

Virtual Mentor

American Medical Association Journal of Ethics
January 2009, Volume 11, Number 1: 6-12.

CLINICAL CASE

Outpatient Commitment: A Treatment Tool for the Mentally Ill?

Commentary by Scott C. Fears, MD, PhD, and Ann Hackman, MD

Dr. Jacobson, a psychiatrist working at an outpatient clinic in Cleveland, was waiting for his next patient, Mr. Miller, an Army veteran who had been living in a homeless shelter. Mr. Miller had been diagnosed with paranoid schizophrenia 10 years earlier following sporadic hallucinations and delusions that alienated him from friends and family. He had tried to cope with his illness by smoking marijuana and, for a time, became addicted to cocaine. On several occasions, he had become verbally assaultive and threatened strangers, prompting brief periods of incarceration. As part of his court-ordered release, Mr. Miller was required to participate in “outpatient commitment”—an arrangement that required him to attend weekly therapy sessions and self-help groups and submit to a supervised medication regimen.

Twenty minutes passed before Mr. Miller arrived at his therapy session and blamed the clinic office staff for his delay. Dr. Jacobson was weary of the excuse; Mr. Miller had used it before, and it had always turned out to be false. Furthermore, Dr. Jacobson sensed that Mr. Miller had become more anxious and irritated during sessions, but he was not sure why. Outpatient commitment had worked for Mr. Miller for several months, but Dr. Jacobson was uncertain about the best way to handle Mr. Miller’s change in behavior. If he reported Mr. Miller’s behavior, he jeopardized their therapeutic relationship. Nevertheless, Mr. Miller’s noncompliance was harmful to himself and possibly others. Dr. Jacobson asked himself whether his decision making would differ if Mr. Miller were not homeless.

Commentary 1

by Scott C. Fears, MD

In an ideal world, no patient would be coerced into treatment. It may be even more important to strive for this ideal in the field of psychiatry where self-motivation is a necessary prerequisite for meaningful change. There are cases, however, in which a physician must intervene despite a patient’s opposition. Traditionally, psychiatrists have used involuntary inpatient commitment as an intervention to address acute, life-threatening situations. More recently, outpatient-commitment laws have been developed as interventions for less-acute situations. These laws were initially proposed in the late 1980s to manage “revolving-door” patients who received periodic inpatient treatment but often relapsed because they did not become engaged in outpatient maintenance.

Outpatient-commitment laws were later expanded in part because of societal fears that individuals with mental illness were violent and uncontrollable. Kendra's Law in New York and Laura's Law in California are examples of legislation influenced by murders committed by mentally ill patients who refused or avoided treatment. In contrast to these motivations, families have advocated for outpatient commitment out of concern for the safety and quality of life of their mentally ill relatives who reject treatment because of their psychiatric symptoms. For physicians, outpatient commitment raises the complicated issue of paternalism and potential conflicts between societal and patient interests. In this commentary I argue that, despite the potential problems associated with outpatient commitment, it is an intervention that, when used with compassion and respect for the patient's dignity, can greatly improve his or her quality of life.

Establishing a Patient-Physician Relationship

Mr. Miller is a patient with whom it is difficult to establish a therapeutic relationship. He has significant paranoia, thought disorder, and impaired judgment. Furthermore, his experience with the legal system has most likely left him with an aversion for institutional authority figures, including, in this case, Dr. Jacobson. Therefore, Dr. Jacobson is in a double predicament; Mr. Miller is unlikely to engage in voluntary treatment, and the coercive nature of outpatient commitment is a major barrier to establishing a therapeutic relationship. Specifically, coercive treatment is likely to aggravate Mr. Miller's paranoia and inhibit the development of a trusting therapeutic bond. Dr. Jacobson must work to make the empathic nature of the relationship apparent, while unambiguously communicating the requirements of the situation.

The situation can create inner tension in Mr. Miller; he will have to accept Dr. Jacobson as both an authoritarian representative of the court (which will lead to anxiety) and an empathic healer who is trying to provide help (which will lead to hope). In nonpsychotic patients with better coping skills than Mr. Miller's, similar feelings of ambivalence often result in treatment noncompliance (lateness for therapy appointments, skipping medications, etc.). It is unreasonable to expect a psychotic patient to be able to follow a regular treatment schedule without exception. Furthermore, Mr. Miller's recent behavior is not surprising and may represent a normal phase of treatment.

