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New Research Continues to Challenge the Need for Outpatient Commitment

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INTRODUCTION

Outpatient Commitment ("OPC"), a mechanism to compel individuals with mental illness to comply with treatment in the community, has been analyzed repeatedly from many perspectives. Legal, philosophical, and clinical analyses are common. Both those observers who favor OPC and those who oppose it have found support for their positions in these disciplines. While the subject of OPC has been debated for at least fifteen years, it is important to revisit the debate now in light of recent research to determine whether the arguments and analyses should be reconsidered. The publication in the last few years of a number of clinical studies makes this a particularly propitious moment to reconsider the issue of OPC. This article reviews these studies and concludes that they offer little evidence in support of the effectiveness of OPC.[2]

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1. The authors thank Michael Allen, Lauren Ben-Ezra, Frank Laski, & Laura Soo-Yung Luyten for their assistance in the preparation of this article.

2. In an effort to avoid being repetitive, this article focuses on new clinical research. For explorations of how earlier clinical research also calls into question the need for and effectiveness of OPC, *see, e.g.*, Steven J. Schwartz & Cathy E. Costanzo, *Compelling Treatment in the Community: Distorted Doctrines and Violated Values*, 20 LOY. L.A. L. REV. 1329 (1987); Susan Stefan, *Preventive Commitment: Misconceptions and Pitfalls in Creating a Coercive Community*, J. HEALTH & HUM. RESOURCES ADM., 459 (1989); Michael Allen & Vicki Fox Smith, *Opening Pandora's Box: The Practical and Legal Dangers of Involuntary Outpatient Commitment*, 52 PSYCHIATRIC SERVICES 342, 342-46 (2001); *see also* Brief of Amici Curiae New York Lawyers for the Public Interest et al., *In re* K.L., 806 N.E.2d 480 (N.Y. 2004).

OPC DEFINED

OPC, also called preventive commitment, Assisted Outpatient Treatment ("AOT"), or Involuntary Outpatient Commitment ("IOC"), is a court order compelling the compliance of an individual living outside of an institution with a treatment regimen or other aspects of community life. The order generally mandates acceptance of psychiatric medication and may mandate receipt of other services, such individual or group therapy, participation in educational or vocation programs, and supervised living arrangements.[3]

OPC statutes have been divided into three types: (1) *preventive or early intervention* statutes that permit OPC for individuals who do not meet civil commitment criteria but who have a recurring psychiatric disorder and a history of hospital admissions; (2) *hospital diversion* statutes that permit OPC for individuals who meet civil commitment criteria but may be treated in the community; (3) *conditional discharge* statutes that permit OPC for individuals who are being discharged from a hospital with aftercare services.[4]

Presently, forty-two states have OPC statutes.[5] One of the earliest provisions was enacted in North Carolina, in 1983.[6] Among the most

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3. *See, e.g.*, Susan, Stefan, *Preventive Commitment: The Concept and its Pitfalls*, 11 MENTAL & PHYSICAL DISABILITY L. REP. 288, 290 (1987) (therapy, supervision in community, and restriction of association); Ronald L. Wisor, *Community Care, Competition and Coercion: A Legal Perspective on Privatized Mental Health Care*, 19 AM. J.L. & MED. 145, 167 (1993) (therapy, educational or vocational programs, and supervised living arrangements).

4. *See* National Association of State Mental Health Program Directors Medical Directors Council, *Technical Report on Involuntary Outpatient Commitment, available at* http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Involuntary_Outpatient_Commitment.PDF (last visited Jan. 7, 2005). Criteria for OPC vary from state to state. Many statutes require a finding that the individual is a "mentally ill person." Many require a finding that the person poses a danger to self or others or is gravely disabled. Some require a finding that the person is in need of treatment in order to prevent relapse or deterioration or re-hospitalization. Some require a finding that the person is unwilling to accept voluntary treatment; others require a finding that the person is unable to make a decision; and still others allow use of the statute if either criteria is met. Many statutes, however, do not require a finding of incompetency to make medical decisions. There are typically additional criteria that assess the proposed treatment plan. *See* Judge David L. Bazelon Center for Mental Health Law, *Involuntary Outpatient Commitment Summary of State Statutes, available at* http://www.bazelon.org/issues/commitment/ioc/iocchartintro.html (last visited Jan. 7, 2005).

5. *See New Law in Florida: Florida Becomes 42nd State to Authorize Assisted Outpatient Treatment, available at* http://www.psychlaws.org/ (last visited Jan. 7, 2005).

