Mandatory Outpatient Treatment
RESOURCE DOCUMENT

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Mandatory outpatient treatment refers to court-ordered outpatient treatment for patients who suffer from severe mental illness and who are unlikely to be compliant with such treatment without a court order. Mandatory outpatient treatment is a preventative treatment for those who do not presently meet criteria for inpatient commitment. It should be used for patients who need treatment in order to prevent relapse or deterioration that would predictably lead to their meeting the inpatient commitment criteria in the foreseeable future.

In 1987, the American Psychiatric Association's Task Force Report on Involuntary Outpatient Commitment endorsed the use of mandatory outpatient treatment under certain circumstances (Starrett et al. 1987). During the decade since publication of the Task Force Report, outpatient commitment has received a great deal of attention by advocacy groups, researchers and legislatures. Additionally, the nation has continued to struggle with the effects of deinstitutionalization and managed care, both of which have resulted in decreasing funds available for inpatient treatment. Mandatory outpatient treatment is getting more public exposure as pressure mounts to find effective treatments that are cost-effective for the chronically mentally ill. In 1995 it was estimated that 750,000 individuals were living in the community who, 40 years previously, would have been patients in state psychiatric hospitals (Torrey and Kaplan 1995). That number is undoubtedly higher now. As of the summer of 1999,40 states and the District of Columbia have commitment statutes permitting mandatory outpatient treatment -- although many of these states do not appear to implement this authority in any systematic way. At the present time, statutory authority for mandatory outpatient treatment is being implemented to some degree in eighteen states and the District of Columbia, and additional states are considering enacting new legislation or amending existing statutes (Delaney 1999).

This Resource Document endorses the view that mandatory outpatient treatment can be a useful intervention for a small subset of patients with severe mental illness who suffer corn chronic psychotic disorders and who come in and out of psychiatric hospitals through the so-called "revolving door." These patients often improve when hospitalized and treated with medication, but they frequently do not remain in treatment after release, leading to a cycle of decompensation and rehospitalization. Although important new studies have been conducted within the past few years, it is not yet possible to draw firm conclusions on the effects of mandatory outpatient treatment from the limited body of empirical literature. Research in this field faces daunting methodological problems. It is particularly difficult to identify and isolate the components of coercive care (i.e., the judicial order versus other informal coercive pressures arising as a result of the order) that may contribute to improved outcomes. As discussed in this Resource Document, however, regimens of mandatory outpatient treatment have been linked to improved patient outcomes when prescribed for extended periods of time and coupled with intensive outpatient services. Based on these findings and on accumulating clinical experience, it appears that mandatory outpatient treatment can be a useful tool in the effort to treat chronically mentally ill patients with documented histories of relapse and rehospitalization. It is important to emphasize, however, that all programs of mandatory outpatient treatment must include intensive, individualized outpatient services.

The purpose of this Resource Document is to provide information to APA District Branches and state psychiatric societies who are working on drafting legislation related to mandatory outpatient treatment. The Resource Document begins with a statement of key conclusions and recommendations based on a review of recent empirical findings and legislative developments. The body of the document contains a more detailed discussion of each issue, together with a current bibliography. The appendix contains several mandatory outpatient treatment statutes that reflect many of the judgments endorsed in this Resource Document.

Conclusions and Recommendations

1. If properly implemented, mandatory outpatient treatment can be a useful tool in an overall program of intensive outpatient services aiming to improve compliance, reduce rehospitalization rates, and decrease violent behavior among a subset of the severely and chronically mentally ill.

2. Mandatory outpatient treatment should not be reserved exclusively for patients who meet the criteria for involuntary hospitalization. It should be available to help prevent relapse or deterioration for patients who currently may not be dangerous to themselves or others (and are not therefore subject to commitment for inpatient treatment) but whose relapse would predictably lead to severe deterioration and/or dangerousness.

3. Predictions about the likelihood of relapse, deterioration, and/or future dangerousness to self or others should be based on the occurrence of such episodes in the recent past, as documented by treatment records.

4. Mandatory outpatient treatment should not be reserved exclusively for patients who lack the capacity to make treatment decisions, and should be available to assist patients who, as a result of their mental illness, are unlikely to seek or comply with needed treatment.

5. Studies have shown that mandatory outpatient treatment is most effective when it includes services equivalent to the intensity of those provided in the assertive community treatment or intensive case management models. States adopting mandatory outpatient treatment statutes must assure that adequate resources are available to provide effective treatment.

6. Data have shown that mandatory outpatient treatment is likely to be most successful when the period of mandated treatment is at least 180 days. Statutes authorizing mandatory outpatient treatment should authorize initial commitment periods of 180 days and should permit extensions of commitment based on specified criteria to be demonstrated at regularly scheduled hearings.

The American Psychiatric Association is a national medical specialty society, founded in 1844, whose 38,000 physician members specialize in the diagnosis and treatment of mental and emotional illnesses and substance use disorders.

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7. A thorough medical examination should be a required component of mandatory outpatient treatment, since many patients needing mandated psychiatric treatment also suffer from medical illness and substance abuse disorders which may be causally related to their symptoms.

8. Clinicians who are expected to provide the mandated treatment must be involved in the decision-making process to assure that the proposed treatment plan is one that they are able and willing to execute. Before treatment is ordered, the judge should be satisfied that there commended course of treatment is available through the proposed provider.

9. Patients should be consulted about their treatment preferences and should be provided with a copy of the mandated outpatient treatment plan, so that they will be aware of the conditions with which they will be expected to comply.

10. Mandatory outpatient treatment statutes should contain specific procedures to be followed in the event of patient noncompliance. Such provisions may include empowering law enforcement officers, upon notification from the treatment provider, to assume custody of non-compliant patients to bring them to the treatment facility for evaluation, but in all cases should include specific provision for a court hearing when providers feel that a patient's noncompliance is substantial and that further informal efforts to motivate compliance would fail.