Motivating Treatment

Unfortunately, Mr. Miller is at high risk for discontinuing treatment, and it is essential that Dr. Jacobson address two issues. First, he must determine why Mr. Miller is becoming more irritable and anxious. It could be a symptom of worsening depression or psychosis or a relapse to cocaine use—conditions that might require medication changes. As alluded to above, however, these symptoms might also be a consequence of Mr. Miller's struggle to establish trusting relationships with his therapist and self-help groups. Dr. Jacobson's second important task, then, is to convince Mr. Miller that, regardless of the underlying cause of his increased anxiety, the possible consequences of his behavior are severe. If he is brought before the court he risks a return to jail. Here, the court can be used as a third-person authority

to substitute for the patient's impaired ability to make good decisions. For example, Dr. Jacobson may frame the treatment goal as, "How do we keep you out of jail?" The approach establishes an alliance with Mr. Miller by providing a concrete goal to motivate treatment. It also has the advantage of focusing on an element of reality that both the doctor and patient agree is important. Mr. Miller may not agree that stable housing, reduction of psychotic symptoms, or decreased cocaine use are important goals, but he is likely to be motivated by avoiding incarceration.

Improving Compliance

Dr. Jacobson must decide whether to report Mr. Miller's recent behavior to the court. In my opinion, he should not report him at this point. In the absence of dangerous behavior, treatment should focus on strengthening the therapeutic alliance. Mr. Miller's inability to conform to structured systems, such as those imposed by employment and social relationships, is a fundamental aspect of his disorder and will always be a factor in his treatment. Rewards like food vouchers, clothing, bus tokens, and hygiene products are much more likely to improve compliance than are punitive measures. If down the line Dr. Jacobson becomes concerned about worsening psychotic symptoms that could lead to potentially aggressive behavior, then inpatient hospitalization is the appropriate decision because it will provide an opportunity to directly treat the underlying condition.

In sum, outpatient commitment creates potentially difficult therapeutic situations. With a patient like Mr. Miller, however, whose psychiatric disorder has led to recurrent social and legal problems, it can be argued that outpatient commitment is the only tool that will afford the opportunity for psychiatric treatment. In the absence of coercion, Mr. Miller will not adhere to treatment, and without it he will continue to have social and legal problems.

Many aspects of Mr. Miller's behavior will be difficult to understand, and those who treat him must be careful to avoid paternalistic assumptions regarding some aspects of his current situation. For example, some individuals choose to be homeless even when provided safe, individual housing. Therefore, the treating team must recognize Mr. Miller's impaired judgment but respect his right to self-determination. Certain aspects of his behavior, however, require clinical attention. Mr. Miller's paranoia and verbally aggressive behavior, for example, should be interpreted as the result of depression, fear, and anxiety. Ultimately, the goal of his treatment should be to relieve the symptoms that often remain unarticulated in patients like Mr. Miller. By using his mental well-being as the frame for treatment and recognizing his need for dignity, outpatient commitment is an intervention that can achieve therapeutic goals.

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Network, a nonprofit organization with a mission to establish long-term housing, social services, and mental health care to homeless individuals in Los Angeles.

Commentary 2

by Ann Hackman, MD

Outpatient commitment is a mechanism used in nearly 40 states that requires people to be adherent with mental health treatment. In our case, Dr. Jacobson's dilemma is representative of many of the problems associated with outpatient commitment that make this intervention a poor solution for individuals like his patient, Mr. Miller. For example, although Mr. Miller had appeared more anxious and irritated during sessions, he had not exhibited psychotic symptoms or seemed threatening or assaultive. He had not relapsed in either cocaine or marijuana use and had been taking his prescribed medications. He was adherent with all aspects of treatment except for getting to appointments on time.

Since the start of his outpatient commitment Mr. Miller had not been charged with a crime. There is only the slightest indication of exacerbation of psychiatric symptoms, and clearly Mr. Miller would not meet criteria for inpatient civil commitment (which typically requires that a person be gravely disabled or dangerous to self or others). Yet under the conditions of outpatient commitment, Dr. Jacobson could report Mr. Miller's repeated lateness for appointments and his fabricated excuse. These conditions would most likely result in the issuance of a hospital warrant, the police handcuffing Mr. Miller, taking him into custody, and an involuntarily hospitalization, possibly for an extended period.

Although the details of this case suggest that the requirement that Mr. Miller participate in treatment may be related to prior criminal charges, outpatient commitment is typically the result of a civil action rather than a criminal one. Outpatient civil commitment allows a person diagnosed with mental illness to be mandated to treatment on the basis of his or her potential dangerousness. It is usually applied to individuals who do not have guardians and who have been deemed by the court to be incompetent to make their own decisions. When the individual fails to comply with treatment requirements (e.g., keeping appointments, taking medications, attending programs, or living in a location designated by the court), he or she may be taken into police custody and confined to an inpatient psychiatric facility.

Those under outpatient commitment need not break the law or display dangerousness or grave disability to be committed involuntarily to inpatient hospitalization. In some states, outpatient civil commitment can be extended repeatedly for periods of up to 6 months without clear criteria for discontinuing the order [1]. Some proponents of outpatient civil commitment argue that it should be applied to anyone with a serious mental illness who lacks insight into that illness and is at risk for becoming homeless, incarcerated, or committing acts of violence including suicide [2].

