USE OF MANDATORY OUTPATIENT TREATMENT IN VIRGINIA
A PRELIMINARY REPORT ON THE FIRST TWO YEARS

Prepared for the Commission on Mental Health Law Reform

by

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Introduction

The civil commitment reforms adopted by the Virginia General Assembly in 2008 included changes designed to make mandatory outpatient treatment (MOT) a more effective component of Virginia's commitment process. Formerly called "involuntary" outpatient treatment, MOT was an optional disposition in the commitment process, but was ordered infrequently and monitored inconsistently.[1] The new legislation, which became effective on July 1, 2008, provides detailed procedures for implementing MOT orders under Virginia Code §37.2-817.[2]

This report reviews the frequency and circumstances under which MOT was ordered from July 1, 2008 through October 31, 2010. Additionally, we have conducted interviews and a survey of Virginia community services boards (CSBs) to help us understand the CSBs' perspectives on MOTs. The report also provides a general description and sample of treatment plans and conditions.

Methods

Beginning July 1, 2008, the Commission requested the files of every case that resulted in an MOT disposition, asking specifically for copies of the 1006-CO (the commitment order), 1006-IE (the report of the independent examiner) and MOT plan from each of these cases. We received a total of 120 MOT files through 10/31/10[3]; however, not every file included all of the requested information. The data for this report was collected from an extensive review of the MOT case files that were actually received from the courts.

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[1] Bonnie, Richard J. Statement prepared for Virginia Tech Review Panel, July 18, 2007.

[2] Most of this report focuses on the use of MOT as a less restrictive alternative to involuntary inpatient admission pursuant to the procedures enacted in 2008. The 2010 General Assembly authorized so-called "step-down" MOT as a transition to the community for patients being discharged from an inpatient commitment, but that procedure did not go into effect until July 1, 2010. As summarized in the last section of this report, the procedure was rarely used during the first half of FY 2011.

[3] Data entered for this same period in the Supreme Court's Case Management System record 75 MOT orders from July, 2008 through June, 2009, 86 for July, 2009 through June, 2010, and 11 for July, 2010 through October, 2010, a total of 172. This suggests that we are receiving about 70% of the files.

The 1006-IE is the report of the Independent Examiner. It provided the Independent Examiner's assessment of the client's mental health status, but in some cases, also included notes on the client's treatment preferences as well as the CSB's treatment preference for the client. The 1006-CO provided information on the hearing. Finally, the MOT plans, when included, provided information on the specific treatment services, conditions, and details on compliance monitoring specified for the client's treatment. More detailed MOT plans also included notes on client treatment preferences. When these forms were unavailable, we attempted to gather relevant information from available forms wherever possible.

A survey of CSBs regarding use of MOT was also conducted using the online survey tool, Survey Monkey, from November 10, 2009 through November 30, 2009.

Overview

In general, a majority of MOT cases came from the Prince William and Staunton General District Courts. MOT was used most frequently in cases involving clients found by the court to be either "likely to harm self" or to "lack[] the capacity to protect self or provide for basic human needs." In the files where information was available, we found that most of the clients agreed to the use of MOT, signifying that MOT is used when clients express a willingness to accept treatment. Also, in most of the cases, MOT was ordered in accordance with the Independent Examiner's recommendation.

About one-third of the clients placed under MOT were required to receive substance abuse treatment services as well as services for treatment for mental illness. A wide variety of services were offered to clients in their treatment plans, although the degree of detail varied among CSBs. At a minimum, compliance with the treatment plans included the condition that clients "must attend all meetings and appointments;" however there were other conditions specified in the plans according to the client's needs. Although most of the treatment plans involved CSB staff only, a handful of treatment plans included private providers. Compliance was generally monitored through meetings and appointments that were scheduled as part of a client's treatment. A majority of these meetings and appointments occurred once a week. Most CSBs determined a client to be materially non-compliant if the client missed three consecutive appointments without making arrangements to reschedule; however this was not a common occurrence.

