

Perspectives on Outpatient Commitment

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INTRODUCTION

In the fall of 2013, Representative Tim Murphy of Pennsylvania introduced comprehensive legislation to reform the federal framework that shapes the delivery of mental health care throughout the United States.¹ Murphy, a clinical psychologist, had been charged by the Republican leadership in the House of Representatives with developing a legislative response to the highly publicized mass school shooting that had taken place in Newtown, Connecticut.² The Murphy Bill was fashioned to reform a number of existing policies and practices, including the Medicaid reimbursement rules for inpatient psychiatric care, the funding requirements for community-based behavioral health services, and the health privacy rules that restrict the communication of patient information to family members and other caregivers of adult psychiatric patients.³ In addition, the bill proposed a system for linking primary care physicians with mental health professionals in order to provide behavioral health services to rural and other difficult to reach patients.⁴ Among the various

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¹ See Helping Families in Mental Health Crisis Act of 2013, H.R. 3717, 113th Cong. (2013).

² See Benedict Carey, *Mental Health Groups Split on Bill to Overhaul Care*, N.Y. TIMES (Apr. 2, 2014), <http://www.nytimes.com/2014/04/03/health/mental-health-groups-split-on-bill-to-revamp-care.html> [hereinafter Carey, *Mental Health Groups Split*].

³ H.R. 3717, *supra* note 1, §§ 201–301; see also 160 CONG. REC. 4, 26 (2014) [hereinafter 160 CONG. REC.].

⁴ H.R. 3717, *supra* note 1, § 201(c)(2); Carey, *Mental Health Groups Split*, *supra* note 2; see 160 CONG. REC., *supra* note 3, at 26–27.

proposals, perhaps the most controversial was a provision designed to encourage the states to make greater use of outpatient civil commitment.⁵

The Murphy Bill was a complex amalgam of proposed policies intended, on the one hand, to serve the government's *parens patriae* interest in promoting the well-being of individuals with mental illness and, on the other, with advancing its police power interest in public safety. The title of the bill, "The Helping Families in Mental Health Crisis Act," and the rhetoric surrounding its introduction, suggest that the various reforms proposed in the bill were designed primarily to assist the families of severely mentally ill patients to access needed services, facilitate the involvement of those families in the treatment of their loved ones, and encourage the retention of treatment-resistant chronic mentally ill patients in clinical settings in the community to ensure their compliance with medication regimens in order to avoid the more severe consequences of decompensation and hospitalization that often result from inadequate treatment.⁶ At the same time, the origins of the bill in the Newtown shootings and its emphasis on enforced treatment signal a primary concern with the police power goal of preventing the violent anti-social behavior that may result from severe mental illness.⁷

Representative Murphy's bill summary reflects this dual focus. While acknowledging that "[t]he mentally ill are no more violent than anyone else, and in fact are more likely to be the victims of violence than the perpetrators," Murphy also asserted that "individuals with untreated serious mental illness are at an increased risk of violent behavior," and presumably would pose less of a risk to the community if the enforced treatment provisions of the bill were enacted.⁸

Given the Murphy Bill's express critique of much within the existing public mental health system and its announced intention to reform that system, the inclusion of both *parens patriae* and police powers objectives in the bill is significant. In some respects, this approach appears to draw from a familiar critical narrative of mental health policy in the United States that has been pressed by a number of commentators for some time. This narrative asserts that the failure of mental health law and policy has been

⁵ See Carey, *Mental Health Groups Split*, *supra* note 2. Outpatient commitment "is a civil court procedure whereby a judge can order a noncompliant mentally ill patient to adhere to needed treatment." Marvin S. Swartz & Jeffrey W. Swanson, *Outpatient Commitment: When it Improves Patient Outcomes*, WESTLAW PSYCHIATRY, Apr. 2008, at 25.

⁶ See generally TIM MURPHY, THE HELPING FAMILIES IN MENTAL HEALTH CRISIS ACT, H.R. DOC. NO. 3717, available at <http://murphy.house.gov/uploads/Four-page%20Summary%20Helping%20Families%20in%20MH%20Crisis%20Act.Apr.2014.pdf> (last visited Feb. 5, 2015).

⁷ See Carey, *Mental Health Groups Split*, *supra* note 2.

⁸ MURPHY, *supra* note 6, at 1.

due in large part to the decision of reformers, courts, and legislatures in the 1970s and 1980s to reject the *parens patriae* foundations of longstanding mental health practice and policy, and to focus instead on the state's police power interest in preventing dangerous conduct.⁹ Representative Murphy and his allies seek to retain—indeed strengthen—the states' policy focus on preventing dangerous conduct on the part of the severely mentally ill, while simultaneously reinvigorating a more paternalistic—indeed coercively paternalistic—government practice rooted in the states' *parens patriae* interests in the health and well-being of persons with mental illness and their families.

In the House of Representatives, the Murphy Bill was met by an alternative set of proposals that were developed by Arizona Representative Ron Barber and supported by the Democratic leadership in Congress.¹⁰ The Barber alternative sought to increase funding for community-based treatment, but did not include provisions to encourage the use of outpatient commitment or other forms of enforced community-based care.¹¹ Critics of the Murphy Bill, including a number of prominent professional groups and other civil rights organizations concerned with the rights of mentally disabled persons, argued that an increased focus on enforced treatment would likely drive individuals with mental illness away from treatment.¹² The critics' preference for voluntary treatment and increased community-located resources, including intensive case management services, assisted housing, and other wraparound resources, was reflected in the Barber alternative.¹³

Part I of this Article provides a brief history of the law governing involuntary civil commitment in the United States, with a particular focus on the reforms of the 1970s that moved the system away from its *parens patriae* foundations and toward a much greater reliance on a police power rationale for involuntary confinement. It also explores the perspective that informed these libertarian reforms and a competing perspective that has emerged in the recent discussions over outpatient commitment. Part II reviews the variety of approaches adopted by states for authorizing outpatient commitment, either as a front-end intervention or as a step

⁹ See, e.g., Rael Jean Isaac & Samuel Jan Brakel, *Subverting Good Intentions: A Brief History of Mental Health Law "Reform,"* 2 CORNELL J.L. & PUB. POL'Y 89, 99, 103, 108 (1992).

¹⁰ See Strengthening Mental Health in Our Communities Act of 2014, H.R. 4574, 113th Cong. (introduced May 6, 2014).

¹¹ See *id.*

¹² See Carey, *Mental Health Group Split*, *supra* note 2.

¹³ Taylor Sisk, *Mental Health Care Reconstruction: Two Visions*, N.C. HEALTH NEWS (July 8, 2014), <http://www.northcarolinahealthnews.org/2014/07/08/mental-health-care-reconstruction-two-visions/>.

down following inpatient hospitalization. Part III, in turn, takes up several issues with respect to funding, implementation, and enforcement that are raised by the calls for increased use of mandated community-based treatment. Part IV reviews the available data on outcomes, particularly with respect to subsequent hospitalizations and criminal system involvement. The Article concludes with a summary assessment of the considerations pushing for and against the greater adoption of outpatient commitment.

I. History: Perspectives and Context

The first civil commitment statutes were enacted in the United States in the late eighteenth century.¹⁴ By the time of the Civil War, the practice of civilly committing severely mentally ill persons was not uncommon, although the legal standards governing these decisions were at best rudimentary.¹⁵ Beginning in the Progressive Era, reformers influenced by Benjamin Rush and Dorothea Dix advocated for more treatment resources for the mentally ill and for an increased “medicalization” of civil commitment.¹⁶ These efforts gained momentum after World War II, as more state hospitals were constructed and new treatment technologies became available.¹⁷ In many American jurisdictions between the 1940s and the early 1970s, the decision whether to approve the involuntary hospitalization of a mentally ill person was made by a physicians board or “lunacy commission” on the basis of highly subjective criteria, and in a majority of states the decision to hospitalize was based simply on the certification of one or more physicians that an individual was mentally ill and in need of treatment.¹⁸ By the mid-1950s, more than a half million individuals were hospitalized in state mental institutions, many essentially for life.¹⁹

Beginning in the late 1960s, the pendulum swung in a more libertarian direction. The roots of this shift can be found even earlier, in a series of

¹⁴ See SAMUEL BRAKEL ET AL., *THE MENTALLY DISABLED AND THE LAW* 14 (3d ed. 1985).

¹⁵ See Stuart A. Anfang & Paul S. Appelbaum, *Civil Commitment—The American Experience*, 43 *ISR. J. PSYCHIATRY RELAT. SCI.* 209, 210 (2006), available at http://doctorsonly.co.il/wp-content/uploads/2011/12/2006_3_14.pdf.

¹⁶ DONALD H. BLOCHER, *THE EVOLUTION OF COUNSELING PSYCHOLOGY* 130–31 (Bill Tucker & J Hurkin-Torres eds., 2000). In this context, “medicalization” means that the criteria for determining whether to commit a patient are focused on his or her need for and amenability to treatment rather than on decisional competency or dangerousness, and that the process for decision relies upon medical personnel rather than judicial officers. *See id.*

¹⁷ *See id.* at 130–36.

¹⁸ *See generally* THOMAS G. GUTHEIL & PAUL S. APPELBAUM, *CLINICAL HANDBOOK OF PSYCHIATRY AND THE LAW* 40 (3d ed. 2000).

¹⁹ *See* Isaac & Brakel, *supra* note 9, at 97.

exposés written by concerned journalists and academics about troubling conditions found in a number of state hospitals,²⁰ and in a set of highly consequential hearings on abuses in public mental hospitals held in the U.S. Senate by the Subcommittee on Constitutional Rights.²¹ Between 1970 and the early 1980s, a wave of statutory reform swept the country, replacing permissive “need for treatment” admissions criteria with new, more libertarian rules requiring a showing that an individual subject to civil commitment posed a danger to him or herself or others.²² A judicialization of the decision-making process also took place during this period, making judges or other judicial officers the primary decision-makers for purposes of involuntary commitment.²³ There was some case law supporting these developments, most prominently the federal district court decision in *Lessard v. Schmidt* in 1972, suggesting that a judicial finding of both mental illness and dangerousness was a constitutional requirement for commitment,²⁴ and the United States Supreme Court’s decision in *Addington v. Texas*, requiring that the criteria for involuntary commitment be established by a standard of clear and convincing evidence.²⁵

Rael Jean Isaac and Samuel Jan Brakel have argued that these reforms—which began with a model civil commitment bill for the District of Columbia in the U.S. Senate, adopted in somewhat modified form by the District of Columbia in 1964,²⁶ and which ignited a process of statutory revision and deinstitutionalization across the country—were founded on two essential premises. The first was that psychiatric patients, including those with severe mental illnesses, ought to be presumed competent to make treatment decisions—including the decision to refuse treatment—absent a judicial finding of incompetency separate from the involuntary

²⁰ See ALBERT DEUTSCH, *THE SHAME OF THE STATES* (1948); Albert Maisel, *Bedlam*, *LIFE*, May 6, 1946, at 102.

²¹ See *In re Ballay*, 482 F.2d 648, 653 (D.C. Cir. 1973); *Constitutional Rights of the Mentally Ill: Hearings Before the Subcomm. on Constitutional Rights of the S. Comm. on the Judiciary*, 88th Cong., 36, 47 (1961); *Hearings to Protect the Constitutional Rights of the Mentally Ill, Hearings on S. 935 Before the Subcomm. on Constitutional Rights of the S. Comm. on the Judiciary*, 88th Cong., 61 (1963).

²² See CHRISTOPHER SLOBOGIN ET AL., *LAW AND THE MENTAL HEALTH SYSTEM* 703–04 (5th ed. 2009). Among the most influential state statutory reforms of this period was the Lanterman-Petris-Short Act, passed by the California legislature in 1967. CAL. WELF. & INST. CODE § 5000 *et seq.* (West 2010 & Supp. 2014).

²³ See SLOBOGIN ET AL., *supra* note 22, at 704.

²⁴ 349 F. Supp. 1078, 1093 (E.D. Wis. 1972).

²⁵ 441 U.S. 418, 443 (1979).