11. Psychotropic medication is an essential part of treatment for virtually every patient who is appropriate for mandatory outpatient treatment. The expectation that a patient take such medication should be clearly stated in the patient's treatment plan. However, whether forced administration of medication should be a consequence of refusal to take medication as prescribed is controversial. This Resource Document does not make a recommendation about whether mandatory outpatient treatment statutes should either permit or preclude forced medication. Although legislation in some states has permitted forced medication, the constitutionality of this practice is uncertain. If forced medication is permitted, it should be allowed only if a court specifically finds that the patient lacks the capacity to make an informed decision regarding his or her need for the medication.

Background

Prior to the 1960's, involuntary treatment of the mentally ill was provided almost exclusively in long-term inpatient facilities operated by state and local governments. The majority of patients suffered from chronic illnesses for which there were no effective treatments that could permit community placement. 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 of these patients as possible (Test and Stein 1978; Andalman and Chambers 1974). Legislators were attracted to the movement by the prospect of saving money through hospital closure and less expensive community treatment (Aviram and Segal 1973). The combination of stricter commitment laws, most of which incorporated the criterion of treatment in the least restrictive environment (Bachrach 1980), and the establishment of federally-supported community mental health centers, led to a massive depopulation of the public mental hospital system. Although rates of short-term hospitalization, especially in general hospitals, have been relatively constant over the past 25 years (Kiesler and Simpkins I993), there has been a 75% reduction in the inpatient census of public mental hospitals over this period (Goldman, Adams and Taube 1983).In 1955, more than 559,000 people were in state psychiatric hospitals; by 1992, that number had fallen to just over 83,000 (Torrey and Kaplan 1995).

The purported effectiveness of deinstitutionalization was predicated both on the availability of effective treatment in the community (Kenny 1985), and on the willingness of patients to accept treatment voluntarily (Chambers 1972). Unfortunately, community resources have not been adequate to serve the needs of many chronic patients, and large numbers of patients have failed to become engaged with the community treatment system. Further, a growing number of young adult chronic patients do not accept the need for treatment, and many of them cannot be treated involuntarily because they fail to meet the strict behavioral criteria of anew generation of commitment laws designed to limit the use of involuntary hospitalization (Bachrach 1982). Many of these patients respond well to treatment when hospitalized, but rapidly relapse 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 have grown in number and become increasingly visible, especially in large urban centers, the need for involuntary outpatient treatment has been increasingly asserted (Bleicher 1967; Myers 1983-4). Over the past 15 years, a growing number of jurisdictions have begun to consider including mandatory outpatient treatment programs as part of their mental health systems and have enacted statutes designed explicitly for what has been called "outpatient commitment."

A few definitions are in order at the outset. Mandatory outpatient treatment or "outpatient commitment" refers to a court order directing a person suffering from severe mental illness to comply with a specified, individualized treatment plan that has been designed to prevent relapse and deterioration. Persons appropriate for this intervention are those who need ongoing psychiatric care owing to severe illness but who are unable or unwilling to engage in ongoing, voluntary, outpatient care. It should be distinguished from "conditional release," a form of treatment where a patient committed to an inpatient hospital is released to the community but remains under the ongoing supervision of the hospital -- if the patient's condition deteriorates he or she can be returned to the hospital. Additionally, there are three types of "outpatient commitment": outpatient commitment as part of a discharge plan from the inpatient setting (a variant of conditional release); an alternative to hospitalization for patients who meet the criteria for involuntary hospitalization; and a "preventative" treatment for those patients who do not presently meet criteria for inpatient hospitalization, but who are in need of treatment to prevent decompensation. It is this last type of treatment that is the subject of this Resource Document.

Although most statutes and much of the literature uses the term "outpatient commitment," many psychiatrists prefer other phrases, such as "mandatory outpatient treatment" or "assisted outpatient treatment" to refer to this practice. The phrase "outpatient commitment" implies a much more coercive approach than is envisioned by proponents of judicial treatment orders or directives. In practice, these devices are used primarily to reinforce the patient's own resolve and are not imposing treatment "against the patient's will" (the idea ordinarily conveyed by the term "involuntary"). Indeed, the use of therapeutic leverage for psychiatric patients closely resembles the tools (such as "directly observed treatment" for patients with tuberculosis) sometimes used on an outpatient basis for patients with contagious diseases, a context in which the term "commitment" is never used. In this Resource Document, whenever appropriate, the phrase "mandatory outpatient treatment" will be used in preference to "outpatient commitment."

Studies on the Efficacy of Mandatory Outpatient Treatment

The empirical data on mandatory outpatient treatment consist of two groups of studies. The "first-generation" studies, which comprise the majority of the work to date, are mostly retrospective or observational in nature and limited in scope. They have been criticized on a variety of methodological grounds, including that most did not attempt to establish whether the legal mandate for treatment was causally linked to the improved outcomes observed (Hiday1996). Additionally, differences in methodology and definitions of success prevented the generalization of their results. Nevertheless, these studies, taken as a group, suggest that mandatory outpatient treatment can be effective in reducing rehospitalization rates and increasing compliance when adequate services are included and the programs have the support of the treatment providers.

First-Generation Studies

North Carolina's mandatory outpatient treatment program is the system that has been studied most extensively. In fact, the first reported study of mandatory outpatient treatment was conducted by Hiday and Goodman (1982) 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 were 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 compare the re-hospitalization rate of the outpatient committees with, for example, the rate of rehospitalization of patients 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 (Miller and Fiddleman 1984; Miller, Maher and Fiddleman 1984) came to less favorable conclusions about the efficacy of outpatient commitment in North Carolina. Miller and Fiddleman (I984) retrospectively studied mandatory outpatient treatment in a North Carolina catchment area different from that studied by Hiday and Goodman (1982). The study was undertaken after enactment of 1979 statutory changes that 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 statute's 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 to44%). 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 were re-hospitalized; after the statutory changes, 9 patients (32.0%) 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 (Miller and Fiddleman 1983), a major problem with mandatory outpatient treatment in the catchment area studied was that a significant proportion of the commitments resulted from negotiation between the patient's attorney and the judge, analogous to a plea bargain 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.