Responses to the interview and survey questions provided us with additional insight on the circumstances under which MOT is used, as well as how CSBs perceive the MOT process.

Data

Frequency and Correlates of MOT Orders

Of the 120 MOT files that we received from the courts, 117 included information on the locality of the hearing. Table 1 shows the frequency and percentage of hearings by locality.

Table 1. Frequency and Percentage of MOT Orders Received by Locality

Locality	Frequency	Percentage
Prince William	46	38.3
Staunton	23	19.2
Fairfax	12	10.0
Smyth	12	10.0
Danville	10	8.3
Russell	5	4.2
Roanoke	3	2.5
Montgomery	2	1.7
Salem	2	1.7
Lancaster	1	0.8
Richmond	1	0.8
Missing	3	2.5
Total	120	100.0

The 1006-CO form was completed and included in 112 of the 120 files. From these files, we were able to see that in the majority of MOT cases, the court determined that the client was either "likely to harm self" (48.7%) and/or "lacked the capacity to protect self or provide for basic human needs" (52.2%). Only 16.5% of the files were for clients found by the court to be "likely to harm others."

From some of the files, we were able to gather data on whether the clients and CSBs agreed to the use of the MOT. Of the 120 cases, only 50 files had concrete documentation of whether the client agreed or disagreed with the use of MOT. Of these 50 documented cases, 46 clients agreed and 4 disagreed. Many of the clients who agreed with the use of MOT did so because they did not want to be hospitalized. Examples of the Independent Examiner's documentation on clients who agreed with MOT include the following: "Patient does not want inpatient treatment, but wants and is willing for outpatient treatment." "[Patient] would like to go home and receive outpatient treatment." Patients who did not agree with the use of MOT were resistant to treatment in general. One Independent Examiner note read, "[Patient] is able to make informed consent – doesn't see need for treatment and doesn't think ETOH is a problem."

Of the 120 cases, only 28 files had concrete documentation of whether the CSB agreed with the use of MOT. Of these 28 documented cases, 3 files included notes indicating that the CSB had objected to the use of MOT for that particular client. In two cases, the CSB objected because they felt that inpatient treatment was more appropriate

for the client or because they did not feel that they had adequate resources to support MOT for that client. In one case, the CSB "refused to accept on outpatient basis" citing "lack of available resources" and the case was continued at the request of the patient until an agreement could be reached with the CSB. In that case, the attending physician at the psychiatric facility where the patient was being evaluated was also involved in negotiating with the CSB.

We also examined whether MOT was being used in cases where a different course of action had been recommended by the Independent Examiner. Eighty-two files provided this information from the Independent Examiner's report (1006-IE). These IE reports indicated that the Independent Examiner had recommended involuntary inpatient treatment for 28 cases, dismissal for 1 case, and MOT for 53 of the 82 cases. These results are shown in Table 2.

Table 2. Frequency and Percentage of Independent Examiner Recommendations among Received MOT Orders

I.E. Recommendation	Frequency	Percentage
MOT	53	44.2
Involuntary Inpatient Tx	28	23.3
Dismissal	1	0.8
Missing	38	31.7
Total	120	100.0

Services Provided and Costs

Of the 120 files, 98 included an MOT treatment plan. We categorized the treatment plans as offering mental health services, substance abuse services, or both. While almost all of the plans ordered mental health services, 44.9% of them also included substance abuse services. Table 3 shows the frequency and percentages for the category of services offered to clients.

Table 3. Frequency and Percentage of Service Category

Category of Service	Frequency	Percentage
Mental Health only	54	55.1
Substance Abuse	4	4.1
Both	40	40.8
Total	98	100.0

Clients of MOT were offered a variety of specific services in their treatment plan. Of the 97 MOT plans that have information about the services offered to the client, 88

were offered more than one service. Table 4 shows the frequency and types of other services that were provided to clients at the CSBs.

