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ISSUE BRIEF

Outpatient Commitment in Mental Health: Is Coercion the Price of Community Services?

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A discussion featuring

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Outpatient Commitment in Mental Health

The American people and their elected officials are becoming increasingly knowledgeable about mental illness, but they are also more and more willing to use the courts to force people with mental disorders into treatment—particularly if those people pose a risk either to themselves or to other people.¹ In the recent words of Sen. Pete V. Domenici (R-N. Mex.),

It is time for Americans to realize that a disturbing number of the most horrific and sad cases of murder and violence in the United States are sadly linked to people who suffer from undiagnosed or untreated mental illnesses. At the same time, we should begin taking action to see that these unfortunate people receive and continue to get treatment.²

Domenici's quote appeared in a May 25 press release to announce "the Mental Health Early Intervention, Treatment, and Prevention Act of 2000," which proposes, among other elements, the formation of a blue ribbon commission to study "the interaction between mental illness and the criminal justice system." To the consternation of some organizations that represent consumers of mental health services, the commission would also make recommendations regarding civil commitment to outpatient settings of people considered too ill and/or too dangerous to be left on their own in their communities.

Against the backdrop of fear and a fragmented system of mental health services, documented in *Mental Health: A Report of the Surgeon General* (December 1999), there seems to be a growing awareness that there are services and medications that can help those most severely affected by mental illness. In fact, the far-reaching Domenici bill, which is being cosponsored by Sen. Edward M. Kennedy (D-Mass.) and Sen. Paul Wellstone (D-Minn.), responds to many of the gaps in services described in the report. However, the proposed legislation also seems to reflect the public's willingness to consider using court-ordered treatment to obtain services for people judged dangerous to themselves or others. And it is not always clear whether support for such action comes from a desire to control a person with mental illness or from an effort to force state and local governments, as well as health providers, to provide services to those under court order who might not otherwise receive them.

At least one study seems to indicate that health officials may provide more services to people receiving

court-ordered treatment.³ Advocates for people with mental illness argue, however, that the loss of civil liberty is too high a price to pay for services.

So far, 37 state legislatures—many of them in the last decade—have passed laws authorizing involuntary outpatient commitment (OPC). In OPC, a court can order a patient to receive treatment in a community setting, providing patients with fewer restrictions than would be possible in a psychiatric institution but allowing professionals to make sure the patients comply with treatment regimens. Before these laws were enacted, the principal alternative available to state and local authorities for coercive intervention on behalf of people with severe mental illness was forcibly institutionalizing them when they became dangerous to themselves or others. This was done through a process of "inpatient commitment," typically following the decision of two psychiatrists that the individual constituted a threat to his or her own safety or that of others. Inpatient commitment is still in use in all 50 states. These days, however, psychiatric hospitalization in the United States serves mostly as a locus of short-term care. According to the surgeon general's report,

The new priorities of psychiatric hospitalization focus on ameliorating the risk of danger to self or others in those circumstances in which dangerous behavior is associated with mental disorder, and the rapid return of patients to the community. . . . Inpatient services

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therefore emphasize safety measures, crisis intervention, acute medication and reevaluation of ongoing medications, and (re)establishing the client's links to other supports and services.

Does outpatient commitment work? The only two randomized controlled studies reveal results that have left them open to interpretation by organizations that take opposing positions on the issue.⁴ And opponents of OPC argue that most of the remedies attributed to OPC can be made available merely by expanding access to effective services. The commission envisioned in the legislation cosponsored by Domenici, Kennedy, and Wellstone would be charged with examining current research on outpatient commitment. If OPC is found effective, the commission would then draft model legislation for the consideration of state policymakers, says a Kennedy staff member.

Although state legislatures must ultimately decide whether to adopt outpatient commitment, these decisions have important implications for the federal government, given the significant contribution made by Medicaid—and to a lesser extent Medicare—to public mental health programs at both the state and the local level. Roughly 36 percent of these programs' funds come from Medicaid (counting both federal and state contributions to the program) and about 27 percent from Medicare. Many state mental health directors have pointed out the important influence federal reimbursement policies under these two programs have had on state policy decisions in planning for and serving people with mental illness.⁵

Discussions about involuntary outpatient commitment often focus on the need for adults diagnosed with severe and persistent mental illness to take their medication. But studies of patients who are under such court orders have shown that medication is not enough—that success seems to require having in place a comprehensive system of services. Last summer, a letter from the Health Care Financing Administration (HCFA) suggested that state Medicaid directors consider such services as a major component of mental health service packages.⁶ Although it is unclear what impact the letter has had on state policies, observers note that federal policymakers seem very interested in ways that federal funding might be used to prevent violence among people who are judged to be at risk because of their mental illness.