6. *See* Elizabeth Dickinson Furlong, *Coercion in the Community: The Application of Rogers Guardianship to Outpatient Commitment*, 21 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 485, 505 (1995).

prominent provisions are Kendra's Law in New York, adopted in 1999, and Laura's Law in California, adopted in 2002.[7] While many states with OPC statutes use their provisions rarely,[8] some states use them more widely.[9] In some of the states without OPC, other devices may be used to compel compliance with psychiatric treatment.[10]

RECENT RESEARCH

There is a great deal of recent research on OPC. This research improves our understanding of OPC and the issues surrounding OPC for at least three reasons. First, there is simply *more* research and therefore more research subjects on a wider range of topics. Second, newer OPC studies have attempted to correct flaws in earlier studies. These new studies include two randomized controlled trials: the New York City Involuntary Outpatient Commitment Pilot Program, a Policy Research Associates study of 142 participants at Bellevue Hospital tracked between 1995 and 1998;[11] and the

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7. *See* N.Y. MENTAL HYG. LAW § 9.60 (1999); CAL. WELF. & INST. CODE §5345 (2002) (outpatient standard only available in counties that have adopted provisions established by this law).

8. *See* Judge David L. Bazelon Center for Mental Health Law, *Seltzer Testimony on Outpatient Commitment*, *available at* http://www.peoplewho.net/readingroom/seltzer.htm (last visited Jan. 7, 2005); M. Susan Ridgely et al., *The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States*, 15 (2001).

9. *See, e.g.*, New York State Office of Mental Health, *Kendra's Law: An Interim Report on the Status of Assisted Outpatient Treatment*, *available at* www.omh.state.ny.us/omhweb/kendra%5Fweb/interimreport/ (last visited Jan. 7, 2005) (from November 1999 through December 3, 2002, 7938 individuals have been referred to local AOT coordinators for investigation to determine potential eligibility for an AOT court order, 2559 petitions have been filed, and 2433 granted).

10. For example, while Massachusetts has no outpatient commitment statute, in the state's Worcester County, probate court judges draft medication guardianship orders with enforcement provisions that allow for police to take non-compliant individuals to a hospital for involuntary medication. *See* Steven Schlang, *Outpatient Commitment, A Dim View*, 39 ADVISOR 3 (1993). In 2002, over 4500 people in Massachusetts took psychiatric medication pursuant to a probate court treatment order. *See* Marylou Sudders, *Commitment Law Won't Help the Mentally Ill*, BOSTON GLOBE, June 12, 2002, at A23. In Western Massachusetts, residents of group homes frequently have such orders. *See, e.g.*, Fred Contrada, *Group Opposes Forced Drugging*, THE REPUBLICAN, Nov. 23, 2003, at C01 (James Bower, a resident in a ServiceNet residence claims he is forced to take psychiatric medication against his will pursuant to court order and that when he refuses, the residence staff call police who bring him to a hospital for a shot of medication).

11. *See* Henry J. Steadman et al., *Assessing the New York City Involuntary Outpatient Commitment Pilot Program*, 52 PSYCHIATRIC SERVICES 330 (2001); Sarah D. Rain et al., *Perceived Coercion and Treatment Adherence in an Outpatient Commitment Program*, 54 PSYCHIATRIC SERVICES 399 (2003); *see also* Policy Research Associates, Inc., *Final Report: Research Study of the New York City Involuntary Outpatient Commitment Pilot Program.*

Duke Mental Health Study of 331 people in North Carolina followed between 1993 and 1996.[12] Third, in 2001, RAND conducted a meta-analysis, that is, a study that examines and critiques earlier studies. Reviewing methodology of researchers, RAND grouped OPC studies into "first" and "second" generation studies and noted limitations of studies in both groups.[13]

This article highlights this newer research on OPC, focusing on studies and reports published since January 2000, and giving particular attention to RAND's 2001 assessment.

NEW RESEARCH UNDERCUTS THE CLAIM THAT OPC IS NECESSARY BECAUSE PEOPLE WITH MENTAL ILLNESSES ARE DANGEROUS

Proponents suggest that OPC is necessary because it is the only effective means of containing dangerous mentally ill individuals while permitting them to continue to live in the community.[14] The public's fear of people with mental illnesses has provided fertile soil for this argument.[15]

Submitted to New York City Department of Mental Health, Mental Retardation and Alcoholism Services (1998); Howard Telson et al., *Report of the Bellevue Hospital Center Outpatient Commitment Pilot Program*, *available at* http.www.psychlaws.org/Medical Resources/Bellevue%20Report%202%20web.htm (last visited Jan. 7, 2005) (counter report to the commissioned study).

