American Psychiatric Association

Task Force Report

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INVOLUNTARY COMMITMENT TO OUTPATIENT TREATMENT

REPORT OF THE TASK FORCE ON INVOLUNTARY OUTPATIENT COMMITMENT

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Publication authorized by the Board of Trustees, June 1987

This is the twenty-sixth report in a monograph series authorized by the Board of Trustees of the American Psychiatric Association to give wider dissemination to the findings of the Association's many commissions, committees, and task forces that are called upon from time to time to evaluate the state of the art in a problem area of current concern to the profession, to related disciplines, and to the public.

Manifestly, the findings, opinions, and conclusions of the Task Force Reports do not necessarily represent the views of the officers, trustees, or all members of the Association. Each report, however, does represent the thoughtful judgment and consensus of the task force of experts who formulated it. These reports are considered a substantive contribution to the ongoing analysis and evaluation of problems, issues, and practices in a given area of concern.

George H. Pollock, M.D.
President, APA 1987—1988

ACKNOWLEDGMENTS

The Task Force wishes to express its appreciation to Richard Bonnie, J.D., for useful suggestions on the statutory language and to Loren Roth, M.D., MPH, for his helpful suggestions on the report as a whole.

ISBN 0-88048-224-9
Library of Congress Catalogue Card No. 87-73006

1400 K Street, NW., Washington. D.C. 20005

REPRODUCTION NOTE

This document differs in pagination from the originally published Task Force Report. To verify a citation or quote, search this document by word or phrase for the statement of interest.

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INVOLUNTARY OUTPATIENT TREATMENT

Prior to the late 1960's, involuntary treatment of the mentally ill was provided almost exclusively in long-term inpatient facilities. The majority of patients suffered from chronic illnesses for which there were no effective treatments which could permit many of them to be discharged into the community. Although the legal authority for commitment emanated from state statutes, the process, essentially dominated by clinicians, held few procedural protections for patients facing commitment (1).

With the growing availability of effective treatment for chronic mental illnesses in the 1960's, the community mental health movement and advocates concerned with patients' civil rights worked for the deinstitutionalization of as many hospitalized patients as possible (2,3). Legislators were attracted to the movement by the prospect of saving money through hospital closure and less expensive community treatment (4). The combination of stricter commitment laws (most of which incorporated the criterion of treatment in the least restrictive environment (5)) and the establishment of federally-supported community mental health centers led to a massive depopulation of the public mental hospital system. Significantly shorter lengths of stay over the past 30 years resulted in a 75% reduction in inpatient censuses in public mental hospitals (6).

The purported effectiveness of deinstitutionalization was predicated both on the availability of effective treatment in the community (7), and on the willingness of patients to accept treatment voluntarily (8). Unfortunately, a majority of the proposed community treatment facilities were never created (6), and many of the discharged patients continued to be unwilling to accept treatment voluntarily (9), discontinuing treatment immediately after discharge. Further, a growing number of young adult chronic patients did not accept the need for treatment, and could not be treated involuntarily because they failed to meet the criteria of reformed commitment laws designed to limit the use of involuntary hospitalization (10). Many of these patients responded well to treatment when hospitalized, but rapidly relapsed after discharge, leading to the "revolving door" syndrome of repeated brief hospitalizations followed by relapse after discharge. As the chronic patients who could not be treated effectively under existing conditions grew in number and became increasingly visible, especially in the psychiatric ghettoes in large urban centers, a need for the provision of involuntary treatment for outpatients became more and more apparent (11, 12).

SURVEYS OF OUTPATIENT COMMITMENT STATUTES

A number of states have made provision for such involuntary treatment. A 1982 survey of state statutes by Luskin revealed that forty-eight of the fifty states had incorporated a requirement that involuntarily committed patients be treated in the least restrictive environment (13). The survey found that while twenty states had enacted provisions for commitment to outpatient treatment as an alternative to involuntary hospitalization, few among them had provided explicit statutory procedures to govern such commitment.

Almost all the states had statutory provisions for outpatient treatment if used as a condition of discharge from inpatient commitment (conditional release). While a number of states provided explicit procedures governing revocation of such conditional release, little in either statute or case law articulated criteria by which decisions to commit to outpatient treatment were to be made. The survey revealed that, in most states, decisions to require outpatient treatment were left up to the unregulated judgment of clinicians (13).

A 1985 survey of state commitment statutes (14) distinguished outpatient commitment from conditional release: in the former, the decision-making power resides with the court rather than with the treatment facility and the decision to order outpatient commitment occurs at the initial commitment hearing. Thus, the two studies are not exactly comparable. The 1985 survey reported that while no state with the exception of New York prohibits outpatient commitment, only 26 states and the District of Columbia make explicit provisions for it. The remaining 24 states neither explicitly prohibit nor establish procedures for out patient commitment.

A mail survey in 1984 questioned mental health program directors and attorneys general in all fifty states, and the District of Columbia, Puerto Rico, and the Virgin Islands about both statutory provisions of outpatient commitment and its implementation in practice (15). Follow-up questionnaires and telephone calls yielded a 100% return rate from the mental health programs, and 74% from attorneys general. Seventy-nine percent of the mental health program directors replied that outpatient commitment was permitted in their jurisdictions. The responding attorneys general (39 jurisdictions) agreed with their mental health directors in only 74% of cases.

In contrast to the findings of the 1982 and 1984 surveys of statutes (13,14), mental health directors, in 37 of the 42 jurisdictions (88%) in which outpatient commitment was permitted, said that commitment could be to outpatient treatment initially. In further contrast to Luskin's findings (13), mental health program directors reported that decision-making power to commit to outpatient treatment was vested predominantly in judicial decision-makers (76%) rather than in treating clinicians (18%) or mental health departments (6%).

A significant problem with statutes, pointed out by Luskin (13), was that they failed, in most cases, to distinguish among populations for whom outpatient— as opposed to inpatient—commitment was appropriate. The 1984 survey of mental health directors (15) continued to support this judgment: 35 of the 43 mental health directors in jurisdictions permitting outpatient commitment said that the substantive criteria for outpatient and inpatient commitment were identical.