This Forum meeting will address the issue of outpatient commitment within the context of what the U.S. surgeon general calls the nation's "seriously deficient" service systems for those who are most disabled by

mental disorders. It will also present the latest research on violence and mental illness and examine the choices two states made—New York to pass outpatient commitment legislation, Maryland to focus its efforts on developing community treatment programs that it hoped would obviate the need for such legislation.

BACKGROUND—THE DEBATE

Pressure is growing on state and federal policymakers to put in place the community programs that have been shown effective in reducing hospitalizations among people with serious and persistent mental illness. But barriers continue to exist. A long-standing decline in the amount of time patients spend in psychiatric hospitals and a recent decline in admissions have not led to increased funding for community programs. And the policies of the federal government's largest payers, Medicaid and Medicare, have begun only relatively recently to promote a community-based treatment system. Also, many mental health professionals have failed to take the fullest advantage of the latest developments in pharmacological and psychosocial resources for their patients.⁷

The debate over outpatient commitment takes place at a time when the public strongly associates violence with mental illness.⁸ Fear of violence often seems tied to the names of men and women with untreated mental disorders who are involved in terrible crimes—Andrew Goldstein, who killed Kendra Webdale, 32, by pushing her under the wheels of a New York City subway train on January 3, 1999, and Russell Weston Jr., accused of fatally shooting two police officers in the Capitol building on July 24, 1999. So the question often becomes, what is the level of risk of an individual becoming violent, and how much coercion is merited in light of that risk? Researchers argue that the vast majority of adults with severe and persistent mental disorders are not violent and that only 3 percent of the violence in this country is attributable to a mental disorder.⁹

A recent study, funded by the John D. and Catherine T. MacArthur Foundation, concludes that individuals with severe mental disorders are no more likely to be violent than their neighbors, unless they are abusing alcohol or drugs, which "significantly raised the rate of violence in both the patient and comparison groups." The report concluded, however, that people with severe mental disorders were more likely to report symptoms of substance abuse. The study also found that friends and family members—not strangers—were usually the victims.¹⁰

“Both sides in the debate over outpatient commitment have spun our research to their advantage,” says John Monahan, Ph.D., director of the MacArthur Research Network on Mental Health and the Law. Supporters of outpatient commitment argue that the MacArthur study enrolled too few adults who would be more likely to be violent and that the impoverished neighborhoods in the study had high levels of violence. Supporters also point to a 1998 study that shows that, in addition to substance abuse, a second factor at work is the failure of a mentally ill person to take prescribed medication. They cite research showing that 40 percent of people with severe mental disorders in the United States are receiving no treatment for their disease.¹¹

Fear of violence appears to have been instrumental in the passage of involuntary outpatient commitment legislation in New York, where policymakers named the bill “Kendra’s Law,” after Goldstein’s young victim. Maryland, on the other hand, has so far chosen not to consider outpatient commitment legislation.

The recent surgeon general’s report seems to raise concerns about coercive interventions in general:

Assuring the small number of individuals with severe mental disorders who pose a threat of danger to themselves or others ready access to adequate and appropriate services promises to reduce significantly the need for coercion in the form of involuntary commitment to a hospital and/or certain outpatient treatment requirements that have been legislated in most states and territories. Coercion should not be a substitute for effective care that is sought voluntarily: consensus on this point testifies to the need for research designed to enhance adherence to treatment.

Outpatient Commitment and the System of Mental Health Services

Although the surgeon general’s report estimates that approximately 20 percent of Americans suffer from a mental disorder every year, it is clear that there are far fewer people whose mental health problems lead to demands for coercive treatment. Serious and persistent mental disorders affect about 5 million adults in the United States—between 2 percent and 3 percent of the population. Major depression has been diagnosed in 1.1 percent, manic-depressive illness or bipolar disorder in 1 percent, and schizophrenia in 1.3 percent. Also, in any six-month period, approximately 3.2 percent of children and adolescents between the ages of 9 and 17 have a severe mental disorder.