12. Researchers have published a number of analyses drawn from Duke Mental Health study data. *See, e.g.*, Marvin S. Swartz et al., *Can Involuntary Outpatient Commitment Reduce Hospital Recidivism? Findings from a Randomized Trial With Severely Mentally Ill Individuals*, 156 AM J. PSYCHIATRY 1968 (1999); Jeffrey W. Swanson et al., *Involuntary Out-Patient Commitment and Reduction of Violent Behaviour in Persons with Severe Mental Illness*, 176 BR. J. PSYCHIATRY 324 (2000); Marvin S. Swartz et al., *A Randomized Control Trial of Outpatient Commitment in North Carolina*, 52 PSYCHIATRIC SERVICES 325 (2001); Marvin S. Swartz et al., *Effects of Involuntary Outpatient Commitment and Depot Antipsychotics on Treatment Adherence in Persons with Severe Mental Illness*, 189 J. NERVOUS & MENTAL DISEASE 583 (2001); Virginia A. Hiday et al., *Impact of Outpatient Commitment on Victimization of People with Severe Mental Illness*, 159 AM. J. PSYCHIATRY 1403 (2002).

13. *See* Ridgely et al., *supra* note 8; *see also* Virginia Aldige Hiday, *Outpatient Commitment: The State of Empirical Research on Its Outcomes*, 9 PSYCHOL., PUB. POL'Y, & L. 8, 12-15 (2003) (discussion of why the methodology of the New York City and Duke studies represented an improvement over the earlier generation of "nonexperimental, naturalistic field studies.")

14. *See, e.g.*, *In re* K.L., 1 N.Y.3d 362, 366 (2004).

15. Over the past half a century, Americans have become more and more fearful of people with mental illness. In 1950, only seven point two percent of people thought people with mental illness were violent, dangerous and frightening. By 1996, that number had increased to twelve point one percent. Even more significant, nearly fifty percent said they would be unwilling to interact with a person with schizophrenia and thirty-seven point four percent said they would avoid interacting with someone with major depression. Jo C.

However, clinical research continues to challenge the contention of a correlation between mental illness and violence.[16] In 2002, researchers for the prestigious MacArthur Network on Mental Health concluded that schizophrenia and psychotic symptoms themselves are *negatively*, if at all, related to the risk of future violence among offenders and individuals who receive psychiatric services.[17] Further, in 2004, British researchers found that even patients being discharged from psychiatric facilities did not pose an inordinate risk of violence.[18]

CLINICAL RESEARCH CHALLENGES THE CLAIM THAT OPC KEEPS INDIVIDUALS WITH MENTAL ILLNESSES OUT OF PSYCHIATRIC HOSPITALS

Proponents argue that OPC keeps psychiatric patients on medication and thereby out of hospitals.[19] For example, a briefing paper by the Treatment Advocacy Center, one of the nation's principal supporters of OPC, cites four studies in support of the proposition that OPC reduces hospital

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Phelan, *Public Conceptions of Mental Illness in 1950 and 1996: What is Mental Illness and Is It to be Feared?*, 41 J. HEALTH & SOC. BEHAV. 188 (2000). Within this context, those favoring OPC have moved the debate from the mental health to the public safety arena. One OPC supporter, Treatment Advocacy Center publicist D.J. Jaffee, actually counseled in 1999: "It may be necessary to capitalize on the fear of violence." Phyllis Vine, *Mindless and Deadly: Media Hype on Mental Illness and Violence*, *available at* http://www.narpa.org media.hype.htm (last visited Jan. 7, 2005).

16. These new findings should be read in conjunction with the conclusions of the MacArthur Risk Assessment study. *See* Allen & Smith, *supra* note 2, at 345 (citing Henry J. Steadman et al., *Violence By People Discharged From Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods*, 55 ARCHIVES GEN. PSYCHIATRY 393 (1998)) (MacArthur Risk Assessment study concluded that when alcohol and substance abuse are not involved, the incidence of violence among recently discharged mental patients is essentially the same as that of others living in the same neighborhoods.)

17. Marnie E. Rice et al., *The Appraisal of Violence Risk*, 15 CURRENT OPINION PSYCHIATRY 589 (2002). In addition, Paul Appelbaum, of the University of Massachusetts Medical School, produced research in 2000 concluding that no relationship exists between delusions (including delusional beliefs that one is being persecuted or that one's mind or body have been taken over by external forces) and an increased risk of violence. *See* Paul Appelbaum et al., *Delusions do not increase risk of violence*, *available at* http://www.rc psych.ac.uk/press/preleases/pr/pr_112.htm.