Table 4. Frequency and Percentage of Services Provided to MOT Clients

Type of Service	Frequency	Percentage of Plans
Individual Therapy	75	77.3
Case Management	60	61.9
Medication Services	55	56.7
Substance Abuse Service	19	19.6
Support Services	14	14.4
Group Therapy	15	12.5
PACT/ICT Services	12	12.4
Crisis Intervention Services	11	9.2
Residential Services	3	3.1

Individual therapy was the most common service provided, followed by case management and medication services. When case management was provided, a case manager was usually assigned to monitor and follow up with the client on a regular basis. Case managers were also in charge of addressing the client's general needs during treatment, such as in "linking and coordinating" the client's treatment overall. Some case managers offered supportive counseling and symptom management skills, however, this was mostly left to the therapists.

Individual therapy was often used for psychoeducation. For example, one treatment plan stated, "Therapist, in weekly scheduled sessions, will provide information to client about his mental illness and the symptoms of his mental illness. Therapist will respond to his questions to assist him with understanding his mental illness." Individual therapy was also used to help evaluate medication needs and to monitor medication compliance, as well as to help clients learn coping skills, including anger management, impulse control, and relaxation techniques.

Medication services ranged from therapists prescribing and monitoring medications with the clients to requiring clients to go into the CSB to swallow pills or receive injections. One plan stated, "[Client] will utilize a twice-weekly pillbox for oral medications and will take all medications as prescribed, as evidenced by staff report and documentation. [Client] will keep all scheduled appointments with PACT nurse for injection every two weeks, as evidenced by staff documentation." Medication services often included a meeting with a psychiatrist every 90 days for medication evaluation.

Treatment Plan and Conditions

The MOT plans allowed us to gather data on treatment conditions that were specified in the plans. All but three plans included the condition that the client must

attend all appointments and meetings. Other conditions that were commonly included in the plans are listed below in Table 5.

Table 5. Frequency and Percentage of Plans by Treatment Conditions

Treatment Condition	Frequency	Percentage of Plans
Must attend all appointments and meetings	94	96.9
Must be compliant with medications	85	87.6
Psychoeducation	34	35.1
Must remain sober	29	29.9
Must improve family relationships	10	10.3
Must maintain behaviors to care for self	6	6.2
Must improve social relationships	4	4.1
Other	3	3.1

The treatment plan conditions were often listed as measurable objectives. For example, one client's MOT plan included objectives for many of the treatment conditions listed in Table 5:

1) Identify consequences of his chemical use
2) Identify how a clean and sober lifestyle will improve various areas of his life
3) Attend five meetings weekly
4) Develop a close relationship with his sponsor and others in recovery
5) Develop skills to identify relapse
6) Pass all screens for alcohol and other drugs
7) Be seen by staff psychiatrist for evaluation of depressive symptoms and follow recommendations
8) Identify how his chemical use has negatively impacted his self concept and begin to challenge irrational beliefs

The MOT plans also provided data on whether patients were involved in the development of their treatment plans and in the specification of the conditions. Of the 97 plans included in the MOT files, 30 plans (30.9%) expressly indicated that the patient was involved in the development of the plan. We looked specifically for phrases such as, "The patient agrees…" and "The patient prefers…" in the plan narrative. One file recorded the client's goals:

Client's Statement #1: I would like to remain at my current residence with my parents.
Client's Statement #2: I would like to build a social life.
Client's Statement #3: I would like to return to school for HVAC.
Client's Statement #4: I would like to be more stable on my medication in order to feel better about myself.
Client's Statement #5: I would like to remain sober.
Client's Statement #6: I would like to remain healthy.
Client's Statement #7: I will continue to care for myself independently.

This client's statements were then used to help the CSB build a treatment plan. Many of the services and conditions were aimed at helping the client to achieve the stated goals.

The Prince William County CSB often attached a form cover letter with the MOT plan when they sent the plan to the judge for approval. This letter included a sentence that stated, "The treatment plan was developed with the fullest possible involvement and participation of [name of client] and reflects his preferences to the greatest extent possible to support his recovery…" Form letters stating that the patient was involved in the development of the plan were not counted in our analysis unless the plan's narrative provided evidence in support of this statement. Additionally, as further evidence of client involvement and approval, 88.7% of the MOT plans we received were signed by the client. When they were not signed, a few plans noted "Client refused to sign."