²⁶ See Isaac & Brakel, *supra* note 9, at 98.

civil commitment decision.²⁷ The second premise was that imminent dangerousness, either to one's self or to others, is an appropriate and necessary predicate for the exercise of the state's coercive power over the mentally ill, particularly with respect to the decision to involuntarily commit an individual to care in a psychiatric hospital.²⁸

Before the late 1960s, the legal status of incompetency for adults was most often established by a presumption triggered by the involuntary civil commitment of someone with a mental disability.²⁹ In most jurisdictions this presumption of incompetency was irrebuttable, and a determination that an individual was subject to civil commitment was the "equivalent of a finding of general incompetency."³⁰ In response to this longstanding practice, many advocates for reform asserted that mental illnesses and other mental disabilities severe enough to warrant inpatient treatment do not necessarily render patients unable to make significant decisions, including the decision either to consent to or refuse psychiatric treatment. Their argument, which prevailed in a number of legislative revisions, was that the rules governing the rights of other patients to give (or withhold) informed consent to treatment ought to apply to psychiatric patients as well, unless a specific finding of incompetency was made.³¹ Thus, in the jurisdictions that adopted this reform, the irrebuttable presumption that a person subject to involuntary commitment is generally incompetent was replaced by the ordinary presumption that all adults are competent until found otherwise by a court of appropriate jurisdiction.³²

The reformers' second premise, that involuntary commitment should be based on dangerousness rather than, or in addition to, one's need for or amenability to treatment,³³ was rooted in a desire to protect the individual

²⁷ *Id.* at 100.

²⁸ *Id.* at 99.

²⁹ See GUTHEIL & APPELBAUM, *supra* note 18, at 222.

³⁰ *Id.*

³¹ See Isaac & Brakel, *supra* note 9, at 109.

³² See GUTHEIL & APPELBAUM, *supra* note 18, at 223.

³³ In a series of cases involving so-called "sexual predators," the United States Supreme Court has exhibited some ambivalence on the question of whether a state may constitutionally use its civil commitment authority to restrain a dangerous individual, even if no effective treatment for the underlying disability is available. Compare *Foucha v. Louisiana*, 504 U.S. 71, 84–86 (1992) (holding that criminal offender with a personality disorder who completed criminal sentence could not be held on grounds of dangerousness), with *Kansas v. Hendricks*, 521 U.S. 346, 351, 356–57 (1997) (holding that the U.S. Constitution does not prevent states from civilly detaining those for whom no treatment is available); see also *Kansas v. Crane*, 534 U.S. 407, 411–14 (2002) (holding that the U.S. Constitution does not allow civil commitment without a determination of whether the sexual offender lacked control over his dangerous behavior).

autonomy and self-determination of persons with mental disabilities.³⁴ On these terms, reformers criticized the “need for treatment” standard for civil commitment that had prevailed for decades as overly paternalistic and insufficiently attentive to the obligation of a democratic society to limit coercive government intervention to circumstances in which it is necessary to ensure the safety of individuals in the community.³⁵

The shift to a dangerousness standard for involuntary confinement combined with the first premise, that individuals subject to civil commitment should be presumed competent, to support arguments that psychiatric patients should retain the right to refuse psychotropic medications and other forms of treatment unless specific judicial findings of incompetence and medical necessity were also obtained.³⁶ Taken together, these two premises fundamentally shifted the foundations on which coercive care of the mentally ill and the mentally disabled rested. At its highpoint in the mid-twentieth century, the use of involuntary civil commitment was best understood as an exercise of the state’s *parens patriae* power to provide for the care and well-being of vulnerable persons. As these reforms developed and the deinstitutionalization of this population proceeded during the last quarter of the twentieth century, that foundational justification gave way and the state’s police power concern for protecting against the dangers associated with severe mental illness largely took its place.³⁷ The changing rationale for the confinement of mentally ill persons and the emerging jurisprudence recognizing their right to refuse treatment were mutually reinforcing developments:

As long as patients were hospitalized on the ground that they needed treatment, it seemed a contradiction in terms to advance a “right to refuse treatment.” . . . But once the *parens patriae* basis for treating the patient was abandoned, and the state committed the individual only because he was dangerous, commitment and treatment were divorced.³⁸

Not only did dangerousness replace a need for treatment as the primary consideration for triggering involuntary commitment, many jurisdictions also implemented judicial or statutory requirements that the

³⁴ See Stephen J. Morse, *A Preference for Liberty: The Case Against Involuntary Commitment of the Mentally Disordered*, 70 CALIF. L. REV. 54, 55 (1982). See generally Symposium, *Mental Illness, the Law, and Civil Liberties*, 13 SANTA CLARA L. REV. 367 (1973).

³⁵ See *Developments in the Law: Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1201 (1974).

³⁶ See, e.g., *Rogers v. Comm’r*, 458 N.E.2d 308, 310 (Mass. 1983); *Rivers v. Katz*, 495 N.E.2d 337, 341 (N.Y. 1986).

³⁷ See Isaac & Brakel, *supra* note 9, at 108.

³⁸ *Id.* at 107–08.

imminence of that danger be established by evidence of a recent overt act.³⁹ Moreover, in some states where civil commitment had been permitted on a showing that mental illness or other mental disability rendered an individual incapable of providing for basic necessities, such as food or housing, a criterion that was a “remnant of the *parens patriae* power,”⁴⁰ the police power notion of danger to self was broadened to include individuals whose illness rendered them “grave[ly] disabled” or significantly impaired with respect to their ability to provide for basic necessities.⁴¹

Both of the premises on which these reforms rested, as well as the more general move away from a reliance on the *parens patriae* authority of the state as the basis for coercive intervention, were and remain subject to intense debate and disagreement among clinicians, patients’ advocates, and others. With respect to the presumption that most psychiatric patients retain the capacity to make an informed choice about whether to receive psychotropic medications or other proposed therapies, Isaac and Brakel argue that severely mentally ill persons “are not the equivalent of heart or cancer patients.” They assert that these individuals’ “presumed competency is a fiction,” and that the very nature of psychosis is that it disrupts thought processes and impairs the individual’s capacity for rational decision-making.⁴²

Proponents of the Murphy Bill’s strong emphasis on outpatient commitment and enforced treatment, as well as other advocates who support assisted outpatient treatment legislation and criticize what they regard as overly libertarian civil commitment standards, seek to reinforce Isaac and Brakel’s distinction between psychiatric patients and surgical/medical patients by emphasizing the prevalence among persons with schizophrenia and severe bipolar disorder of the phenomenon of “anosognosia,” which is a lack of insight about one’s disease and an inability to recognize the need for treatment.⁴³ This lack of understanding,

³⁹ See, e.g., KAN. STAT. ANN. § 59-2946(f)(3)(A) (West, Westlaw through laws effective July 1, 2014); *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated*, 414 U.S. 473 (1974) (finding of dangerousness sufficient to support police power commitment must be based on “a finding of a recent overt act, attempt or threat to do substantial harm”).

⁴⁰ See Isaac & Brakel, *supra* note 9, at 103.

⁴¹ See *id.* As civil commitment has become increasingly centered on the state’s police power interest in restraining and treating patients whose mental disability poses a danger to themselves or to others, the state’s *parens patriae* interest in caring for those who are incapable of caring for themselves has increasingly become concentrated in the judicial process by which incompetency (and guardianship) are determined. See BRAKEL ET AL., *supra* note 14, at 26-27; GUTHEIL & APPELBAUM, *supra* note 18, at 223; see also BRAKEL ET AL., *supra* note 14, at 370.

⁴² Isaac & Brakel, *supra* note 9, at 100.

⁴³ The Treatment Advocacy Center, an organization that has made outpatient commitment

which some argue is not only concurrent with the delusions, hallucinations, or other thought disorders associated with severe mental illness, but is also a product of structural changes in the brain brought about by the underlying pathology,⁴⁴ is said to provide a factual and ethical basis for a more aggressive form of paternalism than is currently reflected in the laws of many states.⁴⁵ Indeed, some even argue that because of the phenomenon of anosognosia, the practice of subjecting severely mentally ill individuals to judicially ordered outpatient treatment does not constitute “involuntary” outpatient commitment at all, but rather “assisted” outpatient treatment. This is the case, they explain, because the imposed treatment is likely what the patient would have chosen had he or she not been afflicted by this neurological disorder that impairs one’s ability to recognize the need for treatment.⁴⁶

On the other side of this debate are a group of clinicians and patients’ advocates who argue that behavioral health treatment ought to be voluntary and subject to the consent of the patient.⁴⁷ In their view, the state’s limited authority under its police powers should be the sole basis for coercive interventions, which should be restricted to situations where an individual’s mental illness or other mental disability poses an immediate and palpable danger to that individual or the public. Inherent in this position, of course, is a deep commitment to the premise that voluntary consent is a coherent requirement with respect even to persons with severe

a centerpiece of their law reform advocacy, defines the condition as follows:

Anosognosia—“lack of insight” or “lack of awareness”—is believed to be the single largest reason why individuals with schizophrenia and bipolar disorder do not take their medications. A result of anatomical damage to the brain, it affects approximately 50% of individuals with schizophrenia and 40% of individuals with bipolar disorder. When taking medications, awareness of illness improves in some patients.

Anosognosia, TREATMENT ADVOCACY CENTER, <http://www.treatmentadvocacycenter.org/problem/anosognosia> (last visited Feb. 5, 2015).

⁴⁴ See *The Anatomical Basis of Anosognosia - Background*, TREATMENT ADVOCACY CENTER (updated May 2013), <http://www.treatmentadvocacycenter.org/about-us/our-reports-and-studies/2143>.

⁴⁵ See Guido R. Zanni & Paul F. Stavis, *The Effectiveness and Ethical Justification of Psychiatric Outpatient Commitment*, 7 AM. J. BIOETHICS 31, 33 (2007); Xavier F. Amador & Andrew A. Shiva, *Insight into Schizophrenia: Anosognosia, Competency, and Civil Liberties*, 11 GEO. MASON U. C.R. L.J. 25, 35, 37 (2000).

⁴⁶ See John Monahan et al., *Reply to Erik Roskes, Letter to the Editor, “Assisted Outpatient Treatment”: An Example of Newspeak?*, 64 PSYCHIATRIC SERVICES 1179, 1179 (2013).

⁴⁷ See Donald H. Stone, *The Benefits of Voluntary Inpatient Psychiatric Hospitalization: Myth or Reality?*, 9 B.U. PUB. INT. L.J. 25, 26–28 (1999).

mental illness. As the David L. Bazelon Center for Mental Health Law puts it:

Forced mental health care is never appropriate, except when there are immediate and serious safety risks. And even then, listening to consumers and respecting their choices is essential to designing service plans that succeed. For choice to be real, systems must offer a wide array of interventions and supports, and consumers must understand their benefits and risks. . . . Coercive systems with a limited menu of medications, office-based therapy and institutional care often result in poor outcomes and discourage help-seeking.⁴⁸

In addition to their disagreement about the capacity of persons with severe mental illness to exercise informed choice regarding medications and other treatments, advocates for voluntary care also stress the crucial role that resources (or their absence) play in the ability of outpatient mental health care providers to successfully manage the chronic relapsing nature of their clients' severe mental illness.⁴⁹ There is general agreement that the development of the community mental health movement in the 1970s and the associated process of deinstitutionalization produced a troubling set of "unintended consequences."⁵⁰ Many patients who had been managed within the structured setting of an inpatient hospital ward through the use of psychotropic medications proved to be difficult to treat in the community.⁵¹ The resulting "revolving cycle of failures for some patients"⁵² led to a dramatic increase in the number of homeless mentally ill persons, as well as an expanding population of mentally ill inmates in jails and prisons. Proponents of an increased reliance on outpatient commitment argue that the inability of many of these outpatients to remain compliant with medication regimens is a consequence of their anosognosia, and the lack of insight inherent in their disease. Advocates for voluntary treatment,

⁴⁸ *Self-Determination*, BAZELON CENTER FOR MENTAL HEALTH LAW, <http://www.bazelon.org/Where-We-Stand/Self-Determination.aspx> (last visited Feb. 5, 2015); see also BAZELON CENTER FOR MENTAL HEALTH LAW & UPENN COLLABORATIVE ON COMMUNITY INTEGRATION, IN THE DRIVER'S SEAT: A GUIDE TO SELF-DIRECTED MENTAL HEALTH CARE 1 (2008), available at <http://www.bazelon.org/LinkClick.aspx?fileticket=OZIEirtDYx4%3d&tabid=104>.

