Commentary: A Major Advance in the Laws Pertaining to Community Treatment for Persons with Severe Mental Illness

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The American Psychiatric Association's Council on Psychiatry and Law has taken an objective, reasoned approach to mandatory outpatient treatment,[1] basing their findings and recommendations on the needs of persons with severe mental illness. What is best for this population appears to be paramount to the Council, and preconceived ideology has been kept to a minimum. The Council has carefully reviewed the research to date and concluded that the "use of mandatory outpatient treatment is strongly and consistently associated with reduced rates of rehospitalization, longer stays in the community, and increased treatment compliance among patients with severe and persistent mental illness." However, the Council recognized that whether "these outcomes are entirely a function of the enhanced services available to committed patients, or whether some of the positive effects are attributable to the judicial order" is an unresolved question. While they believe that additional research is necessary to clarify these issues, they take the position "that policy judgments regarding the desirability of mandatory outpatient treatment need not await the outcome of these additional studies," because "the existing research already provides a strong empirical foundation for including mandatory outpatient treatment as one of the strategic elements of a plan of aggressive community treatment." We applaud these positions and believe that such an approach for mental health treatment is sorely needed if the minority of treatment-resistant, severely mentally ill persons is to be well served in the community.

While the criteria for mandatory outpatient treatment are somewhat vague and not entirely clear as presented under "Conclusions and Recommendations," these criteria are extremely clear and specific in the body of the Resource Document and, in particular, as outlined under "Criteria for Mandatory Outpatient Treatment." We agree strongly that mandatory outpatient treatment should be reserved for persons who need treatment "to prevent a relapse or severe deterioration that would predictably result in the person (becoming a danger to himself or others or becoming substantially unable to care for him or herself in the foreseeable future)." Thus, these recommendations take a need-for-treatment approach and do not rely simply on criteria linked to dangerousness to self or others. It should be emphasized that this need-for-treatment approach is defined stringently. It is far more protective of the liberty interests of the severely mentally ill population than what

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served as the basis for involuntary treatment prior to the extensive modifications to the commitment laws that began in 1969 when California's Lanterman-Petris-Short Act went into effect.

While the Council stringently defines "need-for-treatment," in many states this definition would expand the mandatory treatment standard to include grave disability in addition to dangerousness to self or others. We believe that this change is long overdue. It is important to note that the Council adopts the position that, "mandatory outpatient treatment should not be designed principally to protect the public, but rather to enable severely ill patients to receive the treatment they need, with potential benefits to themselves and to the community."

The Council recognizes the liberty interests at stake under any scheme of mandatory treatment and believes that the imposition of such treatment should be ordered by a court only after a hearing at which the judge finds, on the basis of clear and convincing evidence, that the patient meets the statutorily prescribed criteria for mandatory treatment. In our view, involving an independent trier-of-fact reduces the risk of erroneous application by well-intentioned clinicians and assures due process for the patient.

The Council recognizes that mandatory outpatient treatment is most effective when it includes services equivalent to the intensity of those provided in assertive community treatment or intensive case-management models. The Council wisely recommends that states adopting mandatory outpatient treatment statutes must assure that adequate resources are available to provide effective treatment. From our own perspective, we cannot overemphasize the importance of a comprehensive approach to treatment, as discussed in the next section.

The Importance of a Coherent Treatment Philosophy

To work effectively with resistant, severely mentally ill persons, there is a growing recognition of the importance of identifying and articulating a coherent treatment philosophy in relation to both theory and practice.[2–4] Therefore, we recommend that the Resource Document address the need for a reality-based, comprehensive treatment philosophy that includes the following: clear treatment goals, with attention paid to those expressed by the patient; incorporation of the principles of case management; designation of one person for each patient who has the responsibility for overseeing all aspects of the patient's treatment and rehabilitation; use of outreach, when necessary; emphasis on structure and supervision; appropriately supportive and structured living arrangements; participation in the formulation of the treatment plan by the clinicians who will be providing the treatment; treatment staff who are comfortable with using authority and setting limits; close liaison with the court monitoring the patient, including access to the mental health system's database (and criminal justice databases, if applicable) on each patient; management of aggression and a recognition of the importance of psychotropic medication; and recognition of the role family members have in the treatment of patients.