18. A. Maden et al., *Offending in Psychiatric Patients After Discharge From Medium Secure Units: Prospective National Cohort Study*, 328 BRITISH MED. J. 1534 (study of 959 patients discharged from medium secure units in England and Wales in 1997-98 found only six percent were convicted of violent offenses over two years, leading the researchers to conclude: "The rate of violent offending is so low that there is little scope for overall reduction and it would be better to concentrate on the identification of high risk patients.").

19. *See, e.g.*, Treatment Advocacy Center, *Briefing Paper: Options for Assisted Treatment*, *available at* http://www.psychlaws.org/BriefingPapers/BP3.htm (last visited Jan. 7, 2005).

admissions.[20] However, RAND's 2001 review of OPC research concluded that these studies are flawed.[21]

Moreover, subsequent studies of OPC—studies that RAND considered more reliable—do not demonstrate that OPC is effective at reducing readmission rates or total hospital days. The Bellevue researchers found no significant differences in outcomes for severely mentally ill individuals, either in percent re-hospitalized or in days in hospital, between those with OPC with enhanced services and those with enhanced services alone.[22]

RAND undertook a similar review of the Duke study.[23] RAND concluded that OPC could reduce readmissions and total hospital days, but only if court orders were sustained for more than 180 days, OPC was combined with intensive treatment, and it was imposed upon individuals with psychotic—as opposed to affective—disorders.[24]

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20. *Id.* (citing G. Zanni & L. deVeau, *Inpatient Stays Before and After Outpatient Commitment*, 37 HOSP. & CMTY. PSYCHIATRY 941 (1986); M.R. Munetz et al., *The Effectiveness of Outpatient Civil Commitment*, 47 PSYCHIATRIC SERVICES 1251, 1251-53 (1996); B.M. Rohland, *The Role of Outpatient Commitment in the Management of Persons with Schizophrenia*, Iowa Consortium for Mental Health, Services, Training, and Research (1998); and G.A. Fernandez and S. Nygard, *Impact of Involuntary Outpatient Commitment on the Revolving-Door Syndrome in North Carolina*, 41 HOSP. & CMTY. PSYCHIATRY 1001 (1990)).

21. *See* Ridgely et al., *supra* note 8, at 17-22; *see also* Judge David L. Bazelon Center for Mental Health Law, *Studies of Outpatient Commitment are Misused, available at* http://www.bazelon.org/issues/commitment/ioc/studies.htm (last visited Jan. 7, 2005).

22. *See* Steadman *supra* note 11 (outcomes no different for those subjects with court-ordered treatment and an enhanced service package and those with an enhanced service package only with respect to rehospitalization, arrest, quality of life, symptomatology, treatment compliance, and perceived level of coercion); Ridgely, *supra* note 8, at 25-26 (RAND discussion of Steadman and coauthors' 2001 study). RAND researchers noted a number of limitations of the Bellevue study, including: lack of distinction by providers as to which study participants had AOT orders resulting in inconsistent enforcement; a disproportionate number of participants with substance abuse problems (and thereby likely to have worse outcomes) in the AOT group; a relatively small number of subjects; and weak measures of compliance. Ridgely, *supra* note 8, at 26; *see also* Hiday, *supra* note 13, at 20 (outlining five limitations of the Bellevue study).

23. RAND catalogued five articles that reported data generated by the Duke study. *See* Ridgely et al., *supra* note 8, tbl.C.2 (citing Jeffrey W. Swanson et al., *Can Involuntary Outpatient Commitment Reduce Arrests Among Persons with Severe Mental Illness?*, 28 CRIM. JUST. & BEHAV. 156 (2001); Swanson, *supra* note 12; Swartz, *Findings from a Randomized Trial*, *supra* note 12; Swartz, *A Randomized Control Trial*, *supra* note 12; Marvin S. Swartz et al., *Measuring Coercion Under Involuntary Outpatient Commitment: Initial findings from a Randomized Controlled Trial*, 10 RES. CMTY. & MENTAL HEALTH 57 (1999).

