Opening Pandora's Box: The Practical and Legal Dangers of Involuntary Outpatient Commitment

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Policy makers have recently begun to reconsider involuntary outpatient commitment as a means of enhancing public safety and providing mental health services to people deemed to be noncompliant with treatment. The authors review the therapeutic claims for outpatient commitment and take the position that there is insufficient evidence that it is effective. They offer arguments that outpatient commitment may not improve public safety and may not be more effective than voluntary services. The authors further point out that outpatient commitment may undermine the delivery of voluntary services and may drive consumers away from the mental health system. The authors conclude that outpatient commitment programs are vulnerable to legal challenge because they may depart from established constitutional standards for involuntary treatment. (*Psychiatric Services* 52:342–346, 2001)

A handful of highly publicized violent incidents involving people with mental illnesses has rekindled the debate on involuntary outpatient commitment. Many mental health advocates are seeking new approaches to treating hard-to-serve populations. However, advocates for involuntary treatment have focused on public fears about mental illness and violence (1), which likely increases the stigma felt by people who have been diagnosed as having mental illnesses. Advocates of involuntary treatment have attempted to shift public attention toward mandated treatment strategies and away from voluntary therapeutic models.

We believe there are at least five significant reasons to question the wisdom of outpatient commitment as public policy. First, in our view, there is arguably insufficient evidence that outpatient commitment is effective in improving public safety or treatment compliance or in reducing rehospitalization rates. Second, we believe that these worthy goals could be achieved by providing enhanced and coordinated services and supports, without the potential expense, trauma, and violation of legal rights occasioned by outpatient commitment. Third, unless treatment resources are consistently provided along with outpatient commitment, orders for involuntary treatment may hurt the people most in need of voluntary mental health services and supports by diverting limited resources from proven and successful programs. Fourth, the coercive character of outpatient commitment may actually undermine public safety by alienating people who have mental illnesses from the mental health system. Finally, the ways in which outpatient commitment has been implemented in most states may violate the constitutional right to control one's own treatment decisions.

In this paper we describe current involuntary outpatient commitment practices and outline reasons why outpatient commitment will not achieve its objectives. We also review its legal validity.

Definitions and descriptions

Outpatient commitment is a mechanism used to compel a person with mental illness to comply with psychotropic drug and treatment orders as a condition of living in the community. If prescribed in a treatment plan, outpatient commitment may require that a person participate in full-day treatment programs, undergo urine and blood tests, frequently attend meetings of addiction self-help groups, enter psychotherapy with a particular therapist, or reside in a supervised living situation (2). In many states, orders may be extended for prolonged periods, without clear criteria for ending the order (3).

Outpatient commitment is not typically used for people who are currently dangerous; such individuals are generally held in inpatient settings. Nor does it seek to protect those who are currently incompetent to make treatment decisions (4,5). Rather, it seeks to override the expressed wishes of a legally competent person who is thought to have some potential to become dangerous or gravely disabled in the future.

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Proponents suggest that outpatient commitment is a kinder and gentler alternative to inpatient commitment, homelessness, and jail or prison (6). They claim that outpatient commitment may decrease threats to autonomy occasioned by involuntary hospitalization and point to evidence that those who may most benefit from its targeted use are subpopulations of individuals with mental illness (7). However, at its core, outpatient commitment requires a person, on pain of entering police custody and undergoing rehospitalization, to comply with the treatment decisions of another person, undermining the fundamental right of a competent, nondangerous person to determine the course of his or her treatment (8). It also appears to violate the constitutional rights to travel, to privacy, to personal dignity, to freedom from restraint and bodily integrity, to freedom of association, and to the free communication of ideas (9).

The first formal outpatient commitment laws were enacted in the early 1980s, and about 40 states now have such laws on their books (3,10). More than half the states invoke the law infrequently (11), in large part because of the reluctance of service providers to participate in coercive treatment and because of a lack of community-based services (12).

Will outpatient commitment achieve its objectives?

It may not improve public safety

The root causes of violence in our society are complex, and many have little to do with mental illness. The public is justified in expecting the criminal justice system to protect it against people who commit violent crimes, whether or not they are mentally ill, and the law has long recognized the legitimacy of removing actively dangerous people from the community and confining them in prisons and jails.