Perhaps the most significant ethical concern with outpatient civil commitment is the violation of autonomy and civil rights based on the possibility of future dangerousness. Many consumer groups, some mental health professionals, civil-liberties groups, and the Bazelon Center for Mental Health Law oppose outpatient civil commitment on the premise that a person who is competent and not currently dangerous has the right to determine the course of his or her treatment [1]. Despite the fact that a majority of states have laws allowing outpatient commitment, a thoughtful consideration of the issue by Allen and Smith indicates that Supreme Court rulings including *O'Connor v. Donaldson* and *Addington v. Texas* seem to argue that it is unconstitutional [1, 3-5]. Outpatient civil commitment appears not only to violate the rights of a competent, nondangerous person to refuse treatment but may also violate such constitutional rights as the rights to travel, privacy, freedom from restraint, and free communication of ideas [6].

Proponents of outpatient commitment state that individuals with mental illness often have impaired insight, which justifies use of the commitment as a mechanism for enhancing compliance [2]. This viewpoint dismisses the very real problems and side effects associated with psychiatric medication. Proponents also point to evidence that outpatient civil commitment improves outcomes and decreases violence and hospitalizations [7, 8]. The same may be true, however, of adequate, *unforced* treatment programs. One study indicated that outpatient commitment was no more effective than enhanced and coordinated services in reducing risk of violence and arrest [9].

Too often outpatient civil commitment is a response to an inadequate mental health system. There is every reason to believe that Mr. Miller, who has engaged with treatment, will benefit from it. For example, he might receive Assertive Community Treatment (ACT), an evidence-based program of extensive care-management services. Instead, Mr. Miller is subjected to outpatient commitment and the requirement that he comply with all treatment expectations. It is no surprise that he is having difficulty or that more than two-thirds of people who are homeless and have mental illness struggle with adherence, particularly medication adherence [10]. Mr. Miller is staying in a shelter and is not likely to have a safe place to keep his medications or means to follow instructions (such as take after meals or with water). He almost surely lacks a calendar to help him keep track of appointments or family or friends to facilitate his being punctual.

Considering these circumstances, how could Mr. Miller be expected to meet all of the conditions of his outpatient civil commitment? Further, outpatient civil commitment may sabotage the ability of mental health professionals to build a therapeutic relationship with Mr. Miller. This may be particularly true if he is forced to take medications that cause substantial side effects, such as sedation, which, while mildly problematic for a person who is not homeless, is difficult to manage for someone who is.

My opposition to outpatient civil commitment is not a rejection of all forms of forced treatment. If Mr. Miller were currently dangerous—making threats, harming or trying to harm himself or someone else—or impaired enough that he could not care for his own basic needs, emergency involuntary hospitalization might be in order. If he had co-occurring dementia or otherwise lacked the capacity to make decisions for himself, he could appropriately be found incompetent by a court and have a guardian appointed to make decisions for him. If he committed a crime he might plead guilty and, in lieu of jail time, agree to treatment as a part of his probation. Or he might commit a crime, agree to plead not guilty by reason of insanity (or not criminally responsible), and, if the court made such a finding, have extensive treatment expectations as part of a conditional release.

Absent of any of these circumstances, however, I hope that even the most adamant proponent of outpatient commitment would not report Mr. Miller for being 20 minutes late to his appointment—with the potential consequence of involuntary hospitalization—regardless of his unsubstantiated excuse. Individuals who are mentally ill experience significant barriers to care [11]; for those who are homeless these barriers seem almost insurmountable. When getting up and dressed and taking public transportation to an appointment are compounded by homelessness, not to mention mental illness, how can Mr. Miller be expected to be fully adherent with treatment? Not considered here are medication side effects—possibly sedation, tremor or other abnormal movements, and increased appetite—that can cause even more distress for a person on the streets than for a domiciled person.

What would probably serve Mr. Miller better than outpatient commitment would be assistance in finding a safe place to stay, perhaps at a Safe Haven (a HUD-funded, transitional-housing program for people with mental illness who are homeless and engaging in treatment). There he could receive two meals each day and have access to toilet, shower, and laundry facilities. His medications would not be administered, but they would be monitored. One expectation for Safe Haven residents is that they work with a mobile treatment team, such as ACT, in return for case-management services, assistance with obtaining entitlements such as Supplemental Security Income (SSI), medical assistance, and medication coverage. If Mr. Miller did not attend a scheduled meeting, the team would come to him, and he might easily be persuaded to take medications and adhere to treatment.

Outpatient commitment may in some instances be seen as a short-term solution to a long-term problem, but it constitutes an unacceptable violation of the rights of competent and nondangerous people with mental illness. There are other effective mechanisms for engaging people like Mr. Miller without violating his autonomy and civil rights.

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