Mandated Outpatient Treatment: A Quick Fix for Random Violence?—Not Likely

Howard Zonana, MD

J Am Acad Psychiatry Law 28:124–6, 2000

Civil commitment of the mentally ill has been "a matter whose intrinsic legal difficulties have vexed the jurisprudence of every country" according to Dr. John Callender, President of the Association of Medical Superintendents in 1883.

The forcing of hospitalization on an individual who cannot appreciate the need for it or who is dangerous because of a mental disorder is an unhappy situation for both the patient and the physician. Being compelled to accept a major intrusion on his liberty distresses the patient, and the physician does not like to restrain and treat an angry individual who neither wants the proffered treatment nor accepts the presence of an illness. Mandated outpatient treatment is the most recent extension of civil commitment and is most easily understandable in a historical context.

From the earliest days of colonial America the mentally ill posed problems with which the towns and later the states were forced to contend. In the colonial period, towns passed "warning out" laws that permitted a town to expel a person before the end of a short period (usually 30 days) after which the town became obligated to provide care. Officials would take the individual to the town line and send him on his way with admonitions not to return. As populations grew, this practice became unacceptable when neighboring towns objected. Communities perceived the insane as a disturbing element, similar to criminals. Massachusetts, in the late 1700s, dealt with the apprehension and disposal of the insane by a law entitled, "an act for suppressing Rogues, Vagabonds, Common Beggars, and other idle and lewd Persons."[1] Jails and almshouses became the repositories for the mentally ill until Dorothea Dix began her crusade to establish mental asylums and hospitals (1843).

Until 1881, the idea of a voluntary admission for someone considered mentally ill was inconceivable. Such persons were considered globally incompetent and therefore incapable of signing or understanding a contract. Thus, physician certification and civil commitment by courts became the ticket of entry into mental facilities. The degree of legal protection afforded the mentally ill varied considerably. These vacillations have depended upon the perceived efficacy of mental health treatment, counterbalanced by the need to prevent patient abuse. In 1842, a New York statute required that mentally ill persons be hospitalized within 10 days of the onset of their illness. This was during a period when treatments were perceived as effective and any delays in treatment were deemed harmful. By the 1860s, when Elizabeth Packard was hospitalized under an Illinois statute permitting hospitalization of "wives without the usual evidence of insanity required in other cases," a new era of reform was initiated, which introduced more substantial legal due process protections in civil commitment.[2] For example, many states required

Dr. Zonana is Professor of Psychiatry, Yale University School of Medicine, and Adjunct Clinical Professor of Law, Yale Law School, New Haven, CT.

jury trials and transportation of patients to courts for hearings. This reform period lasted for 20 to 30 years, until about 1890.

By the early part of the 20th century, most legislatures had settled on a strategy of conferring a great deal of discretion on physicians for determining whether a person needed to be hospitalized. Many states, like Connecticut, enacted laws that authorized the hospitalization of the mentally ill. Mental illness was loosely defined as a mental or emotional "condition" having adverse effects on the person's behavior, and the individual also had to be "a fit subject for confinement."[3] Eventually, during the first half of the 20th century the state hospitals became large, total care institutions where the chronically mentally ill often stayed for years.

The rest of the story is well known. In the 1960s and 1970s deinstitutionalization of persons with chronic mental illness was accompanied and accelerated by the civil rights movement. In the legal environment of that day, it was not surprising that a new generation of commitment laws took on a decidedly libertarian cast. The U.S. Supreme Court's decision, *In re Gault,*[4] symbolized a deepening distrust of benevolent uses of coercive authority in its critique of the juvenile court system. In this context, a strong momentum built toward a libertarian model of civil commitment reform, requiring proof of acts indicative of imminent danger and importing procedural safeguards from the criminal justice system. Some commentators argued for the outright abolition of civil commitment. The entire tradition of paternalistically based civil commitment that had been in place for the care and treatment of the mentally ill was under attack.

For the first time, the U.S. Supreme Court began to take cases that highlighted these issues. The Court, in a series of decisions, held that while civil commitment was a "massive deprivation of liberty," it was not equivalent to the incarceration of an individual in a correctional setting, and therefore (all of) the rights attendant to someone accused of crime were not required for civil commitment. On the other hand, a person could not be committed merely to improve his or her condition. There had to be some evidence of dangerousness or grave disability to justify hospitalization.