Thirty of the mental health program directors attempted to estimate how frequently outpatient commitment was used. Nineteen said it accounted for less than 5% of commitments; eight, between 5 and 10%; two, 10%; and one. 20%. There was a strong positive correlation between estimated frequency of use and perceived usefulness of outpatient commitment by the mental health directors and attorneys general.

No attempt was made to correlate questionnaire responses with the statutes in effect at the time of the survey, although some respondents included excerpts from their statutes with their responses. Thus, the replies reflect what respondents thought was the case rather than what the statutes actually provided. However, since both legal and clinical practitioners operate on their understanding of rules and statutes, in reality the impressions were arguably more important than were the statutory intents.

STUDIES OF OUTPATIENT COMMITMENT

While a large number of research studies of involuntary hospitalization have been conducted (16). few specifically have dealt with outpatient commitment. The early studies were limited in scope. and differences in methodology and definitions of success prevented the generalization of their results. Because of these differences, as well as differences in jurisdictions, the authors came to varying conclusions concerning the efficacy of outpatient commitment.

The first reported study, by Hiday and Goodman (17), was generally positive. The authors reported on the experience of one catchment area in North Carolina in 1978-1979. They measured the re-hospitalization rates of the 408 patients committed to outpatient treatment over the two-year period, and found that only 29% were returned to the hospital within the maximum outpatient commitment period of 90 days. Half of those patients were returned because they had not complied with their required treatment plans. not necessarily because they had again become dangerous. Of those who were returned to the hospital, fewer than half were involuntarily hospitalized following the required hearing; most were either returned to the community under a further outpatient treatment order or allowed to seek voluntary hospitalization. The authors concluded that the overall involuntary re-hospitalization rate of 12.5% indicated that for the patients studied outpatient commitment was successful. The authors recognized that the use of re-hospitalization as the criterion of success was subject to criticism. Nonetheless, they did not assess the comparability of re-hospitalization rates with, for example, the rate by which patients were released by the court against medical recommendation. The authors, more concerned with the liberty aspects of commitment, did not attempt to assess the type or effectiveness of the treatment received. Because their approach precluded drawing distinctions between the effects of outpatient treatment and the effects of simply being discharged from the hospital, the applicability of their data to the question of the clinical efficacy of outpatient treatment itself is limited.

Other authors (18.19) came to less favorable conclusions about the efficacy of the practice of outpatient commitment. Miller and Fiddleman (18) retrospectively studied outpatient commitment in a North Carolina catchment area different from that studied by Hiday and Goodman (17). The study was undertaken after enactment of 1979 statutory changes which redefined the patient population for whom outpatient commitment could be ordered, requiring that the proposed treatment be available at the facility to which commitment was proposed. The statute also established specific procedures for dealing with noncompliance with such treatment.

The authors studied all patients committed to outpatient treatment in the catchment area during a period encompassing both six-months prior to and after the statutory changes, following the patients for a year after their initial commitments. The authors investigated re-hospitalization rates and the type and effectiveness of treatment received, as judged by the staff of the mental health centers to which the patients had been committed. They also studied the impact of the statutes' procedural changes.

Some differences were noted between the patients' experiences in the two study periods. Clinicians recommended outpatient treatment for more of the patients who were committed to outpatient treatment after the changes than before (77% as compared to 44%). Consultation as to the appropriateness of the proposed commitment from mental health centers to which patients were committed rose from 6.7% to 19.2% of cases. Court notification to centers of patients committed to them rose from 62.1% to 77.8%. In 64.3% of cases after the law changed as compared with 49.2% before mental health centers took some sort of action if patients did not comply with the court-ordered treatment. In the pre-change study period, none of the outpatients was re-hospitalized; after the statutory changes, 9 patients (32%) were re-hospitalized.

Despite these differences, the authors found that patients' treatment experiences had changed very little. During the post-change study period, mental health center staff were still involved in generating the outpatient treatment plan in fewer than 19% of cases. Moreover, the centers reported that the percentage of patients who complied with their court-ordered treatment plans actually dropped from 77% to 50% in the period after the statutory changes. Mental health center staff evaluated court-ordered outpatient commitment as effective in only 46% of the cases in both study periods.

As has been emphasized in another paper (20), a major problem with outpatient commitment in the catchment area studied was that a significant proportion of the commitments was the result of negotiation between the patient's attorney and the judge, analogous to plea bargaining in criminal cases. Such bargaining frequently ignores both the expressed wishes of the patient and the clinical recommendations of the treatment staffs of both the hospital and the proposed outpatient facility. As a result, many of the commitments were clinically inappropriate and not well accepted by the patients. Community staff understandably were reluctant to implement involuntary treatment with patients who would not benefit from it.

Miller and Fiddleman postulated (18) that another reason why outpatient commitment had not been more successful was the ideological resistance of community based clinicians to involvement in the provision of involuntary treatment. They investigated this hypothesis by surveying attitudes toward involuntary treatment and toward the responsibility for treating chronic patients of nearly 200 clinicians and administrators at one state mental hospital and four representative mental health centers in the hospital's catchment area, the same catchment area which was the subject of their previous outpatient commitment study (21).

The results of the study supported the authors' hypothesis that community clinicians were resistant to treating the types of patients most likely to be subject to outpatient commitment. In contrast to hospital clinicians, they were more likely to endorse statements that commitment should be only to inpatient treatment, and less likely to agree that community staff have an obligation to provide outreach services to patients who don't come voluntarily for treatment. Community clinicians generally did not concur that treating chronic patients should be a community center's primary responsibility, that psychotropic medications are necessary for the treatment of many patients. and that patients committed to outpatient treatment should be given psychotropic medications involuntarily if clinically indicated.

