I
n almost every community in the United States, there is a troubling population of severely mentally ill individuals who are ineffectively served by resource-poor community mental health programs. These individuals frequently relapse and are rehospitalized (1–3), in many cases because their treatment is complicated by nonadherence. They frequently, and often unsuccessfully, interact with many other services and agencies—substance abuse treatment programs, civil and criminal courts, police, jails and prisons, emergency medical facilities, social welfare agencies, and public housing authorities (4–7). Some, while visibly ill, never seek or are engaged in any form of treatment.

Public concern about the quality of community-based treatment is unfortunately focused on rare but highly publicized violent acts committed by these hard-to-serve individuals (8). The pressing need to improve community treatment outcomes has led policy makers and clinicians to focus on legal mechanisms to improve treatment adherence, including court-ordered treatment in the community, often called involuntary outpatient commitment (9). Many states have embraced outpatient commitment as a remedy for the most visible failures of community treatment.

Outpatient commitment is permitted in virtually all states (10–13); however, its use varies considerably among and within states for a variety of reasons, including poor specification and understanding of commitment criteria, weak mechanisms of enforcement and liability, and other concerns of providers (4,10,14–16). Use of outpatient commitment may also be limited because many consumers, mental health law advocates, and clinicians oppose any form of coercion in treatment, arguing that it infringes on civil liberties, extends social control into the community, and alienates mentally ill persons from seeking treatment (17–20). Proposed as a less restrictive alternative to involuntary inpatient commitment, outpatient commitment has amassed a host of supporters and critics, despite a relative paucity of empirical evidence about its risks or benefits.

Proponents of outpatient commitment assert that it works not only by exerting pressure on individuals with mental illness and their families, which motivates adherence to treatment under threat of coercion and greater confinement, but also by putting pressure on the mental health service system and mobilizing supportive services, outreach, and clinical surveillance. This mobilization in turn improves timely access to scarce treatment resources for persons most in need. In the view of those who advocate for it, outpatient commitment provides greater autonomy than would otherwise be expected for mentally ill individuals at risk of relapse and recidivism. Furthermore, if outpatient commitment effectively reduces hospital recidivism, it should conserve resources for reinvestment to extend and improve community-based services (9,10). Nonetheless, as the papers in this special section illustrate, the intensity of the debate about outpatient commitment is considerable.

A recent report from the subcommittee on mandatory outpatient treatment of the American Psychiatric Association’s council on psychiatry and law concluded that outpatient commitment could be a “useful tool in an overall program of intensive outpatient services aiming to improve compliance, reduce rehospitalization rates, and decrease violent behavior among a subset of the severely and chronically mentally ill” (21). The subcommittee recommended that outpatient commitment orders be available for preventive use only for patients with a well-documented history of relapse, deterioration, or dangerousness. It also recommended that the orders be available for patients who, as a result of their mental illness, are unlikely to comply with needed treatment. According to the subcommittee, such orders should be used only when adequate resources are available to provide effective treatment, and they should include statutory authority for initial commitment periods of 180 days with extensions as ordered.

The subcommittee recommended that patients on outpatient commitment receive a thorough medical examination. It pointed out that clinicians providing the mandated treatment should be involved in the decision-making process to ensure that the proposed treatment is available. Patients’ treatment preferences should be assessed, and patients should be informed of expectations about compliance. Finally, the subcommittee recommended that procedures to be followed in the event of a patient’s noncompliance should be specified.

The subcommittee’s resource document does not make a recommenda-
tion about whether outpatient commitment statutes should either permit or preclude forced medication. It recommends that forced medication be permitted only "if a court finds that the patient lacks the capacity to make an informed decision regarding his or her need for the medication."

These recommendations, which are intended to inform policy making on outpatient commitment, are likely to stir further controversy (22–26).

The goal of this special section is to provide a better understanding of the empirical data and the positions of key stakeholders in the national debate on outpatient commitment. Opponents argue that coerced outpatient treatment infringes on civil liberties, damages the self-esteem of persons with mental illness, undermines therapeutic relationships, drives people away from needed services and treatment, and allows policy makers to continue to underfund treatment by "blaming the victims" for treatment failure (17–20). Others assert that any need for outpatient commitment could be obviated by serious investment in a continuum of the services needed by persons with severe mental illness.

Many arguments about outpatient commitment rest on assumptions about the efficacy of legal coercion as a remedy for treatment nonadherence or risk of violence (27). Empirical arguments about the use of coercion depend largely on the frame of reference. Compared with voluntary treatment, outpatient commitment is coercive, but it is less coercive than involuntary hospitalization. The coercion of outpatient commitment occurs within the context of other real limits on the autonomy of persons with severe mental illness. The constricted range of choices available to these individuals in many areas of life is relevant to discussions about the use of coercion in the community.

Evidence of whether outpatient commitment "works" should be an important consideration in these debates, and recent empirical evidence from the North Carolina and New York City outpatient commitment programs are reviewed in this section. However, moral objections to or support of outpatient commitment on the part of many consumers, legal advocates, and clinicians may trump scientific evidence as the policy debates. Therefore, the views of what we hope is a representative spectrum of stakeholders are also featured. We doubt that supporters or opponents of outpatient commitment will come away from this collection of viewpoints in consensus, but we do hope that bringing evidence and debate to the broad audience of this journal's readership will invite new scholarship and an even broader discussion about the appropriate place of coercion in community treatment.

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References

8. Angermeyer MC, M aschingher H: Violent attacks on public figures by persons suffering from psychiatric disorders: their effect on the social distance towards the mentally ill. European Archives of Psychiatry and Clinical Neuroscience 245:159–164, 1995