The Case Against Outpatient Commitment

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Among individuals with severe mental illness, a small proportion commit violent acts. Since these individuals are often not engaged in ambulatory treatment, there has been a move in the states to legislate and implement outpatient commitment programs. The American Psychiatric Association Council on Psychiatry and Law has issued a Resource Document that supports the use of mandatory outpatient treatment. The purpose of this article is to challenge the logic and legitimacy of using the courts to force treatment compliance of individuals who are neither incompetent by legal standards nor at imminent risk of harming themselves or others.

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There has been growing concern about violence among individuals with mental disorders. Both the public and the profession of psychiatry have been particularly concerned about those with psychotic symptoms who are "revolving door" patients.[1,2] These are the individuals who relapse on discharge from the hospital only to be quickly readmitted, cycling through this discharge and readmission process again and again. The seeming predictability of this pattern for certain patients has led the public and some professionals to call for more definitive action. Outpatient commitment has been offered as one strategy for addressing this problem.[3,4]

In 1987, a report was issued by the American Psychiatric Association Task Force on Involuntary Outpatient Commitment.[5] In the report, the Task Force endorsed the use of mandatory outpatient treatment under a set of specified circumstances. In this issue of the Journal, the Subcommittee on Mandatory Outpatient Treatment of the American Psychiatric Association Council on Psychiatry and Law is publishing a Resource Document on this topic.[6] The rationale of the Subcommittee for revisiting this topic was that additional research has been completed and experience gained with outpatient commitment in the decade since the 1987 Task Force report was issued. It was estimated, for example, that 40 states now have laws permitting mandatory outpatient treatment and that at least 18 states are implementing this statutory authority to some degree.[6]

There are major flaws in the logic and recommendations of the Resource Document, as well as problems with the concept of outpatient commitment in general. We outline these concerns in the first section of the article. To further elucidate these concerns, we then present the case of an individual who is in many ways typical of those targeted for outpatient commitment. We use the case to suggest that providing intensive ambulatory treatment rather than depriving patients of their rights should be our principal concern.

A Critique of the Resource Document

A Rose by Any Other Name...

Despite the fact that the published articles and state statutes pertaining to this topic almost all use the term "outpatient commitment," the Resource Document suggests that many psychiatrists would rather use other phrases in referring to this practice. An argument is made that the term "outpatient commitment" implies a level of coercion that the profession does not intend. The Subcommittee recom-

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mends the term "mandatory outpatient treatment" and argues that this practice is not an "involuntary" intervention but is "... used primarily to reinforce the patient's own resolve and [is] not imposing treatment against the patient's will."

However, outpatient treatment is being mandated precisely because it is not being accessed voluntarily. Criterion 3 in the Resource Document makes it clear that persons for whom this approach is utilized choose not to seek outpatient treatment of their own volition. If treatment is not accepted voluntarily but is mandated through the courts, then it certainly involves the commitment of patients against their will.

If we are to use the courts to deprive patients of their civil liberties, we should not obscure the fact that we are taking such action. In our society, we deprive individuals of their liberty under tightly prescribed conditions and with due process. The protection of patients' rights requires that we be clear when we are compromising those rights. This fosters vigilance that rights are compromised only when justified.

The claim that we are only "reinforcing the patient's resolve" is a form of paternalism that serves to discredit the ability of patients to think autonomously and denies their freedom to differ with professionals about what is best for them. It suggests that not only do professionals know what patients need, but they also know what patients want. In this age of consumerism in health care, it is hard to expect much sympathy for this position.

Forcing compliance with treatment deprives patients of certain rights and is an action that should be taken only in compelling circumstances. To insist that we are taking such action because the individual desires us to do so seems a pointless assault on a patient's right to think and to hold opinions. It portrays the professionals involved as unwilling to accept sole responsibility for their actions.

Overriding Competency Decisions

The law, of course, does provide an option for constraining the liberties of individuals when they are incompetent to make decisions about their welfare. The capacity of individuals with psychiatric disorders to make informed decisions is of particular concern since these disorders may impair mental functioning. However, the Resource Document departs from the recommendation of the 1987 Task Force that mandatory outpatient treatment be predicated on an individual's incapacity to make informed treatment decisions.[5]

The Resource Document recommends mandatory outpatient treatment for those patients who are unlikely to comply with "needed treatment," even if these individuals would be deemed competent in a court of law. This stance intentionally and explicitly asserts the right of the profession to override the judgment of legally competent individuals. It singles out those individuals with mental disorders and deprives them of a basic protection afforded by law to all others.