Miller (22) has pointed out that political boundaries and legal regulations often hamper communication between inpatient and outpatient facilities. State regulations and statutes governing confidentiality prevent information sharing between the state hospital system and the county community mental health system. These barriers make attempts to commit patients to outpatient treatment even more difficult, particularly if the outpatient commitment is a conditional release from hospitalization and thus involves a transfer between the two systems of care. In practice, confidentiality statutes and regulations can prevent inpatient staff from involving outpatient staff in the treatment planning required to provide effective outpatient care on conditional release (18).

Bursten (19) studied the effects of 1981-1982 Tennessee statutory changes which created provisions for court-ordered outpatient treatment as a condition for release from inpatient commitment. Like Hiday (17), he used readmission rates of patients committed to such outpatient treatment to measure the success of the new law. His research design was more sophisticated, comparing readmission rates for patients committed to outpatient treatment at four state hospitals with their admission rates before the index admission, and with patient readmission rates at another Tennessee hospital which chose not to utilize the new outpatient provisions. His data, on 156 patients, revealed that decreased readmission rates could not be attributed to the utilization of the new statute. He concluded that since there was no evidence that commitment to outpatient treatment offered patients any advantage over outright discharge, the increased restrictions involved in the commitment, especially the involuntary administration of medication, were not justified by the results. He also postulated that patients ready for discharge arguably were not committable under a dangerousness standard.

In contrast to the somewhat negative conclusions of these preliminary studies in North Carolina and Tennessee, other reports have indicated that outpatient commitment can be quite effective if it has the support of the clinicians involved. Band et. al. reported on a generally positive thirteen-year experience with commitment to outpatient treatment at St. Elizabeths Hospital in Washington, D.C. (23). They studied 94 of the 293 patients committed to outpatient treatment at St. Elizabeths Hospital, who made up over 90% of patients committed to out-patient treatment in the District of Columbia during the study period, providing a detailed analysis of demographic and diagnostic profiles of patients committed to outpatient as compared to inpatient treatment. The study also reported the results of attitude surveys and experiences of staff who had treated committed Outpatients at St. Elizabeths.

The St. Elizabeths staff experience with outpatient commitment was generally favorable. They felt that outpatient treatment was appropriate and effective for the majority of the patients committed to them. The authors attributed the attitudinal difference between the studied staff and other attitudinal reports of out patient treatment staff to two factors: patients are committed to the same facility whether for inpatient or outpatient treatment, and many patients are treated by the same clinicians in both settings. Unlike the more usual situation, in which inpatient and outpatient facilities have separate buildings and staff, the same St. Elizabeths' staff treat patients in both settings, and have no incentive to return difficult patients to inpatient treatment. In addition, since the clinicians work regularly with chronic patients, they are not as reluctant to work with this population as are many other community-based clinicians.

Band and his colleagues also attempted to measure the effectiveness of out patient commitment to St. Elizabeths by comparing the pre- and post-outpatient commitment experience of a cohort of all patients committed to outpatient treatment during 1983 (42 patients). They found that the patients averaged 1.81 admissions in the year prior to their outpatient commitments as compared to 0.95 in the following year. Between the same two periods the average length of hospitalization dropped from 55 to 38 days. The authors pointed out that additional work needs to be done to investigate actual patient functioning, service utilization, family satisfaction, and clinical outcomes. Nonetheless, they concluded that, by at least one measure, their data support the effectiveness of outpatient commitment (24).

Miller et. al. (19) have reported on the effective use of outpatient commitment in Wisconsin. For the past several years in Dane (Madison) and Milwaukee Counties, between 75-80% of all commitment hearings have ended in negotiated dispositions. In most of these cases, the patient agreed to accept outpatient treatment "voluntarily." While technically not outpatient commitment, in practice it has the same effect, since patients know that if the prescribed treatment plan is not followed, there is a good chance of being involuntarily hospitalized. Data for the past few years have indicated that the vast majority of these patients cooperate with their outpatient treatment and avoid hospitalization. There appear to be several reasons for the success of outpatient treatment in these two jurisdictions. Both counties have a wide range of available community-based services, and both have active mental health attorneys representing patients at hearings, with enough time to prepare cases effectively. Because the Milwaukee attorneys have social workers available to them, they can both independently investigate community alternatives to hospitalization and present those alternatives at the hearings. It is also significant that state law reinforces a preference for community-based treatment by placing financial liability on counties if they choose to utilize state inpatient facilities.

In another case report-based article, Geller presented preliminary findings from a study assessing "unofficial" use of coerced outpatient treatment in Massachusetts, a state without formal procedures for outpatient commitment (25). He maintained three bipolar patients in the

community by telling them that he would initiate petitions for involuntary hospitalization if they failed to comply with their treatment plans, which included monitored lithium. This technique successfully interrupted previous chronic cycles of medication noncompliance and repeated extensive hospital admissions for periods ranging from 289 to 625 days. Van Putten (26) reported similarly reduced hospitalization and increased compliance with treatment in an outpatient commitment study sample in Arizona.

While many reports of the use of outpatient commitment have focused primarily on the treatment of psychotic patients with medication, Schneider-Braus presented a New Mexico case of commitment to outpatient psychodynamic therapy (27). Prior repeated hospitalizations had not interrupted the patients' pattern of suicidal behavior: she had never complied with recommended treatment after discharge. The commitment—initially for 30 days and subsequently extended for an additional 6 months—seemed to give the patient both concrete evidence of the therapist's concern and the promise of some stability. Treatment progressed more effectively than before the commitment, resulting in a number of positive behavioral changes that were maintained over a two-year follow-up period.

Perhaps the best large-scale demonstration of the potential effectiveness of involuntary outpatient treatment is the reported success of an Oregon State system for providing aftercare and supervision for insanity acquittees (28). The authors review the first five years of operation of the Psychiatric Security Review Board system to which the majority of the state's insanity acquittees are committed. They concluded that the program had been very successful in preventing repetition of criminal behavior both because it permitted close supervision of the patients. and because the enabling statutes provided for adequate community treatment resources. Since the patients had been proven to have committed criminal acts, it is perhaps not surprising that the state was willing to undertake such close supervision and to commit sufficient resources to aftercare. The program experience demonstrates clearly, however, that of inpatients with chronic mental disorders similar to those of patients for whom involuntary outpatient treatment has been proposed, outpatient treatment can be effective when the treatment is actually available and if adequate supervision is provided.

