

Commentary: Capacity-Based Involuntary Outpatient Treatment

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J Am Acad Psychiatry Law 28:145–8, 2000

Depending on one's point of view, court-ordered community treatment is a tool to help people with serious mental disorders live successfully in the community while furthering their progress of recovery, or it is a glaring example of paternalism gone awry. Treatment-oriented advocates like the National Alliance for the Mentally Ill (NAMI) and the Treatment Advocacy Center are pushing what they increasingly refer to as "assisted" community treatment; rights-oriented advocates like the Bazelon Center on Mental Health Law strongly oppose court-ordered outpatient treatment. Thus, NAMI has a policy statement saying that "Court ordered outpatient treatment should be considered as a less restrictive, more beneficial, and less costly treatment alternative to involuntary inpatient treatment."¹ On the other hand, the Bazelon Center maintains that "Outpatient commitment laws—statutes authorizing courts to require an individual to accept outpatient mental health treatment—are being proposed as a solution to the problem of people with mental illness in jails, homeless on the streets or engaging in violence. In addition to an unacceptable infringement of individuals' constitu-

tional rights, such laws are a simplistic response that cannot compensate for the lack of appropriate and effective services in the community."²

The recent passage of "Kendra's law," New York state's new outpatient commitment statute, is an apparent gain for advocates of assisted treatment. A number of other states are reexamining their commitment statutes and their use of court-ordered outpatient treatment. Should we advocate for more meaningful forms of involuntary outpatient treatment and, if so, what form should they take?

There are basically three distinct approaches to mandatory community treatment: outpatient civil commitment (OPC), conditional release, and guardianship or conservatorship. Conditional release appears to be most appropriate in the forensic setting, for patients found not guilty by reason of insanity or for other mentally ill offenders released from an institution. With civil patients, the greatest attention has been given to outpatient civil commitment, with lesser attention to guardianship.

Ohio has a qualified form of outpatient commitment in its mental health statute. While OPC is rarely used in Ohio, the Summit County, OH system has used it extensively. In many ways Summit County has been an excellent laboratory for the study of OPC. It has a relatively well-funded mental health system with clear prioritizations for the care of the severely mentally disabled (SMD). The great majority of SMD individuals are cared for by a single, comprehensive agency. This agency has strong medical leadership and an emphasis on intensive case management.

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The OPC protocol was carefully developed from the clinical literature with input and support from the local mental health board, the primary treatment agency, and the probate court. There is a single set of criteria for commitment to a hospital or the community, which are essentially dangerousness-based. When patients are committed to the community, they maintain the same right to refuse treatment that they would have in the hospital, but unlike in the hospital setting, there is not an established legal process to get a court order to provide treatment over patients' objections. Essentially, what OPC does permit is court-ordered monitoring. If a patient begins to show early signs of decompensation consistent with an established pattern, a request can be made to the court to order a mandatory evaluation at the psychiatric emergency facility. The threshold for this evaluation is lower than for an emergency commitment, so in theory a patient can be identified at the beginning of his/her slide down the slippery decompensation slope; clinicians and family do not have to wait until the very bottom of the slope is reached before acting. Most often patients evaluated at this time agree to resume the treatment they had stopped and can be returned to the community; only occasionally are they rehospitalized.

Massachusetts has no statute for outpatient commitment. Rather, in parts of the state, the probate court issues enforceable outpatient treatment orders under a substitute decisionmaking process for those with serious mental disorders found incompetent to make their own treatment decisions. The safeguards against inappropriate use of this judicially sanctioned power are many, including a stepwise sequence of involvement of the case manager to attempt to persuade a noncompliant person to take medications; the court-appointed guardian; the outpatient psychiatrist; and the local police. Voluntariness is always favored over enforcement. In Massachusetts, which has some of the best-funded community systems in the United States, this involuntary intervention has been crucial in successful treatment of selected cases. Resources have proved to be necessary to treat these most difficult cases but not always sufficient without the addition of a "tincture of coercion."

Before presenting in detail our opinion that a competency-based approach, like that of Massachusetts, is preferable to a dangerousness-based approach, like that of Ohio, we want to discuss the

recently promulgated "Resource Document on Mandatory Outpatient Treatment" from the American Psychiatric Association (APA) (1999) reprinted in this issue of the Journal.³ This resource document "endorses the view that mandatory outpatient treatment can be a useful intervention for a small subset of patients with severe mental illness who suffer from chronic psychotic disorders and who come in and out of psychiatric hospitals through the so-called 'revolving door.'" The resource document contains 11 specific conclusions and recommendations. Two of these recommendations raise serious concerns.

Recommendation 4 states, "Mandatory outpatient treatment should not be reserved exclusively for patients who lack the capacity to make treatment decisions, and should be available to assist patients who, as a result of their mental illness, are unlikely to seek or comply with needed treatment." The earlier APA "Task Force Report on Outpatient Commitment" (1987), used lack of decisionmaking capacity as a criterion for mandatory outpatient treatment. The current document changed that recommendation, based on the opinion that there are some circumstances in which a patient would likely not comply with treatment but would also not likely be found incompetent. The resource document encourages statutory language, like that found in Kendra's law, in which treatment is mandated for someone who because of his or her mental illness "is unlikely to voluntarily participate in the recommended treatment. . . ."