Compliance

Table 6 shows the frequency and percentage of the MOT cases by the CSB that is in charge of monitoring the case. Of the MOT plans that we received, Prince William County CSB supervised the most cases (37.5%).

Table 6. Frequency and Percentage by CSB in Charge of Monitoring Compliance

CSB	Frequency	Percentage
Prince William County CSB	45	37.5
Fairfax-Falls Church CSB	11	9.2
Valley CSB	10	8.3
Mt. Rogers CSB	6	5.0
Central Virginia CSB	5	4.2
Danville-Pittsylvania CSB	5	4.2
Alleghany Highlands CSB	3	2.5
Blue Ridge Behavioral Health Care	3	2.5
Cumberland Mountain CSB	3	2.5
New River Valley CSB	3	2.5
Piedmont CSB	3	2.5
Harrisonburg-Rockingham CSB	2	1.7
Rappahannock-Rapidan CSB	2	1.7
Dickenson County BHS	1	0.8
Highlands CSB	1	0.8
Middle Peninsula-Northern Neck CSB	1	0.8
Northwestern CSB	1	0.8
Region Ten CSB	1	0.8
Richmond BHA	1	0.8
Southside CSB	1	0.8

Missing	12	10.0
Total	120	100.0

Compliance is monitored through CSB staff members' appointments with the clients. Clients are required to attend all appointments and if they cannot make it, they are instructed to call and reschedule in advance. Of the 96 MOT plans that contained this information, 66 plans specified how often the CSB would be meeting with the client to monitor compliance, 16 plans mentioned the CSB staff monitoring compliance but did not specify how often, and 14 plans did not mention anything about monitoring compliance. Table 7 shows how often CSB staff were required to check in with clients by the 66 plans that included this information. A substantial majority of the plans (71.2%) required CSB staff to check in with clients weekly to monitor compliance with the treatment plan.

Only 19 of the plans included private providers, and only eight of these specified how often private providers should check in with the CSB to monitor compliance of the clients. Seven out of the eight plans asked private providers to monitor compliance once a week, while one of the plans asked the private provider to monitor compliance once a month. Private providers were instructed to notify CSBs immediately following a missed appointment by a client.

Table 7. Frequency in Days that CSB are Asked to Monitor Compliance

How Often (in Days)	Frequency	Percentage
1	5	7.6
2	1	1.5
3	1	1.5
4	1	1.5
7	47	71.2
14	4	6.1
30	6	9.1
60	1	1.5
Total	66	100.0

It is difficult to determine how compliant clients are being with each of their MOT treatment appointments. Out of the 120 files that we received, only 4 files contained Petitions for Review of MOT and 3 files contained Orders for Review of MOT. Of the 4 petitions, two were filed because the clients refused to take any part in their MOT treatment plans. One petitioner wrote, "Client refuses any participation with PACT services and refuses to accept treatment from other treatment providers." In this case, the special justice ordered that the client be admitted for involuntary inpatient treatment, in accordance with the petitioner's recommendation.

In two other Petitions for Review of MOT, the clients were determined to be materially non-compliant because they had missed three consecutive appointments with their treatment providers. The outcome of these petitions was determined on a case-by-case basis based on the information that was included with the petition. In one of these cases, the judge dismissed the case because the MOT order had already expired. In the other case, the judge ordered a rescission of the MOT plan after an independent examiner certified that the client no longer met the criteria for commitment.

Interviews and Surveys on MOT Use

The use of MOT seems to have decreased substantially since the new laws went into effect. We only received a total of 120 MOT files during the entire study period. (In comparison, in the Commission's study of commitment hearings conducted during May, 2007, 73 of the respondents were committed for outpatient treatment during that month alone.) In response to the apparent decrease in MOT use, the Commission interviewed a sample of CSB representatives from Fairfax-Falls Church CSB and Prince William County CSB, and conducted a survey on MOT to explore the reasons for the decline. A total of 32 CSBs responded to the survey.