THE IMPACT OF RECENT STATUTORY CHANGES

Recently, several states have significantly revised their statutes by establishing less stringent criteria for outpatient commitment than for involuntary hospitalization. North Carolina (29) and Hawaii (30), whose legislatures enacted their statutes in 1984, provide for court-ordered outpatient treatment for persons who are mentally ill, under three conditions. They must be capable of surviving safely in the community with available supervision from family, friends or others; be in need of treatment to prevent deterioration, based on history, that would predictably result in dangerousness; and be unable to make an informed decision to voluntarily seek or comply with recommended treatment.

Arizona (31), too, has made recent changes in its outpatient commitment statutes which permit commitment to outpatient treatment. The court must find that the person does not require hospitalization, will be more appropriately treated in an outpatient treatment program, will follow a prescribed treatment plan, and will not likely become dangerous or suffer more physical harm or serious illness if he follows a prescribed outpatient treatment plan. The statute also provides protection for clinicians implementing outpatient treatment, stating that when out-patient treatment constitutes conditional release from hospitalization, the facility medical director is not civilly liable for any act committed by a patient while in conditional outpatient treatment if the medical director has in good faith followed the specified statutory procedures in the release.

The North Carolina statute allows an individual physician both to initiate the outpatient commitment process, and to specify the treating physician. A court hearing is scheduled; an attorney may be appointed if the judge determines it to be necessary for adequate representation of a patient's side of the case. If the district court concurs in the recommendation for involuntary outpatient treatment, a patient may be ordered to attend the outpatient facility for up to 90 days. The commitment may be renewed at rehearings for additional 90-day periods as long as the criteria continue to be met. In contrast, the previous outpatient statutes limited outpatient commitment to no more than one 90-day period, If a patient does not appear at the designated outpatient facility for treatment, the county sheriff is authorized by the commitment order to assume custody and to transport the patient to the facility. In anticipation of an increased outpatient caseload, the General Assembly authorized payments of $2,000 per year per patient committed to facilities providing outpatient treatment under the new law.

The same statute explicitly prohibits the forcible administration of medication as part of the outpatient treatment. After hearings, the legislature determined that such a provision was unnecessary since the most common reasons for the failure to follow court-ordered treatment plans were the lack of either transportation or family support, rather than an explicit refusal by the patient (32). If the patient does not comply with the court-ordered treatment, a supplemental hearing may be scheduled either to reiterate the outpatient treatment order or to order involuntary hospitalization if the stricter criteria (including dangerousness) are met.

The Hawaii statute contains similar provisions. However, in contrast to the North Carolina statute, the petitions may be initiated by any adult, and an attorney is required if the judge determines one is necessary for adequate representation of the patient's case or if an indigent patient requests one.

If the court concurs with an outpatient commitment recommendation, involuntary outpatient treatment may be ordered for up to 180 days, renewable at rehearings for additional 180-day periods. If clear and convincing evidence is presented at a hearing, the court may authorize types or classes of medication in a treatment plan, but such medication may not be administered forcibly to an outpatient. If a patient fails to comply with court-ordered treatment, a supple mental hearing may be scheduled. At such a hearing, the judge may order involuntary hospitalization if the stricter criteria, including dangerousness, are met. A patient may not be re-committed to outpatient treatment at such a supplemental hearing.

A preliminary survey of selected outpatient treatment facilities in North Carolina (33) demonstrated that counties with local inpatient facilities found the new type of outpatient commitment to work well with some patients. Some counties said that a third or more of their commitments were to outpatient treatment; a significant number were initiated locally without prior patient hospitalization. As found at St. Elizabeths, when staff from the same program are responsible for patient treatment regardless of treatment site, outpatient commitment tends to be more effective. Community clinicians working with the new law have found difficulty predominantly in two areas: the patients' ability to refuse medications, and the reliance on hospitalization as the sole consequence of noncompliance (again, usually with medications) with the outpatient treatment plan.

Hiday and Scheid-Cook conducted a more detailed analysis of the impact of the new North Carolina law during the first six months of its operation (34). They studied three of the four geographical regions of the state, and found that the use of outpatient commitment varied from 3.8% to 17.9% of all commitments. In their terms, of 295 respondents committed to outpatient treatment whom the authors followed intensively, 148 (50.2%) were considered to be placed appropriately (meeting all statutory criteria), and 31 (10.5%) were found to be both placed appropriately and actually attending the facility to which they were committed. Patients defined as inappropriately committed included those without histories of prior hospitalizations, dangerous behavior, medication refusal, or diagnoses of severe mental disorders.

They found that those committed to outpatient treatment were more likely to have had prior hospitalizations, more likely to have had prior

outpatient commitments, more likely to have been diagnosed as schizophrenic, and more likely to have refused medication prior to commitment than those not committed. They also found that roughly half of all patients committed to outpatient treatment refused medication and demonstrated other types of noncompliance with treatment during the six-month study period. Noncompliance behavior was not consistent. The episodes of noncompliance were typically infrequent, since an average of 80% of patients made more than six visits to the outpatient facility, and 80% of patients who kept at least one appointment were still in treatment at the end of the six-month study period. Nearly 80% of the patients committed to outpatient treatment remained in the community during the six-month study period, ap proximately the same rate of success as with patients previously involuntarily hospitalized and then released.

The authors also found, as have previous studies (18,20,23), that a major variable in determining the effectiveness of commitment to outpatient treatment was active support from the providers of that treatment. At the beginning of the study period, some facilities indicated that they either opposed the concept of outpatient commitment or did not believe that it would work effectively. Other facilities were more enthusiastic some even created new case manager positions to work with the expected new client population. The belief in the efficacy of outpatient treatment often was translated into programs which reinforced their prior expectations. In contrast, facilities that anticipated difficulty with the new law often found what they expected. However, some facilities that initially had been unenthusiastic about the process were convinced, by their experience, to expand the use of outpatient commitment.

