The evolution of outpatient commitment in the USA:
From conundrum to quagmire

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Abstract

Outpatient commitment (OPC), a major form of involuntary community-based treatment, has evolved in the United States on a state-by-state basis amidst a storm of controversy. The polarizing debate that has gone on intensely about OPC for the last two decades has all too often been devoid of data. This article reviews the various arguments pro and con about OPC, and then examines the research on the effectiveness of OPC. Since the newest data seem to support OPC as a useful tool in dealing with specific subpopulations of persons with chronic mental illness, the paper examines the question of whether OPC is a legitimate use of government power. The most extensive analysis of this question to date has occurred in the New York State Courts which have supported the New York State OPC statute, Kendra’s Law. The paper concludes with an examination of the future of OPC in the states, calling in particular for further research into the question of determining to whom, from a clinical point of view, should OPC be delivered.

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Today, outpatient commitment (OPC) in the U.S.A., by which we mean a statutory and/or court-derived mandate for treatment in the community, is one form of a variety of community-based interventions aimed at increasing outpatient treatment compliance, decreasing use of inpatient resources, and improving quality of life for persons with serious mental illnesses. Other forms of interventions include advance directives (Appelbaum, 1991; Gallagher, 1998; Miller, 1998; Srebnik & LaFond, 1999; Swanson, Tepper, Backlar, & Swartz, 2000), representative payeeships (Dixon, Turner, Kraus, Scott, & McNary, 1999; Luchins et al., 1998), assertive community treatment (Neale & Rosenbeck, 2000; Stein & Santos, 1998) and others (Monahan et al., 2001; Stein & Diamond, 2000). As this article will show, many who oppose OPC support some of these other forms of interventions on the belief that these are less restrictive/ less intrusive. The actual beneficiaries or victims of involuntary outpatient treatment (IOT) (depending upon one’s point of view) have expressed a wide range of opinions about these interventions as reported by persons with mental illness themselves (Fox, 2001; Frese, 1997), or through survey results (Borum et al., 1999; National Alliance for Self-Determination, 1999; Rain, Steadman & Robbins, 2003; Swartz, Swanson, & Monahan, 2003; Swartz, Swanson, Wagner, & et al., 2003; Swartz, Wagner, Swanson, Hiday, & Burns, 2002). There is surely no concurrence on any hierarchy of restrictiveness/intrusiveness.
OPC in the United States has been characterized by considerably more opinion than fact. Commentary far outweighs research. In 2001, Geller (2001) indicated “involuntary outpatient commitment is a contemporary lightning-rod issue in American psychiatry. Its assets and liabilities are all too often lost sight of in a cacophonous bluster that obscures reasoned positions.” This sentiment was echoed by Dvoskin and Spiers (2003): “The debate over the use of mandated outpatient psychiatric treatment has been as polarized as any argument in our field.” In the last few years, mandatory outpatient treatment has been the subject of editorials or op-ed pieces in newspapers in the largest U.S. cities, including New York (“Medicating the mentally ill,” 1999; Satel, 1999), Chicago (“The cost of madness on the streets,” 1999), Los Angeles (Soto, 2001), San Francisco (“Why it’s called ‘Laura’s Law’,” 2002) and Boston (Sudders, 2002).

Ambivalence about OPC in the U.S.A. parallels that found in Europe and Canada and is quite distinct from more positive attitudes about OPC in Australia and New Zealand (Dawson, 2005). Dawson, of New Zealand’s University of Otago, has postulated that this difference is rooted in the distinctly more positive perception of the advantages of OPC held by Australian and New Zealand psychiatrists and other mental health professionals in those countries (Dawson, 2005).

The lack of data on the effectiveness of OPC in the U.S.A. has not stopped advocates and detractors of involuntary community interventions from staking out positions with definitive pronouncements early on in the considerations of this treatment modality. Hence, Isaac and Armat (1990) stated, “...outpatient commitment can keep a certain type of patient in the community: this is someone who does well on medication but consistently stops taking it heading to rapid deterioration. Such people often become revolving-door patients...” (p. 331). Those on the other side have made equally bald statements, both bold and unfounded. Thus, Stefan (1987) referred to involuntary outpatient interventions as “preventive commitment” while Schwartz and Costanzo (1987) dismissed such interventions as demonstrating “distorted doctrine and violated values.” IOT, in the form of OPC, has risen to the status lately of being the subject of active debate in the professional literature (Appelbaum, 2003; Goldman & Swartz, 2001; Ridgely, 2003; Segal, 2001; Szmukler & Hotopf, 2001).

