions had had updates since the research phase began, looking for amendments or newly enacted laws between August 31, 2015 and March 1, 2016. In addition, for the batch 1 states, the supervisor checked all the citations of relevant laws to verify whether any of them had been amended, since the research for batch 1 states began the earliest.