In 1984, North Carolina's outpatient commitment statute was again revised, this time expanding the program into a "preventative" model of outpatient treatment. Under the newer statutory scheme, mandatory outpatient treatment can be ordered by a judge after finding that a patient meets four criteria: mental illness; capacity to survive safely in the community with supervision from family or friends; treatment history indicative of a need for treatment to prevent deterioration which would predictably result in dangerousness; and the illness-limiting or -negating ability to make an informed decision to seek or comply voluntarily with recommended treatment. An initial commitment period of up to 90 days is allowed. Forced medication is not permitted; when a patient does not adhere with the treatment plan, the clinician may request that law enforcement officers escort the patient to the community provider for examination (N.C. Gen Stat. Sets. 122C-261,263,265,267, and 271-275 (1997).

A 1990 study based on record review of 4,179 severe mentally ill patients in NorthCarolina under involuntary outpatient treatment after the statutory changes showed an 82%reduction in hospital readmissions and a 33% reduction in length of hospital stay (Femandez and Nygard 1990). Additionally, Hiday and Scheid-Cook conducted a statewide study of patients involved in civil commitment hearings and who were chronically mentally ill, had previously been hospitalized, and had histories of medication refusal and dangerousness (Hiday and Scheid-Cook 1989; 1991). Six months after the hearings, outcome data for patients who received outpatient commitment were compared with data for patients who were released and patients who were involuntarily hospitalized. While no differences in rehospitalization rates or lengths of stay were observed, patients who were committed to outpatient treatment were significantly more likely than patients with the other two dispositions to utilize aftercare services and to continue in treatment. Patients committed to outpatient treatment who "begin it with at least one visit to obtain treatment (both medication and psychotherapy), tend to show up for scheduled appointments without needing additional court action or assistance from law officers, and tend to remain in treatment after their [commitment] orders expire. Given the characteristics of revolving door patients -- psychosis, chronicity, dangerousness, multiple hospitalizations, and treatment refusal -- these results represent a major accomplishment" (Hiday and Scheid-Cook1991, at p. 87).

A number of mandatory outpatient treatment programs in other states have also been studied. Bursten (1986) studied the effects of the 1981-1982 Tennessee statutory changes which created provisions for court-ordered outpatient treatment as a condition for release from inpatient commitment. Readmission rates of patients committed to such outpatient treatment were used as the index of success of the new law. Under the research design, 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. The data, on 156 patients, revealed that decreased readmission could not be attributed to the utilization of the new statute. The authors 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. They also postulated that patients ready for discharge arguably were not committable under the dangerousness standard.

In contrast to the somewhat negative conclusions of the Tennessee study, other reports have indicated that mandatory outpatient treatment 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. Elizabeth's Hospital in Washington, D.C. (1984).They studied 94% of the 293 patients committed to outpatient treatment at St. Elizabeth's Hospital, who made up over 90% of patients committed to outpatient 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. Elizabeth's.

The St. Elizabeth's 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 outpatient commitment staff and other outpatient treatment staff to two factors: patients are committed to he same facility whether for inpatient or outpatient treatment, and many patients are treated by the same clinicians in both settings. Unlike the more typical situation, in which inpatient and outpatient facilities have separate buildings and staff, the same St. Elizabeth's 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 outpatient commitment to St. Elizabeth's by comparing and pre- and post-outpatient commitment experience of a cohort of all patients committed to outpatient treatment during 1983 (42patients). 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 mandatory outpatient treatment (Zanniand deVeau 1986).

Miller et al. (1984) reported on the effective use of mandatory outpatient treatment in Wisconsin. For several years in the early 1980's, between 7580% of all commitment hearings ended in negotiated dispositions in Dane (Madison) and Milwaukee Counties. 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 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.

Arizona's commitment statute was revised in 1983 to allow for mandatory outpatient treatment, Van Putten and colleagues (1988) reviewed retrospective data of patients at a county hospital in Tucson for whom inpatient commitment was sought before outpatient commitment was available and compared it to similar groups of patients after mandatory outpatient treatment was instituted. The authors noted that the data suggest that "when involuntary outpatient commitment is used within clearly defined statutory guidelines and with appropriate clinical judgment, benefits are likely." In addition to observing shorter inpatient stays after outpatient commitment became available, the authors found that 71% of patients treated with mandatory outpatient treatment maintained treatment contact with outpatient mental health centers after their commitment orders had expired, a dramatic improvement in follow-up rates.

Geller, of the University of Massachusetts, has published two small studies. In one, he describes three cases of coerced community treatment in Massachusetts, each with profoundly positive results (Geller 1992). In that program, patients were entered into coercive treatment (an informal program conducted under the emergency hospitalization provision of the Massachusetts civil commitment statute) because of histories of psychotically-based dangerousness, high utilization of inpatient services and chronic noncompliance. The treatment was coercive in its structure because it did not allow for alternative sites for treatment, choices of psychiatrist or changes in treatment plans, and noncompliance resulted in commitment. In each of the cases, hospitalization was dramatically reduced during the coerced treatment periods. In one of those cases, the patient had 33 hospital admissions during 26 years, with a median community tenure of seven days. During the first period of coercion, which lasted eight months, he was medication compliant, employed part-time, socially appropriate and required no hospital admissions. Hethen was released from coercive care and subsequently was committed four times to the state hospital. After re-initiating coercive community treatment, however, the patient again did remarkably well. Although he did have one brief admission, he had remained free of inpatient care 1,054 days prior to that time. In another small study in Massachusetts (Geller, Grudzinskas, et al. 1998), 19 patients with court orders for outpatient commitment were matched to all and to best fits on demographic and clinical variables, and then to individuals with the closest fit on hospital utilization. Outcomes indicated the commitment group had significantly fewer admissions and hospital days after the court order.

One of the largest-scale demonstrations of the potential effectiveness of mandatory outpatient treatment is the reported success of an Oregon State system for providing after-care and supervision for insanity acquittees (Rogers, Bloom and Manson 1984). 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.