1. History of the polarizing debate

While there were rare discussions of IOT in any form before the 1980s (Bleicher, 1967), the topic has really been a focus for the last 20 years. Throughout the two decades, the pattern of commentary overriding data has been consistent. Commentaries prior to 1990 by mental health professionals were generally written by psychiatrists (Appelbaum, 1986; Geller, 1986a; Miller, 1988; Mulvey, Geller & Roth, 1987) with other disciplines occasionally represented (Wilk, 1988). It appears there was an attempt by these author-practitioners to examine all sides of the issue. Some legal scholars provided balanced overviews (Brooks, 1987; “Institute of Law, Psychiatry and Public Policy,” 1988) in this era, but others polarized the issue quickly (Schwartz & Costanzo, 1987; Stefan, 1987). The 1990s saw a steady interest in IOT, especially in OPC, by psychiatrists (Draine, 1997; Geller, 1991, 1993, 1995, 1996a; Miller, 1992, 1999) and sometimes other medical disciplines (Smith, 1995), and by legal scholars (Berg & Bonnie, 1996; Furlong, 1995; Keilitz, 1990; Slobogin, 1994; Tavolaro, 1992). The opening years of the twenty-first century have witnessed, by a veritable explosion in interest in OPC, commentary from those in the mental health field (Appelbaum, 2001; Hoge & Grotolle, 2000; Miller, 2003; Monahan, Swartz & Bonnie, 2003; Munetz, Galon & Frese, 2003; Munetz, Geller & Frese, 2000; Swartz & Monahan, 2001; Torrey & Zdanowicz, 2001; Zonana, 2000) equaled if not exceeded by legal scholars (Allen & Smith, 2001; Cornwell & Deeney, 2003; Costello, 2003; Grudzinskas, 2002; Heyman, 2001; Perlin, 2003; Petril, Ridgely & Borum, 2003; Saks, 2003; Schopp, 2003; Winick, 2005). In each of the disciplines, there has been a wide range of opinions about OPC. Despite a verbal eruption on the subject of OPC, articles after 1990 have done little to advance the earliest analyses of IOT (Appelbaum, 1986; Geller, 1986a; Miller, 1998; Mulvey et al., 1987); due to the paucity of research, studies reviewed in 1990 (Geller, 1990) are repeatedly referred to with, until recently, only small incremental gains to report.

One of the common comments about OPC is that if a local mental health system had more resources and was better coordinated, coercion in community treatment would not be necessary (Allen & Smith, 2001; Dvoskin & Spiers, 2003; Schwartz & Costanzo, 1987). This opinion, most often expressed by those who do not provide community-based treatment and care to persons with serious mental illnesses, is without foundation. Ironically, one of the earliest accounting by a psychiatrist of his experience using coercion in the community (Geller, 1986a) was about treatment rendered in an especially well-funded and operated system of care (Geller, Fisher, Simon, & Wirth-Cauchon, 1990), the best funded by far in its era (Geller & Fisher, 1991). Even so, forthright debate on this issue was generated within psychiatry, as well as it should have been (Geller, 1982, 1987; Leong, 1987; Mossman, 1987).
Organizations have taken positions on OPC, sometimes quite strong positions. Some advocacy organizations, including the Treatment Advocacy Center (2000) (Torrey and Zdanowicz, 2000) and NAMI (National Alliance for the Mentally Ill, 1995) have endorsed OPC. Others, including the National Mental Health Association (n.d.a,b), the Bazelon Center (n.d.a,c), the California Network on Mental Health Clients (2001), the National Association for Rights Protection and Advocacy (n.d.); and the National Council on Disability (2000) have expressed strong negative opinions, as have a few professional associations, such as the International Association of Psychosocial Rehabilitation Services (n.d.). Associations and groups representing psychiatrists have generally taken a more middle of the road position, seeking more outcome data before declaring. These include the American Association of Community Psychiatrists (2002), the American Psychiatric Association (1987, 1999), and the National Association of State Mental Health Program Directors (2001).

Drawing from these sources, one can formulate an overview of the fundamental arguments for and against OPC. The pro argument states that because most refusal of or noncompliance with treatment is rooted in mental illness, and because the symptoms of mental illness abridge an individual’s autonomy, small intrusions into self-determination—“a tincture of coercion”—actually increases freedom. The initial infringement on liberty allows noninstitutional life where it would not otherwise occur. Basically, this position is founded on the proposition that the freedom to be ignored, under- or unserved and psychotic is no freedom at all; leads to a compromised existence behind a locked door, e.g., psychiatric hospital, jail, prison; and deprives a person of life in the least restrictive or most integrated setting.

OPC increases the effectiveness of treatment at the system and at the individual levels by a) delivering treatments more broadly, b) being a proactive rather than reactive intervention, c) inducing more active participation in treatments, d) enhancing rehabilitation, e) improving therapeutic relationships, f) expanding individuals’ perceptions of the benefits of treatment, and g) facilitating the appreciation of community life by allowing for a sustained period of psychosis-free living in communities.

OPC is cost-effective in that it reduces inpatient recidivism and utilization of crisis intervention; decreases involvement with the criminal justice system by persons whose real needs are for services for mental illness; and facilitates persons with serious mental illnesses entering, returning to, or sustaining themselves in the workforce. OPC improves quality of life.

The con argument states that OPC is another social control mechanism in the guise of benevolent coercion that will be directed to a larger cohort of persons with mental illness than would ever be in institutions in the current era of treatment (the “net widening” proposition). Treatments of dubious value are forced on marginally difficult persons in a process where coercion overtakes treatments. Efforts at mixing state monitoring and community treatments have not succeeded in the past, and OPC will simply be another failed attempt.

OPC becomes too expensive and too intrusive much too quickly. From monitoring treatment, OPC moves to monitoring all manner of social or situational aspects of a committed person’s life. OPC is ordered despite professionals’ poor predictive capacities and can become even more intrusive than inpatient commitment for OPC does not separate government’s intrusion into a person’s locus of room and board (traditional involuntary hospitalization) from capacity to treat over objection (which should require a showing of incompetency).

