I. Examine the American Psychiatric Association position statement on an involuntary outpatient commitmentLinks to an external site.Open this document with ReadSpeaker docReader . Now, consider the position statement on involuntary mental health treatment provided by Mental Health AmericaLinks to an external site..
    I. In what ways are the positions similar? In what ways do they differ? How do they compare to the legal requirements in your intended state of practice?
    II. After reading the position statements, with which statement do you find yourself more philosophically aligned? Explain why.
    III. What legal recourse do clients have if they disagree with involuntary treatment decisions in your intended state of practice?
    IV. At times, providers may experience moral distress when ordering involuntary treatment. What type of situation might create moral distress for you? What resources exist for providers experiencing moral distress?
    V. In what ways might your perspective about involuntary psychiatric treatment impact the choices you make in practice?
II. **Integration of Evidence:** Integrate relevant scholarly sources as defined by program expectationsLinks to an external site.

I. Involuntary outpatient commitment is a civil court procedure where a judge orders a person who has severe mental illness to comply with an outpatient treatment plan designed to prevent relapse and dangerous deterioration (American Psychiatric Association, 2020). The American Psychiatric Association (APA) and Mental Health America (MHA) positions are similar because both recognize involuntary treatment as an ethically serious intervention that must include due process, individualized treatment planning, least-restrictive care, and access to adequate community services. They differ in emphasis: APA supports involuntary outpatient commitment/ Assisted Outpatient Treatment (AOT) as a useful, recovery-oriented tool for a narrow group of people with severe mental illness when voluntary care has failed, while MHA is more autonomy-centered and states that involuntary treatment should be rare, last-resort, and limited to serious/imminent risk or near-certain need for inpatient care (Mental Health America, n.d.). Maryland law now aligns more closely with APA because Maryland passed AOT legislation requiring statewide implementation. While inpatient involuntary admission still requires clear and convincing evidence of mental disorder, findings point to significant improvements across a range of client outcomes upon receipt of AOT, spanning domains of treatment adherence, clinical functioning, and social functioning (Johnson et al., 2025).

II. I find myself more philosophically aligned with MHA because its position prioritizes autonomy, dignity, trauma-informed care, and voluntary engagement before coercion; however, I also recognize APA's practical concern that some clients with severe and persistent mental illness experience repeated relapse, hospitalization, incarceration, or dangerous deterioration when treatment adherence fails. As a future PMHNP, I would support involuntary treatment only