Interviews with CSB Staff in Prince William and Fairfax-Falls Church

CSB representatives brought up a few barriers to the use of MOT since the new laws went into effect. First, some of the special justices are opposed to MOT because they "don't want the headache," and because the MOT cases "keep them on the hook." Special justices are required to approve of the comprehensive treatment plan that is drafted by CSBs after the hearing occurs, and are also responsible for overseeing the compliance process if a client is non-compliant. CSB representatives reported that some special justices have expressed the view that the new MOT statutes involve too many complicated steps and they are not given additional compensation to follow through with each step. In fact, MOT use declined significantly in Fairfax-Falls Church from FY10 to the beginning of FY11. Fairfax-Falls Church CSB reported that they have been getting more resistance from special justices against MOTs because of this "hassle factor." In some cases, the special justices are so resistant that even when the CSB, the independent examiner, the attorney and the client are all in agreement with MOT, the special justices are still reluctant to approve it. However, other CSB representatives felt that as more MOTs are ordered, everyone involved in the process becomes more comfortable doing MOTs. In Prince William County CSB, there were 36 MOT orders in FY10, a substantial increase from FY09, when there were only 13 entered during the entire year.[4]

From the perspective of the Fairfax-Falls Church CSB, MOT may be more difficult to implement due to a general lack of resources. Many of the services that are appropriate for a client's treatment have long waiting lists. To further complicate things, CSBs are required to draft a comprehensive MOT treatment plan within 5 days of the

[4] Although the number of MOT orders in Prince William County declined significantly during the first quarter of FY 2011, informed CSB staff indicated that this decline was directly attributable to a temporary staffing shortage and that use of MOT in appropriate cases is expected to resume.

commitment hearing. Meeting this 5-day deadline can be especially challenging since the CSB has to get all of the resources in place, all of the providers on board, and the providers, CSB, client and special justice must all agree on a treatment plan. If a particular service is unavailable to the client at the time of the hearing, the CSB often cannot recommend MOT for that client. CSB representatives have expressed the view that implementing MOT might be less challenging if they had a longer turnaround time.

At Prince William County CSB, two aspects of their civil commitment process help make MOT more feasible. First, they almost always wait a full 48 hours for the temporary detention period. CSB representatives stated that this period of detention "can be helpful to the client and can change the way the client is thinking and behaving," oftentimes allowing them to become more open to treatment on an outpatient basis. Secondly, in addition to the required prescreening that takes place following a TDO, Prince William County CSB performs a second evaluation of the client immediately prior to the hearing. It is often during this second prescreening that a client might express a willingness to participate in outpatient treatment and the CSB representative will draft an initial treatment plan to submit to the special justice at the hearing.

Prior to the revision of MOT laws, Prince William County CSB would often recommend dismissal for clients who they felt were not exhibiting symptoms severe enough to warrant inpatient treatment. They would then schedule outpatient follow-up care to these clients so that they could monitor the client's progress after the hearing. Now, these clients are the ones who are being recommended for MOT. The revised MOT laws provide a more formal infrastructure for the CSBs to follow-up with and offer outpatient treatment to clients who "fall somewhere in between inpatient and dismissal, almost as a compromise." With few exceptions, clients who are under MOT orders in Prince William County and Fairfax-Falls Church have been very cooperative with treatment.

Survey of CSBs on MOT

A ten-question survey was conducted using the online survey tool Survey Monkey from November 10, 2009 through November 30, 2009. A total of 32 CSBs responded. The surveys contained a combination of multiple choice and open-ended answer formats. The CSBs that responded provided us with some valuable information about their CSB's perspective of MOT and the specific circumstances under which MOT is being used at their CSB. A key issue explored in the survey is why MOT is so rarely used.