OPC lowers the standard for involuntary treatment and it’s a slippery slope from OPC to a need for treatment standard. Coercion, fundamental to the OPC process, undermines the therapeutic relationship, leads to alienation from treatment, and increases stigma. OPC is of dubious ethics because individuals are duped into complying with non-enforceable court orders. Ultimately, OPC does not improve quality of life.

Despite all this examination of OPC, it has been difficult to determine where it is legally sanctioned, much less the prevalence of its usage. There have been surveys done over the past 20 years of statutes that authorize OPC (Bazelon Center, n.d.b; Brakel, Parry & Weiner, 1985; Kelitz & Hall, 1985; Miller, 1992; Torrey & Kaplan, 1995), but such surveys fail to include states where extensive IOT comparable to statutorily defined outpatient commitment takes place through legal means other than state statutes, e.g., Massachusetts (Geller, Grudzinskas, McDermeeit, Fisher, & Lawlor, 1998; Geller, McDermeeit, Grudzinskas, Lawlor, & Fisher, 1997).

In the light of extensive surveying, commentary, and position statements, what does the research actually show?

2. Research

While there is some overlap, research into OPC can be conceived of as three generations of studies.

First generation studies are basically case studies, and represent the rare instances where the person conducting the treatment may actually be writing about that treatment. Those reports that fall into this category are summarized in...
Table 1, presented in chronological order. Most of these outcomes are positive, but in many instances, where the treator and investigator were one in the same, there are several artifacts: lack of objectivity and the effect of the treator rather than the coercion per se being the major two.

The second generation of studies are best characterized as quasi-experiments and surveys. These studies are summarized in Table 2, presented by jurisdiction. Overall, OPC, based on these studies, holds promise as an effective tool, but is little utilized.

The third generation of studies involves three states’ efforts that have or will include controlled studies and their derivatives: North Carolina, New York and California. While North Carolina has a longstanding statute, New York and California have more recently introduced statutorily-based involuntary outpatient treatment and the political fall-out both before and after the statute has been deafening.

North Carolina’s longstanding statute means that third generation research can build upon second generation studies (see Table 2). The difficulties of conceiving of and executing a controlled study of OPC are significant, as described by the Duke research group that has done this work (Swanson et al., 1997; Swartz et al., 1997). This group has made a valiant effort, one which they have extensively documented in terms of process and outcomes (Compton et al., 2003; Hiday, Swartz, Swanson, Borum, & Wagner, 2002; Swanson et al., 2001; Swanson, Swartz, Elbogen, Wagner, & Burns, 2003; Swanson, Swartz, & Estroff, 1998; Swanson, Swartz, Wagner, & Burns, 2000; Swartz, Swanson, Hiday, et al., 2001; Swartz et al., 1999; Swartz, Swanson, Wagner, Burns & Hiday, 2001; Wagner, Swartz, Swanson, & Burns, 2003). That research such as this will struggle to ever achieve the standards of bench research is demonstrated by at least two major shortcomings in these researchers’ methodology, both of which were out of their control. First is the North Carolina statute itself. In order to be eligible in North Carolina for OPC, an individual must be “capable of surviving safely in the community with available supervision from family, friends or others” (North Carolina Gen. Stat., 1993). But many states discharge inpatients daily, without OPC, who do not meet this criteria, much less with OPC. The second, as the authors articulate in each of their articles, is that they had to violate the randomization for persons with “histories of serious assaults involving weapon use or physical injury to another person within the

### Table 1: Case studies

<table>
<thead>
<tr>
<th>Authors</th>
<th>State</th>
<th>N</th>
<th>Subjects</th>
<th>Measures</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geller (1986a)</td>
<td>MA</td>
<td>3</td>
<td>Patients characterized by lengthy psychiatric history, psychologically based dangerousness, noncompliance, and recidivism</td>
<td>Treatment compliance, community tenure, readmission rate, quality of life</td>
<td>Improvement on all measures</td>
</tr>
<tr>
<td>Geller (1986b)</td>
<td>PA</td>
<td>1</td>
<td>32-year-old man with schizoaffective disorder</td>
<td>Psychotic symptoms, compliance</td>
<td>Improvement on all measures</td>
</tr>
<tr>
<td>Schneider-Braus (1986)</td>
<td>NM</td>
<td>1</td>
<td>41-year-old woman with “severe borderline personality”</td>
<td>Treatment compliance, use of inpatient setting, suicidality</td>
<td>Improvement on all measures</td>
</tr>
<tr>
<td>Schmidt and Geller (1989)</td>
<td>MA</td>
<td>8</td>
<td>Patients under OPC by probate court order</td>
<td>Rehospitalization, length of hospitalizations</td>
<td>Success for six patients, failure for one patient refractory to neuroleptics and for one who received inadequate follow-up</td>
</tr>
<tr>
<td>Geller (1992)</td>
<td>MA</td>
<td>3</td>
<td>Same cases as above (Geller, 1986a)</td>
<td>Rehospitalization, length of stay</td>
<td>Dramatic decrease in number and days of hospitalization over follow-ups of 2, 4 and 4 years</td>
</tr>
<tr>
<td>Munetz, Grande, Kleist and Peterson (1996)</td>
<td>OH</td>
<td>20</td>
<td>Patients maintained on OPC at least 12 months</td>
<td>Service utilization</td>
<td>OPC led to decreased admission and length of stay at state hospital; decreased use of psychiatric emergency service; no change in use of general hospital or crisis stabilization beds; increase in psychiatric appointments; no change in employment or substance abuse</td>
</tr>
<tr>
<td>Munetz, Grande, Kleist, Peterson, and Vuddagiri (1997)</td>
<td>OH</td>
<td>20</td>
<td>Same cases as above (Munetz et al., 1996)</td>
<td>Qualitative outcome one year after OPC terminated</td>
<td>10 of 18 patients had a good outcome</td>
</tr>
</tbody>
</table>