⁴⁹ See Richard J. Bonnie et al., *Mental Health System Transformation After the Virginia Tech Tragedy*, 28 HEALTH AFF. 793, 801 (2009).

⁵⁰ Zanni & Stavis, *supra* note 45, at 32. "In 1963, Congress passed the Community Mental Health Centers Act, which provided funding for the establishment of outpatient treatment centers. The CMHC Act was representative of a widespread effort to move the locus of treatment from isolated hospitals to the patients' communities." SLOBOGIN ET AL., *supra* note 22, at 706.

⁵¹ See Marc F. Abramson, *The Criminalization of Mentally Disordered Behavior: Possible Side-Effect of a New Mental Health Law*, 23 HOSP. & COMMUNITY PSYCHIATRY 101 (1972).

⁵² Zanni & Stavis, *supra* note 45, at 32.

on the other hand, argue that the revolving door problem has more to do with the federal government's failure to fully fund the CMHC system and the lack of resources in state mental health systems to support the needs of an expanding population of deinstitutionalized outpatients.⁵³

There is equally intense disagreement regarding the second premise that drove the reforms of the 1970s, that dangerousness rather than a need for treatment should be the principal basis for state intervention in the lives of persons with severe mental illness.⁵⁴ This debate, together with the controversy over the question of patient capacity for self-determination, has marked the boundaries of the highly polarized policy discussions concerning outpatient commitment that are reflected in the reactions to the proposed outpatient commitment provisions in the Murphy Bill and other state level efforts to adopt or expand the use of outpatient commitment.⁵⁵ Critics of the status quo reliance on dangerousness as the key criterion for involuntary civil commitment argue that it reflects a category mistake. They argue that if involuntary hospitalization is understood as a therapeutic intervention, then basing the decision to employ this intervention on a showing of imminent dangerousness makes no sense because "dangerousness is not a disease or any form of diagnostic entity."⁵⁶ In the view of these critics, "[W]hen a patient is dangerous, it is often

⁵³ See Paul F. Stavis, *Why Prisons are Brim-Full of the Mentally Ill: Is Their Incarceration a Solution or a Sign of Failure?*, 11 GEO. MASON U. C.R. L.J. 157, 157-58, 169 (2000). "Only somewhat over half of the projected 2,000 community mental centers have become operational." SLOBOGIN ET AL., *supra* note 22, at 707.

⁵⁴ See generally Darold A. Treffert, *The Practical Limits of Patients' Rights*, 5 PSYCHIATRIC ANNALS 4 (1975) (writing critically of the "freedom to suffer outside an institution").

⁵⁵ For example, in January 2014, a bill was introduced in the Maryland State Senate that would have created a system of outpatient commitment in the state. S.B. 831, 2014 Leg. 434th Sess. (Md. 2014). At a February committee meeting, the competing positions were well articulated. The Bill's sponsor, Senator Dolores Kelley, referred to it as a necessary compromise to insure individual safety and welfare; others who spoke in favor included a Montgomery County police officer, an advocate for families of persons with mental illness, and a physician. Those who spoke in opposition included a representative from the Maryland Disability Law Center, a representative from Mental Health America of Maryland, a non-profit service and education provider, a Baltimore Mental Health Court Judge, and a representative from the State's Department of Health and Mental Hygiene. *Hearing on S.B. 831 Before S. Fin. Comm.*, 2014 Leg., 434th Sess. (Md. 2014), available at <http://mgaleg.maryland.gov/webmga/firmcommittees.aspx?pid=av&tab=subject7> (audio recording accessible through pull-down menu). A cross-filed bill, although not identical, was introduced in the Maryland House of Delegates. H.D. 767, 2014 Leg., 434th Sess. (Md. 2014). The Senate bill was placed on hold pending the outcome of a task force study ordered by the legislature. The House bill was withdrawn.

⁵⁶ Isaac & Brakel, *supra* note 9, at 100 (citing Stephen Rachlin, *Civil Commitment, Parens Patriae and the Right to Refuse Treatment*, 1 AM. J. FORENSIC PSYCHIATRY 174, 177 (1979)).

because he has inappropriately been allowed to deteriorate, untreated. Hospitalization should come *before* a person slips to this point.”⁵⁷

On the other side, proponents of the 1970s reforms argue that dangerousness is precisely the right criterion, because the government decision at issue is whether to restrain an individual without his or her consent. They assert that the question of what, if any, therapeutic measures to deploy is a separate matter, and one better resolved by the individual himself or herself, or by a substitute decision-maker in those instances in which the individual lacks the capacity to provide informed consent.⁵⁸ In any case, these proponents point out, the focus on dangerousness serves to limit the exercise of coercive state power, which has the virtues of promoting individual autonomy (a deontological good) and encouraging persons with behavioral health needs to seek care voluntarily (a consequentialist good). An overly paternalistic approach, on the other hand, because it provides the basis for more coercive treatment, could serve to drive mentally ill individuals away from the treatment system and deter their willingness to undertake care voluntarily.⁵⁹

Implicit in the debate over the role of dangerousness in this system are even more problematic disagreements about the capacity of the mental health professions to make reasonably accurate predictions regarding the potential of an individual with severe mental illness to engage in violent behavior and about whether persons with mental illness are more violence prone than other groups in the general population.⁶⁰ Questions about the ability of psychiatrists and other mental health professionals to accurately predict future dangerousness became especially contentious some years ago in the context of capital sentencing proceedings in which testimony of this sort had played a crucial role in jury recommendations in support of

⁵⁷ *Id.*

⁵⁸ See BAZELON CENTER FOR MENTAL HEALTH LAW & UPENN COLLABORATIVE ON COMMUNITY INTEGRATION, *supra* note 48, at 1.

⁵⁹ See *id.* at 13; see also Jo C. Phelan et al., *Effectiveness and Outcomes of Assisted Outpatient Treatment in New York State*, 61 PSYCHIATRIC SERVICES 137, 138 (2010) (“In opposition to outpatient commitment, the National Mental Health Association has argued that ‘service can only be effective when the consumer embraces it’ and that coercive treatment can have negative unintended consequences.”). In *Humphrey v. Cady*, the United States Supreme Court, in dicta, suggested that involuntary civil commitment ought to be based on a “judgment that [the person’s] potential for doing harm, to himself or to others, is great enough to justify such a massive curtailment of liberty.” 405 U.S. 504, 509 (1972). This language proved highly influential to lower federal courts that found dangerousness to be a constitutional requirement for civil confinement. See, e.g., *Colyar v. Third Judicial Dist. Court for Salt Lake Cnty.*, 469 F. Supp. 424, 431–32 (D. Utah 1979).

⁶⁰ See BRAKEL ET AL., *supra* note 14, at 34 n.106.

death sentences.⁶¹ While the American Psychiatric Association took the position that psychiatrists have no expertise in predicting dangerousness, a divided United States Supreme Court in 1983 concluded, in part because dangerousness predictions are so essential to involuntary civil commitment determinations, that capital sentencing juries should be entitled to rely on this evidence.⁶²

The track record of mental health professionals' efforts to predict future violence has not been good. In their classic 1974 critique, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, Bruce Ennis and Thomas Litwack relied on substantial data suggesting that clinicians' predictions of dangerousness were likely to be no more accurate than chance.⁶³ Indeed, research from the 1970s reported false positive rates ranging from 66% to as high as 92%.⁶⁴ For a variety of reasons, however, these critiques may have been overstated to some degree. First, more recent research focusing on the use of newer actuarial tools has found that the accuracy of clinical predictions of violence has improved somewhat, perhaps reducing the rate of false positives below 50%.⁶⁵ In addition, other commentators have pointed out that the reported rate of false positives may be inflated because most studies on prediction accuracy rely on follow-up police and hospital records that tend to underreport the relevant incidents of violent behavior.⁶⁶ Moreover, because many positive determinations of potential dangerousness support a decision to institutionalize the patient at issue, some of the relative lack of future violence may be due to the structured setting and supervision that accompany that decision and may not reflect the rate of dangerous behavior that these patients presumably would have exhibited had they

⁶¹ See George E. Dix, *Expert Prediction Testimony in Capital Sentencing: Evidentiary and Constitutional Considerations*, 19 AM. CRIM. L. REV. 1, 41 (1981).

⁶² *Barefoot v. Estelle*, 463 U.S. 880, 898 (1983). The APA's position was set out in its amicus brief in *Barefoot*, and was relied upon by Justice Blackmun in his dissent. *Id.* at 916, 920 (Blackmun, J., dissenting). Interestingly, Blackmun suggested that the high error rate exhibited by experts in predicting dangerousness might be acceptable in civil commitment determinations, but not in capital proceedings, given the very different costs of false positives in these respective contexts. *Id.* at 923–24.

⁶³ See Bruce J. Ennis & Thomas R. Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CALIF. L. REV. 693, 701 (1974).

⁶⁴ See, e.g., Bernard L. Diamond, *The Psychiatric Prediction of Dangerousness*, 123 U. PA. L. REV. 439, 451 (1974); Ernest A. Wenk & Robert L. Emrich, *Assaultive Youth: An Exploratory Study of the Assaultive Experience and Assaultive Potential of California Youth Authority Wards*, 9 J. RES. CRIME & DELINQ. 171, 192 (1972).

⁶⁵ See John Monahan et al., *An Actuarial Model of Violence Risk Assessment for Persons with Mental Disorders*, 56 PSYCH SERV. 810, 814 (2005).

⁶⁶ See SLOBOGIN ET AL., *supra* note 22, at 479.

been released directly into the community.⁶⁷ Finally, a number of writers have pointed out that the assessment of error rates in this context must take into account the low base rate of violence in the population generally. Because the incidence of violent behavior is so low in general, even relatively accurate predictions of violence are likely to generate significant false positives.⁶⁸

In this sense, it may be that psychiatrists and other mental health professionals actually are fairly good at identifying many of the patients who would be likely to act out in dangerous or violent ways in the near future. The cost of relying on these assessments, however, is that the resulting civil commitment net is likely to ensnare a goodly number of others who are not in fact dangerous. Assuming this assumption is sound, the question becomes whether the preventative value of positive predictions outweighs the harms associated with the inevitable false positives.⁶⁹ If the basis for involuntary confinement is rooted entirely in police power concerns with violence prevention, the trade-off of public safety versus individual liberty will remain a difficult issue, at least as long as there remains a substantial rate of false positives. On the other hand, critics who seek to reinvigorate the *parens patriae* foundations of enforced treatment may avoid the dilemma of balancing violence prevention against individual autonomy.⁷⁰

Honest disagreement over cost-benefit assessment is one feature in the complex landscape within which the question of whether to expand the use of outpatient commitment arises.⁷¹ Unfortunately, not all of the

⁶⁷ See George E. Dix, *Clinical Evaluation of the "Dangerousness" of "Normal" Criminal Defendants*, 66 VA. L. REV. 523, 543 (1980).

⁶⁸ See Isaac & Brakel, *supra* note 9, at 104.

⁶⁹ As Brakel, Parry, and Weiner explain:

Lost among all the scientific and not-so-scientific argumentation about dangerousness and the talk about "false positives," and the like is the fact that what to do with potentially dangerous persons amounts to a political question. . . . [T]he "community" is likely as a matter of politics to disagree with the researchers' assumption that it must forego detention of the 35% or 25% true positives in deference to the liberty interests of the "innocent" 65% or 75%

BRAKEL ET AL., *supra* note 14, at 36 n.132.

⁷⁰ See ALAN A. STONE, *MENTAL HEALTH AND LAW: A SYSTEM IN TRANSITION* (1975).