24. *See* Ridgely et al., *supra* note 8, at 22-25. Moreover, RAND noted that the findings of the Duke study were limited for several reasons: the treatment array included an adherence protocol to ensure enforcement that might not exist in reality; the sample was

RAND ultimately concluded that people placed on OPC in the Bellevue and Duke studies achieved outcomes that were indistinguishable from those in the control groups who had enhanced services but no court order:

> the results of the second generation of research on outpatient commitment are consistent in supporting the need for intensive community-based services to prevent relapse, violent behavior, and criminal recidivism among people with severe mental illness. They are less consistent, however, in providing clear and convincing evidence concerning the importance of the court mandate *per se*.[25]

Since the RAND report was released, a 2004 Australian study of 754 subjects found that OPC alone failed to reduce psychiatric hospitalization admission rates in the first year after the introduction of community treatment orders.[26]

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limited to patients discharged from hospitals and therefore might not have been generalizable; and, as the study did not describe voluntary service use among the comparison group not subjected to an OPC order, OPC in this instance could not solely be attributed to benefiting outcome or services. *See* Ridgely et al., *supra* note 8, at 24-25; *see also* Judge David L. Bazelon Center for Mental Health Law, *supra* note 21.

The Duke study researchers also concluded that intensive treatment when combined with sustained OPC of greater than 180 days significantly reduced violent behavior compared to individuals receiving less than long term assisted outpatient treatment. *See e.g.*, Swanson, *supra* note 12 (63.3% not in long-term AOT repeated violent acts during the year of study compared with only thirty-seven point five percent of those in long-term AOT, and when OPC was combined with routine outpatient services, reduction was by fifty percent from forty-eight percent to twenty-four percent); *see also* Swartz, *A Randomized Controlled Trial*, *supra* note 12 (for individuals with a history of multiple hospital admissions combined with arrest and/or violence in prior year, the risk of arrest was reduced by seventy-four percent (twelve percent compared to forty-seven percent risk)). However, as one observer notes, "[n]either outpatient commitment alone nor frequent services alone was associated with less violent behavior. It was the combination of the two that had a significant effect." Hiday, *supra* note 13, at 18. Moreover, as discussed herein, the Duke study had limitations. *See* Ridgely, *supra* note 8, at 24-25.

25. Ridgely, *supra* note 8, at 26.

26. *See* Stephen R. Kisely et al., *Impact of Compulsory Community Treatment on Admission Rates: Survival Analysis Using Linked Mental Health and Offender Databases*, 184 BRITISH J. PSYCHIATRY 432-38 (2004). Kisely and his co-authors note that "court-ordered treatment in the USA is different from compulsory community treatment prescribed by a mental health professional, the intervention used in Australasia and Canada, and proposed for England and Wales." *Id.* at 2 (citations omitted). However, RAND authors screened in studies of OPC conducted in either the U.S., Canada or Britain. Ridgely et al., *supra* note 8, at 6. *See also* Neil J. Preston et al., *Assessing the Outcome of Compulsory Psychiatric Treatment in the Community: Epidemiological Study in Western Australia*, 324 BRITISH MED. J. 1244 (2002) (study of 456 subjects finds that introduction of compulsory treatment in the community did not lead to reduced use of health services, suggesting that therapeutic gains might be better achieved through enhancing the quality and assertiveness

RECENT RESEARCH CHALLENGES THE CLAIM THAT THE BENEFITS OF OPC OUTWEIGH ITS DRAWBACKS BECAUSE PSYCHIATRIC MEDICATIONS ARE SAFE AND EFFECTIVE

Newer research also challenges the claim that OPC works because it ensures that individuals with mental illnesses receive psychiatric medications. This argument is based on the assumption that these medications are safe and effective. Moreover, recent studies have found that many commonly prescribed psychiatric medications have serious side effects and questionable efficacy.

Koller and Doraiswamy have concluded that a decision to refuse treatment with anti-psychotics—including the new generation of atypical medications—might represent a sound medical decision. For example, in 2002, researchers reported that the new anti-psychotic olanzapine could be linked to early onset diabetes.[27] And, in May 2003, The Lancet published a meta-analysis of 31 previous studies involving 2320 patients comparing the new generation of anti-psychotics with older low-potency conventional drugs. The researchers found that only one new generation medication, clozapine, was associated with fewer neurological side effects and higher efficacy than the older drugs.[28]

The Food and Drug Administration ("FDA") also recently concluded that these new medications have alarming side effects. In 2004, the FDA issued a Public Health Advisory asking manufacturers of ten antidepressant drugs, including Prozac, Zoloft, Paxil and Lexapro, to add a warning statement that recommends close observation of adults and children for worsening depression or the emergency of suicidality.[29]

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of other forms of community treatment).

27. *See* Press Release, Elizabeth A. Koller & Murali Doraiswamy, Duke University study (July 1, 2002).

28. *See* Stefan Leucht, *New Generation Anti-Psychotics Versus Low-Potency Conventional Antipsychotics: a Systematic Review and Meta-analysis*, 361 THE LANCET 1581 (2003).