The authors concluded from their data that although some patients are being committed inappropriately and some facilities are not taking advantage of the new provisions, outpatient commitment, in fact, is working with a group of chronically mentally ill who otherwise would not accept treatment.

IMPLICATIONS FOR THE FUTURE USE OF OUTPATIENT COMMITMENT

Clinicians and patient advocates alike had hoped that the establishment of the national community mental health center system would facilitate the deinstitutionalization of most, if not all, involuntarily hospitalized mental patients (35), who could then be treated effectively as outpatients on a voluntary basis. Some communities were able to establish comprehensive services addressed to the population of chronic patients released from hospitals in the 1960's and 1970's (36). The census of state mental hospitals did fall from 555,000 in 1955 to 138,000 in 1980 (6). Yet a number of reports have made it clear that deinstitutionalization has not been the panacea for the mentally ill that proponents had predicted (37,38). While lengths of stay were falling (6), admission rates to mental hospitals actually have increased significantly. Attempts to close the hospitals have met with little success (39).

There are many complex reasons for the relative failure of deinstitutionalization. One major factor has been the disinclination of many patients to seek voluntary outpatient treatment after release from hospitals (39). In particular, the failure of patients with psychotic illnesses to continue with medication after discharge is a leading cause of involuntary re-admissions to inpatient facilities (40). Much of the success of early community-based treatment programs de pended upon the careful selection of patients and the willingness to develop (and fund) aggressive outreach services to locate patients who would not come into the centers on their own (41.42). However, recent studies have demonstrated that many community-based centers prefer not to deal with noncompliant patients (6,20). As federal funding for community mental health centers has dwindled, the fiscal incentives for the provision of services to deinstitutionalized patients also has decreased significantly (43). Consequently, a significant number of patients who had been hospitalized (or who would have been hospitalized previously) are receiving little or no treatment in their communities. Many are homeless (44); others have come under the control of the criminal justice system through arrests, competency to stand trial evaluations, or insanity pleas (45-47).

There is evidence, however, that these trends have begun to change. The original goal of the community mental health center movement to provide services to deinstitutionalized patients—has been receiving greater emphasis by national organizations and state legislatures. The plight of the chronic patient in the community has received greater attention in the professional literature than in the past (11); residency programs are placing increased emphasis on training psychiatrists to deal with this population (48).

A growing number of patients and advocates are challenging judicial and clinical decisions to discharge patients against their will or to prevent voluntary admissions (49), in what Rachlin has called "involuntary communitization" (50). Others are demanding the provision of promised community-based services for discharged or never-hospitalized patients (49,51). Despite the purported in voluntary nature of civil commitment (52), several studies of patients' attitudes toward commitment reveal that once treatment has had an opportunity to be effective, the majority of patients realize that involuntary treatment was in their best interests (53). Some patients have even consciously arranged to be committed, realizing that the structure provided by the commitment is necessary to overcome their resistance to therapy at times when they are most ill (27,54). Formal commitment thus may reassure patients who are fearful of rejection by providing assurance that the facility, too, is committed to providing treatment.

Task Force members are in agreement that such commitment to outpatient treatment can be a preferable alternative both to involuntary hospitalization and to no treatment for a specific population of patients. The patients for whom such commitment might be expected to be most effective include those with psychotic illnesses which respond well to antipsychotic medication, but who have a demonstrated pattern of noncompliance with medication after inpatient discharge. Another target population would be those patients who need externally imposed structure in order to function as outpatients, but who are not capable of requesting the establishment of such structure on their own.

Because of the problems discussed above, it is crucial that clinicians provide substantial input into the decision-making process for involuntary outpatient treatment. Judicial officials should not be able to commit someone to clinically inappropriate outpatient treatment simply because it is perceived as either "less restrictive" or more convenient than hospitalization. Outpatient commitment should not become simply another method through which community officials can delegate to clinicians the authority and responsibility to control socially undesirable persons without regard to their treatment needs. Placing the prime responsibility for the initiation of outpatient commitment in clinical hands, as is done in North Carolina, would be an effective barrier to the use of outpatient commitment absent strong clinical justification.

Clinical input is equally important because of the shift in social concern from the protection of individual rights to the protection of society from dangerous acts. For many years, psychiatrists have been accused of utilizing existing commitment laws as preventive detention (55,56). Although commitment practice reforms have made it more difficult to utilize hospitalization to control merely irritating persons, the ascendancy of dangerousness criteria for commitment and the growing trend toward the use of tort litigation to pressure outpatient clinicians to prevent their patients from harming third parties (57) have combined to create significant pressure to commit patients without clear clinical justification (58). Given the legal practice of equating the degree of control with liability (59), it is certainly possible that clinicians who accept outpatients committed to their care might bear greater legal responsibility for their actions than had the patients been seen under other circumstances. Courts might well expect clinicians to be more assertive in following up with outpatients formally committed to their care than they are with voluntary outpatients, regardless of their clinical condition. It is essential,

therefore, that clinicians be provided with reasonable immunity for their decisions if they are to accept committed patients.

It also should be possible to commit patients to outpatient treatment without first having to hospitalize them unless they require hospitalization on clinical grounds. Similarly, it should be possible, as in North Carolina and Hawaii, to commit patients to outpatient treatment without the strict criterion that they be dangerous, as long as sufficient evidence exists to establish that, without such intervention, the patients would deteriorate to a point that hospitalization would be necessary. As incorporated into the revised outpatient commitment statutes in both Hawaii and North Carolina, the best evidence for predictions of deterioration is past experience. Strict adherence to such criteria would provide strong safeguards against the indiscriminate use of outpatient commitment to control annoying or unpleasant persons who do not suffer from severe mental disorders requiring psychiatric intervention.