Part of this table was previously published in reference Geller, 1990.
Table 2  
Quasi-experimental studies and surveys

<table>
<thead>
<tr>
<th>Authors</th>
<th>State</th>
<th>N</th>
<th>Subjects</th>
<th>Measures</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Santiago, and Berren (1988)</td>
<td>AZ</td>
<td>35</td>
<td>All OPCs to county hospital in Tucson, August 7, 1983–August 6, 1984</td>
<td>Treatment compliance, length of inpatient hospitalization and community tenure</td>
<td>OPC “can be a useful clinical tool to treat seriously mentally ill dangerous individuals”</td>
</tr>
<tr>
<td>Band et al. (1984)</td>
<td>DC</td>
<td>274</td>
<td>OPCs to St. Elizabeths Hospital, 1971–84</td>
<td>Demographic and clinical variables comparing OPCs with inpatient commitments</td>
<td>OPCs were women referred by CMHC, general hospitals, and police; had prior hospitalizations; and had diagnoses of schizophrenia, bipolar disorder, major depression, and mental retardation</td>
</tr>
<tr>
<td>Zanni and deVeau (1986)</td>
<td>DC</td>
<td>42</td>
<td>St. Elizabeths Hospital patients changed from voluntary to OPC, 1983</td>
<td>Number of admissions, inpatient hospital days year before and after OPC</td>
<td>Fewer admissions after OPC, trend toward shorter stays</td>
</tr>
<tr>
<td>Christy, Boothroyd, Petriila, and Poythress (2003)</td>
<td>FL</td>
<td>300</td>
<td>Medicaid SSI recipients for mental disorder who participated in a managed care study</td>
<td>Prevalence of OPC</td>
<td>10.4% had any lifetime experience with OPC</td>
</tr>
<tr>
<td>Christy et al. (2003)</td>
<td>FL</td>
<td>113</td>
<td>Persons with mental illness facing minor court charges</td>
<td>Prevalence of OPC</td>
<td>16.8% had any lifetime experience with OPC</td>
</tr>
<tr>
<td>Rohland, Rohrer, and Richards (2000)</td>
<td>IA</td>
<td>81</td>
<td>All persons over 5 year period with OPC to a university outpatient clinic</td>
<td>Outpatient visits, emergency visits, hospitalizations, length of stay for year before and after OPC</td>
<td>Statistically significant increase in outpatient visits and decrease in emergency visits, hospital admissions and length of stay</td>
</tr>
<tr>
<td>Rohland et al. (2000)</td>
<td>IA</td>
<td>63</td>
<td>Subset of sample above with OPC of 1 year or longer</td>
<td>Same as Rohland et.al. above</td>
<td>Same as Rohland et.al. above</td>
</tr>
<tr>
<td>Rohland et al. (2000)</td>
<td>IA</td>
<td>25</td>
<td>Subset of sample above with OPC of 5 years or longer</td>
<td>Same as Rohland et.al. above</td>
<td>Same as Rohland et.al. above except decrease in emergency visits was not statistically significant</td>
</tr>
<tr>
<td>Geller, McDermeit, Grudzinskas, Lawlor, and Fisher (1997)</td>
<td>MA</td>
<td>19</td>
<td>First patients in central Massachusetts on involuntary outpatient treatment orders (IOTO) at 6 month follow-up</td>
<td>Hospital admissions and days</td>
<td>IOTO patients had significantly fewer hospital admissions and days than matched controls</td>
</tr>
<tr>
<td>Geller, Grudzinskas, McDermeit, Fisher, and Lawlor (1998)</td>
<td>MA</td>
<td>19</td>
<td>Same sample as above (Geller et al., 1997) with 2-year follow-up</td>
<td>Hospital usage</td>
<td>Decreased hospital usage in IOTO group and in group matched for similar inpatient utilization histories; equivocal benefit of IOT</td>
</tr>
<tr>
<td>Wood and Swanson (1985)</td>
<td>NB</td>
<td>18</td>
<td>All OPCs through Omaha Mental Health Board to university outpatient department, October 1979–September 1982</td>
<td>Lengths and loci of commitments</td>
<td>Practitioners reticent to end committed status</td>
</tr>
<tr>
<td>Hiday and Goodman (1982)</td>
<td>NC</td>
<td>167</td>
<td>OPCs in one court, January 1978–December 1979</td>
<td>Rehospitalization rate</td>
<td>OPC effective and less restrictive</td>
</tr>
<tr>
<td>Miller and Fiddelman (1984)</td>
<td>NC</td>
<td>67</td>
<td>All OPCs six months before and six months after 1979 statute changes</td>
<td>Participation of community mental health center (CMHC), court’s role</td>
<td>Improved OPC statute made little change in practice</td>
</tr>
<tr>
<td>Hiday and Scheid-Cook (1987)</td>
<td>NC</td>
<td>295</td>
<td>All OPCs from sample of 1226 civilly committed patients, fiscal year 1985</td>
<td>Treatment compliance, social interaction, no dangerous episodes</td>
<td>OPC successful for “appropriate” patients who show up at CMHC and begin treatment</td>
</tr>
<tr>
<td>Scheid-Cook (1987)</td>
<td>NC</td>
<td>295</td>
<td>Same sample as above (Hiday &amp; Scheid-Cook, 1987)</td>
<td>Demographic clinical variables</td>
<td>OPCs were males with schizophrenia, in mid-30s, recidivists with history of medication refusal</td>
</tr>
<tr>
<td>Hiday and Scheid-Cook (1989)</td>
<td>NC</td>
<td>38</td>
<td>“Revolving-door” patients</td>
<td>Treatment compliance, Rehospitalization, community functioning</td>
<td>OPC a viable less restrictive alternative to involuntary hospitalization</td>
</tr>
</tbody>
</table>
preceding year” (Swartz, Swanson, Hiday, et al., 2001). These, however, are persons who might prove to be major beneficiaries of OPC; they were excluded in many of the authors’ analyses. There are also other biases that could have affected the outcomes that the authors themselves discuss (Swartz, Swanson, Hiday, et al., 2001). While a discussion of the finer points of the authors’ findings as reported in each of their papers is beyond the scope of this paper, all the authors’ major findings are well summarized by them in one single article (Swartz, Swanson, Hiday, et al., 2001):