Dangerousness Versus a Need for Treatment

The Resource Document would be more sound if it suggested that commitment be based on an assessment of dangerousness to self or others. However, the position taken by the Subcommittee explicitly departs from this stance. It asserts that outpatient treatment should be mandated based on the "need for and availability of appropriate treatment to prevent substantial mental or emotional deterioration."[6]

The most defensible criterion for restricting the rights of an individual is imminent danger to self and others; this has been the traditional basis for commitment decisions throughout the country.[7] While the application of this criterion can be complex and controversial, it highlights the nature of the risk that must be present to warrant placing limitations on individuals' rights. In discarding this approach, the Subcommittee has placed in its stead an ambiguous criterion that again asserts a professional's assessment of "need" as sufficient justification for constraining another person's civil liberties. This type of standard is so vague that it raises concern that individual rights will be compromised without due cause. Its constitutionality is unclear.[8]

Only for Individuals with Mental Illness

What remains unexplained in the Resource Document is why individuals suffering from mental illness should uniquely be subjected to standards and procedures that compromise their civil liberties. It is difficult to imagine other medical specialties arguing for the authority to abridge the constitutional rights of patients who are legally competent and do not evidence imminent danger to self or others. It is also difficult to imagine other medical specialties asserting their right to mandate treatment through the courts, against the wishes of a patient, based solely on

a claim that there is a clinical "need" and appropriate and available treatments.

Citizens of this country have the right to make decisions about their health care even if, from a professional perspective, those decisions are detrimental to their health. Patients frequently decline to follow medical and professional recommendations for a host of reasons. Some of these decisions are driven by fear or misinformation. Others are based on very personal quality-of-life concerns, with patients consciously opting to trade potential long-term medical benefits for shorter-term gains such as freedom from the pain associated with aggressive medical procedures or freedom from the side effects of medications. These decisions, along with the give and take between providers and patients in the decision-making process, are an inherent part of the health-care landscape. Only in psychiatry are we trying to avoid this natural dynamic by asserting a professional responsibility to make decisions for competent individuals.

The Medication Factor

Outpatient commitment is intended for and typically applied to individuals with severe and persistent mental disorders, especially disorders of a psychotic nature. The effectiveness of antipsychotic medications in treating these disorders has been well-documented through controlled research. Antipsychotic medications are currently considered a necessary, though not sufficient, element of the treatment of schizophrenia[9] and other psychotic disorders.

In light of the essential role of medications in treating the symptoms and behaviors that are the target of mandatory outpatient treatment, it seems inconsistent that the Subcommittee chose to take no stand on the issue of forced medication. Concern that providers and patient advocates would oppose physically forced medications was noted as a reason that the 1987 Task Force recommended that medications not be forced, and may have been a concern for the Subcommittee as well.[6] Nonetheless, the Subcommittee's stance on medications is fraught with difficulty.

In the current Resource Document, it is pointed out that individuals who are noncompliant with medications could be taken involuntarily to a treatment facility for evaluation. It is argued that the prospect of being forced to a facility repeatedly until one took medications would lead most individuals to become medication-compliant. Thus, the essential strategy being suggested is to hassle individuals within the limits of the law to achieve compliance with medications that cannot be forcibly administered by law. While the ultimate goal might be admirable, the means to achieve the desired end should be viewed as unacceptable. It devalues the individuals being served and undermines the physician-patient relationship.

This approach is reminiscent of some assertive community treatment (ACT) teams that have employed "in your face" tactics to pressure patients to comply with treatment and prescribed medications.[10] Some teams have moved from assertive to aggressive approaches. For example, the assertive concept of not allowing patients to fire providers can reflect the providers' persistence and commitment to help patients. On the other hand, it can be taken to the aggressive extreme in which providers repeatedly ignore the stated wishes of legally competent individuals, intruding into their lives and refusing to negotiate the terms and conditions of treatment.

Even more troubling regarding the Resource Document is the suggestion that, although forced medication compliance may not be permitted under a state's outpatient commitment statute, most patients probably believe that forced administration is permitted.[11] The implication is that patients are likely to comply with prescribed medications because they mistakenly believe that the medications might otherwise be forced. A strategy that relies on patient misinformation to foster its success violates ethics principles, the integrity of the physician-patient relationship, and the notion of informed consent. The profession has an obligation to educate patients subject to mandated outpatient treatment about the scope and limits of the mandate. To do otherwise is to employ deception of individuals under the guise of attempting to promote their health and welfare.