We believe an important recommendation made by the Council is that "patients should be consulted about their treatment preferences and should be provided with a copy of the mandated outpatient treatment plan, so that they will be aware of the conditions with which they will be expected to comply." Generally, mental health professionals believe that community treatment of severely mentally ill persons should focus on the stabilization of the illness, the enhancement of independent functioning, and the maintenance of internal and external controls that prevent the patient from decompensating and/or acting violently. It is hoped these goals will be shared by the patient. Further, it is crucial that the patient's goals be incorporated into the treatment plan, if possible. Important aspects of the discussion between clinician and patient are that the patient understand which behaviors and symptoms are of concern, why they are of concern, what is expected of the patient by both the clinician and the court, and how the treatment can help the patient meet these expectations.[5]

An important obstacle to resistant, severely mentally ill persons receiving outpatient treatment is that community mental health resources may be inappropriate for many members of this population.[6,7] For instance, mentally ill persons may be expected to come to outpatient clinics when the real need for a large proportion of this population is outreach services where professionals go to them. The Council on Psychiatry and Law recognizes this problem when it cites the assertive community treatment and intensive case management models as examples of the kinds of treatment needed by severely mentally ill persons.

In our experience, patients referred for mandatory outpatient treatment usually lack internal controls; they need external controls and structure to organize them to cope with life's demands.[8–10] For instance, it is generally believed by most mental health professionals that staff should insist that severely mentally ill patients' days be organized by meaningful, therapeutic activities such as work, day treatment, and various forms of social therapy.[11] The Resource Document addresses structure for the population discussed here by recommending that treatment be mandatory, under the jurisdiction of the court, and contain specific procedures to be followed in the event of patient noncompliance.

Although it may go beyond the scope of the Resource Document, we would hope that the clinicians involved in mandatory outpatient treatment programs recognize that survival in the community for the great majority of these treatment-resistant, severely mentally ill persons appears to depend on an appropriately supportive and structured living arrangement.[4] This can often be provided by family members. In many cases, however, the kind and degree of structure that the patient needs can be found only in a living arrangement outside the family home where a high staff-patient ratio exists, medication is dispensed by staff, curfews are enforced, and therapeutic activities structure most of the patient's day. Some patients need a great deal of structure and supervision in their housing situation, others need only a minimal amount, and most fall somewhere in between. How much structure does a patient need? The treatment staff member or the case manager assigned to each patient needs to decide whether a particular living arrangement (family home or facility) has the appropriate amount of structure to meet the needs of the patient.

The Council recognizes that outpatient treatment, to be effective, must have the support of the clinicians who will be conducting the treatment. It wisely recommends that these clinicians be involved in the decision-making process and participate in the formulation of the treatment plan to assure that the proposed plan is one that they are able and willing to execute. Thus, the Council recommends that a treatment plan be presented to the court before outpatient treatment may be ordered. This would enable judges to make more informed decisions and outpatient clinicians to exercise appropriate control over which patients are committed to them for treatment. In our experience, probably no factor has proved more important in the failure of mandatory outpatient treatment than asking mental health professionals in outpatient settings to implement plans in which they had no input in formulating but for which they are now expected to assume responsibility.

It also has been found that the mental health system regards many resistant mentally ill persons as extremely difficult to treat and, therefore, is often reluctant or unable to serve them.[12, 13] Given a choice, most of us prefer to work with mentally ill persons who are cooperative with our treatment, adapt quietly to living in the community, and do not need an inordinate number of limits and structure. However, if mandatory outpatient treatment is to be successful, those involved in the treatment of this population need to be comfortable in working with resistant, severely mentally ill persons.

