

Pro/Con: Outpatient Commitment for the Severely Mentally Ill

Some psychiatrists feel that outpatient commitment has a legitimate role in treating mentally ill individuals, especially those who are not even aware of their disease.

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Many communities struggle with how to care for people with severe mental illness, a population often poorly served by existing mental health services [1]. The problem gained public attention following several high-profile crimes committed by persons with mental disorders, like the case of a schizophrenic man who pushed a woman, Kendra Webdale, to her death before a New York subway train in 1999 [2]. New York soon responded with Kendra's Law, which established procedures for outpatient commitment of some mentally ill persons [3]. Legislatures nationwide soon followed suit, and virtually every state now has similar provisions; yet, disagreement continues over the ethics and efficacy of the practice [1].

Outpatient commitment involves a court order requiring a patient to follow a treatment plan [4,5]. The treatment plan may include participation in self-help groups, psychotherapy, medication and may require supervised living, and urine or blood tests. Noncompliance may result in inpatient commitment or forced compliance [4]. In March 2001, *Psychiatric Services* devoted a section to the subject of outpatient commitment. Authors E. Fuller Torrey and Mary Zdanowicz argue that outpatient commitment has a legitimate role in the treatment of severely mentally ill individuals, who may lack an awareness of their disease. Michael Allen and Vicki Fox Smith raise concerns about outpatient commitment's effectiveness, legality, and long-term effect on the delivery of voluntary health services.

Torrey EF, Zdanowicz M. Outpatient commitment: what, why, and for whom. *Psychiatric Services*. 2001;52:337-341.

Torrey and Zdanowicz argue that the current voluntary mental health system cannot appropriately care for severely mentally ill patients. They assert that many people with schizophrenia and bipolar disorder are cognitively impaired and lack the ability to make decisions about their treatment [4]. Consequently, those patients often fail to comply with physicians' orders, endangering themselves and the public. Numerous studies show that severely mentally ill people who are noncompliant face significantly greater risks of homelessness, suicide, violent behavior, and incarceration [4]. Those risks, the authors argue, justify coerced treatment.

Torrey and Zdanowicz recommend outpatient commitment for anyone with a severe psychiatric disorder "who has impaired awareness of his or her illness and is at risk of becoming homeless, incarcerated, or violent or committing suicide" [6]. It would constitute another form of assisted treatment, alongside advance directives and assertive case management, and would not replace inpatient commitment for truly dangerous people. The authors estimate that 100,000 people in the United States might qualify for outpatient commitment [4].

- **Efficacy.** Torrey and Zdanowicz point to evidence that outpatient commitment at least doubles rates of treatment compliance and can reduce the need for hospital admissions by 60-80 percent [4]. One study found

that extended outpatient commitment halved the probability of violent behavior [7]. The authors note that in all of these studies outpatient commitment "had to be combined with available and adequate outpatient services" [8].

- **Competence.** Like Alzheimer's disease and cerebrovascular accidents, schizophrenia and bipolar disorder affect the prefrontal cortex, an area essential to insight and understanding [4]. These deficits often cannot be remedied with medication. Torrey and Zdanowicz argue that many people with severe mental illness may lack the self-awareness to understand and follow treatment recommendations. For these individuals outpatient commitment may be the appropriate solution, the authors contend.
- **Patient-Physician Relationship.** Some argue that coerced treatment may damage the patient-physician relationship and make it less likely that the patient will continue to seek treatment. Torrey and Zdanowicz present studies showing that most people with severe mental illness who are coerced into treatment agree with the decision in retrospect [9,10]. Seventy-one percent of patients in one survey agreed with the statement, "If I become ill again and require medication, I believe it should be given to me even if I don't want it at the time" [11].
- **Civil Liberties.** Perhaps Torrey and Zdanowicz's most contentious claim is that mental illness itself may constitute a biological deprivation of liberty. Rather than restricting a patient's free will, they suggest that outpatient commitment actually enables it. They note that delusions and hallucinations often influence the thoughts and actions of mentally ill people and that outpatient commitment may help these patients think rationally again [4]. The authors further make the case for outpatient commitment as a tool to protect the public by comparing it to the accepted practice of involuntary hospitalization of patients with communicable diseases like tuberculosis [4].