In Ohio, a group of 20 patient with diagnoses of schizophrenia, schizoaffective or bipolar disorder and a history of recurrent hospitalizations, noncompliance and good response to treatment were identified and committed to outpatient treatment (Munetz, Grande, et al. 1996). The protocol included several key provisions: commitment criteria were the same for hospital and community-based placements; the forcible administration of medication was not permitted; noncompliance in and of itself did not result in a return to the inpatient setting; and the presence of an outpatient commitment order lowered the threshold for ordering an evaluation to consider rehospitalization. During the one-year study period, the patients experienced significant reductions in visits to the psychiatric emergency service, hospital admissions, and lengths of stay compared with the 22 months before commitment. The authors acknowledged that their study was limited by its retrospective design, lack of control group and small same size, but nonetheless concluded that their "findings lend support to the concept that involuntary civil commitment to a community setting can be effective in improving treatment compliance and reducing hospital use. Patients who benefit most appear to be those . . . who have demonstrated repeated cycles of psychotic decompensation, involuntary hospitalization and treatment, good response, discharge, noncompliance with treatment, and psychotic decompensation."

In 1998 Rohland reported the results of her retrospective study of Iowa's outpatient commitment statute. During the five-year study period, 57 patients were committed to outpatient treatment. Thirty-nine met the study criteria (age at least 18 and diagnosis of schizophrenia or other psychotic illness) and were matched to a control subject who had an inpatient admission during the study period. The study found that mandatory outpatient treatment "appears to improve compliance with treatment in about 80% of patients [and appears] to be successful in reducing hospital and emergency room use by persons, who, as a group, are characterized by having a history of medication noncompliance, a history of substance abuse, use of more than two different types of antipsychotic medications during a five-year period, and use of a depot form of antipsychotic medication" (Rohland 1998).

Second-Generation Studies

More recently, two "second-generation" studies of mandatory outpatient treatment have been completed, one in North Carolina and the other in New York. Rather than focusing mainly on outcome measures such as rehospitalization rates and compliance, these studies attempted to identify the cause of better patient outcomes. Both studies tried to control for potentially confounding factors such as intensity of treatment and informal coercion. More importantly, both sought to determine whether the commitment order has an independent effect on compliance and treatment when intensive community services are consistently and aggressively provided.

The Duke Mental Health Study is the first randomized controlled trial of mandatory outpatient treatment. The conceptual model of the study, developed by Swartz, Swanson and co-authors (1997), has as its primary independent variable the court order, but it also assumes that other less formal coercive influences may shape the behavior of patients, clinicians and service systems. Briefly, the model posits that the commitment order, or the patient's perception of the consequences of noncompliance, may have a primary direct effect of increasing the patient's adherence behavior. Once this behavior is changed, it may itself affect treatment outcomes. For example, in response to compliance, the patient may experience renewed community mental health resource support,. or increased social supports which may then help to increase the patient's overall functioning and ultimately result in decreased hospitalization rates or lengths of stay in hospital. However, this model also acknowledges that outpatient commitment may succeed through intensification of case management activity. In response to the presence of a court order, clinicians may intensify their efforts to ensure patient compliance. The authors point out that these mechanisms are not mutually exclusive.

Under the study design, patients (all of whom had severe mental illness and had a history of involuntary hospitalization) identified during hospitalization to be appropriate for outpatient commitment were randomized to outpatient commitment with case management ("OPC" group) or case management services alone (the "control" group), and then followed by periodic interview for 16 months and by record review for two years. An additional group of patients with a recent history of serious violence were placed in a nonrandomized comparison group and were placed in outpatient commitment (owing to ethical considerations that precluded them from being assigned to the control group). While there was no significant difference in rehospitalization rates between control and OPC groups, patients who underwent sustained periods of outpatient commitment beyond the initial court order (which is only for up to 90 days)did have 57% fewer admissions and 20 fewer hospital days over the study period compared to controls. Moreover, sustained outpatient commitment was shown to be particularly effective for patients suffering from non-affective psychotic disorders (72% decrease in readmissions and 28 fewer hospital days). However, when the North Carolina data were probed more deeply, it was found that sustained outpatient commitment reduced rehospitalization only when combined with a higher intensity of outpatient services (averaging seven services per month), thus emphasizing the importance of ensuring that adequate resources are allocated to outpatient programs (Swartz, Swanson, et al. in press 1999b).

The data were also analyzed to assess the effect of mandatory outpatient treatment on violent behavior. The results are similar to the rehospitalization data. Patients who underwent sustained periods of outpatient commitment had a significantly lower incidence of violent behavior during a one-year follow-up period compared to patients who received case management services alone and to patients who underwent shorter periods of commitment (22.7% versus 36.8% and 39.7% rates of violence, respectively). The authors also found that patients who underwent sustained mandatory outpatient treatment and received regular services (more than three services per month), and who additionally abstained from substance abuse and were compliant with medications, had the lowest likelihood of any violence (13% predicted probability versus 53% predicted probability for patients who did not undergo regular, sustained outpatient commitment, abused substances and were medication non-compliant) (Swanson, Swartz et al. 1999).

Swartz and co-authors also sought to establish whether the intended coercive effect of outpatient commitment was secondary exclusively to the presence of the court order (Swartz, Hiday, et al., 1999). Using the Admission Experience Survey - developed by the MacArthur Foundation Research Network on Mental Health and the Law, and modified for outpatient treatment - they found that OPC patients perceived a statistically significant increased level of coercion as compared to controls, but that this effect was explained in part by the behavior of case managers, who themselves may have been more vigilant with their patients in response to the presence of the court order. This finding is as predicted by the study model.

The only other randomized controlled trial of mandatory outpatient commitment was conducted in New York. In 1994, the New York State legislature passed a bill providing for a three-year pilot project of involuntary outpatient treatment at Bellevue Hospital in New York City. The legislature hired Policy Research Associates, Inc. ("PRA") to conduct a research study of the pilot program. Substantively, the program provided for a range of intensive outpatient treatment and included involuntary medication, but only for those patients found by the court to lack the capacity to give informed consent for treatment. During the research period (11months), inpatients at Bellevue Hospital who were deemed appropriate for outpatient commitment were randomized to receive either of intensive community treatment with a court order ("outpatient commitment") or intensive community treatment alone ("control"). PRA's final report, released in December, 1998, found no statistically significant differences between the outpatient commitment and control groups for rehospitalization or hospital days during the study period. However, both groups experienced a significantly smaller rehospitalization rate during the study period than during the year preceding the target admission (from 87.1% to51.4% for outpatient commitments and from 80.0% to 41.6% for controls). The authors of the study concluded that, although the court order itself did not seem to produce better patient outcomes, "the service coordination/resource mobilization function of the program seemed to make a substantial positive difference in the [patients'] experiences" (PRA 1998).