Outpatient commitment is still a relatively new and untested treatment modality, with the potential to provide effective treatment to patients not now being reached in a timely fashion by the mental health care delivery system. Yet the new modality poses the risk of extending state control over those who exhibit merely socially unacceptable behavior. Moreover, those opposed to involuntary hospitalization may try to utilize outpatient commitment under all circumstances in an effort to make such hospitalization even more difficult. Because a growing number of states are investigating the increased use of commitment to outpatient treatment, clinicians should provide whatever information and experience they possess to assist policy makers in formulating the best possible systems. It is also crucial that clinicians and researchers monitor the impact of such changes in order to evaluate the clinical effectiveness of the treatment provided, and to continue to provide relevant data to policy-makers for future revisions.

The American Psychiatric Association's Guidelines for the Psychiatric Hospitalization of Adults (60) does not contain provisions for initial commitment to outpatient treatment, although it does provide for conditional release. It has been criticized for ignoring this option (61), particularly since a number of legislatures are actively considering adopting outpatient commitment statutes. We believe it is imperative for clinical professionals to provide their experience and expertise to help to shape these new laws. To that end, we offer a proposed supplement to the APA Guidelines.

PROPOSED SUPPLEMENT TO AMERICAN PSYCHIATRIC ASSOCIATION GUIDELINES FOR LEGISLATION ON THE PSYCHIATRIC HOSPITALIZATION OF ADULTS (60)

The Task Force on Involuntary Outpatient Commitment believes that the American Psychiatric Association Guidelines for Legislation on the Psychiatric Hospitalization of Adults provides the most appropriate model for legislation governing the involuntary psychiatric treatment of adults. The Guidelines already provide for involuntary placement in outpatient facilities by requiring that commitments be "consistent with the least restrictive alternative principle." (61, Section 6.C.2) For those jurisdictions considering the adoption of more definitive procedures to govern involuntary outpatient commitment, we recommend the following additions to the Guidelines.

Section 3: Definitions

"Outpatient commitment" means a court order directing a person to comply with specified treatment requirements, not involving the continuous supervision of the person in a residential setting. that are reasonably designed to alleviate or reduce the person's illness or disability, or to maintain or prevent deterioration of the person's mental or emotional functioning. The specified requirements may include, but need not be limited to, taking prescribed medication, reporting to a facility to permit monitoring of the person's condition, or participating in individual or group therapy or in educational or vocational programs.

Section 6A: 1 80-day Outpatient Commitment

Sections 6A(A)-(B) identical to Sections 6(A)-(B)

6A.C. Criteria for 180-day outpatient commitment. A person may be com mitted to outpatient treatment for a period of up to 180 days if, after the hearing conducted pursuant to Section 6A(D), the court determines, on the basis of clear and convincing evidence, that:

I. the person is suffering from a severe mental disorder; and

2. the person, without treatment, (a) is likely to cause harm to himself or to suffer substantial mental or emotional deterioration, or (b) is likely to cause harm to others; and

3. the person lacks capacity to make an informed decision concerning his need for treatment; and

4. the person has been hospitalized for treatment of severe mental disorder within the previous two years and has failed to comply on one or more occasions with the prescribed course of treatment outside the hospital; and

5. an acceptable treatment plan [as defined in Section 9.B] has been prepared which includes specific conditions with which the patient is expected to comply, together with a detailed plan for reviewing the patient's medical status and for monitoring his or her compliance with the required conditions of treatment: and

6. there is a reasonable prospect that the patient's disorder will respond to the treatment proposed in the treatment plan if the patient complies with the treatment requirements specified in the court's order; and

7. the physician or treatment facility which is to be responsible for the patient's treatment under the commitment order has agreed to accept the patient and has endorsed the treatment plan.

Commentary

Since a major purpose of commitment to outpatient treatment is to permit effective treatment of mentally ill persons before their conditions deteriorate to the point where they require inpatient treatment, we recommend that the substantive standards for outpatient commitment be based on the need for and the availability of appropriate treatment, prevention of physical or psychological deterioration, and inability to make a rational treatment decision. The American Psychiatric Association Guidelines for Legislation on the Psychiatric Hospitalization of Adults already contains *parens patriae* standards as sufficient criteria for commitment to inpatient treatment; jurisdictions that adopt these Guidelines obviously would utilize them for less restrictive outpatient commitment as well as for involuntary hospitalization. We recognize that some jurisdictions may choose not to authorize involuntary hospitalization without evidence of dangerousness. However, some of these jurisdictions may be willing to consider in voluntary outpatient treatment without the same degree of evidence of dangerousness as is required for commitment to inpatient treatment.

Another alternative to standards, based chiefly on a need for treatment, is the approach adopted by North Carolina and Hawaii. Their revised statutes permit outpatient commitment of patients who currently may not be dangerous to themselves or to others, but whose predictable deterioration would lead to such dangerousness. Such an approach might provide a useful compromise position between advocates of a need-for-treatment standard and those who feel that the loss of freedom and privacy involved in any form of involuntary treatment can be justified only on the basis of present or future dangerousness. Both North Carolina and Hawaii have operationalized their definitions of deterioration to the point of dangerousness by requiring that determinations be based on past treatment records. This approach has the virtue of providing specific evidence of past behavior, the best basis for prediction of future behavior. However, it restricts the use of outpatient commitment to patients with prior treatment histories. Such a compromise would permit the involuntary

treatment of patients with chronic and severe illnesses, the majority of the proposed target population for outpatient commitment. Further, it might be more palatable to legal critics who demand evidence amenable to evaluation by nonclinical decision-makers.

Another difficulty to overcome is the definition of psychological or emotional deterioration itself, especially if it is not linked directly to dangerousness. Al though statutory definitions of dangerousness have not been noted for their clarity, they have at least had the virtue of standing the test of time in a number of jurisdictions. Some patient advocates can be expected to resist commitment standards based on clinical terms which are difficult to operationalize in behavioral terms. On the other hand, it can be argued effectively that clinicians are much better at predicting clinical deterioration in patients with severe chronic illnesses than at predicting non-clinical (and much rarer) conditions such as dangerousness. Once again, the accuracy of the predictions would be increased by requiring the predictions to be made on the basis of past treatment histories. However, such increased precision would come at the cost of excluding patients suffering their first documented episode of illness.