It seems clear in examining the issue of outpatient commitment for the people who do not comply with

treatment that OPC cannot be separated from a discussion of mental health services. Common ground among the groups that argue for and against commitment can be found in their mutual belief that the nation’s citizens who suffer from serious and persistent mental illness should have access to high-quality comprehensive services that include housing, the development of social skills, social services, and, when appropriate, vocational rehabilitation. These components seem crucial to improving client outcomes, according to the authors of “Managing Fragmented Public Mental Health Services,” a report produced in 1997 by the Milbank Memorial Fund.

The report reviews efforts to coordinate systems of care for people with severe mental illness and indicates that there are several success stories about the creation of service systems that offer severely ill individuals continuity of care across a major urban services system. These individuals experienced improved quality of life, however, only in certain circumstances—for example, when this continuity of care was accompanied by enhanced supported housing services.

Whether people with mental illness make the news as perpetrators or victims of violence, they have frequently been through the revolving door of a fragmented and poorly maintained mental health care system, as the surgeon general’s report documents. Over the last 30 years, the nation has emptied or dramatically reduced the size of its psychiatric hospitals, but the promised network of community services was never fully developed, and adults with mental illness have swelled the ranks of the homeless. The U.S. Census Bureau reported in December 1999 that 39 percent of almost two million homeless people on an average night in February 1996 had overt signs of mental illness, a rate that remains unchanged from 1987 and may indicate that solutions such as treatment and supportive housing are still not being fully used or are inadequately funded.

Negative public perceptions of the mental health system appear to undermine concern for the civil liberties of people with serious mental disorders. On November 21, 1999, after Andrew Goldstein’s first trial had ended in a hung jury, *New York Times* reporter Michael Winerip quoted a 32-year-old graphics designer and juror who said she found Goldstein guilty after finding him more rational than she had expected. But she also said that she could not ignore the “ramifications of our judgment.”

According to data provided by the Judge David L. Bazelon Center for Mental Health Law, more than 30

states have implemented intensive case management (ICM) to provide mental health services, including the well-respected form of ICM known as assertive community treatment (ACT). (Further discussion of ICM and ACT appears below on page 8.) But even the states with the most successful programs face considerable financial and logistical barriers to address the problems of poverty and homelessness among their sickest residents.

A policy advisor in a state that has adopted outpatient commitment legislation concedes that the target of the policy is as much the provider as it is the patient, a point he prefers to make anonymously. “A lot of providers don’t want to treat the people who are at higher risk for relapsing because they are the most difficult to treat,” the policy advisor says. “We now have the ability to encourage accountability among providers. We can bring people in for examination before they get dangerous to themselves or others.”

Mental health professionals say they are optimistic that the lives of the nation’s most severely mentally ill citizens will begin to improve because of the development of powerful drugs with fewer unpleasant side effects and because of the increasing understanding of what support services are needed to aid the recovery process.

There continues to be a lack of adequate community services, however, resulting in a phenomenon known as “trans-institutionalization,” according to a federal study released last year by the U.S. Department of Justice. Psychiatric hospitals, which in 1955 had a high of 559,000 patients, in 1995 housed a total of 69,000. At the same time, the nation’s jails and prisons, “often the only institutions open 24 hours a day and required to take the emotionally disturbed, now have 283,000 inmates with severe mental illness—16 percent of the total jail population,” according to a July 11, 1999, press release issued by the Justice Department. “Jails have become the poor person’s mental hospitals,” Northwestern University sociologist Linda Teplin told the *Baltimore Sun*, in an interview published on July 12, 1999.

The study of the incidence of mental illness in correctional settings detailed how emotionally disturbed patients go from homelessness to incarceration and back, with little treatment. And the crimes for which they are arrested are often the result of their illnesses. Some experts recently have questioned the notion of trans-institutionalization, however, given the surgeon general’s estimate that 20 percent of the public experiences a mental disorder in a year—a prevalence rate that seems close to the percentage of mentally ill inmates reported by the Department of Justice.