Of the 32 respondents, a large majority (87.5%) reported having a total of five or fewer MOT cases since the new laws went into effect on July 1, 2008. One CSB reported having seven cases and three CSBs reported having more than ten cases. (See Table 8). This data confirms the finding that a majority of MOT cases are occurring in a very small number of jurisdictions. In fact, 80% of CSB respondents reported that MOT cases at their CSB had stayed the same or decreased since the new laws went into effect.

Table 8. Frequency of MOT Cases at CSBs Since July 1, 2008

# of Reported MOT Cases in CSBs since July 1, 2008	# of CSBs
None	13
1 – 5	15
6 – 10	1
More than 10	3

The survey results on the services that are being provided to MOT clients corresponded with our analysis of MOT plans. CSB survey respondents indicated that Medication Management, Individual Therapy, and Case Management were the top three services being provided, followed by Substance Abuse Services and PACT/ICT Services. Interestingly, a majority of CSB respondents (73.3%) reported that their CSB had adequate resources to deal with clients under MOT orders. However, respondents also indicated that the availability of the clinical staff to see clients is very limited, and many of the respondents reported that their CSBs would not be adequately prepared to handle additional cases, if MOT use were to increase.

The Commission's survey on MOT also asked CSBs to indicate the most common circumstances for which they would recommend MOT for a patient at their commitment hearing. There were three? general circumstances that emerged from their responses. The most common scenario that would warrant a recommendation for MOT is a situation in which a client has been through multiple hospitalizations and failed to comply with outpatient follow-up upon discharge. Some examples of CSB responses that indicated this situation are as follows: "When a consumer who has had multiple hospitalizations under a TDO has failed to follow-up with mental health and psychiatric services upon discharge." "Long-term clients who have a history of non-compliance and have tried all less restrictive alternatives." "Previous history of failure to comply with services, resulting in repeated involuntary hospitalizations, but not currently seen as dangerous."

The second most common circumstance for which CSBs would recommend MOT is when a client is actively engaged in treatment or understands and acknowledges a need for treatment. Some examples of the responses that indicated this situation were: "Individual is active/engaged in treatment; agreeable to MOT; cognitively insightful into own illness and understand need for continued treatment." "If client has capacity and is willing." "Individual is willing to participate, has the capacity to understand, and is not a significant danger to others."

Lastly, noncompliance with outpatient services in general, with or without a history of multiple hospitalizations, was a common circumstance for which MOT would be deemed appropriate by CSB staff. One CSBs respondent said, "Currently or

previously having received intensive outpatient services (PACT, Psychiatric rehabilitation) but noncompliant." Another CSB said, "…lack of capacity on the part of the consumer to follow through." Some CSBs indicated that MOTs were recommended to clients who needed "encouragement to participate in outpatient treatment." They viewed MOT as a way to provide "additional motivation for client to attend services."

When asked for their opinions of why MOT orders might be declining, CSB respondents cited similarities between MOT criteria and inpatient admission criteria, as well as the burden of MOT laws on judges and CSBs. Table 9 shows the explanations and the percent of CSBs who thought the explanation was "highly relevant" or "relevant."

Table 9. Explanations for Decline in MOT Use

Explanation	% of CSBs
MOT criteria are the same as inpatient admission criteria	70.3%
Burden of new MOT laws on judges	66.7%
Burden of new MOT laws on CSB	62.9%
Judges' interpretation of new laws	59.2%
Insufficient behavioral health resources	55.5%
Turnaround time for development of MOT plan is too short	40.7%

Survey on Step-Down MOT Use

The 2010 General Assembly approved a provision for the use of a "step-down" MOT, as a transition to the community for patients being discharged from inpatient commitment. This "step-down" MOT applies to persons who have had two or more prior commitments within the past 36 months and a history of lack of compliance with treatment. Although this procedure went into effect on July 1, 2010, there is very little evidence that it is being used. In December of 2010, an e-mail survey about "step-down" MOT use was sent to the 40 CSBs in Virginia. They were asked the four following questions: 1) Has your CSB used the "step-down" MOT procedure? 2) Have you found it useful? 3) What kind of cases have you been using it for? and 4) What kinds of problems have you run into? 33 out of 40 CSBs responded to the survey. According to the responses, 29 CSBs had never used the "step-down" MOT procedure, while four CSBs reported that they had used it. These four were Cumberland Mountain, Harrisonburg-Rockingham, Region Ten, and Valley CSB.