⁷¹ Lawrence Gostin has suggested that "[t]he inherent prerogative of the state to protect the public's health, safety, and welfare (known as the police powers) is limited by individual rights to autonomy, privacy, liberty, property, and other legally protected interests. Achieving a just balance . . . poses an enduring problem for public health law." Lawrence Gostin, *Legal Foundations of Public Health Law and its Role in Meeting Future Challenges*, 120 PUB. HEALTH 8, 10 (2006).

interconnected issues that drive discussion in this area have been disentangled and examined with sufficient care. Not infrequently, proposals to increase the use of enforced treatment in the community (or to broaden the criteria for involuntary inpatient commitment) are triggered by highly salient acts of public violence committed by persons with histories of severe mental illness. Thus, the most publicized experiment in this area, New York's Kendra's Law,⁷² was passed by the New York legislature after Andrew Goldstein, an individual with schizophrenia, pushed Kendra Webdale in front of a subway train and caused her death.⁷³ As others have noted, however, Mr. Goldstein probably would not have been subject to Kendra's Law had it been in place prior to this tragedy because he had been seeking treatment for some time and therefore would not have met the statute's eligibility requirements.⁷⁴ Leaving aside the ways in which this law is thus under-inclusive in terms of targeting the dangerous mentally ill, it is also likely to be over-inclusive, sweeping up persons in the community who are mentally ill and not engaged actively in effective treatment, but who do not present an immediate threat.⁷⁵ The question, then, is whether other interests relating to these individuals can effectively be served through the mechanism of judicially ordered outpatient care, such that the costs associated with such a regime are worth the effort.

One possible interest has to do with addressing the distress experienced by the families of chronically mentally ill adults—often young adults just leaving adolescence—who fail to adhere to voluntary outpatient treatment plans but who do not meet the rigorous standards for involuntary inpatient commitment.⁷⁶ In the absence of clear evidence of imminent danger to self or others, even severely decompensated individuals who reject voluntary outpatient care or who have difficulty accessing scarce outpatient treatment resources may end up burdening

⁷² See generally N.Y. MENTAL HYG. § 9.60 (West, Westlaw through L. 2014) ("Kendra's Law").

⁷³ See Swartz & Swanson, *supra* note 5, at 28; see also Marvin S. Swartz, *Introduction to the Special Section on Assisted Outpatient Treatment in New York State*, 61 PSYCHIATRIC SERVICES 967, 967 (2010).

⁷⁴ See, e.g., SLOBOGIN ET AL., *supra* note 22, at 795.

⁷⁵ This is by definition, as the criteria by which an individual becomes subject to Kendra's Law do not include imminent dangerousness; rather, the law permits an intervention if an individual, *inter alia*, "is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to the person or others. . . ." N.Y. MENTAL HYG. § 9.60(c) (emphasis added).

⁷⁶ See generally April Groff et al., *Caregiving for Persons with Mental Illness: The Impact of Outpatient Commitment on Caregiving Strain*, 192 J. NERVOUS & MENTAL DISEASE 554, 554–62 (2004).

their families, living on the street, or in jail.⁷⁷ Proponents of expanded outpatient commitment argue that these distressing outcomes can be reduced, and this gap in the continuum of care filled, if persons with significant histories of mental illness and treatment noncompliance can be connected to ongoing treatment, case management, and monitoring through the use of judicial hearings and mandated treatment orders.⁷⁸

A second, related interest that might be served by an effective system of outpatient commitment is held by those charged with managing the fiscal and operational needs of the criminal justice system. Advocates for assisted outpatient treatment and other forms of outpatient commitment point to a dramatic increase in the number of persons with mental illness in the criminal justice system even as the population of individuals served in the state hospital system has declined over the long course of deinstitutionalization.⁷⁹ Inmates with mental disabilities, particularly severe mental illness, are difficult to manage in jails and prisons, are especially vulnerable to abuse by guards or other inmates, and are costly to care for.⁸⁰ Thus, if enforced treatment interventions in the community were effective in preventing these individuals from becoming enmeshed in the criminal system, the costs associated with those interventions might be a reasonable investment.⁸¹

There is some empirical evidence that some forms of outpatient commitment can lead to reduced rates of criminal conduct on the part of participants.⁸² However, because the relationship between mental illness and criminal system involvement is complex, and in most cases not directly

⁷⁷ See Virginia A. Hiday et al., *Impact of Outpatient Commitment on Victimization of People with Severe Mental Illness*, 159 AM. J. PSYCHIATRY 1403, 1403 (2002).

⁷⁸ See Zanni & Stavis, *supra* note 45, at 40. *But see* Phelan et al., *supra* note 59, at 137 (explaining that while the lives of people subject to outpatient commitment were “modestly improved,” the data is unclear on whether this measured improvement is the result of enhanced treatment and other resources associated with outpatient commitment or with legal coercion per se).

⁷⁹ See E. FULLER TORREY, NOWHERE TO GO: THE TRAGIC ODYSSEY OF THE HOMELESS MENTALLY ILL 5 (1988); E. FULLER TORREY ET AL., PUBLIC CITIZEN’S HEALTH RESEARCH GROUP & THE NATIONAL ALLIANCE FOR THE MENTALLY ILL, CRIMINALIZING THE SERIOUSLY MENTALLY ILL: THE ABUSE OF JAILS AS MENTAL HOSPITALS 40, 50 (1992).

⁸⁰ See sources cited *supra* note 79; see also Michael Winerip & Michael Schwartz, *Where Mental Illness Meets Brutality in Jail*, N.Y. TIMES, July 14, 2014, at A1.

⁸¹ See Jeffrey W. Swanson et al., *Can Involuntary Outpatient Commitment Reduce Arrests Among Persons with Severe Mental Illness?*, 28 CRIM. JUST. & BEHAV. 156, 159–60 (2001). Certainly, an additional group of individuals with a substantial interest in this regard are those persons with chronic mental illness who could be helped to avoid criminal system involvement through effective outpatient treatment. *See id.*

⁸² See Allison R. Gilbert et al., *Reductions in Arrest Under Assisted Outpatient Treatment in New York*, 61 PSYCHIATRIC SERVICES 996, 996–97, 999 (2010).

causal,⁸³ the precise criteria by which individuals are included in these enforced treatment regimens and the range of services they are offered will have a significant impact on their effectiveness in reducing arrests. Research suggests that the cohort of offenders whose mental disorders directly cause their criminal conduct is comparatively small.⁸⁴ Individuals whose criminal conduct is the product of other factors, either brought about by an underlying mental disability or associated with it, such as homelessness, low educational attainment, and unemployment, make up a much larger category of offenders in the system.⁸⁵ Finally, the likelihood that outpatient commitment will reduce criminal system reinvolvement for the substantial group of criminal offenders who suffer both from mental illness and co-occurring substance use disorders and/or personality disorders is exceedingly problematic. The co-morbidity of these disabilities requires intensive and specialized services, and these offenders therefore present especially difficult challenges to a system of enforced treatment designed to accomplish crime reduction or reduced criminal recidivism.⁸⁶

Statutes that set out the criteria for outpatient commitment vary considerably among the states.⁸⁷ A few states rely on a determination that the patient is likely to deteriorate if not treated.⁸⁸ These state laws are unlikely to be effective in identifying the individuals most at risk of entering the criminal system, given that most mental illness does not directly lead to criminal conduct. A more frequent approach requires the judge to find that an individual has had one or more prior hospitalizations and/or arrests within the relatively recent past, is unlikely to adhere to

⁸³ See E. Lea Johnston, *Theorizing Mental Health Courts*, 89 WASH. U. L. REV. 519, 528 (2012) (stating assumption by supporters of mental health courts of a “causal link” between an individual’s mental illness and his or her criminal offense “appears misplaced”).

⁸⁴ See Jennifer L. Skeem et al., *Correctional Policy for Offenders with Mental Illness: Creating a New Paradigm for Recidivism Reduction*, 35 LAW & HUM. BEHAV. 110, 117 (2011). Some research reports that only about 10% of offenders with mental illness engage in criminal conduct as a direct consequence of their disability. *Id.* at 117–18 (identifying a study finding that out of 113 arrestees with mental illness, “8% had been arrested for offenses that their psychiatric symptoms probably-to-definitely caused, either directly (4%) or indirectly (4%)”).

⁸⁵ See Johnston, *supra* note 83, at 566, 573. A significant percentage of offenders with mental illness become enmeshed in the criminal justice system because their mental disabilities “contributed to their job loss, decline into poverty, and/or movement into environments rife with antisocial influences, all generic risk factors for criminal justice involvement.” *Id.* at 560.

⁸⁶ *Id.* at 559–60 (discussing and citing the findings of William H. Fisher et al., *Community Mental Health Services and Criminal Justice Involvement Among Persons with Mental Illness*, in COMMUNITY-BASED INTERVENTIONS FOR CRIMINAL OFFENDERS WITH SEVERE MENTAL ILLNESS 43–44 (William H. Fisher ed., 2003)).

⁸⁷ See *infra* text accompanying notes 99–125.

⁸⁸ See, e.g., TEX. HEALTH & SAFETY CODE ANN. § 574.034 (West, Westlaw through Third called Sess. of the 83rd legislature).

treatment voluntarily, and is likely to deteriorate as a consequence to the point of becoming dangerous or gravely disabled.⁸⁹ These selection criteria are better suited to identifying the group of mentally ill persons in danger of entering the criminal system, if only because recent past involvement is likely a good predictor of future untoward conduct and may serve as a proxy for the other factors that are also predictive, such as homelessness, lack of family attachment, and the like.⁹⁰ A third group of states requires a finding that the individual lacks the capacity to make an informed and rational decision regarding treatment.⁹¹ While potentially relevant to other interests that might be served by a system of enforced treatment, particularly those founded upon *parens patriae* principles, these jurisdictions are unlikely to select the individuals most at risk of offending and entering the criminal system, given that idiosyncratic decision-making by itself is not, in most cases, directly related to criminal offending.⁹²

With respect to the range of services that are provided pursuant to judicial order, because mental illness most often does not hold a simple causal relationship with criminal system involvement, outpatient commitment programs that focus on medication management or that target participants' mental illness in isolation are unlikely to produce substantial reductions in criminal conduct.⁹³ Instead, programs that seek to address the full range of factors contributing to the dysfunction of participants are more likely to have a measurable impact both on their capacity to function safely in the community and to avoid criminal system involvement.⁹⁴ This, of course, has significant resource implications for proposals to expand the use of outpatient commitment as a means to reduce the number of mentally ill individuals who end up in jails and prisons, because simply mandating adherence to medication regimens is unlikely to achieve this goal.

A third interest that might be served by a comprehensive system of enforced treatment in the community is held both by the individuals whose chronic relapsing conditions ensnare them in the revolving door of the public mental health system, and by those charged with operating that system. The individual rights-focused approach to regulating state

⁸⁹ See, e.g., LA. REV. STAT. ANN. § 28:66 (A) (West, Westlaw through 2013 Reg. Sess.).

⁹⁰ See Skeem et al., *supra* note 84, at 117–18.

⁹¹ See, e.g., GA. CODE ANN. § 37-3-1(12.1) (LexisNexis through 2014 Reg. Sess.).

⁹² See Johnston, *supra* note 83, at 573.

⁹³ See *id.* at 573 (“[T]he provision of mental health treatment alone is not an effective strategy for reducing the recidivism of offenders with mental illnesses.”).

⁹⁴ See Skeem et al., *supra* note 84, at 121 (“[T]he effectiveness of correctional programs in reducing recidivism is positively associated with the number of criminogenic needs they target”).

interventions came under pressure in the 1980s, most notably in the form of *Guidelines for Legislation on the Psychiatric Hospitalization of Adults* recommended by the American Psychiatric Association (the APA). The guidelines recognize that many patients discharged from inpatient care to the community suffer deteriorating mental health over time because they fail to engage or adhere to effective treatment.⁹⁵ The APA's Guidelines would permit commitment when an individual "will if not treated suffer or continue to suffer severe and abnormal mental, emotional, or physical distress, and this distress is associated with significant impairment of his judgment, reason, or behavior causing a substantial deterioration of his previous ability to function on his own."⁹⁶ The APA has stated that this provision is intended to permit the commitment of "severely mentally ill individuals who are moving toward sudden collapse" and that it applies to a group "commonly excluded from the mental health system by current legal standards."⁹⁷

In recent years, a small but significant minority of states have absorbed this "potential-for-deterioration" ground into their civil commitment provisions (either for inpatient commitment, outpatient commitment, or both) although there has not been a general return to the "need for treatment" approach that dominated before 1970.⁹⁸ Clearly, decision makers in these jurisdictions have concluded that *parens patriae*-based interventions may improve the functioning and quality of life of individuals with chronic mental illness, both in the short and longer terms, and may also yield longer-term police power benefits in preventing dangerousness, and are therefore worth the costs to patient autonomy. The mechanics by which this policy shift is effectuated are important, however, particularly when the deterioration ground functions as a basis for outpatient commitment. In order to facilitate analysis of these questions of implementation, a consideration of the statutory context within which this policy choice is made follows.