MARYLAND AND NEW YORK— DIFFERENT CHOICES

Officials in Maryland and New York examined similar research and listened to the voices of people representing the same sorts of groups when they decided whether or not to pass legislation on outpatient commitment. In New York, the death of Kendra Webdale seems to have fueled passage of Kendra’s Law. In Maryland, the legislature has decided not to consider such legislation, says W. Lawrence Fitch, J.D., based on the recommendation of a committee he headed that was authorized to study “promoting consumer participation in community-based mental health services.” Fitch, director of forensic services for the Maryland Mental Hygiene Administration and an associate professor of law and psychology at the University of Maryland, notes that there have been efforts to sway Maryland legislators to embrace outpatient commitment, particularly since the media began writing about Joseph Palczynski, who killed four people and took three others hostage before police shot and killed him on March 21. A March 24 article in the *Baltimore Sun* (“A Difficult, Elusive Diagnosis; Evaluation Varied: Severe Mental Illness to Plain ‘Meanness’”), seems to indicate that psychiatrists who had evaluated him over the years rarely agreed in their diagnoses of Palczynski’s condition: “Over the years, many psychologists and other professionals evaluated Palczynski, usually at the request of the criminal justice system. Rarely did they reach the same conclusion.” Fitch argues that because there were indications Palczynski was often not symptomatic when off medication, he would not necessarily have qualified for outpatient commitment.

Influential Studies

There are two “second generation” randomized controlled trials of outpatient commitment that reportedly most influenced the legislatures of both states, but their results seem to have been used to support different conclusions.

The Duke Mental Health Study (1997) compared two groups of people with mental illness that were both offered intensive services. One group had been committed under court order and one had not, but, when looking at short-term results, researchers from the Duke University Medical Center found little difference in the hospitalization rates between the two groups. When commitment was extended to at least six months, however, patients who were under court order averaged 57 percent fewer hospitalizations and 20 fewer hospital days.¹²

Interestingly, the impact seems to have been not on the patients alone, but also on the mental health system, according to Marvin Swartz, M.D., an associate professor at Duke's department of psychology and behavioral sciences. "This suggests that outpatient commitment has to be applied in a sustained manner and that the longer the people get outpatient commitment, the more intensive treatment they get," says Swartz. "It seems to work on the system in that the judge has said that you must pay attention to this person because I do not want to see him back in this courtroom."¹³

The second piece of influential research was a three-year pilot study of outpatient civil commitment at New York City's Bellevue Hospital, whose results were released in December 1998. In its most dramatic conclusion, the report said it had found "no statistically significant differences" between (a) the experimental group that were being treated under court order and assertive community treatment and (b) a control group that was receiving only the community treatment. The study concludes that

the service coordination/resource mobilization function of the Coordinating Team seemed to make a substantial positive difference in the post-discharge experiences of both experimental and control groups. The court order itself had no discernible added value in producing better outcomes.¹⁴

Not all the researchers working on the study agreed with the conclusion that the court order had had no impact, however, arguing in part that the members of the control group and their providers may have thought they too were under court orders to comply with treatment.¹⁵ The Bellevue study's finding that outpatient commitment "had no discernible added value" swayed neither New York's governor nor its legislature, which enacted the law in November.

Opponents of outpatient commitment argue that assertive community treatment programs and other high-quality community care programs make outpatient commitment unnecessary. They are supported in their arguments by numerous consumer groups and by many organizations that represent the mental health profession. The American Psychiatric Association, however, endorses outpatient commitment as "a useful intervention for a small subset of patients with severe mental illness," according to "model guidelines" issued by the APA in its "Resource Document on Mandatory Outpatient Commitment" (December 1999): "One important finding emerges from this developing body of research: Use of mandatory outpatient treatment is strongly and consistently associated with reduced rates of hospital-

ization, longer stays in the community, and increased treatment compliance among patients with severe and persistent mental illness." But the APA notes that more research is necessary in order to fully understand how much of the success of outpatient commitment can be attributed to enhanced services.