For the small number of people whose mental illness makes them dangerous to themselves or others but who have not committed criminal acts, the law permits state authorities to seek involuntary hospitalization, at least on an emergency basis. So long as a person continues to meet this dangerousness standard, hospital discharge, even with an outpatient commitment order, appears to be clinically and legally irresponsible. It serves neither public safety nor individual rights to have currently dangerous people released into the community.

However, there is limited evidence that outpatient commitment will make either the public or people diagnosed with mental illness any safer. Compared head-to-head with a program of enhanced and coordinated services, outpatient commitment is no more effective in preventing subsequent acts of violence and arrest (13).

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In fact, the people whose conduct helped revive the debate about forced treatment would not likely have been candidates for outpatient commitment in many states. They include Andrew Goldstein, who pushed a woman in front of a New York City subway train, and Russell Weston, who shot and killed two guards at the U.S. Capitol. Each was actively seeking treatment and services, and each was repeatedly turned away. Medication nonadherence was alleged to have been a problem in both cases. However, innovative treatment approaches such as peer outreach or intensified outreach efforts are more likely than court orders to successfully engage people alienated from the mental health system. In the cases of Goldstein and Weston, there was little evidence that coerced treatment was needed; in fact, their greatest need was for appropriate services, which have been dramatically underfunded for more than 40 years (14).

The mental health system on its own is ill equipped to enforce compliance with outpatient commitment orders. Building in enforcement, such as police and court resources, may increase the costs of administering already underfunded treatment programs (15). It may also make people with a history of hospitalization wary of contact with the mental health system or frightened to disagree with their doctors or family members, because doctors and family members are empowered under the outpatient commitment laws in many states to secure forced treatment orders against them (2).

It may not be more effective than voluntary services

Policy makers should review the research literature, which shows that outpatient commitment confers no apparent benefit beyond that available through access to effective community services. Researchers in the Bellevue outpatient commitment study, the only controlled study that explicitly provided enhanced community services, concluded that individuals provided with voluntary enhanced community services did just as well as those under commitment orders who had access to the same services (13). The study compared persons subjected to outpatient commitment with those who were offered access to the same intensive services. Researchers found no additional improvement in patient compliance with treatment, no additional increase in continuation of treatment, and no differences in hospitalization rates, lengths of hospital stay, arrest rates, or rates of violent acts.

More recent research by Swartz and colleagues (7,16) in North Carolina found that outpatient commitment had no clear benefit unless it was sustained for at least six months and accompanied by high-intensity community services and supports. The North Carolina investigators also found that

outpatient commitment benefited only a small portion of the population potentially subject to such commitment. Given the differing results of the Bellevue and North Carolina studies, caution should suggest that outpatient commitment be avoided until more definitive studies are available.

A number of other studies frequently cited in support of outpatient commitment have either lacked appropriate control groups (17,18) or have focused on small and poorly described groups of subjects (19). Although numerous other studies have been undertaken, none has documented a clear link between outpatient commitment and positive therapeutic outcomes (20,21).

It may undermine service delivery

Research has shown that enhanced and coordinated mental health services are an effective means of improving outcomes for consumers and for the public. The U.S. Surgeon General (22) recently noted that "the need for coercion should be reduced significantly when adequate services are readily accessible. . . . Randomized clinical trials have shown that psychosocial rehabilitation recipients experience fewer and shorter hospitalizations than comparison groups in traditional outpatient treatment."

Psychosocial rehabilitation programs have demonstrated long-term improvements in the lives of participants. At the end of one ten-year program, 62 to 68 percent of the participants showed no signs of mental illness (23). Other voluntary programs, such as California's Village Integrated Service Agency, have been shown to reduce rehospitalization rates, increase employment income, and reduce stress on family members (24). Greater reliance on peer counseling and self-help groups has led to a dramatic decrease in the number and duration of hospitalizations and to improvement in self-esteem for participants (25,26).

Governmental support for mental health systems is declining in real terms (14). When such systems are required to make services available to people for whom a court has ordered treatment, others may be deprived of effective voluntary services. Every dollar prioritized for coerced treatment is a dollar that is not available to pay for effective voluntary services, such as peer support, outreach, adequate housing, jobs programs, and rehabilitation.