When individuals were hospitalized for long periods of time, hospitals would often undertake a discharge process using furloughs or parole, a period of time in which a patient could be released into the community; but if difficulties arose, the patient could be returned to the hospital without having to undergo a recommitment hearing, which required court approval. This procedure began to be challenged in the courts, but it was probably more affected by the fact that many patients required Social Security benefits to live in the community. If the patient remained on the hospital books, she/he was unable to obtain disability benefits and therefore had to be legally discharged.

As deinstitutionalization became the ethos, treatment of the mentally ill in their communities became the standard of care. The courts, however, have come to see psychotropic medication as substantially different from other medications in the medical pharmacopoeia. These medications have been seen as mind altering, and as intruding upon a person's right to think, thereby requiring constitutional protections. Instead of being seen as something that heals or ameliorates intrusive symptoms, psychotropic medication has been equated frequently with brain surgery and electro-convulsive therapy. The solution has been to insert extensive procedural due process rights, making forced medication a difficult and often impossible remedy. Managed care has "raised the stakes" by shortening the average length of stay in most mental facilities to one week or less. Many patients, both because of a lack of appreciation of their mental condition and/or side effects of the medication, frequently discontinue their medication. Shortly after hospital discharge, they quickly deteriorate, which frequently leads to multiple or "revolving door" hospitalizations and arrests for disorderly or inappropriate behavior. This type of scenario has greatly increased the number of mentally ill in the jails and prisons. Families and prison officials have not been pleased.

One proposed solution has been the introduction of "mandated outpatient treatment." Legislators and the public see it as a "quick fix" to enhance public safety. There has been virtually no opposition to the use of mandated outpatient treatment in circumstances involving insanity acquittees and sex offenders. Physicians generally have supported this concept, but only for a small group of chronic patients who have frequent inpatient admissions and who, when treated, show substantial improvement. On the other hand, there is substantial opposition from patients without a significant criminal history and from civil

rights groups, who see this as an inappropriate and substantial intrusion into people's lives. Despite very limited and controversial data regarding efficacy, New York state recently passed Kendra's Law,[5] an outpatient commitment statute, named after a young woman who was pushed in front of a subway train by a man with a long history of chronic mental illness. It is not unusual for a tragedy that makes national headlines to serve as a springboard for passing what would otherwise have been much more controversial legislation.

There is less appreciation for the fact that treatment for a reluctant or refusing population can be quite costly and that it involves an extraordinary degree of personnel time and raises difficult moral and ethical questions. Most states now have some form of assertive community treatment programs (ACT teams). These programs attempt to engage reluctant patients in treatment via a process of compassionate interest and a willingness to participate in routine activities, such as helping someone obtain food, housing, or disability benefits. The teams bring medication to patients' homes. This activity raises the dilemma of how far one can continue to press for health goals when a patient says he does not wish any further treatment.

Mandated outpatient treatment comes in at least two forms. The first mandates that a patient appear for treatment. If she/he does not attend as required, the police may be called, and the individual may be taken to a hospital and evaluated as to whether or not she/he meets civil commitment criteria. The second form is available in a smaller number of states that allow the use of involuntary medication for mandated outpatients.

The American Psychiatric Association has on two occasions reviewed the literature and made policy recommendations regarding outpatient treatment.[6] Their second effort, a "resource document,"[7] and commentaries thereon have been published in this issue of the Journal. This is an area that is quite difficult to study, and not many researchers have been attracted to the endeavor. It remains difficult to ascertain what added value comes from a court order mandating treatment. The need for such legislation seems driven by the political context of health care. Legislators frequently have many misconceptions and believe that the statute will prevent random violence against unsuspecting citizens. Mental health professionals need to be aware of the limited literature available and to participate in the discussions that ensue when these proposals are generated in their state legislatures.

References

1. 1788 Mass. Acts and Laws, ch. 21 (Feb. 25, 1788)
2. Dershowitz A: The origins of preventive confinement in Anglo-American law: Part II. The American experience. U Cin L Rev 43:781–846, 1974
3. Mayock v. Martin, 245 A2d 574 (Conn 1968)
4. In re Gault, 387 U.S. 1 (1967)
5. NY CLS Men Hyg § 9.60 (1999)
6. APA Task Force Report No. 26: Involuntary Commitment to Outpatient Treatment. Washington, DC: American Psychiatric Association, 1987
7. Gerbasi JB, Bonnie RJ, Binder RL: Resource document on mandatory outpatient treatment. J Am Acad Psychiatry Law 28:127–44, 2000