Telson and his colleagues at the Department of Psychiatry at Bellevue Hospital issued their own report of the pilot program (Telson, Glickstein and Trujillo 1999). Their data include not only the data from the 1 l-month study period, but also data from the beginning of the pilot program on July 1,1995 through January 1,1999. The report qualifies many of PRA's findings. Importantly, the Bellevue report points out that the operative difference between experimental and control conditions (judicial orders) was misunderstood by patients and providers, especially in the early part of the study, and that many patients in the control group may have perceived that their treatment was being provided under judicial authority. Further, the report emphasizes that providers found the court orders helpful and that, while there was no statistical difference between number of hospital days for the two groups, the trend is considerable (43 days for outpatient commitment group versus 101 days for the control group). Additionally, non-substance abusing psychotic patients in the outpatient commitment group were rehospitalized far less frequently (25%) than those in the control group (45%). The report concludes: "Bellevue has ultimately

understood outpatient commitment to be a mechanism which may, in conjunction with good, coordinated, clinical services, promote access to and compliance with outpatient care among patients who have refused and rejected treatment due to mental illness. And, in Bellevue's experience, most patients, providers and families have agreed that the potential benefit offered by outpatient commitment is much greater than any harm it may cause" (Telson, Glickstein and Trujillo 1999, at p.37).

In August, 1999 the New York State legislature enacted a permanent outpatient commitment statute. It uses the term "Assisted Outpatient Treatment" rather than outpatient commitment and differs from the pilot program in that treatment can be court-ordered without a current hospitalization, and that forced medication for non-compliant patients is no longer permitted (NYS Bill S05762).

Criteria for Mandatory Outpatient Treatment

Because of the liberty interests at stake under any scheme of mandatory outpatient treatment, the imposition of such treatment should be ordered by a court only after a hearing at which the judge finds, on the basis of clear and convincing evidence, that the patient meets the statutorily-prescribed criteria for the mandatory treatment. Based on a review of the literature, this Resource Document proposes the following criteria as necessary and appropriate to restrict the use of mandatory treatment to patients who have demonstrated by their behavior and clinical histories a strong probability of relapse and deterioration - a constitutionally indispensable predicate for the use of the court's coercive authority. The criteria are listed below, followed by commentary on several of the key elements.

A person would be eligible for mandatory outpatient treatment if:

1. The person is suffering from a severe mental disorder [an illness, disease, organic brain disorder, other condition that (a) substantially impairs the person's thought, perception of reality, emotional process, or judgment, or (b)substantially impairs behavior as manifested by recent disturbed behavior]; and
2. In view of the person's treatment history, the person now needs treatment in order to prevent a relapse or severe deterioration that would predictably result in the person [becoming a danger to himself or others or becoming substantially unable to care for him or herself in the foreseeable future][meeting the state's inpatient commitment criteria in the foreseeable future]; and
3. As a result of the person's mental disorder, he or she is unlikely to seek or comply with needed treatment unless the court enters an order for mandatory outpatient treatment; and
4. The person has been hospitalized for treatment of a severe mental disorder within the previous two years and has failed to comply on more than one occasion with the prescribed course of treatment outside the hospital; and
5. An acceptable treatment plan 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.

The major purpose of mandatory outpatient treatment is to permit effective treatment of mentally ill persons before their conditions deteriorate to the point where they require inpatient treatment. This goal is best served by substantive standards for mandatory outpatient treatment based chiefly on the need for and the availability of appropriate treatment to prevent substantial mental or emotional deterioration. The 1987 Task Force proposed statutory language based on such a standard and Idaho has enacted an outpatient commitment statute, effective July 1, 1999, which is based on the APA proposals.

It must be recognized, however, that most state laws governing involuntary psychiatric treatment do not conform to the APA's need-for-treatment approach, relying instead on criteria linked to dangerousness to self or others. Under state statutes using a dangerousness model, the most useful approach to mandatory outpatient treatment is the one adopted by North Carolina, Georgia, Hawaii and New York. Their statutes permit outpatient commitment of patients who currently may not be dangerous to themselves or others (and are not therefore committable to inpatient treatment), but whose predictable deterioration would lead to such dangerousness. For example, the New York statute criterion is: "In view of the patient's treatment history and current behavior, the patient is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to the patient or others." Such a preventative approach provides 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 dangerousness.

All four of these states require that predictions of a "likely deterioration leading to dangerousness" 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. Although these statutes restrict the use of mandatory outpatient treatment to patients with prior histories of treatment and relapse, it is just such persons with chronic and severe illness who comprise the majority of the target population for mandatory outpatient treatment.

This Resource Document suggests alternative language to specify the reference point for the "preventative" criterion of mandatory outpatient treatment. One formulation would tie the mandatory outpatient treatment criterion to the state's criteria for inpatient commitment. The other would use a formulation that couples foreseeable deterioration either to dangerousness or to a state of inability to care for one's own basic needs. This formulation reflects the understanding that mandatory outpatient treatment should not be designed principally to protect the public, but to rather to enable severely ill patients to receive the treatment they need, with potential benefits to themselves and to the community.

Criterion (3) above replaces the 1987 Task Force Report's recommendation that mandatory outpatient treatment be predicated on the patient's capacity to make an informed treatment decision. This standard, although compatible with the American Psychiatric Association's parens patriae stance, may be difficult to prove in some clinical circumstances that are otherwise appropriate for mandatory outpatient treatment. The alternative language proposed in this Resource Document links lack of treatment compliance with mental illness, an approach followed by New York which authorizes mandatory outpatient treatment if the patient, as a result of his or her mental illness, is "unlikely to voluntarily participate in the recommended treatment. .." Adoption of this or similar language would facilitate mandatory treatment of persons whose past treatment records predict future noncompliance and deterioration, but for whom more formal determinations of "incompetence" are unlikely.