Of the four CSBs who reported using the "step-down" MOT procedure, two of them had only used it once. Both of these CSBs had a positive experience with their "step-down" case and it also seemed that in both cases, the client agreed with the plan to use a "step-down" procedure. The remaining two CSBs that reported using the "step-down" procedure had each used it a couple of times. One CSB stated that they had used it

a couple times with Western State Hospital with moderate success. They felt that, "it's a good structure to have, but still very cumbersome to implement the review process if there are compliance problems." Furthermore, local special justices are still skeptical and unenthusiastic about oversight: "He'd rather we just TDO the person back to the hospital." The other CSB stated that they used it most often with "individuals who are chronic and are frequently non-compliant/detained who 'buy into' being compliant with the Court." They also reported some resistance from the special justices in their jurisdiction because of a "continued lack of understanding," stating that they were "continuing to educate."

Twenty-nine CSBs reported that they had never used the "step-down" MOT procedure. The major reasons for the lack of use are listed below:

1. ***Documentation of prior commitments***. A "step-down" MOT may be used only if the person has been subject to an order for involuntary admission at least twice within the past 36 months. Special justices in some jurisdictions say that testimony regarding two prior commitments is hearsay and is therefore inadmissible in court unless a court-certified copy of the commitment order is admitted. In addition, even if the CSB could obtain certified copies of prior commitment orders, step-down MOT may be ordered only if the person has "a history of lack of compliance with treatment." For this, respondents' attorneys are saying that the testimony is hearsay unless it is provided by the prior treatment providers with first-hand knowledge of the client.

2. ***Resistance by special justices.*** Many CSBs have stated that MOTs and the new "step-down" MOTs are unpopular with the special justices because MOT "has no teeth" and "is more of a hassle than it's worth."

3. ***Concerns regarding the consequences of "step-down" MOT non-compliance.*** Many of the CSBs expressed concerns about the lack of consequence for clients who are non-compliant with the MOT order. One CSB said, "In reality if the client doesn't follow through with the MOT we can do nothing unless they again met commitment criteria and then they should be re-detained. So what is the point of doing?" Another CSB expressed, "If there was a clear consequence for the client (jail, state hospitalization, mandatory 14 day stay, etc.) when they did not comply with the order, perhaps we would feel better about using it."

4. ***Limited resources for outpatient treatment***. CSBs cite a lack of resources as another major reason why the "step-down" MOT procedure is not being used. For some, it is the fear of "a lot of case management, paperwork, and manpower." Others feel that they do not have the outpatient services that are needed to adequately support an MOT order. One CSB stated "the biggest roadblock is the collaboration it would take between CSB, the hospital, the legal team and the courts and everyone is already overwhelmed."

5. ***Restrictiveness of eligibility criteria***. Many of the CSBs have not been able to use the “step-down” procedure because they feel that the criteria required for a “step-down” case are too narrow and restrictive. They have not been able to identify a case that meets the criteria for “step-down” MOT.

Concluding Comments

There were great variations in the information recorded in each MOT file and the Commission was unable to interview and survey every CSB in the state. However, it appears that CSBs and special justices are reluctant to order MOT for a variety of reasons. Moreover, when used, the MOT process still lacks standardization. Although each court must fill out the 1006-CO, the 1006-IE, and approve of an MOT treatment plan for each client, there are large differences in the specificity and detail of the information included in these forms, specifically in the MOT treatment plan. Some of the plans were very comprehensive, with goals, objectives and strategies. Others only outlined the treatment plan in general terms.