The Resource Document states that "clinicians in mandatory treatment programs need specific skills and training to appropriately manage their dual roles as therapists and social control agents."[14] Thus, treatment staff need to be unambivalent about the use of authority. The clinical uses and therapeutic value of authority appear to be a cornerstone of successful community treatment for resistant, severely mentally ill persons.[4, 15, 16] When treatment is effective, the staff are comfortable about: insisting consistently and reasonably that the imposed conditions of treatment be followed; monitoring patients' compliance with prescribed psychotropic medications; and monitoring patients to detect the use of alcohol or illegal drugs. They have no problems with insisting that patients live in appropriately structured and supportive residential settings. They are willing to promptly rehospitalize patients in community facilities at times of crisis and feel comfortable in making such recommendations to the court.

In those cases in which contact between the patient and family members is anticipated, the role of the family cannot be overestimated. Family members involved with the patient can provide emotional support, monitor the patient's medication, treatment, and rehabilitation, and supervise the patient's money.[17] In addition, when family members are guided and instructed in ways to help stabilize their mentally ill relative, the relationship between them can improve and stress on the family can be alleviated. Therefore, we recommend that the Resource Docu-

ment give more emphasis to the role of involved family members and their potential therapeutic effect on their severely mentally ill relative.

Issues of Ethics, Compliance, and Length of Treatment

The Resource Document acknowledges the legal and ethical aspects of treating persons under the jurisdiction of the court. We agree that severely mentally ill persons who are being considered for mandatory outpatient treatment should be apprised of all the conditions and limitations that will be imposed on them, why they will be imposed, and what will happen to them if they do not comply before consenting to such a disposition.[14] These conditions may include: limits to confidentiality, with respect to both past and present treatment and criminal history, and sharing such information with the court[18]; supervision and monitoring by various authority figures, such as judges, therapists, and case managers; mandatory compliance with treatment and other imposed conditions; residing in an appropriate living situation; and being aware of the possibility that nonadherence to the terms and conditions may result in loss of their outpatient status.

The Council on Psychiatry and Law takes the position that the statutes for mandatory outpatient treatment must contain a mechanism for some forcible intervention to promote treatment compliance. We agree that "a judicial order is not a panacea either for 'curing' or for 'controlling' treatment resistant patients, but it does appear to play a useful role in some cases, when combined with enhanced and well-designed services." The Resource Document notes that the court order may increase the vigilance of case managers over their patients.[19] Thus, we would recommend that the Resource Document go further and endorse the monitoring of mandatory outpatient treatment by the court on a regular basis and not just in cases of noncompliance with the court-ordered treatment plan. Such a mechanism has been shown to improve outcome in terms of fewer hospitalizations, fewer rearrests, and less violence and homelessness.[20]

We believe that the position put forth by the Resource Document on the response to noncompliance is a reasonable one. For example, with regard to psychotropic medications, a position is not taken on whether forced medication should be permitted or precluded. However, it is recognized that even if statutes do not authorize forced medication, there is a need for some coercive power to enforce adherence. For instance, if the patient does not take court-ordered medication, he or she could be taken to the outpatient treatment facility where the medication could again be offered. If all else fails, there could be authority to take the patient to a hospital. If taking medications is part of the court order, the court should make it clear to the patient that taking medications will be expected if he or she wants to remain in the community.

The Council concludes that mandatory outpatient treatment is likely to be most successful when the period of mandated treatment is at least 180 days or longer, and we agree with this conclusion. Every clinician knows that treatment and rehabilitation of persons with severe mental illness is not a short-term process. In addition, research cited in the Resource Document has shown that the majority of persons in mandatory outpatient treatment who remained in the program for a six-month period tended to be adherent to their medication regimens.[21]

Conclusion

We believe that the Resource Document written by the APA's Council on Psychiatry and Law is a major step forward in formulating a balanced and reasoned approach to laws addressing the community treatment of severely mentally ill persons who are resistant to treatment. The Council has carefully reviewed the most recent research pertaining to mandatory outpatient treatment. They have put ideology aside and focused realistically on the needs of a subpopulation of severely mentally ill persons who have been neglected and left to live on the streets, have been inappropriately incarcerated in our jails, and have caused great anguish for families who have found themselves unsupported and helpless as they witness the plight of their loved ones.

We endorse the recommendations presented in the Resource Document and hope that they will form the basis of new laws for mandatory outpatient treatment nationwide.

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