29. *See* U.S. Food and Drug Administration, *Worsening Depression and Suicidality in Patients Being Treated with Antidepressant Medications, Public Health Advisory, available at* http://www.fda.gov/medwatch/safety/2001/dec01.htm (last visited Jan. 7, 2005). In 2001, the FDA had required GlaxoSmithKline to add a warning label to its packaging of its product, Paxil, acknowledging reports of serious withdrawal symptoms among some patients who stop taking the drug. *See* U.S. Food and Drug Administration, *Summary of Safety-Related Drug Labeling Changes Approved By FDA Center for Drug Evaluation and Research, available at* http://www.fda.gov/medwatch/safety/2001/dec01.htm (last visited Jan. 7, 2005.)

NEW RESEARCH RAISES QUESTIONS ABOUT THE EFFECTIVENESS OF OPC IN IMPROVING TREATMENT COMPLIANCE

Although one of the principal rationales for outpatient commitment is that it improves compliance with medications, "few previous studies have directly addressed the issue of whether OPC improves adherence with prescribed medications and scheduled mental health appointments."[30] A recent study that examined this issue concluded "the randomized controlled trial found no significant difference in the rate of treatment adherence between the two randomly assigned groups."[31] The study noted that a large proportion of outpatient commitment orders were not continued, and "[a]s a result, about two thirds of the OPC group spent less than half the year actually under court-ordered treatment. . . . Our study found no evidence of benefit associated with OPC when applied in this limited manner to subjects who were not deemed to be seriously violent."[32] Although the study did find significantly increased compliance among persons who were on extended OPC orders and received intensive community services, the authors concluded that "extended OPC *alone* was not significantly associated with improved compliance,"[33] and that extended OPC was significantly associated with use of depot medications,[34] which, not surprisingly, increased rates of compliance.

NEW RESEARCH CONFIRMS THAT INDIVIDUALS SUBJECT TO OPC DO NOT PERCEIVE THAT IT IMPROVES THEIR LIVES

Although outpatient commitment was first adopted in the 1980s, no research was done on whether the individuals subjected to OPC perceived that it improved their lives until recently. A number of recent new studies

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30. Swartz et al., *supra* note 12, at 584.

31. *Id.* at 587 (54 of 100 subjects in the OPC group adhered to treatment, as did 55 of the 113 subjects who were not subject to OPC; 45 subjects with a baseline history of serious violence were not randomized, and excluded by the authors from consideration for the purpose of this conclusion).

32. *Id.* at 587.

33. *Id.* at 588 (emphasis in original); *see also* H. Ryan Wagner et al., *Does Involuntary Outpatient Commitment Lead to More Intensive Treatment?*, 9 PSYCHOL., PUB. POL'Y & L. 145, 157 (2003) (examining receipt of outpatient mental health services among subjects in the Duke Mental Health Study, found that while those subjects whose OPC order was renewed during the study year received more total outpatient visits, case management and outpatient counseling visits compared with subjects who had only an initial order, the trial was not a strict randomized controlled trial and ascribing this phenomenon simply to OPC was difficult as the "receipt of outpatient clinical services was influenced by two interrelated factors: clinical needs and extended OPC orders.").

34. A depot medication is an injection that, because of its time-release properties, has long-lasting effects (up to three weeks).

examine the effects of involuntary outpatient commitment on the subjective quality of life experience in persons with severe mental illness,[35] whether these individuals endorse OPC as a positive benefit in their lives[36] and whether they perceive it as coercive.[37]

Not surprisingly, people who are subjected to OPC feel coerced, and those who are subject to longer terms of OPC feel more coerced, an effect that was significant even after adjustment for other potential predictors of perceived coercion.[38] Another unsurprising finding was a significant relationship between perceived coercion and the administration of depot medication.[39]

Nor did individuals who experienced OPC conclude that it was beneficial for them. "A majority of subjects [prior to discharge and after one year] did not believe OPC to be personally beneficial because they did not believe OPC was effective, or because they did not acknowledge their own need for treatment, or both."[40] The most frequent pattern of response was negative at the beginning and end of OPC, but the second most frequent pattern of response was positive at the beginning and negative at the end.[41]

Finally, researchers looking at a variety of measures of quality of life, including homelessness, number of arrests, criminal victimization, violent behavior, substance abuse, global functioning, and psychiatric symptomatology, found that "[t]he court order for outpatient commitment *per se* was not associated with higher quality of life; we found no significant difference between control and OPC groups on 12-month [quality of life] score."[42] As in other studies, researchers found that if individuals were on longer periods of OPC, there was an indirect effect on quality of life, mediated by "treatment adherence, case manager reminders,

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35. *See* Jeffrey W. Swanson, Marvin S. Swartz, Eric B. Elbogen, H. Ryan Wagner, & Barbara J. Burns, *Effects of Involuntary Outpatient Commitment on Subjective Quality of Life in Persons with Severe Mental Illness*, 21 BEHAV. SCI. & L. 473 (2003).