⁹⁵ See American Psychiatric Association, *Guidelines for Legislation on the Psychiatric Hospitalization of Adults*, 140 AM. J. PSYCHIATRY 672 (1983).

⁹⁶ *Id.*

⁹⁷ *Id.*

⁹⁸ See, e.g., ALA. CODE § 22-52-10.2 (West, Westlaw through Act 2014-457 of the 2014 Reg. Sess.); N.C. GEN. STAT. § 122C-263(d) (West, Westlaw 2014 Reg. Sess. of the Gen. Assemb.); OR. REV. STAT. § 426.005(1)(e)(iv) (West, Westlaw 2014 Reg. Sess.); TEX. HEALTH & SAFETY CODE ANN. § 574.034 (West, Westlaw through third called session of the 83rd legislature).

II. Overview of State Law Approaches to Outpatient Commitment

In general terms, there are three different models of outpatient commitment.⁹⁹ All three models involve a legal order requiring a patient to report regularly to a community clinic or other community-based provider for treatment.¹⁰⁰ The first model, conditional release, permits outpatient commitment only after some form of inpatient commitment.¹⁰¹ This back-end commitment model is authorized in a number of states and permits the release of an individual on the condition that he or she adhere to a specified outpatient treatment regimen.¹⁰² In most cases, failure to comply can result in the individual being returned to inpatient status.¹⁰³

The second model permits the front-end commitment of an individual to community-based outpatient treatment without any preliminary requirement of inpatient treatment, but on the same eligibility criteria as those governing inpatient commitment.¹⁰⁴ At least twenty-five states have adopted this approach.¹⁰⁵ This second model can be further subdivided into two variations. The first variation provides for either inpatient or outpatient commitment on the same libertarian grounds that have dominated the law for some time. While states with this kind of law provide for outpatient commitment, their provisions do not reach individuals whose illness has not progressed to the point where a court could plausibly find by clear and convincing evidence that they pose a

⁹⁹ This section provides a brief overview of the legal approaches adopted around the country for mandating the treatment of persons with serious mental disabilities, and places the various outpatient commitment provisions in that context. Necessarily, this overview presents information in general terms and does not focus on the many details that distinguish one state's legal regime from another's.

¹⁰⁰ See SLOBOGIN ET AL., *supra* note 22, at 791.

¹⁰¹ See generally SAMUEL BRAKEL ET AL., *supra* note 14, at 205–08.

¹⁰² *Id.* at 231–34 (identifying forty states that maintain statutory arrangements providing for the conditional release of inpatients from psychiatric hospitals).

¹⁰³ A number of state and lower federal courts, relying on the United States Supreme Court's decision in *Morrissey v. Brewer*, 408 U.S. 471 (1972), in which the Court held that due process requirements apply to the revocation of parole in the criminal justice context, have held that some formal process is required before the revocation of the conditional release of a psychiatric patient can be effectuated. See, e.g., *True v. State Dep't of Health & Welfare*, 645 P.2d 891, 93–94 (Idaho 1982). *But see* *Dietrich v. Brooks*, 558 P.2d 357, 361 (Or. Ct. App. 1976) (distinguishing parole and permitting summary revocation of conditional release).

¹⁰⁴ See Amy Allbright et al., *Outpatient Civil Commitment Laws: An Overview*, 26 MENTAL & PHYSICAL DISABILITY L. REP. 179, 179 (2002).

¹⁰⁵ The states in this group include Arizona, Arkansas, Colorado, Delaware, District of Columbia, Idaho, Iowa, Kentucky, Mississippi, Missouri, Nebraska, North Dakota, Nevada, New Jersey, Ohio, Oklahoma, Oregon, Rhode Island, South Dakota, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin.

danger to self or others, or are gravely disabled.¹⁰⁶ Twenty-one states fall into this category.¹⁰⁷ The alternative variation of the second model again permits either inpatient or outpatient commitment on the basis of identical eligibility criteria, but permits either form of commitment on grounds that go beyond the traditional libertarian standard to include a potential-for-deterioration alternative.¹⁰⁸ Several states have adopted this approach, although there is considerable variation in how the deterioration criterion is set out.¹⁰⁹

As a conceptual matter, the decision of a state legislature to provide for either inpatient or outpatient commitment on the same substantive standard may reflect an effort to implement the least restrictive alternative doctrine.¹¹⁰ The legislatures in some states have sought to accomplish a similar result not by providing for front-end outpatient commitment, but by including a least restrictive alternative criterion in the statutory provisions governing inpatient commitment.¹¹¹

¹⁰⁶ See, e.g., IDAHO CODE ANN. § 66-329(11) (West, Westlaw through the 2014 Second Reg. Sess. of the 62nd Idaho Legislature) (if patient is deemed mentally ill and, because of such condition, is found likely to injure self or others (or gravely disabled), the court shall order treatment for an indeterminate period of time not to exceed one year); MO. ANN. STAT. § 632.350(5) (West, Westlaw through 2014 Second Reg. Sess. of the 97th Gen. Assemb.) (court must find that patient presents a likelihood of serious harm to self or others and that a program appropriate to handle patient's condition has agreed to accept him or her; outpatient treatment under supervision of mental health program in least restrictive environment shall not exceed 180 days); 50 PA. CONS. STAT. ANN. § 7304(a) (West, Westlaw through 2014 Reg. Sess.) (court must find by clear and convincing evidence that the patient poses a clear and present danger to self or others); S.D. CODIFIED LAWS § 27A-1-2 (West, Westlaw through the 2014 Reg. Sess.) (a person is subject to involuntary commitment if the person has a severe mental illness, is a danger to self and others, and is likely to benefit from treatment).

¹⁰⁷ These states include Arizona, Arkansas, Colorado, Delaware, District of Columbia, Idaho, Iowa, Kentucky, Mississippi, Missouri, Nebraska, Nevada, New Jersey, Ohio, Oklahoma, Rhode Island, South Dakota, Utah, Washington, West Virginia, and Wisconsin.

¹⁰⁸ See, e.g., OR. REV. STAT. § 426.005(1) (West, Westlaw through 2014 Reg. Sess. legislation) (a mentally ill person is eligible for involuntary treatment if one or more of the following are demonstrated: dangerous to self or others; unable to provide for basic personal needs, or a person who has twice been placed in a hospital or inpatient facility in the past three years, is exhibiting behavior similar to that which preceded those incidents, and will likely deteriorate without treatment); VT. STAT. ANN. tit. 18 § 7611 (West, Westlaw through the laws of the Adjourned Sess. of the 2013-2014 Vt. Gen. Assemb.) (includes provision for "patient in need of further treatment" that covers patients receiving adequate treatment but who will deteriorate if it is discontinued).

¹⁰⁹ These states include North Dakota, Oregon, Vermont, and Virginia.

¹¹⁰ See SLOBOGIN ET AL., *supra* note 22, at 791.

¹¹¹ See, e.g., KY. REV. STAT. ANN. § 202A.026 (West, Westlaw through 2014 legislation) (no person shall be involuntarily treated unless he or she presents a danger to self, family, or others as a result of mental illness, can reasonably benefit from treatment, and for whom such

The third model of outpatient commitment can be thought of as a form of “preventive commitment.”¹¹² This model, operative in more than a dozen states,¹¹³ while also permitting front-end outpatient commitment,¹¹⁴ utilizes eligibility criteria that depart from (and generally are less libertarian than) the jurisdiction’s inpatient commitment provisions.¹¹⁵ The

treatment is the least restrictive alternative); MD. CODE ANN., HEALTH-GEN. § 10-632(e)(2) (West, Westlaw through 2014 Reg. Sess. of Gen. Assemb.).

¹¹² See SLOBOGIN ET AL., *supra* note 22, at 791.

¹¹³ These States are Alabama, California, Florida, Georgia, Hawaii, Illinois, Indiana, Kansas, Louisiana, Maine, Minnesota, Michigan, New York, North Carolina, Pennsylvania, South Carolina, and Texas. See, e.g., Bruce J. Winick & Ken Kress, *Outpatient Commitment: A Therapeutic Jurisprudence Analysis*, 9 PSYCHOL. PUB. POL’Y & L. 107, 111 (2003).

¹¹⁴ Outpatient commitments need not, however, be front-ended under this model. In New York State, for example, a great many “Assisted Outpatient Treatment” orders are arranged as a “step down” from inpatient care. The 2009 Program Evaluation for New York’s Kendra’s Law reported that “in nearly three-quarters of all cases, it is actually used as a discharge planning tool for hospitalized patients. Thus, AOT is largely used as a transition plan to improve the effectiveness of treatment following a hospitalization . . .” Marvin S. Swartz et al., *New York State Assisted Outpatient Treatment Program Evaluation*, OFFICE OF MENTAL HEALTH at vi (June 30, 2009), http://www.omh.ny.gov/omhweb/resources/publications/aot_program_evaluation/report.pdf.

¹¹⁵ See, e.g., CAL. WELF. & INST. CODE § 5246 (West, Westlaw through 2014 Reg. Sess.) (person must suffer from mental illness to the extent that noncompliance has resulted in hospitalization or mental health services at a correctional facility at least twice in past thirty-six months or at least one violent act or threat in past forty-eight months; must be the least restrictive placement and be likely to benefit the patient); FLA. STAT. ANN. § 394.4655(1) (West, Westlaw through the 2014 Sp. “A” Sess.) (person may be ordered to involuntary outpatient placement upon a court finding that the person has a mental illness, history of noncompliance (at least twice been admitted in past thirty-six months or engaged in at least one violent act in past thirty-six months), and is likely to benefit from the proposed treatment); GA. CODE ANN. §37-3-1(12.1) (LexisNexis through 2014 Reg. Sess.) (person must be mentally ill and require such treatment to avoid predictably and imminently becoming an inpatient; the patient’s mental status must make him or her unable to voluntarily seek or comply with treatment); 405 ILL. COMP. STAT. ANN. 5/1-119.1 (West, Westlaw through 2014 Reg. Sess.) (person is eligible if he or she meets criteria for inpatient commitment and yet treatment can be reasonably ensured by court mandating outpatient care, or absence of treatment is reasonably expected to increase symptoms to the point that person would meet criteria for commitment); LA. REV. STAT. ANN. § 28:66(A) (West, Westlaw through 2013 Reg. Sess.) (a patient may be ordered to outpatient treatment if suffering from mental illness, unlikely to participate in treatment, such treatment is necessary to avoid relapse, it is likely patient will benefit, and patient has history of noncompliance (at least twice in past thirty-six months, it was significant factor in hospitalization or mental health services at correctional facility or has engaged in one or more violent acts, attempts, or threats in the past thirty-six months)); MICH. COMP. LAWS ANN. § 330.1401(1) (West, Westlaw through 2014 Reg. Sess.) (person may qualify for outpatient commitment based upon a showing of failure to meet basic needs, impaired judgment that makes the patient unable to understand the need for treatment, or noncompliance history

so-called “Assisted Outpatient Commitment” (AOT) statutes are included within this group.¹¹⁶

With respect to statutes in the second and third category that go beyond the criteria of dangerousness or grave disability, outpatient commitment is often based on a prediction that the person will deteriorate into dangerousness or will become gravely disabled if treatment is not engaged and maintained. Notwithstanding this common focus, state legislatures have developed a variety of triggers, beyond the traditional civil commitment criteria, for determining which individuals with mental disabilities will be subject to this more aggressive form of intervention. Recognizing that the following categorical descriptions work a bit of homogenization given the actual level of legal variation in these provisions, it is fair to say that the following types of triggers are most common:

- (A) The individual is unable to make a rational, informed decision about treatment.¹¹⁷ This criterion is, in effect, a kind of competency determination not unlike the legal standard that frequently

within past forty-eight months (at least two institutionalizations or at least one violent act)); MINN. STAT. ANN. § 253B.065(5) (West, Westlaw through 2014 Reg. Sess.) (allows for “early intervention” treatment on the following criteria: refusal to accept appropriate treatment; mental illness manifested by instances of grossly disturbed behavior or faulty perceptions; and either interference with ability to care for self or past history with inpatient treatment (at least two times in past three years, exhibiting symptoms substantially similar, and reasonably expected to deteriorate)); S.C. CODE ANN. § 44-17-580 (West, Westlaw through End of 2013 Reg. Sess.) (a court may order outpatient commitment on the basis of clear and convincing evidence that the patient lacks sufficient insight or capacity to make decisions about treatment or if there is a likelihood of serious harm as manifested by threats or attempts of physical harm); TEX. HEALTH & SAFETY CODE ANN. §574.034 (West, Westlaw through 2013 Third Called Sess. of the 83rd Legislature) (judge may order outpatient treatment only if appropriate mental health services are available to the patient and the judge finds clear and convincing evidence that the mental illness is severe and persistent, and if not treated will lead to deterioration of the ability to function independently; when determining eligibility for outpatient rather than inpatient treatment, the court may look at any actions occurring within the two years preceding the hearing).