Several authors (61-65) have pointed out that effective outpatient treatment— whether voluntary or involuntary—presupposes the availability of the facilities and the resources necessary to implement community-based treatment under involuntary conditions and that the history of deinstitutionalization has not pro vided reassurance that these resources will be forthcoming. With the broader criteria for commitment which many supporters of outpatient commitment recommend, and which have been implemented in North Carolina and Hawaii, there is a fear that outpatient commitment might provide the mental health system with increased control over many patients whose freedom is currently safe from interference, without the benefits of treatment to justify the intrusion (61,63,66). These arguments are well founded in the history of involuntary commitment in general, and any system of commitment which would apply to a larger number of patients must provide both increased protections for those at risk, and increased resources to guarantee that effective treatment can be provided (67).

6.A .D. Hearing on 180-day outpatient commitment

Sections 6A.D.(1)-(8) identical to 6.D. (1)-(8).

9. The court shall enter an order discharging the person unless it finds by clear and convincing evidence that the person satisfies all of the criteria for commitment in subsection 6A.C., in which event it shall enter an order committing the person for evaluation and treatment for a period of "up to 180 days." The conditions of the treatment plan shall be specified, and a copy of that treatment plan shall be provided to the patient at the hearing.

If at any time during the 180-day (or any subsequent) commitment a patient substantially fails or refuses to comply with the treatment plan. as it may be amended from time to time by the treating facility or physician, the physician or treatment facility to whose care the patient was committed shall proceed in accordance with section 13 below. Notwithstanding other provisions in these statutes, staff of inpatient facilities in which patients are being treated may communicate with outpatient clinicians without patient consent in order to develop outpatient treatment plans.

Commentary

For several reasons it is essential that clinicians who would provide the treatment be directly involved in the decision-making process when involuntary outpatient treatment is proposed. Since we suggest that outpatient commitment be based on a need for treatment rather than on protection of the patient or others from dangerous behavior (which may be accomplished by the assumption of physical control attendant upon hospitalization), the provision of such treatment is obviously crucial as justification for commitment. Before commitment is ordered, the decision-maker should be satisfied that the proposed outpatient treatment is available through the proposed provider and has a high likelihood of being effective, as demonstrated by the patient's past response to treatment. These requirements, if taken seriously, would prevent the arbitrary use of commitment to control merely socially undesirable behavior, a use of commitment laws that opponents of the expanded use of outpatient commitment fear would result. Such requirements also would involve the outpatient providers directly in the planning of the treatment. Some of the most vocal critics of commitment to outpatient treatment have been clinicians at outpatient facilities who have feared they would be inundated with uncooperative patients who would not benefit from any treatment available at the facility, but for whom the facility would be held responsible.

By requiring that a treatment plan be presented to the hearing officer before outpatient commitment could be ordered, outpatient clinicians would be able to exercise control over the patients to be committed to them and to provide the decision-maker with information on the proposed treatment upon which a commitment decision would be based. The patient should be provided with a copy of the treatment plan so that he/she will be aware of the conditions with which he/she will be expected to comply.

If outpatient treatment is to be ordered as a conditional release from inpatient treatment, information sharing between inpatient and outpatient treatment staffs should not be prohibited by regulations governing confidentiality.

Section 12: Supervision of Outpatients

12.A. Noncompliance with Court Order

1. If a patient substantially fails to comply with the requirements specified in the outpatient commitment order, the physician or staff of the treatment facility shall make reasonable efforts to obtain the patient's voluntary compliance. If the patient repeatedly fails to report, as required, to the treatment facility or physician's office, and the director of the treatment facility or the physician believes that there is a significant risk of deterioration in the patient's condition, the director of the facility or the physician shall notify the police.

2. The outpatient commitment order constitutes a continuing authorization for the police, upon request of the director of the facility or the physician, to transport the patient to the treatment facility or the physician's office for the purpose of making personal efforts to obtain the person's voluntary compliance with the requirements of the outpatient commitment order. Except as authorized under Section 4 of the Act, however, the patient may not be detained at the facility or the physician's office for more than one hour, and may not be physically coerced to take prescribed medication.

3. If a patient substantially fails to comply with the requirement of the court order after reasonable efforts have been made to obtain his voluntary compliance, the director of the treatment facility or the physician shall so notify the court promptly in writing and shall recommend an appropriate disposition.

4. Nothing provided in this section shall limit the authority of any physician or the director of the treatment facility to detain and treat the patient pursuant to the emergency authority conferred by Section 4 of this Act. If such authority is exercised, the director of the facility or the physician shall promptly notify the court in writing.

12.B Supplemental Hearing

Within 5 days of receiving the notice transmitted pursuant to Section 12.A (3) or (4) that a patient has substantially failed to comply with the requirements of the outpatient commitment order, the court shall hold a supplemental hearing in accordance with the procedures specified in Section 6. After hearing evidence concerning the patient's current condition and compliance with the court order, the court shall make whichever of the following dispositions it deems appropriate:

1. Upon finding that hospitalization is necessary to prevent the patient from harming himself or others or to prevent substantial deterioration of the patient's mental or emotional condition, the court shall commit the patient to an inpatient facility for the balance of the commitment period.

2. Upon finding that the patient continues to meet the criteria for outpatient commitment set forth in Section 6A.C., and that an additional

trial of outpatient treatment appears warranted, the court shall renew, with any necessary modifications, the order of outpatient commitment.

3. Upon finding that neither condition 1 nor condition 2 above are met, the court shall rescind the commitment order.

Commentary

While the majority of jurisdictions currently permit commitment to outpatient treatment as a condition of release from involuntary hospitalization, few have established effective procedures to provide direct commitment to outpatient treatment without an initial hospitalization. Since one major goal of a system of outpatient commitment is to prevent unnecessary hospitalization by permitting clinical intervention before a patient deteriorates sufficiently to require hospitalization. it is important to provide a procedure to make an initial commitment to outpatient treatment.