subjects who underwent sustained periods of outpatient commitment beyond the initial court order and who received relatively intensive outpatient treatment had fewer hospital admissions, spent fewer days hospitalized, and were less likely to be violent or to be victims of crime. Sustained outpatient commitment was shown to be particularly effective in reducing the number and duration of hospitalizations for individuals with nonaffective psychotic disorders. In addition, for a subgroup of patients with a combined history of multiple hospitalizations and previous arrests or episodes of violence, sustained outpatient commitment was associated with a significant reduction in the likelihood of rearrest during the study year.

New York State has made two distinct attempts at using OPC. The first of these was a pilot study in New York City, particularly well described from start to finish by Telson (2000). The second is based on a state statute, referred to as Kendra’s Law (New York State Office of Mental Health, n.d.b). The first effort drew some attention (Duffy, 1994; Gould, 1995; Rosenthal, 1998); the second brought on an onslaught (Coalition to Stop Outpatient Commitment, n.d.; Guastaferro, 1999; Jaffe, 2003; Kupersanin, 2000; NAMI, 1999; Treatment Advocacy Center. NYCLU actively working against Kendra’s Law, 2000; Rosack, 2000; Smith, 1999; Webdale, 2003).

The pilot program had a research component as part of its conception (Telson, Glickstein, & Trujilo, 1999). The design was to be the randomization of 150 patients to either OPC and enhanced services or enhanced services only. The research component appears to have affected the clinical decision making so that patients who were not referred for OPC before the research began were subsequently referred in order to get the required number of subjects within the research time frame (Telson et al., 1999). Despite these and other methodologic difficulties, the psychiatrists at Bellevue Hospital Center (the site of the pilot project) believe that OPC had some tangible benefits: improved coordination of services and commitment to a difficult to serve population by Bellevue and over 80 provider agencies; improved compliance with treatment by patients on OPC orders; positive response to orders by patients; the necessity for appropriate and good quality services; improved mobilization of resources secondary to OPC orders; improvement in access to and compliance with clinical services in patients known to be historic refusers and rejectors of services; and progressively increasing requests by families and providers for OPC orders (Telson et al. 1999).

The research results were first available in a final report submitted to the New York City Department of Mental Health, Mental Retardation and Alcoholism Services (Policy Research Associates, 1998). This report, which came out before the Bellevue Hospital Center Report (Telson et al., 1999), found that the OPC orders had little effect. The overall conclusion reads, “the experimental and the control groups were remarkably similar on all outcome measures over the follow-up period. There is no indication that, overall, the court order for outpatient commitment produces better outcomes for clients in the community than enhanced services” (Policy Research Associates, 1998). The Bellevue