¹¹⁶ See, e.g., N.Y. MENTAL HYG. § 9.60(C) (West, Westlaw through 2014) (“Kendra’s Law”) (A court may order AOT if it finds that a patient is suffering from a mental illness and is unlikely to survive safely in the community without supervision. In addition, there must be a history of noncompliance, such that mental illness was a significant factor necessitating hospitalization or mental health services at a correctional facility in the past thirty-six months or resulted in one or more acts of violent behavior toward self or others in the past forty-eight months. The treatment must be necessary to avoid relapse resulting in harm to self or others).

¹¹⁷ See, e.g., ALA. CODE § 22-52-10.2 (West, Westlaw through Act 2014-457 of the 2014 Reg. Sess.); KAN. STAT. ANN. § 59-2946(f)(2) (West, Westlaw through 2014 Reg. Sess.); N.C. GEN. STAT. § 122C-263(d)(1)(d) (West, Westlaw through 2014); S.C. CODE ANN. § 44-17-580(A)(1).

governs the appointment of a guardian for the purposes of directing the medical care of a disabled individual.¹¹⁸

- (B) The individual has a history of mental illness that has either: (1) at least twice within a specified period of time been a significant factor in necessitating hospitalization or receipt of mental health services in a correctional facility; or (2) resulted in one or more acts, attempts, or threats of serious violent behavior toward self or others within a specified time period.¹¹⁹
- (C) The individual, as a result of his or her mental illness, is unlikely to voluntarily participate in treatment but would likely benefit from such treatment.¹²⁰
- (D) The individual, if he or she does not receive treatment, will continue to deteriorate and will either become impaired in his or her ability to function independently or will become imminently dangerous to himself or herself or others.¹²¹
- (E) The individual is unlikely to survive safely in the community without support or supervision.¹²²

These triggering criteria appear in the state statutes in a variety of combinations and configurations. A few states focus particularly on D, a determination that the patient is likely to deteriorate if not treated.¹²³ A more frequent combination is B, C, D, which requires the decision-maker to find that the individual has had past difficulties, is unlikely to adhere to treatment voluntarily, and is likely to deteriorate as a consequence to the point of becoming dangerous or gravely disabled.¹²⁴ Other states have

¹¹⁸ See BRAKEL ET AL., *supra* note 14, at 378–85.

¹¹⁹ See, e.g., CAL. WELF. & INST. CODE § 5250; FLA. STAT. ANN. § 394.4655(1)(e); LA. REV. STAT. ANN. § 28:66(A)(4); MICH. COMP. LAWS ANN. § 330.1401(1)(d); N.Y. MENTAL HYG. § 9.60(C)(4).

¹²⁰ See, e.g., GA. CODE ANN. § 37-3-1(12.1); FLA. STAT. ANN. § 394.4655(1)(h); LA. REV. STAT. ANN. § 28:66(A)(4); VA. CODE ANN. § 37.2-817 (West, Westlaw through the End of 2014 Reg. Sess.).

¹²¹ See, e.g., ALA. CODE § 22-52-10.2; N.C. GEN. STAT. § 122C-263(d); OR. REV. STAT. § 426.005(1)(d) (West, Westlaw through 2014 Reg. Sess.); TEX. HEALTH & SAFETY CODE ANN. § 574.034(b) (West, Westlaw through the 2013 Third Called Session of the 83rd Legislature).

¹²² See, e.g., CAL. WELF. & INST. CODE § 5346(a)(3); FLA. STAT. ANN. § 394.4655(1)(b); N.C. Gen. Stat. § 122C-263(d) (West, Westlaw through 2014 Reg. Sess. of the Gen. Assemb.); N.Y. MENTAL HYG. § 9.60(C).

¹²³ See, e.g., TEX. HEALTH & SAFETY CODE ANN. § 574.034(b); FLA. STAT. ANN. § 394.4655(1)(b).

¹²⁴ See, e.g., LA. REV. STAT. ANN. § 28:66(A); MICH. COMP. LAWS ANN. § 330.1401(1)(d).

adopted the combination of statutory criteria A, C, D, which includes a required finding that the individual lacks the capacity to make an informed and rational decision.¹²⁵ Interestingly, virtually no state has adopted both the A and B-type criteria. Thus, jurisdictions that require a finding of past difficulties generally do not explicitly require a finding of decisional incapacity and vice versa.

III. Funding, Implementation, and Enforcement Issues

With these general patterns in mind, several issues presented by outpatient commitment are worth considering. The first has to do with resources. The Kaiser Family Foundation has estimated that in fiscal year 2010, the fifty states spent nearly \$38,000,000,000 overall on mental health services.¹²⁶ The states receive some support for community mental health through funding obtained under federal mental health and community service block grants.¹²⁷ Nevertheless, given the pressure in many states and at the federal level to expand community-based mental health treatment and to increase the use of outpatient civil commitment, this level of funding remains inadequate to meet the needs of all those who require treatment and other associated services.¹²⁸ There are important questions about how the states allocate these limited resources to achieve the various goals identified by advocates for effective behavioral health care in the community. For example, in many rural states the expansion of outpatient treatment and the proposed increase in the use of outpatient commitment would require an increase in physician employment and retention programs—as well as programs to train and support other clinicians—to ensure that there are enough mental health providers to serve the needs of the state.¹²⁹ For more urban states, funding is needed to expand community health centers.¹³⁰

¹²⁵ See, e.g., GA. CODE ANN. § 37-3-1(12.1).

¹²⁶ *State Mental Health Agency (SMHA) Mental Health Services Expenditures*, KAISER FAMILY FOUNDATION, <http://kff.org/other/state-indicator/smha-expenditures/#table> (last visited Feb. 5, 2015).

¹²⁷ SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP'T OF HEALTH & HUMAN SERVS., *FUNDING CHARACTERISTICS OF STATE MENTAL HEALTH AGENCIES 60* (2009), available at <http://store.samhsa.gov/shin/content/SMA11-4655/SMA11-4655.pdf>.

¹²⁸ See *Strengthening Mental Health In Our Communities Act of 2014*, H.R. 4574, 113th Cong. (2014).

¹²⁹ See, e.g., MONT. DEP'T OF PUB. HEALTH AND HUMAN SERVS., *BLOCK GRANT APPLICATION: COMMUNITY MENTAL HEALTH PLAN AND REPORT* (Sept. 1, 2013), <http://www.dphhs.mt.gov/Portals/85/amdd/documents/CMHBG-application.pdf>; *State-Designated Shortage Areas: Psychiatry & Mental Health*, NEBRASKA DEP'T OF HEALTH & HUMAN SERVICES (2013), available at <http://dhhs.ne.gov/publichealth/Documents/StateShortageAreasPSYCH2013.pdf>.

¹³⁰ See, e.g., *Pennsylvania Dep't of Public Welfare Budget Request for FY 2014-2015*,

Few statutes authorizing outpatient commitment provide funding for new or dedicated treatment resources or even provide that individuals subject to outpatient commitment should be accorded priority in accessing the community-based resources that are already in place. By contrast, Kendra's Law was "unique in that the intent of the statute [was] not simply to authorize court-ordered community treatment, but also to provide the resources and oversight necessary for a viable, less restrictive alternative to involuntary hospitalization."¹³¹ Thus, the law included an appropriation of \$32,000,000 directly allocated to the program and \$125,000,000 for enhanced community services.¹³²

Because patients subject to an outpatient commitment order under Kendra's Law receive preference for intensive case management services and assertive community treatment services, concerns were raised that the law would divert needed resources from other individuals who voluntarily seek community-based treatment, even with the enhanced resources provided in the legislation and its reauthorization.¹³³ Researchers who have studied this issue of "queue jumping" have come to a mixed set of conclusions.¹³⁴ Apparently, in the first three or four years of the regime, the preference given to patients subject to outpatient commitment under the statute (AOT patients) "may have crowded out some individuals with serious mental illness who did not meet criteria for outpatient commitment."¹³⁵ Thereafter, as "new AOT orders leveled off in the state and then declined," the increased capacity of the system became available to non-AOT patients.¹³⁶ Looking ahead, because the expanded treatment and service capacity created by passage of Kendra's Law is now fully utilized in New York, "competition for services in the near future may intensify, with unknown effects on AOT relative to non-AOT recipients."¹³⁷

In 2012, the State of New Jersey allocated \$3,000,000 to five regional behavioral health centers to implement involuntary outpatient commitment care. In addition, approximately \$32,000,000 was earmarked for community-based treatment and housing services.¹³⁸ In many other

DEPARTMENT OF PUBLIC WELFARE BUDGET REQUEST: MENTAL HEALTH SERVS. (2014), available at http://www.dpw.state.pa.us/cs/groups/webcontent/documents/report/p_010997.pdf.

¹³¹ Swartz, *supra* note 73, at 967.

¹³² E.g., Swartz et al., *supra* note 114, at 46.

¹³³ See *id.* at viii; Swartz, *supra* note 73, at 968.

¹³⁴ See Jeffrey W. Swanson et al., *Robbing Peter to Pay Paul: Did New York State's Outpatient Commitment Program Crowd Out Voluntary Service Recipients?*, 61 PSYCHIATRIC SERVICES 988, 993-94 (2010).

¹³⁵ Swartz, *supra* note 73, at 968.

¹³⁶ Swartz et al., *supra* note 114, at viii.

¹³⁷ *Id.*

¹³⁸ Press Release, State of New Jersey Department of Human Services, DHS Launches

states, however, the adoption of outpatient commitment provisions has not been linked to the legislative appropriation of substantial new treatment resources or other service capacity. This has been the case even in a number of jurisdictions that require adequate community-based resources as a condition for an outpatient treatment order.¹³⁹

In Maine, significant funding has been directed to assertive community treatment (“ACT”) efforts and to other “evidence-based” community treatment practices.¹⁴⁰ Consistent with this policy decision, Maine’s inpatient commitment statute requires the court to find specifically “that adequate community resources for care and treatment of the person’s mental illness are unavailable” before an individual can be involuntarily hospitalized.¹⁴¹ Further, the state’s outpatient commitment provision only permits such outpatient commitment if the court is able to find that “community resources are available to support the treatment plan.”¹⁴² Similarly, in Texas, the governing statute only permits a court to order community-based treatment if it finds “that appropriate mental health services are available to the patient.”¹⁴³ In Virginia, if the community service coordinator responsible for developing a comprehensive mandatory outpatient treatment plan “determines that the services necessary for the treatment of the person’s mental illness are not available or cannot be provided to the person in accordance with the order for mandatory outpatient treatment,” the statute directs the agency to send the matter back to the court for further review.¹⁴⁴ In yet another variation on

Involuntary Outpatient Commitment (IOC) (May 24, 2012), http://www.state.nj.us/human_services/news/press/2012/approved/20120524.html.