It may drive consumers away

Although informal coercion by family members, case managers, and others may overcome some consumers' reticence about getting treatment (27), legal coercion in the form of court orders for outpatient commitment may have the unintended consequence of driving many consumers away from the mental health system. Seeking to avoid both coercive practices and the stigma attached to mental illnesses, many consumers may not seek basic services and supports until emergency circumstances arise and hospitalization becomes necessary.

We have the technology to provide essential services and supports, even to the hardest-to-reach people, but we have failed to fund the effort to do so.

The literature suggests that effective mental health treatment is based on a therapeutic alliance between the professional and the consumer (28–31) and that the right to refuse unwanted treatment bolsters this alliance by assuring patients that they have input into their treatment (32, 33). The right to refuse unwanted treatment can be critical for people who have previously been stripped of significant autonomy through the involuntary commitment process (34) —people who, by virtue of their past hospitalizations, may now be subject to outpatient commitment. By its very nature, outpatient commitment may undermine the treatment alliance and increase consumers' aversion to voluntary involvement with services (35).

Involuntary mental health treatment of any kind can also undermine the ultimate long-term goal of patient independence. Research has shown that many mentally ill homeless individuals have opted out of the mental health system after being forcibly medicated. Some of these individuals choose life in the streets rather than institutionalization, partly to avoid compulsory administration of psychotropic medications (36).

Coerced treatment may ensure compliance while the individual is under a court order. However, it may also prevent the formation of patterns of behavior that will lead the individual to voluntarily seek out and actively participate in treatment once the order has expired. One study in New York found that patients who exercised their right to refuse certain treatments and to participate assertively in their own treatment were more likely to succeed outside the hospital environment as independent members of the community (37).

Questionable legal validity

Beyond their practical limitations, outpatient commitment statutes such as "Kendra's Law" in New York (2) may violate long-established constitutional protections against forced treatment. However, a recent challenge to the constitutionality of outpatient commitment was rejected by a King's County, New York, trial court (38). Since the U.S. Supreme Court established requirements for involuntary treatment nearly a quarter century ago (39), courts and legislatures have established stringent standards for commitment, requiring proof of a mental disability that poses a substantial threat of serious harm to oneself or others (40). According to some commentators, involuntary commitment is a "massive curtailment of liberty" (41), should be limited to emergency circumstances (28), and cannot be justified on an indefinite basis (42).

The law recognizes a strong presumption of competence to make treatment decisions and has established a person's right to make his or her own medical decisions as one that is fundamental and should not be interfered with absent a compelling state interest (8). Although restraining a currently dangerous person may be permissible, a mere desire to prevent future deterioration absent dangerousness has generally not been found to be a compelling interest (43). When a person is not dangerous and when no court has made a formal finding of incompetence, the government cannot substitute its judgment about mental health treatment (4). Risk assessment tools have improved dramatically in the past 15 years (44,45); however, they still lack the level of precision required to abridge the fundamental right of a person to control his or her treatment.

Most people with mental illnesses are never involved in violent acts (46) and are capable of weighing treatment options and making rational and valuable contributions to their own treatment (47). Despite alterations in thinking and mood, people with psychiatric disorders are not automatically less capable than others of making health care decisions (48–51).

Most courts have made it clear that states have no legal basis to force a competent person to take psychotropic or other drugs against his or her will absent an emergency (52,53). This doctrine would appear to extend to outpatient commitment and would preclude court enforcement of an order requiring medication adherence as a condition for remaining in the community.

Advocates for legally mandated treatment have sought to avoid this legal conundrum by suggesting that nearly half of the persons with schizophrenia or manic depression, although legally competent to make treatment decisions, lack the insight necessary to recognize their need for treatment (6). However, the construct of insight lacks specificity and legal meaning. Its use beclouds accepted legal norms, which limit the use of involuntary treatment for competent individuals.

Conclusions

Even if outpatient commitment were found to "work" for a small population, the question remains of whether it is the most effective means of engaging that population and providing essential services and supports in the community. We have the technology to provide essential services and supports, even to the hardest-to-reach people, but we have failed to fund the effort to do so. Outpatient commitment appears to be a short-sighted solution that may over time also undermine long-term treatment alliances. We believe efforts are far better directed toward fundamentally improving our public mental health system. ♦

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