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<tr>
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<th>Subjects</th>
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<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fernandez and Nygard (1990)</td>
<td>NC</td>
<td>4140</td>
<td>All persons committed to OPC in NC between July 1, 1985 and June 30, 1988</td>
<td>Number of admissions and length of stay at NC state hospitals before and after OPC</td>
<td>Statistically significant decrease in number of admissions and length of stay</td>
</tr>
<tr>
<td>Hiday and Scheid-Cook (1991)</td>
<td>NC</td>
<td>38</td>
<td>Same sample as above (Hiday &amp; Scheid-Cook, 1989)</td>
<td>Treatment compliance</td>
<td>Improved compliance as measured by number of CMHC visits, in treatment at CMHC at 6 months, noncompliance other than medication refusal</td>
</tr>
<tr>
<td>Scheid-Cook (1991)</td>
<td>NC</td>
<td>295</td>
<td>Same sample as above (Hiday &amp; Scheid-Cook, 1987)</td>
<td>Least restrictive alternative, social control, revolving door, induce treatment Readmission rate</td>
<td>“OPC provided both social control and greater individual liberty”</td>
</tr>
<tr>
<td>Bursten (1986)</td>
<td>TN</td>
<td>78</td>
<td>All OPCs, July 1, 1981–March 1, 1983</td>
<td></td>
<td>OPC did not reduce readmissions</td>
</tr>
</tbody>
</table>

Part of this table was previously published in reference Geller, 1990.
Hospital Center Report responds to the research findings, pointing out areas of agreement (more process than outcome) and disagreement (outcome and clinical significance) (Telson et al., 1999). The research group went on to publish their findings in a paper that basically mimics its report to New York City (Steadman et al., 2001). The findings and thoughts of those who actually did the legal and clinical work never achieved publication.

Results from the state-wide statutorily-based OPC were first reported after one year by the New York State Office of Mental Health (Berg, 2002; New York State Office of Mental Health, 2003, n.d.a). The report examined the demographic, diagnostic, and service use patterns of recipients of OPC, referred to in New York State as “Assisted Outpatient Treatment” (AOT). The report then compared outcomes prior to AOT and while enrolled in AOT across variables of services received; incidence of psychiatric hospitalization, homelessness, arrests, and incarcerations; service engagement and adherence to medication; harmful behaviors; improvement in social, interpersonal and family functioning; and improvement in task performance. All results were reported as percentage of the whole cohort and all percentages moved in the direction to show better outcomes under AOT. The second report (New York State Office of Mental Health, 2003) basically repeated the findings of the first, but with better graphics; outcomes were still limited to six months follow-up.

After five years, New York State made its final report, one which contained most favorable data on AOT (Kendra’s Law, 2005). As a predicate to the findings it should be noted that the New York Governor’s budget for 2005–2006 contained $32 million for operation of services in support of Kendra’s Law and $125 million for enhanced community services. Thus, increased services accompanied the evolution of AOT.

Through December 31, 2004, there were 10,078 referrals and 4041 petitions filed, of which 93% were granted. Of 3493 orders eligible for renewal (those whose initial order lasted six months), 64% were renewed. The most frequent reason for non-renewal (76%) was that the individual had improved and no longer needed AOT. The second most frequent reason (10%) was that the person was hospitalized in what was expected to be a long-stay hospitalization. The average length of time a recipient remained under court order was 16 months. At the end of the court order most persons were living independently (52%) or in supervised community-based settings (22%). Demographics of AOT recipients showed that 66% were male; 75% never married; 66% non-Caucasian; 71% with schizophrenia or other psychotic disorders; and 52% with coexisting alcohol and other substance abuse.

The benefits of AOT were presented as those that accrued to the individual and those that impacted upon the local mental health system. At 6 months, AOT recipients showed major service use changes (remember services were enhanced): increases by 89% in use of case management, 67% in use of substance abuse services, 63% in housing or housing support services, and 106% in adherence to medication (as measured by blood levels). The percent reduction of AOT recipients with difficulties is self-care and community living averaged 23% for 13 variables ranging from 29% in prepare meals, take care of own possessions and maintain adequate hygiene to 11% for access transportation. The percent reduction of AOT recipients with difficulties in social, interpersonal and family function averaged 22% for eight variables, ranging from 29% ask for help when needed to 14% manage leisure time. The percent reduction of AOT recipients with difficulties in task performance averaged 23% for eight variables, ranging from 26% for understand and remember instructions to 19% for completes tasks without errors. The percent reduction of AOT recipients showing harmful behaviors (one or more episodes reported in the past 90 days) average 44% across 10 variables, ranging from 55% for physically harm self/made suicide attempt to 29% for theft.

Longer-term findings (entire course of AOT treatment for each individual) showed, in before AOT and during AOT comparisons, reductions of 87% in incarceration, 83% in arrest, 77% in psychiatric hospitalization and 74% in homelessness rates. Gains in all areas measured during the first 6 months were sustained or improved when measured over the life of each AOT commitment.

A sample (n=76) of AOT recipients were interviewed about their AOT experience. Fifty-four percent reported feeling angry and 53% reported embarrassment about being on AOT. On the other hand, 63% reported that being court-ordered into treatment had been a “good thing for them.”

Improvements to the local mental health system included new mechanisms for case finding and assessment, greater accountability at the local level, improved access, and greater collaboration between the mental health and court systems. Treatment plans were improved, becoming more individualized and more encompassing. Finally, AOT implementation resulted in a finer ability to prioritize the use of resources for those in greatest need.