Allen M, Smith VF. Opening Pandora's box: the practical and legal dangers of involuntary commitment. *Psychiatric Services*. 2001;52:342-346.

Allen and Smith dispute Torrey and Zdanowicz's essential claim that outpatient commitment has benefits over existing mental health services. Furthermore, they argue that it poses significant risks to patient autonomy and individual civil liberties and may erode trust in the patient-physician relationship.

- **Efficacy.** Allen and Smith question the conclusions of the studies cited by Torrey and Zdanowicz since few of them were controlled. They point to a controlled study from New York's Bellevue outpatient center, published in the same issue of *Psychiatric Services*, that showed outpatient commitment was no more beneficial than enhanced voluntary services [12]. Although a few studies show benefits to long-term outpatient commitment when matched with high-intensity community services, the authors suggest caution in the absence of definitive evidence.
- **Competence.** Outpatient commitment "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," Allen and Smith write [13]. Yet, mental illness does not necessarily preclude the ability to determine one's own treatment, they argue, a right protected by law. The authors point out that by law an adult is presumed to have the capability to make his or her own medical decisions and suggest that this right should not be violated in the absence of a compelling state interest [5].
- **Patient-Physician Relationship.** Outpatient commitment threatens the provision of voluntary mental health services for the mentally ill by undermining the trust-based "treatment alliance" between patient and professional, the authors write [5]. While patients may be compliant during the course of an outpatient commitment, the right to refuse treatment is essential to a patient's participation in ongoing treatment, the authors assert. When outpatient commitment ends, patients may be wary of future treatment [5].
- **Civil Liberties.** Although the courts set strict limits on the use of coerced treatment, many states allow for the extension of the treatment for long periods without explicit criteria for stopping the treatment [5]. In nonemergency cases, courts generally require a person to be found both incompetent and a danger to herself or others before imposing mental health treatments [5]. Dangerousness can be especially difficult to prove, the authors argue. Courts have generally found it unacceptable to restrain someone on the possibility that he or she might become dangerous at some future time, and forced medication is generally only permitted in emergencies [5]. The same legal standard would likely extend to outpatient commitment, the authors assert. If a patient is

truly dangerous, the person ought to be hospitalized; otherwise, forced treatment infringes on the civil liberties of the patient.

Conclusion

The authors' views on outpatient commitment are illuminated by their responses to the case of Russell Weston, a severely mentally ill man who shot and killed 2 guards at the US Capitol in 1998. Although he had trouble with noncompliance, Weston repeatedly sought treatment but was turned away.

Torrey and Zdanowicz argue that this case demonstrates the dangers of untreated illness and the need for outpatient commitment. They view the primary problem as noncompliance born of clouded thinking, regardless of the availability of voluntary mental health services [4].

Allen and Smith argue that the Weston case points to the need for improved voluntary mental health services [5]. Had they been available, services such as peer outreach could have addressed Weston's problems. It is likely that Weston would not have been a candidate for outpatient commitment in any case because he sought voluntary treatment, Allen and Smith write.

Among the unanswered questions in this debate is whether the few severely mentally ill people who are both incompetent and dangerous are better served by enhanced voluntary treatment or outpatient commitment. This question will likely be answered against the backdrop of another unsettled debate running through both articles over the relative costs of outpatient commitment and enhanced voluntary treatment.

Discussion Questions

1. How dangerous is "too dangerous" for a severely mentally ill person to be left unsupervised?
2. Some argue that outpatient commitment is a poor substitute for more comprehensive mental health services. Would outpatient commitment be useful under any circumstances if more expensive, enhanced, but currently unavailable mental health services were shown to be as effective?
3. How do the uncontrolled studies cited by Torrey and Zdanowicz and the controlled studies cited by Allen and Smith reflect their respective views on outpatient commitment versus enhanced voluntary mental health services for severely mentally ill people?
4. Is a risk of homelessness sufficient for outpatient commitment, as Torrey and Zdanowicz suggest?

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