The Unknown Effects of Judicial Orders

All other considerations aside, the fatal flaw in the Resource Document is its conclusion that the available research evidence on mandated outpatient treatment supports and warrants its use. There does appear to be a significant correlation between the use of mandated outpatient treatment and increased community tenure.[12, 13] As the Subcommittee acknowledged, however, the positive effects may be entirely due to the enhanced services available to committed

patients rather than due to the independent effects of the judicial order.

The Subcommittee has argued that conducting research to determine whether judicial orders have effects independent of the enhanced services would be a "daunting empirical task" and that the use of mandatory outpatient treatment need not await the outcome of such studies. This stance might be justified if we were debating whether to offer patients additional services. However, we are debating the merits of depriving individuals of their rights and liberties.

The very real possibility exists that society, through its mental health systems, has been offering inadequate behavioral health services to those most in need and that we are using mandated outpatient treatment as a mechanism for ensuring adequate service provision to selected individuals. The notion that the profession would resort to depriving patients of their rights to ensure that they receive adequate services is misguided and does grave injustice to those we are to treat. By supporting this position, the Subcommittee is continuing to foster the bias and second-class citizenship that has for far too long been the bane of individuals suffering from mental illness.

One argument offered in the Resource Document in support of mandatory outpatient treatment is that it "commits" providers and legislators to meeting the needs of these patients. Research on the provision of ACT in managed systems of care has produced further evidence that our treatment systems for individuals with severe mental illness remain seriously underfunded.[14] While we have proven treatments,[15–17] we have inadequate resources to offer these treatments to all those in need.[18] Our energies should be directed to working with legislators to ensure that effective treatments are available to those individuals deemed appropriate for the treatment.

Finally, the principle of providing the "least restrictive" treatment alternative has a long tradition in the field of behavioral health and has been addressed in many state statutes.[19, 20] Individuals suffering from mental disorders should first receive intensive treatments without the imposition of a judicial order mandating compliance. This will allow a determination as to whether this less restrictive approach is sufficient. Legal mandates for treatment, if they are to be used, should not occur until appropriate treatments have been provided on a voluntary basis and have been shown to be ineffective.

The Case

Personal History

Eric was a 38-year-old man who dressed in a "punk" style with black garments, multiple earrings, heavy dark make-up, and spiked hair. His psychiatric history dated back to his early teens when he was first hospitalized because of psychotic symptoms and suicidal intent. Over the ensuing 25 years he was diagnosed with numerous disorders, most often some form of schizophrenia. In addition to psychosis, he suffered from symptoms of paranoia, depression, and fairly severe emotional lability.

For the decade after the initial onset of his symptoms, Eric was hospitalized repeatedly and, in fact, spent the majority of these years in private and public psychiatric institutions. Since that time, hospitalizations have been intermittent, although not infrequent. Between hospitalizations, he made sporadic use of the ambulatory services offered through a community mental health center, which included office-based supportive treatment and pharmacotherapy. While his clinical response to medications was generally quite positive, his compliance as an outpatient with prescribed medications was poor.

Eric's interpersonal skills were not well-developed and his social relationships were few in number and short in duration. He was arrested, at least several times, on charges of assault and threatening, with the aggression directed at family, friends, and strangers. The legal consequences of these acts were minimal.

Despite the severity of his illness, Eric had been living alone for the previous 15 years, demonstrating considerable resourcefulness in handling the activities of daily living. He resided in a quiet residential urban area in an apartment building occupied principally by young families and retirees. Conflicts with neighbors had been increasingly frequent, but had not jeopardized his living situation until an incident occurred that is described below.

The Incident

Eric became suspicious of a young man residing in a nearby apartment and assaulted him with his fists one afternoon in the courtyard of the building. The victim's injuries were significant, but not severe. Another neighbor witnessed the attack and called the police. Eric was arrested on an assault charge but was transported directly to a local emergency room as he

was known by the police to have psychiatric problems and was exhibiting psychotic symptoms.

Eric was sent to the inpatient unit of the community mental health center for evaluation under an emergency certificate issued by the psychiatrist in the emergency room. The assault served as a catalyst for the residents of his apartment who began an organized campaign of calling the landlord, the administrators of the mental health center, and state and local legislators. The objectives of this campaign were to have Eric either hospitalized or incarcerated on a long-term basis. Failing that, the neighbors wanted to ensure that he was evicted from his apartment and forced to accept outpatient treatment.