While it is important to count events, this really only scratches the surface of what is necessary to examine when and how IOT should be used. In New York State the statutorily-defined eligibility criteria for AOT are: (1) be eighteen years of age or older; (2) suffer from a mental illness; (3) be unlikely to survive safely in the community without supervision, based on a clinical determination; (4) have a history of non-adherence with treatment that has (a) been a significant factor in his or
her being in a hospital, prison or jail at least twice within the last 36 months; or (b) resulted in one or more acts, attempts or threats of serious violent behavior toward self or others within the last 48 months; (5) be unlikely to voluntarily participate in treatment; (6) be, in view of his or her treatment history and current behavior, in need of AOT in order to prevent a relapse or deterioration which would be likely to result in: (a) a substantial risk of physical harm to the individual as manifested by threats of or attempts at suicide or serious bodily harm or conduct demonstrating that the individual is dangerous to himself or herself, or (b) a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm; (7) be likely to benefit from AOT; and (8) if the consumer has a health care proxy, any directions in it will be taken into account by the court in determining the written treatment plan. However, nothing precludes a person with a health care proxy from being eligible for AOT (Berg, 2002; California Psychological Association, 2003; California Treatment Advocacy Coalition, n.d.; Herbert, Downs, & Petrila, 2001). As should come as no surprise to those reading this history of OPC, the authors were unable to reach any policy-guiding conclusions.

California’s OPC statute, one in which OPC is also referred to as AOT, went into effect on January 1, 2003. This statute, referred to as ‘Laura’s Law’ (in the new tradition of naming OPC statutes after victims whose death was caused by violence an individual with chronic mental illness), is too new to have any outcome data available. It has, however, generated nothing short of cacophonies from quarters throughout the political spectrum (Appelbaum, 2003; California Psychological Association, 2003; California Treatment Advocacy Coalition, n.d.; Herbert, Downs, & Young, 2003; Kupersanin, 2001; “Last boost on ‘Laura’s Law’,” 2002; Rand, n.d.; Swanson, 2001). Again, no data, but an abundance of opinions. Appelbaum’s (2003) opinions are particularly worthy of attention as he analyzes the California statute and puts it into a national perspective. Appelbaum notes that the California law is more restrictive than the New York statute, is a “sham system of outpatient commitment” since the law was passed with no funding necessary to meet the mandates, and “suffers from a profound ambivalence about the legitimacy and value of mandatory outpatient treatment.”

California had hoped to proceed differently from many of the other states by commissioning the Rand Institute for Civil Justice to do a study of the policy implications for California of adopting OPC. A well-qualified trio of researchers produced a report based on a literature review, interviews, and a study of OPC in eight other states (Ridgely, Borum, & Petrila, 2001). As should come as no surprise to those reading this history of OPC, the authors were unable to reach any policy-guiding conclusions.

In California, AOT is only available in those counties that create programs for this new intervention option and have it authorized by resolution of the county’s board of supervisors. In encouraging citizens of California to advocate for their county to adopt and sanction AOT procedures, the California Treatment Advocacy Coalition and the Treatment Advocacy Center opine that AOT works “spectacularly.” This conclusion derives from the third generation North Carolina studies cited above. (A Guide to Laura’s Law, 2003).

3. Is OPC a legitimate use of government power? The New York example

The passage of Kendra’s Law in New York State has kept those in the legal field quite busy. Three attorneys, in a guide written for “clinicians of all disciplines” on New York mental health law include a chapter on AOT (Behnke, Perlin, & Bernstein, 2003). They point out some noteworthy features of New York’s AOT law. Services under AOT are any that treat a person’s mental illness, avoid relapse that would lead to harm or rehospitalization, and help the individual live in the community. That’s a wide range of services, far more than simply attending to medication compliance. At the hearing the level of proof is clear and convincing. No AOT order goes into effect unless a treatment plan has been submitted to the court. The court can not add anything to the proposed treatment plan, but can reduce or eliminate treatment mandates.

AOT treatment is delivered through AOT programs and these programs “own” the medical record; the patient–clinician relationship is not private. Finally, the law does not include specific enforcement provisions. However, noncompliance is a factor in a physician’s consideration of an evaluation for involuntary hospitalization.

Legal writers were quick to jump on the issue of the constitutionality of Kendra’s Law. The Fordham Law Review published an article (Guterman, 2000) asserting that the statute “infringes on the constitutional rights of the mentally ill and fails to address their mental health needs.” The author proclaims freedom to refuse unwanted treatment is a
fundamental right; psychiatrists and judges would be empowered to “control basic functions based on subjective impressions and biases”; the principle of least restrictive alternative is violated; the state is derailed from focusing on voluntary programs and recovery-oriented services; too many individuals could be put on psychiatric medications with “unacceptable high risks of toxicity and unpropitious side effects”; and the measure would be ineffective because “coercive treatment does not work.” A Journal of Law and Policy article (O’Connor, 2002) indicated Kendra’s Law would both further stigmatize those with mental illness and fail to protect society from individuals who were violent due to their mental illness. All this is said without any documentation of data in support of proclamations.

On the other hand, the University of Pennsylvania Law Review published an article (Watnik, 2001) that stated, “Kendra’s Law is both narrowly tailored” and “rationally related” to its goals of caring for persons with mental illness and protecting society from individuals with mental illness who “are not aware of the nature and consequences of their actions.” The author concludes that assuming only appropriate candidates for AOT are assigned to AOT, “the state’s goals are compelling enough to justify restrictions on individuals’ liberties.”