¹³⁹ As the New York State evaluators put it: “Because the implementation of the AOT Program in New York was accompanied by an infusion of new services, it is impossible to generalize these findings to states where services do not simultaneously increase.” Swartz et al., *supra* note 114, at viii. Dr. Jo Phelan and her colleagues, in the course of considering the potential positive impact that coerced outpatient treatment might produce, have made a similar observation in concluding that Kendra’s Law has yielded some promising outcomes: “[I]t is important that our findings be viewed through the lens of the overall effect of outpatient commitment and not the effects of legal coercion per se. Assisted outpatient treatment is a ‘package deal’ that includes coerced treatment but also access to enhanced services.” Phelan et al., *supra* note 59, at 142.

¹⁴⁰ See ME. DEP’T OF HEALTH AND HUMAN SERVS., BLOCK GRANT APPLICATION (Feb. 6, 2013), available at <http://www.maine.gov/dhhs/samhs/mentalhealth/blockgrant/MHBlockGrantApplicationFY%202014Final083013.pdf>.

¹⁴¹ ME. REV. STAT. ANN. tit. 34-B, § 3864(6)(A) (West, Westlaw through the 2013 Second Reg. Sess. of the 126th Legislature).

¹⁴² *Id.* at § 3873-A(1)(D).

¹⁴³ TEX. HEALTH & SAFETY CODE ANN. § 574.034(b)(1) (West, Westlaw through Third Called Sess. of the 83rd legislature).

¹⁴⁴ VA. CODE ANN. § 37.2-817(H) (West, Westlaw through the End of 2014 Reg. Sess. and

this theme, assisted outpatient treatment in California is authorized only in those counties that have adopted state legislation known as “Laura’s Law,”¹⁴⁵ which obligates local government to provide necessary community-based services.¹⁴⁶ No statewide funding on the order of that associated with Kendra’s Law in New York has been made available in California to support its outpatient commitment statute.

A second issue worth noting is the effect, if any, that a patient’s prior disposition toward treatment is permitted to have on a court’s decision to order outpatient treatment. This concern over protecting the patient’s interest in self-determination is reflected in the Minnesota statute authorizing outpatient commitment.¹⁴⁷ In addition to other more familiar criteria, the statute permits “early intervention treatment” upon a judicial finding that “the proposed patient, when competent, would have chosen substantially similar treatment under the same circumstances.”¹⁴⁸ This provision reflects a perspective that Elyn Saks has termed the “Different Person Theory” of competency, which focuses on the changes in personality and decisional capacity that acute mental illness may bring about. In Saks’s account, a person’s capacity should be judged not on an external objective standard of reasonableness but on whether, given her values and beliefs, the individual has been “transformed by mental illness into a different person,” so that we can say, “she is simply not herself.”¹⁴⁹ Consistent with this perspective, the Minnesota statute permits the imposition of outpatient treatment notwithstanding the patient’s present reluctance, on the ground that his or her authentic self would have consented absent the distortions introduced by acute mental illness. Also consistent with this notion of future consent is a provision in New York’s AOT statute, which provides that “[i]f the [patient] has executed a health care proxy . . . any directions included in such proxy [shall be taken into account by the court in determining] the written treatment plan.”¹⁵⁰

includes cc. 1 and 2 from the 2014 Sp. S. I).

¹⁴⁵ 2002 Cal. Legis. Serv. 5046 (West).

¹⁴⁶ See 2014 Cal. Legis. Serv. 1847 (West); CAL. WELF. & INST. CODE § 5346(a) (West, Westlaw through Ch. 931 of 2014 Reg.Sess.). In California the funding for involuntary outpatient commitment occurs through “Medi-Cal,” California’s state based Medicaid program. There are concerns regarding the spending for outpatient services considering the expansion of Medicaid services within the state. See CALIFORNIA HEALTH CARE FOUNDATION, CALIFORNIA HEALTH CARE ALMANAC: MENTAL HEALTH CARE IN CALIFORNIA: PAINTING A PICTURE (2013), available at <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/M/PDF%20MentalHealthPaintingPicture.pdf>.

¹⁴⁷ MINN. STAT. ANN. § 253B.065(5)(b)(3)(i) (West, Westlaw through end of 2014 Reg. Sess.).

¹⁴⁸ *Id.*

¹⁴⁹ Elyn R. Saks, *Competency to Refuse Treatment*, 69 N.C. L. REV. 945, 959 (1991).

¹⁵⁰ N.Y. MENTAL HYG. § 9.60(C)(8) (West, Westlaw through 2014).

A third important issue has to do with the relationship between the findings required for outpatient commitment and those typically associated with a judicial determination of incompetence and the appointment of a guardian. Virtually all of the state provisions that authorize outpatient commitment for persons who are not dangerous either explicitly or implicitly require a finding that the individual is unlikely to voluntarily participate in needed treatment.¹⁵¹ Even if the decision to forego treatment is objectively a bad decision from the point of view of the costs and benefits involved, however, the rules in many states governing competency determinations generally require more than a bad (or even a very bad) decision. Often, they also require a finding of impaired capacity to engage in a rational decision-making process.¹⁵² In light of this emphasis on the capacity of individuals to weigh and consider alternatives, it is significant that not all states with outpatient commitment laws require the court to make specific findings of decisional incapacity.¹⁵³

Of the commitment statutes that do require the court to make specific findings, perhaps the most elaborate is in Wisconsin, where the law permits a court to determine an individual's dangerousness by finding that he or she:

evidences either incapability of expressing an understanding of the advantages and disadvantages of accepting medication or treatment and the alternatives, or substantial incapability of applying an understanding of the advantages, disadvantages and alternatives to his or her mental illness in order to make an informed choice as to whether to accept or refuse medication or treatment¹⁵⁴

¹⁵¹ See, e.g., GA. CODE ANN. § 37-3-1(12.1) (Lexis through the 2013 Reg. Sess.); LA. REV. STAT. ANN. § 28:66(A) (2008).

¹⁵² See UNIF. PROBATE CODE art. 5 (West, Westlaw through 2013). The traditional approach for determining incompetency leading to the appointment of a guardian was focused on whether the individual was capable of making decisions that produce reasonable outcomes. A number of states, however, have adopted an alternative approach, developed as part of the Uniform Probate Code, which shifts the emphasis from reasonable outcomes to the soundness of the individual's decision-making process itself. See SLOBOGIN ET AL., *supra* note 22, at 947.

¹⁵³ See, e.g., OR. REV. STAT. § 426.005(1)(e) (West, Westlaw through 2014 Reg. Sess.).

¹⁵⁴ WIS. STAT. ANN. § 51.20(1)(a)(2)(e) (West, Westlaw through 2013). A somewhat less detailed provision of this type can be found in Arizona as well. See ARIZ. REV. STAT. ANN. § 36-501(5) (West, Westlaw through the Second Reg. and Second Special Sesss. of the 51st legislature) (“‘Danger to others’ means that the judgment of a person who has a mental disorder is so impaired that the person is unable to understand the person’s need for treatment and as a result of the person’s mental disorder the person’s continued behavior can reasonably be expected, on the basis of competent medical opinion, to result in serious physical harm.”).

The Wisconsin Supreme Court's decision upholding the constitutionality of this provision, *In re Commitment of Dennis H.*, noted in part that the statute is within the State's *parens patriae* powers precisely because it is directed to individuals found incapable of making effective treatment decisions.¹⁵⁵ By contrast, the New York state court decision upholding Kendra's Law, *In re K.L.*, rejected the respondent's argument that the law's failure to require proof that he lacked capacity to make treatment decisions, as in the Wisconsin statute, rendered it unconstitutional.¹⁵⁶ In part, the New York court based its decision on its determination that "a violation of the order, standing alone, ultimately carries no sanction, . . . [but] simply triggers heightened scrutiny on the part of the physician, who must then determine whether the patient may be in need of involuntary hospitalization [under the ordinary standards applicable for inpatient commitment]."¹⁵⁷ A patient's compliance with treatment ordered under Kendra's Law rests, then, as the New York court stated, on the "compulsion generally felt by law-abiding citizens to comply with court directives," and on the possibility of being subject to a seventy-two hour hospitalization for evaluation.¹⁵⁸

The New York decision highlights the problematic nature of enforcing compliance with an outpatient commitment order. Many states have statutory provisions that address the consequences facing individuals who do not comply with outpatient commitment. In a number of these states, a permissible consequence is a return of the noncompliant individual to an inpatient facility, either for evaluation or ongoing treatment.¹⁵⁹ Some

¹⁵⁵ See *In re Commitment of Dennis H.*, 647 N.W.2d 851, 855 (Wis. 2002). As Justice Sykes explained: "Mentally ill persons who meet the fifth standard's definition are clearly dangerous to themselves because their incapacity to make informed medication or treatment decisions makes them more vulnerable to severely harmful deterioration than those who are competent to make such decisions. The state has a strong interest in providing care and treatment before that incapacity results in a loss of ability to function." *Id.* at 862.

¹⁵⁶ *In re K.L.*, 806 N.E.2d 480, 484 (N.Y. 2004).

¹⁵⁷ *Id.* at 485.

¹⁵⁸ *Id.*

¹⁵⁹ See, e.g., ALASKA STAT. ANN. § 47.30.795 (West, Westlaw through legislation effective June 24, 2014); ARIZ. REV. STAT. ANN. § 36-540 I(4); IND. CODE ANN. §§ 12-26-14-4 to 14-5 (West, Westlaw with all 2014 Public Laws of the 2014 Second Reg. Sess. and Second Reg. Technical Sess. of the 118th Gen. Assemb.); MINN. STAT. ANN. § 253B.097 (West, Westlaw with legislation through the end of the 2014 Reg. Sess.); MISS. CODE ANN. § 41-21-74 (West, Westlaw through 2014 Reg. and First and Second Extraordinary Sess.); N.D. CENT. CODE § 25-03.1-21 (West, Westlaw through chapter 522 (end) of the 2013 Reg. Sess. of the 63rd Legislative Assembly); OR. REV. STAT. ANN. § 426.275(3) (West, Westlaw through chapter 522 (end) of the 2013 Reg. Sess. of the 63rd Legislative Assembly); S.C. CODE ANN. § 44-17-580 (West, Westlaw through End of 2013 Reg. Sess.); UTAH CODE ANN. § 62A-15-637 (West, Westlaw through 2014 Gen. Sess.); WIS. STAT. ANN. § 51.20; WYO. STAT. ANN. § 25-10-110 (West, Westlaw through the

jurisdictions require a hearing before the individual is transferred,¹⁶⁰ and most require that the individual meet the statutory standard for inpatient commitment before involuntary hospitalization is permitted.¹⁶¹ Remarkably, at least a half dozen states' statutes fail entirely to address the question of enforcement.¹⁶²

Generally, a patient's failure to adhere to an outpatient commitment order, standing alone, cannot be the basis for inpatient commitment. Further, the law in several jurisdictions precludes the use of an individual's noncompliance as evidence for purposes of meeting the standard for inpatient commitment.¹⁶³ While statutes in a few other states take the opposite approach and permit a showing of noncompliance to serve as some evidence that involuntary inpatient treatment is necessary,¹⁶⁴ if the noncompliant patient is not imminently dangerous or otherwise subject to involuntary hospitalization, there may be no realistic remedy for the patient's refusal to comply with ordered community-based treatment.¹⁶⁵ In theory, such noncompliance could be subject to a proceeding for contempt, but it is unlikely that such an approach is often pursued. In fact, some state legislatures have expressly prohibited using an individual's failure to comply with outpatient commitment as grounds for an order of contempt.¹⁶⁶

2014 Budget Sess.).

¹⁶⁰ See, e.g., MINN. STAT. ANN. § 253B.097; N.D. CENT. CODE ANN. § 25-03.1-21; S.C. CODE ANN. § 44-17-580.