36. *See* Marvin Swartz, John Monahan & Jeffrey Swanson, *Endorsement of Personal Benefit of Outpatient Commitment Among Persons with Severe Mental Illness*, 9 PSYCHOL., PUB. POL'Y & L. 70 (2003).

37. *See* Rain et al., *supra* note 11; Marvin S. Swartz, Ryan H. Wagner, Jeffrey W. Swanson, Virginia A. Hiday, & Barbara J. Burns, *The Perceived Coerciveness of Involuntary Outpatient Commitment: Findings from an Experimental Study*, 30 J. AM. ACAD. PSYCH. & L. 207 (2003).

38. Swartz et al., *supra* note 37.

39. Rain et al., *supra* note 11.

40. Swartz et al., *supra* note 36, at 79.

41. *Id.*

42. Swanson et al., *supra* note 35, at 487.

and hospital readmissions."[43]

NEW REPORTS CALL FOR ALTERNATIVES TO OPC

A series of collaborative reports by individuals in the vanguard of U.S. mental health treatment challenge the claim that OPC is an appropriate treatment approach. These leaders reject coercive forms of treatment such as OPC and call for voluntary alternatives.

In 2003, the consumer issues subcommittee of the President's New Freedom Commission on Mental Health urged that the mental health system at all levels increase individual consumer self-determination. The subcommittee counseled that "a recovery oriented mental health system embraces the values of self-determination, empowering relationships, meaningful roles in society and eliminating stigma and discrimination."[44] The Commission's Subcommittee on Rights and Engagement reached a similar conclusion:

> Too often, the services absent from a community's mental health care continuum are precisely those services that would most likely engage the consumer in voluntary treatment. Consumer-oriented approaches such as employing consumers as providers and establishing consumer-operated services might increase the likelihood of engaging hard-to-reach consumers.[45]

The 2001 RAND report sounded the same theme. The report noted that, although OPC proponents argue that coercion is necessary, providers may not agree. The report quotes an observer: "the closer you get to the front line the less there is a desire to [force treatment] because of the very real concerns about relationships with patients, need for documentation, and liability."[46] The RAND researchers concluded that the best studies suggest that the effectiveness of outpatient commitment is linked to the provision of intensive services in a number of areas and not to the court mandate to accept medication.[47]

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43. *Id.*

44. *See* President's Freedom Commission, *Report of the Subcommittee on Consumer Issues* (2003).

45. *See* President's Freedom Commission, *Report of the Subcommittee on Rights and Engagement* (2003); *see also* U.S. Surgeon General's Office, *Report on Mental Health, U.S. Department of Health and Human Services* (1999) (coercion must be significantly reduced through the provision of adequate and accessible mental health services and must not be a substitute for effective voluntary care).

46. *See* Ridgely et al., *supra* note 8, at 73.

47. While a 2003 study that examined the attitudes of stakeholders, including persons in treatment for schizophrenia and related disorders and clinicians treating such disorders, found that stakeholders viewed OPC as less deleterious and restrictive than involuntary

Also in 2001, the Medical Directors Council of the National Association of State Mental Health Program Directors warned that treatment compliance is not a panacea for mental illness and that many other factors are also important to recovery. The Council concluded that:

> current research fails to provide strong evidence that IOC is the best remedy for consumer non-compliance in treatment. Regardless of whether a state utilize [sic] IOC, funding a strong community-based service provision system is essential to increase consumer engagement in treatment. Ironically, if these services were readily available, the need for coercive measures would likely be minimized or eliminated.[48]

These reports echoed the 2000 recommendation of the National Council on Disability:

> [l]aws that allow the use of involuntary treatments such as forced drugging and inpatient and outpatient commitment should be viewed as inherently suspect, because they are incompatible with the principle of self-determination. Public policy needs to move in the direction of a totally voluntary community-based mental health system that safeguards human dignity and respects individual autonomy.[49]

CONCLUSION

This article updates research into several frequently examined issues related to OPC. This research is important, but there are still further topics of research to be explored. As one observer has suggested, studies should evaluate the success of OPC as measured in ways other than reduction of