New York State’s population did not have to wait long for New York’s courts to weigh in on the constitutionality issue. First, in re Urcuyo (2000)1 the Supreme Court of New York (a lower level New York State court) found that Kendra’s Law did not violate an individual’s due process or equal protection rights. Notably the court found there is not a requirement of a “finding of incapacity before a court can order a patient to follow a course of medical treatment.” The court also highlighted the fact that Kendra’s Law did not unconstitutionally deprive an individual of a right to refuse medical treatment and did not lead to any punitive remedy for failure to comply with a medical treatment plan, but rather such refusal or noncompliance could lead to an evaluation by a physician. The court pronounced that “Kendra’s Law provides the means by which society does not have to sit idly by and watch the cycle of decompensation, dangerousness and hospitalization continually repeat itself.”

Next, in a New York Superior Court, in re Martin (2001)2, the findings parallel those of the first case. This court indicated that the argument that a physician’s clinical judgment did not present a probable cause standard was not sustainable. Further, the court found that prior notice before confinement following noncompliance was not required. This court rather eloquently stated that “the statute [Kendra’s Law] is mindful of, indeed solicitous toward, the civil liberties of the patients....”

Finally, the Court of Appeals of New York State, on February 17, 2004, decided in re K.L. (2004)3 that Kendra’s Law did not violate due process or equal protection rights by not requiring a finding of incapacity before an individual may be ordered to comply with AOT, did not violate due process rights by failure to provide notice and a hearing prior to the “temporary removal of a noncompliant patient to a hospital”, and did not violate the constitutional prohibition against unreasonable search and seizure by not requiring a physician to have “probable cause or reasonable grounds to believe that a noncompliant assisted outpatient is in need of involuntary hospitalization” prior to seeking removal of the individual.

Thus, the New York courts have, to date, rejected the constitutional challenges to Kendra’s Law. Several New York newspapers praised the courts’ actions (Newsday, February 20, 2004; New York Post, February 25, 2004). Newsday called the decision “a triumph of common sense.”

4. Future

While most states now have outpatient commitment statutes, until recently few states made much use of them (Monahan, 2001). The states continue to be all over the place on the issue of OPC. After considerable debate in Florida (Hudson et al., 2004; “Kendra’s Law is good,” 2004; “Pass Reform,” 2004; Webdale, 2004) the state passed court-ordered outpatient treatment for persons with severe mental illness who refuse medication because their illness precludes rational decisions around medication (Landmark legislation, 2004). West Virginia, after contemplating a pilot project (Finn, 2004), authorized “outpatient treatment compliance orders” in at least four and no more than six judicial circuits by a modification to its state code in April 2005 to be effective July 1, 2006 (West Virginia, 2005). Michigan enacted an OPC law known as Kevin’s Law on March 29, 2005 (Michigan’s new treatment law, 2005) while New Jersey’s Governor’s Task Force on Mental Health recommended AOT for New Jersey on March 31, 2005

1 re Urcuyo, 714 N.Y.S. 2d 862 (2000).
Throughout the history of OPC, and continuing to the present, there have been calls for further research of OPC (American Association of Community Psychiatrists, 2002; American Psychiatric Association Council on Law and Psychiatry, 1999; Geller, 1986a, 1991, 1996b, 2001; Hiday, 2003; President’s New Freedom Commission on Mental Health, 2003; Swartz et al., 1995; Swartz, Swanson, & Hannon, 2003). And this is exactly right. Myths abound, while facts remain scarce. For example, advocates proclaim that fear of coercion will drive individuals with serious mental illnesses away from treatment rather than assist their engagement in treatment. Research to date does not support this proclamation (Swartz, Swanson, & Hannon, 2003).

Fundamental to further research is determining to whom, from a clinical perspective, should OPC be delivered. Geller (1990) made an attempt to do so, but such attempts have been rare. If we don’t do this, we continually study outcomes in a heterogeneous population only some of whom might be expected to benefit from OPC. It is no wonder, then, that results are so often equivocal.

It is clear that reasonable, well-informed people can differ on IOT and its specific application through OPC. Much of the alleged debate, however, has been individuals talking past one another rather than to each other. In a “Pro and Con (2004, January)” piece titled, “should psychiatric treatment be mandated for outpatients who are severely mentally ill?”, for example, Michael Faenza (President and Chief Executive Officer of the National Mental Health Association) speaking for the con position, states, “A system based on fear and coercion neither promotes nor supports recovery.” Paul Appelbaum (a past president of the American Psychiatric Association and Chairperson of the Department of Psychiatry at the University of Massachusetts) indicates, “There is an appropriate role for mandating outpatient treatment for patients who have evidenced an inability to manage their own illness through repetitive decompensation and repeated hospitalizations.” One can endorse both positions, and a reasonable clinician might very well do so.

OPC in the USA has deteriorated from a conundrum to a quagmire by a process devoid of sufficient evidence on either side of a political, polarizing debate. It’s time to put a moratorium on the debate and obtain the data. Research, designed to produce valid responses to the question of the efficacy and effectiveness of OPC, and all forms of IOT for that matter, is not out of reach. Studies in North Carolina and New York State are nascent efforts that can lead the way to further refined studies. There is no reason that OPC cannot move toward an evidence-based practice in the same manner as we are trying to move all of psychiatric interventions.

References