New York's Decision—Kendra's Law

On August 27, 1999, New York Gov. George Pataki signed legislation giving judges the authority to require certain people to accept treatment in an outpatient setting. Kendra's Law, its critics say, goes further than similar statutes in other states. The law requires a history of mental illness and a lack of compliance with treatment. Also, the individual should either have been hospitalized twice in the previous three years or have behaved violently at least once in the previous four years. Mental health officials must also prove that the individual would not be likely to comply with a treatment plan on a voluntary basis.¹⁶

But John Tauriello, deputy commissioner and counsel for the New York State Office of Mental Health in Albany, argues that the rights of people with severe and persistent mental disorders are well protected by the legislation. "We built in certain basic protections: The right to counsel, the right to a hearing, the right to present witnesses and evidence, the right to apply to court to vacate or modify court hearings, and the right to participate in the treatment plan."¹⁷

He notes that there must be "clear and convincing evidence" that a person cannot survive safely in the community and a pattern of lack of compliance to treatment and/or violent behavior. "Most important, we have to show that there is no less restrictive alternative that would work short of a court order."

According to a March 14 article in the *Buffalo News* ("County Estimates Kendra's Law Will Cost \$1.6 million"), there are indications that the legislation has not been entirely well received by county mental health officials. According to the article, Erie County health officials estimated the legislation would cost the county \$1.4 million more than the state will allocate the county to cover the costs of Kendra's Law. As of March, the county had received more than 60 petitions for outpatient commitment, but only one person had been placed under court order. Michael Weiner, the Erie County mental health commissioner, said the local share of implementing Kendra's Law would mean that other areas, such as housing and services for high-risk children and adolescents, would be placed "on the back burner."

“We have other high-priority needs that we can't get to because they are not mandated,” Weiner told the *Buffalo News*. “We have to give this (Kendra's Law) top priority because it's legislated.”

Tauriello notes that the purpose of the law was to make sure the people who needed services would get them. As of April, the state had more than 100 people who had been placed under court order and more than 350 who were receiving enhanced community services after they had been evaluated under Kendra's Law but not committed. He said that most of the people considered for outpatient commitment had been in inpatient settings.

In mid-May, New York's legislature appropriated the \$42 million that Pataki had promised for intensive case management services, as well as \$126 million that is earmarked for housing and case management services for people with mental illness.

Maryland's Choice—No OPC

The Maryland State Legislature commissioned a study last fall to review the latest treatment literature and to recommend a course of action for providing services to people with serious mental illness. The study group, made up of academics with expertise in mental health law, mental health professionals, and state policymakers, met 12 times to review professional literature, to examine laws in other states, and to hear from three national experts. In its December 1999 “Report to the Joint Chairmen: Promoting Consumer Participation in Community-based Mental Health Services,” the committee recommended against outpatient commitment, arguing that legislation would pose a threat to civil liberties, divert scarce resources, and damage the relationship between patients and their therapists.

“No one we talked to felt strongly about outpatient commitment other than family members [of adolescents and adults with severe mental disorders],” says Fitch, who headed the committee. “And, as a practical matter, most states already have in place emergency custody orders for evaluating people. Our feeling was that outpatient commitment might upset the therapeutic alliance—that the threat of involuntary treatment might drive people away.”

Like mental health officials in New York, those in Maryland intend to identify “high-risk consumers,” assigning them to ACT teams to make sure they get enhanced services. The quality of the ACT programs is monitored through client satisfaction surveys and periodic outcome reviews by an independent firm.

At the moment, however, such services are not widely available outside of metropolitan areas. Funding is limited and there are difficulties with signing up providers because of low reimbursement rates. Also, the state had decided not to pay providers for “outreach” unless clients consented to accept their services. The committee's report summarizes the challenge faced by state officials in implementing their plan:

While most of these services are available throughout Maryland, not every jurisdiction offers the full range of services necessary to support consumers with the most complex needs. Baltimore City, Montgomery County, and a few other jurisdictions have very active [ACT] services, but in many areas of the state—particularly rural areas—ACT services have not yet been established. Where such services are available, moreover, they are not always in sufficient supply to meet the demand.

Nonetheless, state mental health officials say they are counting on well-funded and well-organized ACT teams “to promote consumer participation in community-based mental health services.” In deciding not to support legislation that would allow involuntary outpatient commitment, the committee assigned to recommend action on the state's mental health services system concluded that “it is the availability of appropriate services, not the existence of a court order, that keeps people engaged in treatment. The challenge is to assure the availability of a full complement of mental health services in every community.”