The criteria also require development of a treatment plan that includes specific conditions with which the patient will be expected to comply. The treatment plan, individually tailored to meet the patient's needs, should explicitly specify all components of the patient's care, including medications and other aspects of the treatment, such as required visits to a facility to permit monitoring of the patient's condition, individual or group therapy, and educational, vocational or substance abuse programs. With respect to medications, particular classes of drugs should be specified, rather than the names and doses of specific medications. Identifying the optimal agent and dose for a particular patient can involve trials of several different medications in the same class. Requiring that only the class be specified in the treatment plan will give the clinician and patient needed flexibility in the treatment and will avoid additional, unnecessary hearings on treatment plan "changes" that are technical, and not substantive, in nature. Additionally, since a number of studies have shown that a large population of patients brought for psychiatric treatment also suffer from significant medical

illness (Hall, et al. 198 1; Johnson and Anath 1986) -- 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.

The criteria require that the proposed treatment plan include services adequate to successfully treat the patient. Several authors 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 provided reassurance that these resources will be forthcoming. With the broader criteria for commitment sought by many supporters of mandatory outpatient treatment -- which have been implemented in several states -- many observers fear that mandatory outpatient treatment might authorize increased control by the mental health system, without the benefits of treatment to justify the intrusion (Rubenstein 1985; Mulvey, et al. 1987; and Zusman 1985). These arguments are well-grounded in the history of involuntary commitment in general, and any system of commitment which would apply to a large number of patients must provide both increased protections for those at risk, and increased resources to guarantee that effective treatment can be provided (Miller 1986).

A model of treatment that has been gaining popularity in many jurisdictions and that would be appropriate for mandatory outpatient treatment programs is the Program for Assertive Community Treatment (PACT) model. First developed in the 1970's in Wisconsin, the model proposes care by a multidisciplinary team of providers that takes full responsibility for care of a fixed caseload of patients (Thompson 1990). The PACT model uses a team-based approach with social workers, nurses, and psychiatrists. Like the inpatient multidisciplinary model, team members share responsibility for their patients. PACT teams try to provide all necessary psychiatric, social, and rehabilitative care and, as appropriate, provide that care at the patient's home, work or place of leisure. Such care requires mobility and flexibility on the part of all team members. Intensity of services can vary depending on the individualized needs of the patient and intensity can be rapidly increased if necessary to appropriately manage exacerbations of illness.

Most importantly for the purposes of this Resource Document, PACT teams provide assertive outreach services. This means that they continue care and continue to offer services even when the patient is reluctant or not cooperative. Providers and patients at times "agree to disagree" with each other but continue the treatment relationship even during periods of patient noncompliance. The main goal of PACT is to keep patients in contact with services, reduce days patients spend in hospital and improve patient quality of life. PACT has been studied extensively over the past twenty years and has been found consistently to be associated with improved medication compliance, social functioning and quality of life and reduction of hospitalization (Drake and Burns 1995; Stein, Test and Arnold 2975; Test and Stein 1980; Weisbrod, Test and Stein 1980). A recent extensive review article finds that, as compared with people receiving standard community care, patients receiving PACT were more likely to remain in contact with services, less likely to be admitted to hospital, and more likely to have significantly improved accommodation status, employment, and patient satisfaction (Marshall and Lockwood 1998). In jurisdictions where PACT-level services are available, a subset of previously noncompliant patients will likely respond to treatment with the PACT model and may, therefore, not require mandatory outpatient treatment

.Clinicians who are expected to provide the mandated treatment must be directly involved in the decision-making process and the development of the treatment plan. Before mandatory outpatient treatment is ordered, the judge should be satisfied that the recommended course of 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 arouses opposition to the expanded use of mandatory outpatient treatment. Such requirements also would involve the outpatient providers directly in the planning of the treatment. Some of the most vocal critics of mandatory 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.

In fact, clinicians in mandatory treatment programs need specific skills and training to appropriately manage their dual roles as therapists and social control agents (Trotter 1999).Given the potential for role conflict, clinicians in mandatory treatment programs need to clarify their roles, responsibilities, and relationships with patients. Clinical and legal obligations to third parties such as case managers, courts, and probation officers need to be specified. Confidentiality dilemmas in mandatory treatment should be anticipated and appropriately managed in advance. Specific treatment techniques for managing resistant or difficult patients have been described, and clinicians working in mandatory treatment programs should be familiar with the available literature in this area (Harris & Watkins 1987; Larke 1985; Rooney 1992; Trotter 1999).

By requiring that a treatment plan be presented to the hearing officer before outpatient commitment may be ordered, judges would be able to make better informed decisions and outpatient clinicians would be able to exercise appropriate control over which patients are committed to them. The patient should also 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. A legislative proposal for mandatory outpatient treatment under consideration in Virginia additionally suggested that the treatment plan take "into consideration all relevant circumstances, including any reasonably possible alternative treatments preferred by the person, as expressed in an advance directive or otherwise"(Institute of Law, Psychiatry and Public Policy 1998). The addition of such language would likely comfort patients and their advocates who fear the heavy-handedness of coercive care (Lidz 1997; Treffert 1999). Recent research by the MacArthur Foundation Network on Mental Health and the Law (Monahan et al. 1996) has found that notions of "procedural justice" -- patients' feelings about being included in the decision making, the nature of the treating team's intention, the absence of deceit and receiving respect --were closely linked to perceptions of coercion.

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

Length of Treatment

Since the patients for whom mandatory outpatient treatment is most effective generally suffer from chronic disorders, it is important that the statutes allow for continued extensions of commitment, based on specified grounds to be demonstrated at regularly scheduled hearings. Brief, time-limited periods of mandated treatment 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. As noted above, the North Carolina experience indicates that benefits of mandatory outpatient treatment are only realized when patients participate in the program for an extended period of time (180 days) (Swartz, et al. in press 1999b). During all hearings on extensions of commitment, the court must find, on the basis of clear and convincing evidence, that the patient continues to meet all criteria for mandatory outpatient treatment; otherwise, the patient must be released from court order.