The problem with this recommendation becomes clear in the context of recommendation 11, the issue of court-ordered medication. The resource document argues, and we agree, that "psychotropic medication is an essential part of the treatment for virtually every patient who is appropriate for mandatory outpatient treatment." Having said that, recommendation 11 goes on to discuss the controversy around forced administration of medication, but it endorses no position on this issue other than to state: "If forced medication is permitted, it should be allowed only if a court specifically finds that the patient lacks capacity to make an informed decision regarding his or her need for the medication."

In developing recommendations that acknowledge the need for a broader standard, including prevention of deterioration as well as prevention of dangerousness, the APA resource document moves the field closer to what we believe would be ideal invol-

untary outpatient treatment legislation. However, by failing to require lack of decisionmaking capacity or competency, the APA document leaves us with a cumbersome system in which patients can be court-ordered into treatment, which they can then refuse. An outpatient commitment order under the APA recommendations would not mandate medication and would require a second legal process to determine decisionmaking capacity. Clinicians (and courts) would continue to be in the position of potentially misrepresenting the meaning of the court order, implying that the order includes a mandate to take medication, which in fact does not exist.⁴

The APA document is correct in moving past the criterion of dangerousness alone. Dangerousness has come to be accepted as a nearly essential element for involuntary confinement in a psychiatric hospital. Using mental health law to exert the states' police powers, confinement independent of treatment presumably serves to protect the patient and society from dangerous acts. However, dangerousness as an ongoing basis for outpatient commitment is problematic. If a person is truly imminently dangerous, maintenance in or release to the community is difficult to justify. What is argued instead is that without treatment the person would again become dangerous. This becomes a form of "preventive commitment," using past history of dangerousness to predict future dangerousness. In his legal analysis of preventive commitment, Slobogin⁵ argues that a predicted deterioration standard based on a patient's history would pass constitutional muster, but only if the commitment were time-limited. A dangerousness standard appears to limit the length of time a mandatory community treatment order could stay in force. Yet, there is a group of patients who need long-term mandatory community treatment. Further, by continuing to emphasize the link between dangerousness and serious mental illness, we unnecessarily add to the stigmatization of those with serious mental disorders.

The fundamental issue for the vast majority of patients for whom mandatory community treatment may be appropriate is the need for treatment in the face of continued treatment refusal. Individuals who are capable of making an informed decision have the right to refuse treatment and should be allowed to do so. Despite the APA's recommendation, societal values and extensive case law clearly put us past a time

when a *parens patriae* stance can be taken to permit involuntary treatment orders for individuals who are not imminently dangerous and are able to make an informed decision about their need for psychiatric treatment. Patients appropriate for mandatory outpatient treatment persistently lack the capacity to make informed decisions about their treatment. For many of these individuals, there is an apparent capacity lacuna around their need for psychiatric treatment. For these patients, a guardian should be authorized to give consent to such treatment, with appropriate due process protections for patients who object to their guardians' decisions.

Unlike the commitment process in which, despite all due process protections, decisions are essentially in the hands of doctors and lawyers, the guardianship or conservatorship process brings a third party, the guardian, into the picture, which can be a significant advantage. The recovery concept emphasizes the importance of involving persons with serious mental illness in both their own treatment and in the system of treatment. Persons who themselves have experienced mandatory treatment and are now well should have the opportunity to be involved in some way in helping those now ill and undergoing mandatory treatment. Their doing so would give a strong message of respect to those with serious mental illness, is consistent with the concept of procedural justice, and may diminish the level of perceived coercion.

Two ways in which such participation by recovering patients could take place are capacity review panels and organized guardianship programs. A capacity review panel could consist of a family member, a person with serious mental illness, and a mental health professional; together they would be charged with reviewing the recommendations for mandatory community treatment prior to a required guardianship court hearing. If any panel member disagreed with the treatment team's plan, he/she could choose to testify as a patient advocate at the hearing. An organized guardianship program could be a non-profit agency staffed by persons recovering from serious mental illness, who would act as limited guardians for persons found incompetent to make treatment decisions. In addition to providing guardians, a scarce resource in itself, such a program would place a peer alongside the beneficiary of mandatory community treatment.

Using competency as the first step in determining appropriateness for mandatory outpatient treatment

creates the potential for obtaining court orders to treat people who are not dangerous. For patients who grossly deteriorate when ill, we believe this is an appropriate use of our *parens patriae* responsibility. This proposal is consistent with the APA Resource Document's recommendations. However, there may be an uncomfortably large group of patients who, on careful examination, are found to lack decisionmaking capacity. It is not conceivable that all such patients should/would be candidates for mandatory treatment. Carefully considered clinical guidelines, such as those proposed by Geller,⁶ will be critical in assuring that mandatory outpatient treatment is considered only when less intrusive alternative interventions have failed and only when the coercive intervention is likely to be effective.

The dilemmas that surround the issue of involuntary outpatient treatment are not simple. Two important comments by former members of the U.S. Supreme Court remind us of the dialectical tension between patients' rights and needs. Chief Justice Warren Burger indicated that a person who "is suffering from a debilitating mental illness, and in need of treatment is neither wholly at liberty or free of stigma"⁷ and Justice Louis Brandeis stated: "Experience should teach us to be most on our guard to protect liberty when the government's purposes are beneficent. . . . The greatest dangers to liberty lurk in

the insidious encroachment by men of zeal, well meaning, but without understanding."⁸

While the choices around involuntary outpatient treatment may be difficult ones, capacity-based involuntary outpatient treatment is the most ethical approach. It is just plain wrong to fail to provide treatment to individuals with serious mental illnesses like schizophrenia if they lack the capacity to understand their need for treatment. Arguments against this approach ignore the realities of these devastating brain disorders.

References

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