As an alternative to outpatient commitment, and to give individuals with severe mental disorders some control over their treatment, the Maryland House of Delegates has been considering a bill, “Voluntary Admission to Mental Health Facilities—Application by Health Care Agents.” House legislators referred the bill to committee and the state senate took no action on it before the end of the last session. Although its future is currently uncertain, if enacted, it would allow people with mental disorders to choose a surrogate who could make treatment decisions if the need should arise. “We think providers can be trained to help people plan for their treatment by executing advance directives,” says Fitch.

Maryland, a state with 5 million people, has about 70,000 people who receive services for mental illness from the state's public mental health system. The mental health budget is \$638.8 million out of a total budget of \$3 billion for health care. State hospitals account for \$224 million.

According to Timothy Santoni, deputy director of the state's Mental Hygiene Administration, Maryland has

a fairly good mix of services, and we are trying to move the people we can out of state hospitals. That is an on-going issue. We're trying to make the system in the community consumer friendly so people can get the services they need in a package they like and are going to accept.¹⁸

Policymakers in both Maryland and New York have committed themselves to funding assertive community treatment services. Late last fall, Pataki put a moratorium on efforts to reduce the number of beds in the state's psychiatric hospitals and requested funds that were recently appropriated for more supervised housing, more beds for long-term state hospital care, and more intensive case management services, such as ACT.

"This is going to be the biggest infusion of money in the mental health system we've seen in many years," Tauriello says. "And we're going to take steps to make sure the money is used in a way that providers are more accountable, that they coordinate care, and that they provide the highest quality care."

Community Services—A Brief History

Before the de-institutionalization movement of the 1950s and 1960s, the United States did commit adults diagnosed with schizophrenia, like Weston and Goldstein, to mental institutions. With the discovery of powerful antipsychotic drugs in the 1950s, and at a time when people began to demand civil rights for many of the nation's most beleaguered citizens, the focus of treatment moved from the mental hospital to the community. Congress passed the Community Mental Health Center Construction Act of 1963, which was designed to encourage the development of mental health centers that would serve patients in their communities. The centers did not live up to the hopes of legislators and advocates who had promoted them. They were criticized for, among other things, having failed to serve a sufficient percentage of the people with serious and persistent mental illness.¹⁹

Recognizing the problem of access, the National Institute of Mental Health in the late 1970s began the Community Support Program (CSP) that would provide coordination of mental health services in the community. Because there were few financial rewards built in to the coordinating role, however, the CSP networks reportedly failed to conform to the original idea. Since then, the case management system that developed has undergone a number of changes—particularly in the role of the case manager, who is now more likely to provide mental health services than might have been true in the past.

Many recent studies of successful programs of service delivery have focused on intensive case management and its variant, ACT. This model aims to provide for a patient or consumer's every need. "Among the fundamental elements of effective service delivery are integrated community-based services, continuity of providers and treatments, and culturally sensitive and high-quality empowering services," notes the surgeon general's report. ACT and other ICM programs have been shown to be effective in reducing hospitalizations and in stabilizing the housing situation, but have had less success in helping people find employment or develop social skills or in addressing substance abuse problems, which affect about half the people with severe mental illness. ICM programs have been called overly coercive, however, particularly those that do not provide consumers with a role in either the design or implementation of the programs.

The surgeon general's report notes that assertive community treatment programs are

generally popular with clients . . . and family members. . . . There are also some preliminary results suggesting that employing peer (i.e., consumer) or family outreach workers on the multidisciplinary assertive community treatment teams increases positive outcomes . . . and creates more positive attitudes among team members toward people with mental illness.

Further along the spectrum of community care, as noted in the surgeon general's report, are newer but relatively unstudied models that try to build on an individual's strengths as well as those of the community in which he or she lives. These seem to have developed in response to the need for programs that would help people become more independent by helping them develop job and social skills.

SUPREME COURT DECISION

A recent decision by the U.S. Supreme Court may further efforts to make sure that states provide high-quality community services to people who are in mental hospitals for lack of an appropriate place to go. The suit, *Olmstead v. L.C.*, had been brought against the State of Georgia on behalf of two women with mental retardation who had been kept in an institution because no community placement had been found for them. The Supreme Court upheld a lower court finding that the state should move to place the women in an appropriate community setting under the terms of the antidiscrimination provision contained in the public services portion of the Americans with Disabilities Act of 1990.