Response to Noncompliance

Formulating reasonable procedures for mandatory outpatient treatment is a challenging task, especially when the treatment order is imposed at the "front end" of the process (as compared with conditional release from hospitalization) -- a hearing must be held in the community prior to assumption of custody over a

prospective patient; and there must be a mechanism, other than hospitalization, through which to manage noncompliance. It seems reasonable to require the treating clinician to exercise efforts to obtain the patient's voluntary compliance with the treatment plan. After reasonable effort is exerted, however, if the patient remains in substantial noncompliance with the treatment, the statute must contain a mechanism for some forcible intervention to promote compliance. One option is to include in the initial commitment order an explicit authorization for law enforcement officers to assume future custody of the noncompliant patient upon receiving notice from the responsible clinician. The patient would be transported to the outpatient facility for a short period of time for evaluation, where it can be hoped that the patient will be persuaded to accept the prescribed treatment without requiring another hearing. This is the statutory scheme in several jurisdictions, including the District of Columbia and Utah. (Under New York law, the treating clinician must consult with the Director of the treatment facility, who is given the authority to arrange to have the patient transported to the facility for evaluation.) Alternatively, the law could provide that police custody may be asserted only on the authorization of a judicial officer, upon a reliable and adequate showing of noncompliance by the responsible clinician. This is the strategy employed by Georgia and North Carolina, where the treating clinician can petition the court for an exparte order authorizing a peace officer to take the patient to the treating facility or the nearest emergency room for evaluation. Since either of these approaches requires a significant, if temporary, abridgment of the patient's liberty, some advocates can be expected to oppose such procedures, insisting on a formal hearing.

Whatever procedure is adopted should be clearly spelled out by statute. Moreover, it would be desirable for the legislature to specify what the clinician must do to discharge his or her duty to the patient, and to potential victims, if the patient harms anyone else despite the clinician's efforts to promote compliance with the order.

In sum, it is important for mandatory outpatient treatment statutes to ensure that the treatment orders empower and mandate law enforcement officers to assume custody of non-compliant persons upon notification from the treatment providers. (This is particularly important in the case of post-release outpatient commitment, in which judges located in one jurisdiction order treatment in another jurisdiction.) In addition, law enforcement officers should be carefully educated about the need for an expedient response to noncompliance in order to forestall their resistance to involvement. One county in North Carolina has gone so far as to have some of its treatment staff officially deputized to permit them to carry out these functions.

Interestingly, a 1991 study of North Carolina's mandatory outpatient treatment program found that law enforcement officer involvement appears to be utilized less frequently than had been anticipated. "Despite the fact that OPC is involuntary, with stringent methods provided to enforce it, primary clinicians seldom used these methods, employing softer means to obtain compliance. At the first "no show," clinicians most often telephoned or sent a letter. In only one case did a primary clinician call the sheriff and in no case did one threaten to do so. Their less stringent methods were relatively effective, for only 38% failed to show a second time. Again, phoning and sending letters were the methods of handling this situation. Failure to show a third time was reduced to 22.6%. The methods used by this time were more forceful: calling the sheriff, threatening to call the sheriff, and taking out a new civil commitment petition. . . .Remarkable is the fact that close to half of these patients (45.2%) never failed to show for their appointments without giving an acceptable excuse and rescheduling during the three months of their OPC; and after a second no show over three fourths (77.4%) met their scheduled appointments and activities" (Hiday and Scheid-Cook 1991 at p. 87).

Beyond whether this function of police transport is provided for by statute, however, the statute must also authorize treatment providers to petition the court for a supplemental commitment hearing in the event of substantial noncompliance. At that hearing, the court should have three options: it could continue the mandatory outpatient treatment order if the patient continues to meet all the statutory criteria and the court finds that it remains appropriate (with any modifications necessary to the treatment plan, as discussed and developed by the patient and his treatment team); it could order involuntary admission to the hospital if the patient meets their patient commitment criteria; or it could discharge the patient from mandatory outpatient treatment. It is important to provide such supplemental hearings in light of the fact that some may view outpatient commitment as creating the implication of greater control over patients, and, therefore, greater liability for patient behavior. Such an increase in potential liability could generate inappropriate pressures and could further discourage outpatient clinicians from agreeing to accept patients under judicial mandates.

If mandatory outpatient treatment 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.

The Issue of Forced Medication

Since mandatory outpatient treatment works most effectively with patients who do well on psychotropic medications but continually stop taking them upon discharge from a hospital, the initial hearing should determine the need for medications as part of the treatment plan. The 1987 Task Force Report recommended that such medication not be forced physically on committed outpatients, and offered several reasons for taking this position. In addition to logistical and procedural concerns, the I987 Task Force was concerned that providers and patient advocates would be opposed to physically-forced medication and that this opposition could even jeopardize entire programs of mandatory outpatient treatment. However, some clinicians are concerned that mandatory outpatient treatment programs that do not permit the forced administration of medication lack "teeth" and, therefore, would be ineffective. Clearly this is a controversial issue.

Successful mandatory outpatient treatment programs need some coercive power to enforce compliance. Even if statutes do not authorize forced medication, all techniques short of force should be used to promote compliance. For example, 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, and the taking of prescribed medication should be specified as one of the patient's obligations in the court order. If the patient does not comply with court-ordered medication, that fact should be sufficient evidence of lack of compliance with the treatment plan to cause the patient to be taken to the outpatient treatment facility for treatment. Once at the facility, the medication could again be offered to the patient, even if it would not be forced on 1him or her if refused. It is likely that the prospect of repeated involuntary visits to the treatment facility would result in medication compliance for many patients. Moreover, recent work in North Carolina indicates that, in spite of the fact that the statute does not authorize the forcible administration of medication, most patients do believe that mandatory outpatient treatment requires medication compliance (Borum et al., in press 1999).