Such procedures frequently may be administratively more complicated than those attendant to conditional release from hospitalization, both since hearings must be held in the community prior to assumption of custody over a prospective patient, and since there must be a mechanism, other than hospitalization, through which to manage non-compliance. The initial commitment order must explicitly authorize law enforcement officers to assume future custody of non-compliant patients. Moreover, there must be a mechanism through which treatment providers can easily trigger the assumption of custody when a patient is significantly out of compliance with the treatment plan. Ideally, the mechanism would provide that the patient be taken to the outpatient facility to receive the prescribed treatment without requiring another hearing. Since this would require a significant, if temporary, abridgement of the patient's liberty, some advocates can be expected to oppose such procedures. North Carolina and Hawaii have met this objection by mandating that a new hearing be held if the patient does not comply with the court-ordered treatment. In North Carolina, if a judge finds that the non-compliance was substantial, he may re-initiate outpatient treatment, order hospitalization, or discharge the patient from the commitment (29). In Hawaii, a judge may either discharge the patient or order hospitalization if the patient meets the inpatient criteria (30).

Particularly in the case of post-release outpatient commitment, in which judges located in one jurisdiction order treatment in another jurisdiction, the statutes must ensure that outpatient commitment orders empower and mandate law enforcement officers to assume custody of non-compliant patients upon notification from the treatment providers. In addition, considerable education of law enforcement officers should be provided to forestall their resistance involvement. One county in North Carolina has gone so far as to have some of their treatment staff officially deputized to permit them to carry out these functions.

Unfortunately, hearings for re-hospitalization for non-compliance with out patient treatment—the only alternative in most states authorizing outpatient commitment—consume significant amounts of time, take treatment staff away from treatment responsibilities, and permit the patient's condition to deteriorate further before a decision can be reached. In addition, re-hospitalization may not be either clinically or legally appropriate. In particular, jurisdictions that establish outpatient commitment provisions with substantive criteria less strict than for in voluntary hospitalization may find that patients, satisfying outpatient commitment criteria but not complying with the treatment plan, may not meet criteria for inpatient commitment. This leaves the hearing officer with no realistic alternatives unless the statutes provide for re-initiation of the outpatient commitment.

If outpatient commitment is to be ordered as a condition of release from inpatient treatment, solutions to administrative problems — including political, financial and legal barriers to the transfer of patients between facilities, and the continuity of their care — must be explicitly provided in any enabling legislation or regulations. Such provisions may be necessary since many inpatient facilities are operated by state governments while outpatient clinics are operated by local governments. In particular, the capacity to transfer information between inpatient and outpatient treatment providers should be unimpeded. Statutory changes may be required to overcome existing regulations designed to protect patient privacy by preventing disclosures of information without explicit voluntary consent.

Since outpatient commitment works most effectively with patients who do well on psychotropic medications but continually stop taking them upon discharge from a hospital. the hearing should determine the need for medications as part of the treatment plan. We recommend that such medication not be forced physically on committed outpatients for several reasons. First, it is often impractical for individual physicians or small clinics to have sufficient personnel to give medications to noncompliant patients. Second many outpatient clinicians are strongly opposed to coercing patients to take medications. Because of this op position, they would not implement provisions for physically forced medication even if they existed. Moreover, they might oppose the whole concept of outpatient commitment, as has happened in practice (20). Third, such provisions could he expected to arouse such strong opposition from some patient advocates that they might well jeopardize the adoption of a whole package of revisions in outpatient commitment. Such problems have come to light during deliberation over a pro posed revision to the commitment statutes in Wisconsin.

Hiday's detailed study of the effects of North Carolina's new statute (34) demonstrated that 70% of committed patients who came in for treatment had no medication refusals over the six month study period; 84% were still in treatment at the end of the six months. Thus, in the only study to date analyzing the impact of revisions similar to those proposed here, the vast majority of patients who came to the treatment facility complied with appropriate medication, and extraordinary measures, such as physically forcing medication, were not necessary. These data are, limited of course, to one jurisdiction. The Task Force strongly suggests that future studies be directed specifically to a full assessment of the extent to which refusal of medication occurs under need-for-treatment criteria. Should such studies indicate that refusal is a significant problem, further statutory revisions could be proposed, based on evidence rather than on speculation.

In addition, provisions for the coerced administration of medication to out patients might well create the implication of greater control over patients, and, therefore, greater liability for patient behavior. Such increase in potential liability could place on clinicians inappropriate pressure to administer medication forcibly, even against their clinical and ethical judgment, further increasing resistance from outpatient clinicians to accept patients committed to their care.

Although the Task Force believes that medication should not be physically forced on an outpatient, the hearing officer should make it clear that (if it is so decided) taking medications will be expected of the patient if he/she wants to remain outside the hospital. If the patient does not comply with court-ordered medication, that fact should be sufficient evidence of lack of compliance with the treatnient plan to cause the patient to be taken to the outpatient treatment facility for treatment. Jurisdictions that have developed procedures to administer medication involuntarily may wish to omit this provision.

Since the patients for whom outpatient commitment is most effective generally suffer from chronic disorders, it is important that the statutes allow for continued extensions of the commitment, based on specified grounds to be demonstrated at regularly scheduled hearings. Brief, time-limited periods of outpatient commitment are unlikely to be effective with chronic patients: the conditions which required the initial commitment order are quite likely to continue for significant periods of time.

Since a number of studies have shown that a large population of patients brought for psychiatric treatment also suffer from significant medical illnesses (68,69)—some of which are causally related to their psychiatric symptoms—a thorough medical examination should be a required component of outpatient commitment to psychiatric treatment. Patients who are involuntarily hospitalized receive such evaluations automatically, but outpatients, for a variety of reasons may be as resistant to medical evaluation as to psychiatric evaluation.

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