The court did give the states an opportunity to defend themselves against similar claims, if they could prove that placing an institutionalized person in the community would fundamentally alter a state's program. To do this they could cite:

- How much it would cost to provide community services to a client.
- The availability of resources.
- The necessity of keeping available a range of facilities and of being evenhanded in the distribution of services.

"*Olmstead* is being taken very seriously," says Bernard Arons, director of the Center for Mental Health Services at the Substance Abuse and Mental Health Services Administration. "It heightens the awareness that there are insufficient community resources for people who should be served in the community."²⁰

VIOLENCE AS REASON FOR OUTPATIENT COMMITMENT

The recent and widely reported tragic deaths in New York and on Capitol Hill were caused by the actions of adults diagnosed with severe mental disorders, reinforcing the public's assumption that violence is associated with mental illness and that it could be prevented by predicting who will become violent. But there are several difficulties associated with developing outpatient commitment legislation based on a desire to prevent violence. A statement taken from the Web site of the American Psychiatric Association notes the following about the "predictability of dangerousness."

Psychiatrists have no special knowledge or ability with which to predict dangerous behavior. Studies have shown that even with patients in which there is a history of violent acts, predictions of future violence will be wrong for two out of every three patients.

Until recently, research had generally supported this statement, but in a report published in April 2000 in the *British Journal of Psychiatry*, the authors said they were able to classify more than 70 percent of a group of patients into either a low-risk or high-risk categories for violence. The article proposes using an actuarial tool to assess the risk of violence among psychiatric patients.²¹

"The actually observed rates of violence in the low- and high-risk categories were 5% and 45% respectively," write the authors of the study. In other words, this pioneering study did not purport to predict violent behavior among a majority of even those it identified as

high-risk patients—although its authors point out that it is "vastly more accurate than the most optimistic study of the accuracy of psychiatrists or psychologists at predicting violence."

John Monahan, who co-authored the study, notes that the ability to accurately predict the risk of violence is particularly important, given the public's willingness to use force to prevent it. But he notes that outpatient commitment is only one of several ways a small group of individuals with severe mental illness are convinced to accept treatment.

The health care system, the criminal justice system, and the social welfare system each provides ways of drawing people into treatment and keeping them there.

- Psychiatric advance directives, for example, allow people with mental disorders to choose a surrogate to make decisions for them, and to make choices in advance about their treatment during times when they might be incapacitated.
- Mental health courts are being tested in five communities, with 25 more courts in the planning stages, and additional ones that will be instituted if Domenici, Kennedy, and Wellstone succeed in passing their Mental Health Early Intervention, Treatment, and Prevention Act. The courts use minor offenses and their consequences as leverage to convince people with severe mental illness to accept mental health services in the community.
- Family members, therapists, and case managers are among the people named as "representative payees," appointed to receive checks from the Supplemental Security Income or Social Security Disability Insurance on behalf of a person with severe mental illness. Access to these funds can be made contingent on adherence to treatment. The threat of eviction from subsidized housing can also serve as a means to encouraging people to accept treatment.
- Mandatory inpatient commitment is an option for serving those who constitute a threat to themselves or others.

Coercion may be an inevitable part of the lives of people with severe mental disorders who resist treatment, says Monahan. But he notes that there are ways to reduce the experience of coercion. "It is possible that the more people with mental disorders experience procedural justice, the more positively they will respond to treatment, even if they would prefer not to be treated," he says.

In "Coercion in the Provision of Mental Health Services: The MacArthur Studies," Monahan and his

co-authors wrote, “a patient’s belief that others acted out of genuine concern, treated the patient respectfully and in good faith, and afforded the patient a chance to tell his or her side of the story are associated with low levels of experienced coercion.”²²

IMPLEMENTING OPC LEGISLATION

The issue of commitment seems to pit groups representing families of adults with severe mental illness against other groups speaking for the consumers of mental health services. Many of the consumer groups are supported by organizations that represent mental health professionals.