Empirical studies of mandatory outpatient treatment tend to indicate that outcomes would not be significantly improved by allowing forcible administration of medication, and that, even if available, forced medication will rarely be necessary in clinical practice. The New York pilot program authorized forcible, involuntary medication, but only for those patients who were also judicially established to lack capacity to make treatment decisions. The Bellevue report noted that "medication orders reflect the appropriate treatment options for an individual patient. The medication orders have been viewed as a mechanism to insure that patients who, as a result of mental illness, are ambivalent about

treatment understand the importance of taking medication." During the entire period of the pilot program, there were no reports of medication being forcibly administered in the community (Telson, Glickstein and Trujillo 1999).

Hiday's study of the effects of North Carolina's statute, which does not authorize forcible, involuntary medication, also supports the contention that the forcible administration of medication is unlikely to be necessary for the vast majority of patients. Compared to the control group, patients who were committed to outpatient treatment attended the community mental health center significantly more often and were significantly more likely to be in treatment at the six-month follow-up even though most of their court orders had expired three months after the initial hearings and had not been renewed. A majority of all study participants refused medication at least once during the six-month study period, which the authors noted as "not surprising given their histories." However, the patients who were committed to outpatient treatment were less likely to refuse medication than patients who were released at their initial civil commitment hearings. Moreover, the authors concluded, "the fact that the overwhelming majority of patients who were committed to outpatient treatment remained in treatment for six months indicates that their medication refusal and other noncompliance was overcome or minimized. Outpatient commitment is clearly successful in inducing compliance with aftercare services and directives." (Hiday and Scheid-Cook 1989 at p. 56-57).

It should be recognized, however, that the threat of force may be needed for a small subpopulation of severely and chronically mentally ill patients who "fail" mandatory outpatient treatment programs, i.e., those who do wind up back in the hospital after deteriorating to the point where they require involuntary medication under emergency criteria. Some portion of these readmissions might be avoidable only if involuntary, forced medication is available.

Two United States Supreme Court cases have addressed the right to refuse medical treatment, including psychotropic medication. Washington v. Harper, 494 U.S. 210 (1990), and Riggins v. Nevada, 504 U.S. 127 (1992), establish that individuals have a fundamental liberty interest in avoiding the administration of unwanted psychotropic medication. These cases can be read as implying that statutes authorizing forcible administration of medication on patients who are not presently dangerous would face constitutional difficulty, at least to the extent they were not limited to patients judicially established to lack the capacity to make treatment decisions. Jurisdictions choosing to permit involuntary medication would be well-advised to do so only in conjunction with such a capacity determination.

In summary, psychotropic medication is an essential part of treatment for virtually every patient who is appropriate for mandatory outpatient treatment. The expectation that a patient take such medication should be clearly stated in the patient's treatment plan, and aggressive measures should be taken to promote compliance. However, whether forced administration of medication should be a consequence of refusal to take medication as prescribed is controversial. This Resource Document does not make a recommendation about whether mandatory outpatient treatment statutes should either permit or preclude forced medication. Although legislation in some states has permitted forced medication, the constitutionality of this practice is uncertain. If forced medication is permitted, it should be allowed only if a court specifically finds that the patient lacks the capacity to make an informed decision regarding his or her need for the medication.

Conclusion

Since the publication of the Task Force Report in 1987, mandatory outpatient treatment has received increasing public attention, owing in large part to occasional, highly publicized incidents of violence by untreated persons with severe mental disorders, and to other difficulties posed by the "revolving-door" patients who suffer from severe and chronic mental illness and who are difficult to engage in ongoing treatment. Over the past ten years, as discussed in this Resource Document, the body of scientific literature on the effects of mandatory outpatient treatment has grown considerably, and many jurisdictions have enacted or are considering enacting so-called outpatient commitment statutes. It is only, however, within the past year that results of the first randomized controlled trials of mandatory outpatient commitment have been available.

One important finding emerges from this developing body of research: Use of mandatory outpatient treatment is strongly and consistently associated with reduced rates of rehospitalization, longer stays in the community, and increased treatment compliance among patients with severe and persistent mental illness. The only unresolved question is whether these outcomes are entirely a function of the enhanced services available to committed patients, or whether some of the positive effects are attributable to the judicial order. Taken together, the New York and North Carolina studies are equivocal on this point, and additional research will be needed to clarify it.

This Resource Document supports the view that policy judgments regarding the desirability of mandatory outpatient treatment need not await the outcome of these additional studies. This is because the existing research already provides a strong empirical foundation for including mandatory outpatient treatment as one of the strategic elements of a plan of aggressive community treatment. A judicial order is not a panacea either for "curing" or for "controlling" treatment-resistant patients, but it does appear to play a useful role in some cases, when combined with enhanced and well-designed services. This conclusion is reached for several reasons. First, discerning and measuring the independent effect of a judicial order, while avoiding selection bias and controlling for all of the other important variables (intensity of services and other coercive pressures, for example) is a daunting empirical task; to insist on strong proof from randomized controlled trials as a prerequisite for implementing a plan of mandatory outpatient treatment would be a mistake in light of the strong association between mandatory outpatient treatment, improved compliance and reduced rehospitalization. Additionally, Swartz and Swanson (under review, 1999a) have pointed out that programs demonstrate wide variability in the implementation and practice of mandatory outpatient treatment, rendering findings across studies difficult to interpret. They propose the development of practice guidelines for outpatient commitment.

Second, there is no evidence that a judicial order reduces or offsets the positive effects of enhanced treatment; the only question is whether it has additive effect - and the Duke study suggests that it does, at least among patients subject to extended orders. Third, there is abundant evidence that enacting and implementing mandatory outpatient treatment concentrates the attention and effort of the providers; that is, the judicial order may help to enhance the services by "committing" the providers to the patients' care. This is not an inconsequential effect. Finally, enacting mandatory outpatient treatment may also help to "commit" the legislature to provide the funding needed to provide enhanced community services for all patients, whether or not they are subject to a commitment order. In a political context, enacting mandatory outpatient treatment may provide the leverage for increased funding for community mental health services, and particularly for the severely mentally ill population.

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