The campaign came to a head when the neighbors organized a courtyard rally to galvanize support to block Eric's discharge and return. Representatives of the police department and the mental health center attended this meeting. As the police began to gather information from residents about past conflicts with Eric, it became clear that some had felt terrorized by him. However, others viewed him kindly and described how helpful he had been to them. These differences of opinion soon turned into arguments between residents.

The state and local legislators became quite active in the case, pressing the administrators of the mental health center to "resolve" the situation. They volunteered to come up with additional funds to treat this patient if such funds would "take care of the problem." They too were interested in the mental health center controlling Eric's behavior and forcing his compliance with outpatient treatment, although the state had no outpatient commitment law.

Eric was found incompetent to stand trial and was transferred to an inpatient unit where, through psychiatric treatment and education about the legal system, he was soon restored to competency. In the legal process, Eric was represented by a public defender who focused solely on his responsibility to get the lightest possible sentence for Eric. The public defender was successful in getting the sentence reduced to probation, although the judge stipulated that Eric must move out of the neighborhood and comply with treatment.

The mental health center increased the intensity of the outpatient treatment, transferring the case to a clinician and a case manager, who were more flexible and willing to conduct outreach and home visits with Eric. However, ACT was either not available or not offered. The staff helped Eric relocate, and he remained stable for a brief period. However, his acceptance of treatment and compliance with medications continued to be sporadic. He was subsequently rearrested on multiple occasions for making threatening calls to his old neighbors. Each time that he appeared in court the charges were dropped or his probation time was extended.

Analysis

This case represents the all too common scenario in which an individual with a severe mental disorder and a history of violence is not actively engaged in psychiatric treatment and then violates the law due to the uncontrolled illness. Many would argue that it is precisely this type of patient that demonstrates the need for outpatient commitment statutes in the states. To the contrary, we suggest that this case demonstrates the need for the provision of appropriate psychiatric care.

In retrospect, it is rather remarkable that Eric functioned independently in the community and remained out of serious trouble for so long, given that little was offered to him in terms of psychiatric services. The treatment approach used by the mental health center prior to the incident was traditional and office-based. Eric was offered appointments at the center, but there was little follow-up if he did not keep his appointments. Outreach was not conducted as a tool for engagement, and it left his clinician blind to Eric's worsening condition, a fact that would have been evident from one glance at the apartment where he had scattered flour on the floor to detect footprints of intruders.

Even without an outpatient commitment statute, legal mechanisms existed for committing Eric to an inpatient facility when he posed an imminent risk to himself or others. Such mechanisms were used by emergency room personnel immediately after the incident. They would have been available to outpatient personnel before the incident had they been in contact with Eric and aware of his deteriorating clinical status. The failure to provide ACT and to use existing legal mechanisms for commitment were, in all likelihood, contributing factors to the unfortunate sequence of events in this case. In light of those events, the neighbors and legislators clamored for confinement, forced outpatient treatment, and forced medications.

The legislators' interest in this case presented a

missed opportunity for providers to educate legislators about the need to fund adequate services for all such patients. Legislators who evidenced little interest in mental health funding during budget sessions showed considerable interest in funding for this patient in response to the public outrage. This was a true opportunity to work on gaining the "commitment" of legislators.

Finally, it is important to note that the judge in this case, as part of the sentencing process, stipulated that Eric should comply with outpatient treatment as a condition of his probation. This scenario is repeated across the country on a daily basis. However, such mandates are seldom accompanied by the provision of the intensive ambulatory services envisioned by the Subcommittee that produced the Resource Document.

In a sense, these instances provide a natural experiment in which to examine the effects of a judicial order without an augmentation of services. From our observation, the effects of an order alone, unaccompanied by intensive treatment and outreach, are typically minimal. We have considerable evidence that ACT approaches are effective. We have little evidence, experimental or anecdotal, that judicial orders depriving outpatients of their rights produce positive treatment outcomes. In the absence of such evidence, we must protect patients' rights, not eviscerate them. Eric needed treatment, not a cumbersome legal intervention.

Conclusion

The Subcommittee on Mandatory Outpatient Commitment has made a well-intentioned effort to address a complex problem. It is wrenching for professionals and for society at large to be able to predict with some accuracy certain risks to health and safety, and yet be unable to prevent their occurrence. We should be motivated to address this problem. However, the evidence suggests that our efforts should be focused on providing assertive or intensive ambulatory treatments to those in need, rather than seeking to limit the rights of patients who are neither incompetent nor would qualify for inpatient commitment in a court of law. While as professionals we may believe that we know what is best for our patients, the most challenging part of professional responsibility may be refraining from the violation of patient liberties to achieve the desired ends.

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