Some of the professionals who are willing to consider the value of outpatient commitment appear to perceive it as a tool, but not an important one in a comprehensive system of mental health care. At either extreme are those who would put great emphasis on implementation of outpatient commitment legislation and those who view it as an inappropriate use of scarce resources and a monstrous violation of civil rights.

Seeming to reflect the lack of consensus in society, authorities are not eager to seek involuntary commitment, even on an outpatient basis and, in half of the states in which outpatient commitment legislation is in place, it is rarely used, according to a March 1, 2000, report from the National Conference of State Legislatures’ Health Policy Tracking Service. Montana and Illinois, the last states to provide psychiatric treatment to Russell Weston, for example, have passed such legislation, but mental health professionals saw no reason to recommend it for Weston.

E. Fuller Torrey, president of the Treatment Advocacy Center, a nonprofit organization that works to promote outpatient commitment, says that pressure to implement the legislation will have to come from the families of people with mental illness and from criminal justice officials. “Outpatient commitment will only be implemented if people begin to ask themselves if it is reasonable to leave people living out on the street,” he says. “If people become aware that there is an alternative, the answer is going to be no.”

CONCLUSION

The debate over the issue of outpatient commitment elicits visceral responses from the organizations that argue either for or against such legislation. On one side are those who say that outpatient commitment is being

used as an easy fix for a system that is in disarray and lacks the resources to offer necessary and comprehensive services. They argue that the crucial relationship between therapist and client is threatened by the possibility of coercion. Proponents of outpatient commitment argue that high-quality services cannot overcome the lack of awareness many people have of their illness. Monahan suggests that, as outpatient commitment and other forms of coercion become more common, the policies must be tied to increasing resources for mental health services as well as making sure that the people who are subject to these actions believe that they have been treated fairly and with concern for their well-being.

On an optimistic note, it is clear that both consumers and researchers are becoming more aware of what combination of services and medication can be of help to people with severe mental disorders.

This Forum meeting will examine the cases made for and against outpatient commitment legislation in the context of the necessity of coercion in public policy for mental health, the civil liberties of people with mental illness, and the supply of community-based services for people with serious and persistent mental illness. It will also review why one state—Maryland—chose not to pass outpatient commitment legislation and why another state—New York—did. It will also examine the two most widely cited pieces of research about the impact of outpatient commitment, as well as the promise of the latest assertive community treatment options.

A number of questions arise in a discussion of outpatient commitment and mental health care in general. Among them are the following:

- How great is the threat of violence from people with severe mental disorders, and does that threat warrant passage of outpatient commitment legislation?
- What has been the relative importance of high-quality community treatment services in studies of the effectiveness of outpatient commitment?
- What difference can high-quality community treatment programs (such as ACT) play in maintaining compliance to treatment and preventing the need for using more coercive methods of exacting compliance?
- Will psychiatrists and psychologists ever be able to predict with sufficient accuracy the likelihood of violent behavior on the part of people with serious and persistent mental illness?
- If, as one researcher concludes, outpatient commitment leads state health officials to provide compre-

hensive services to individuals under court order, are there alternative ways of obtaining the same results?

- For individuals placed under outpatient commitment, how can the individual experience of coercion be reduced?
- How will the states ensure the quality of the community-based services that are provided to individuals with severe mental disorders?
- What role can Congress play in encouraging the use of Medicaid and other federal funds to cover services and medications that can help improve compliance and quality of life, and, perhaps, obviate the need for coercive measures?
- What role can advance directives play in protecting the rights and dignity of individuals with severe mental disorders during the times they are considered legally incompetent to make decisions about their own care?

This Forum session will begin with an overview of mental health and the law by **John Monahan, Ph.D.**, Doherty Professor of Law at the University of Virginia and director of the MacArthur Research Network on Mental Health and the Law. This will be followed by short presentations by representatives of two organizations that have opposing views on the issue of outpatient commitment, **Chris Koyanagi**, policy director at the Judge David L. Bazelon Center for Mental Health Law, and Ron Honberg, director of legal affairs for the National Alliance for the Mentally Ill. Two state government officials—**John Tauriello, J.D.**, deputy commissioner and counsel for the New York State Office of Mental Health in Albany, and **W. Lawrence Fitch, J.D.**, director of forensic services for the Maryland Mental Hygiene Administration—will then discuss their respective states' decision on outpatient commitment legislation.

ENDNOTES

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