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hospitalization, the study had a number of limitations: the vignettes used depicted a clinically unstable patient; the vignettes did not detail the enforcement of the OPC; the patient stakeholders were persons who were already engaged in treatment; and researchers spoke only to individuals in North Carolina who may not be representative of people of other regions of the country. *See* Marvin S. Swartz et al., *Assessment of Four Stakeholder Groups' Preferences Concerning Outpatient Commitment for Persons with Schizophrenia*, 160 AM. J. PSYCH. 1139 (2003). Further, the study's design—to compare OPC with involuntary hospitalization and other unpleasant outcomes—may reflect more on stakeholders' feelings about the other outcomes than on their feelings about OPC. Moreover, in another study of the same group of patients, researchers noted that "36% of subjects with schizophrenia spectrum disorders reported fear of coerced treatment as a barrier to seeking help for a mental health problem . . . ." Marvin S. Swartz et al., *Does Fear of Coercion Keep People Away from Mental Health Treatment? Evidence from a Survey of Persons with Schizophrenia and Mental Health Professionals*," 21 BEHAV. SCI. & L. 459, 469-70 (2003).

48. National Association of State Mental Health Program Directors Medical Directors Council, *supra* note 4, at 3.

49. National Council on Disability, *From Privileges to Rights: People Labeled with Psychiatric Disabilities Speak for Themselves*, 6 (2000).

hospital days, lengths of hospital stays, and number of arrests such as the impact of OPC on the individual's connection to community life, satisfaction with living arrangements, and feelings of empowerment.[50]

Researchers should examine potential harms as well. For example, new data suggests that racial bias may skew the implementation of OPC toward black individuals.[51] In the research underlying many of the studies cited in this article, over two thirds of the individuals under outpatient commitment were African-American.[52] Although this figure matches the proportion of severely mentally ill individuals in the state hospital, it is not clear whether the proportion holds true for the surrounding community population. Researchers also should evaluate the impact of OPC on the service delivery system — how using coercion affects service providers, the impact in terms of resource allocation, and the impact on consumer empowerment and anti-stigma campaigns.[53] Additionally, as OPC statutes age, researchers should evaluate their long-term impact.[54]

The fact that outpatient commitment appears to be of limited effectiveness should certainly give pause to policymakers. However, even effective strategies to induce desired social goals — confessions of

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50. *See* Michael Allen, *Waking Rip van Winkle: Why Developments in the Last Twenty Years Should Teach the Mental Health System Not to Use Housing as a Tool of Coercion*, 21 BEHAV. SCI. & L. 503, 507 n.25 (2003).

51. New York State Office of Mental Health, *An Interim Report on the Status of Assisted Outpatient Treatment* (2003), *available at* http://www.omh.state.ny.us/omhweb/kendra%5Fweb/interimreport/ (last visited Jan. 7, 2005) (AOT Program Status, Characteristics of AOT recipients reports 40% of recipients are Black (Non-Hispanic), 29% are White (Non-Hispanic), and 21% are Hispanic). While these statistics are consistent with demographic statistics of individuals receiving intensive case management without AOT, *id.*, they are not consistent with the demographics of the population of New York. *See* New York QuickFacts, U.S. Census Bureau, *available at* http://quickfacts.census.gov/qfd/states/36000.html

(last visited Jan. 7, 2005) (New York racial demographics in 2000 were as follows: Black or African-American—15.9%, White—67.9%, and Hispanic or Latino origins—15.1%); *see also* Eric B. Elbogen et al., *Psychiatric Disability, the Use of Financial Leverage, and Perceived Coercion in Mental Health Services*, 2 INT'L J. FORENSIC MENTAL HEALTH 119, 126 (2003) (in study of coercion of individuals with psychiatric disabilities through control over the individual's money, African-American participants reported greater financial coercion leading researchers to note that "policymakers instituting mandated community treatments need to take special measures to ensure equal protection for all clients with serious mental illness.").

52. See studies cited at notes 35, 36 and 37, *supra*.

53. *See* Hiday, *supra* note 13, at 23. Hiday also suggests studying, in trials that include all the range of types of clients typically subject to OPC, whether alternative treatment programs—if fully funded—could reduce or obviate the need for OPC. *See id.* at 23.

54. *See id.* at 21.

criminals, for example — may sometimes bow to greater social values of privacy, liberty and independence. Social science researchers cannot make and do not pretend to make these judgments. The Supreme Court did not strike down school segregation in *Brown v. Board of Education*[55] because it was educationally ineffective but because it was unequal. Likewise, our drive to provide mental health treatment to people who do not want it must be constrained not only by concerns that to do so is ultimately ineffective, but also by the realization that to do so may violate their rights.

55. 347 U.S. 483 (1954).