¹⁶¹ See, e.g., ALA. CODE § 22-52-10.3(f) (West, Westlaw through Act 2014-457 of the 2014 Reg. Sess.); D.C. CODE § 21-548 (LexisNexis through laws effective as of May 19, 2014, and through D.C. Act 20-306); NEB. REV. STAT. ANN. § 71-933 (LexisNexis through the 2013 103rd First Sess. Annots. Westlaw through Sept. 6, 2013); NEV. REV. STAT. § 433A.323 (LexisNexis through the Seventy-Seventh (2013) and the Twenty-Seventh Special (2013) Sess.); VA. CODE ANN. § 37.2-817.1 (LexisNexis through the 2014 Reg. Sess. and Acts 2014, Sp. Sess. I, c. 2, of the Gen. Assemb. Annots.); W. VA. CODE ANN. § 27-5-2 (LexisNexis through the 2014 Reg., First and Second Extraordinary Sess.).

¹⁶² These states include Arizona, Colorado, Delaware, District of Columbia, Missouri, Montana, Ohio, Rhode Island, South Dakota, and Utah. BAZELON CENTER FOR MENTAL HEALTH LAW, INVOLUNTARY OUTPATIENT COMMITMENT: SUMMARY OF STATUTES 3, 5-6, 17-18, 23, 26, 28, 30 (2000), available at <http://www.bazelon.org/LinkClick.aspx?fileticket=CBmFgyA4i-w%3D&tabid=324>.

¹⁶³ See, e.g., LA. REV. STAT. ANN. § 28:71(G) (LexisNexis through 2013); N.Y. MENTAL HYG. § 9.60(n) (West, Westlaw through 2014).

¹⁶⁴ See, e.g., W. VA. CODE § 27-5-2.

¹⁶⁵ Cf. Swartz & Swanson, *supra* note 5, at 26 ("Without clearly defined steps for implementation, an outpatient commitment order can be likened to a message in a bottle—a cry for help at risk of non-delivery.")

¹⁶⁶ See, e.g., N.Y. MENTAL HYG. § 9.60(n); TEX. HEALTH & SAFETY CODE ANN. § 574.037(c)(3) (West, Westlaw through 2013 Third Called Session of 83rd Leg.).

Some state laws seek to identify measures short of involuntary hospitalization that courts might deploy to encourage adherence to outpatient treatment requirements. In Maine, for example, a reviewing court is permitted to incentivize the process by removing restrictions on the patient in exchange for his or her achievement of specified goals under the treatment plan.¹⁶⁷ In Indiana, if an individual is unable to comply with an outpatient commitment order, the court is authorized to put in place other treatment options, including supervised group living, as an alternative to full inpatient commitment.¹⁶⁸ For the most part, however, most outpatient commitment schemes rely, as the court in *In re K.L.* put it, on the “compulsion generally felt by law-abiding citizens to comply with court directives.”¹⁶⁹ Proponents argue that leveraging the “power of the robe” for therapeutic purpose in this fashion is an entirely appropriate strategy for assisting the small number of treatment-resistant chronic patients who otherwise would cycle through the system disrupting their communities and drawing unnecessarily on limited resources.¹⁷⁰ Critics charge that it is not ethical for care providers to collude in suggesting to patients that negative legal consequences may be imposed for non-adherence, when in fact no such consequences are likely or even possible in many jurisdictions.¹⁷¹ As Hoge and Grottole have put it: “A strategy that relies on patient misinformation to foster its success violates ethics

¹⁶⁷ See ME. REV. STAT. ANN. tit. 34-B, § 3873-A(7) (West, Westlaw through the 2013 Second Reg. Sess. of the 126th Leg.).

¹⁶⁸ IND. CODE ANN. § 12-26-14-4(b)(2) (West, Westlaw through the 2014 Second Reg. Sess. and Technical Sess. of the 118th Gen. Assemb., P.L. 1 through P.L. 226).

¹⁶⁹ *In re K.L.*, 806 N.E.2d 480, 485 (N.Y. 2004).

¹⁷⁰ See TREATMENT ADVOCACY CENTER BACKGROUND: NO RELEVANCE TO ASSISTED OUTPATIENT TREATMENT (AOT) IN THE OCTET STUDY OF ENGLISH COMPULSORY TREATMENT (2014), available at <http://www.treatmentadvocacycenter.org/storage/documents/Research/may2013-octet-study.pdf> [hereinafter TREATMENT ADVOCACY CENTER].

The theory behind the black-robe effect is that a judicial process and a judge’s imprimatur increase the likelihood that the patient will take to heart the need to adhere to prescribed treatment. It is not a single factor but a host of related ones that combine to send a potent message: the ritual of being summoned to court and taking part in a hearing, the recognition that a fair-minded third party has listened to both sides and ultimately agreed with clinicians that assisted treatment is warranted, the cultural perception of the judge as an authority figure, and the inclination of many judges to use their bench as a sort of civic pulpit.

Id.

¹⁷¹ See Michael A. Hoge & Elizabeth Grottole, *The Case Against Outpatient Commitment*, 28 J. AM. ACAD. PSYCHIATRY & L. 165, 166 (2000).

principles, the integrity of the doctor-patient relationship, and the notion of informed consent.”¹⁷²

In the final analysis, the perceived or actual coercion experienced by individuals subject to an outpatient commitment order may be less important than the legal obligation such orders create for community providers, case managers, and others responsible for implementing the mandated therapeutic regimen.¹⁷³ While the available outcome studies are not entirely conclusive on the positive effects that outpatient commitment has on individual patients,¹⁷⁴ they do, on balance, suggest that these interventions may produce some overall improvements in relevant metrics such as frequency and length of subsequent hospitalizations, involvement in the criminal justice system, and the like.¹⁷⁵ As some thoughtful researchers have cautioned, however, these positive data may or may not be directly attributable to the coercion inherent in outpatient commitment, and may instead be the result of the increased resources, monitoring, and coordination inherent in this approach.¹⁷⁶

IV. Outcome Studies: The Effectiveness of Outpatient Commitment

There are relatively few controlled studies that measure the effectiveness of outpatient commitment practices. Some of the non-controlled studies are of limited value given the difficulties in making comparisons across study groups with dissimilar characteristics and the dangers of selection effects “whereby clinicians and courts select patients for a predicted good outcome.”¹⁷⁷ A comprehensive evaluation of the experience under Kendra’s Law, mandated by the New York state legislature as part of its reauthorization process, however, does provide a more detailed picture of the effects of mandated outpatient treatment, at least under the conditions that pertain in New York.¹⁷⁸ This evaluation, as well as research from several other states, suggests that outpatient commitment can reduce either the rate of hospital readmissions, the length of such inpatient stays, or both, and provides some evidence that enforced

¹⁷² *Id.* at 167.

¹⁷³ See Zanni & Stavis, *supra* note 45, at 37 (“Committed patients tend to receive additional staff attention . . .”).

¹⁷⁴ See *infra* text accompanying notes 177–84.

¹⁷⁵ See Phelan et al., *supra* note 59, at 141–42; Zanni & Stavis, *supra* note 45, at 34–37.

¹⁷⁶ Zanni & Stavis, *supra* note 45, at 37 (“Additional research is needed to study the causative factors underlying committed patients’ improvements, namely, does having an outpatient commitment order garner additional community services or does the threat of judicial intervention improve treatment compliance?”).

¹⁷⁷ Swartz & Swanson, *supra* note 5, at 26.

¹⁷⁸ See Swartz et al., *supra* note 114.

outpatient treatment can, in some circumstances, improve the quality of life and overall functioning of participants.¹⁷⁹

One of the earliest controlled studies, conducted by researchers at Duke University, involved individuals with serious mental illness in North Carolina who were discharged from inpatient treatment between 1993 and 1996.¹⁸⁰ A small number of the 331 patients in the study who had a recent history of violent behavior were placed in a nonrandomized comparison group. The remaining 264 study subjects were randomly assigned either to an experimental group that received outpatient commitment or a control group that did not receive outpatient commitment but did receive the same community-based treatment, case management, and other services as the experimental group.¹⁸¹ The researchers reported no statistically significant difference between the two groups in terms of re-hospitalization rates, days of hospitalization, arrest, or homelessness during the first six months following release. They did, however, find that the group subject to outpatient commitment fared better than the control group on these measures if they remained under an outpatient commitment order for more than six months.¹⁸²

While the Duke researchers speculated that outpatient commitment might produce improved outcomes for participants who remain subject to a commitment order for an extended period of time, they conceded that the key variable, length of time under outpatient commitment, was not itself randomly assigned.¹⁸³ Thus, as critics of the study have pointed out, if community providers disproportionately released patients who were more resistant to treatment or difficult to serve, then the pool of patients who were left in the study group after the initial six-month period of commitment would not provide a reliable basis for comparison with the control group.¹⁸⁴

¹⁷⁹ See *id.*; Mark R. Munetz et al., *The Effectiveness of Outpatient Civil Commitment*, 47 PSYCHIATRIC SERVS. 1251, 1251–52 (1996). See generally M. SUSAN RIDGELY ET AL., THE EFFECTIVENESS OF INVOLUNTARY OUTPATIENT COMMITMENT: EMPIRICAL EVIDENCE AND THE EXPERIENCE OF EIGHT STATES (RAND CORP. 2001), available at http://www.rand.org/content/dam/rand/pubs/monograph_reports/2007/MR1340.pdf.

¹⁸⁰ See Marvin S. Swartz et al., *Can Involuntary Outpatient Commitment Reduce Hospital Recidivism? Findings from a Randomized Trial in Severely Mentally Ill Individuals*, 156 AM. J. PSYCHIATRY 1968 (1999).

¹⁸¹ *Id.* at 1969; Swartz & Swanson, *supra* note 5, at 27.

¹⁸² See Swartz et al., *supra* note 180, at 1971.

¹⁸³ See *id.*

¹⁸⁴ Swartz and Swanson believe the critics' speculation is unlikely. They report that "[h]igher-risk subjects appeared in preliminary analyses to have received longer periods of commitment," which would make the study's findings of the effectiveness of extended outpatient commitment even more robust, but they concede that "unknown selection factors

A second controlled study from the mid-1990s, conducted by Henry Steadman and his colleagues in New York, followed two randomly assigned groups of patients for one year following their release from Bellevue Hospital in New York City.¹⁸⁵ All of the study subjects had histories of chronic severe mental illness. One group was subject to outpatient commitment orders and received intensive case management, community treatment, and other enhanced services. The other group received the same package of case management, treatment, and enhanced services but was not subject to an outpatient commitment order.¹⁸⁶ The researchers found no statistically significant difference between the groups in terms of re-hospitalization, arrests, homelessness, or other quality of life measures, although both groups experienced improvements on most of these measures compared with their own functioning in the year prior to their admission to Bellevue.¹⁸⁷ The researchers interpreted these data to suggest that intensive case management and the enhanced treatment and other services likely produced the improved outcomes, but that the variable of a court mandate had no additional positive effect on participants.¹⁸⁸ Critics of this study have argued that the outpatient commitment orders were not enforced systematically and providers “did not clearly distinguish between the control and experimental groups.”¹⁸⁹ They have also argued that the study size probably was too small to produce the positive effects they believe outpatient commitment is capable of generating.¹⁹⁰

More recently, researchers in Great Britain conducted a randomized controlled study seeking to measure the effects of mandatory outpatient treatment on patients discharged from inpatient care.¹⁹¹ The Oxford Community Treatment Order Evaluation Trial (OCTET), published in the British journal, *The Lancet*, in 2013, sought to evaluate outcomes when patients with severe mental illness released from inpatient treatment “receive equivalent levels of clinical contact” in community-based

could have affected OPC [outpatient commitment] duration.” Swartz & Swanson, *supra* note 5, at 27.

¹⁸⁵ See Henry J. Steadman et al., *Assessing the New York City Involuntary Outpatient Commitment Pilot Program*, 52 *PSYCHIATRIC SERVS.* 330, 330 (2001).

¹⁸⁶ See *id.*; see also Swartz & Swanson, *supra* note 5, at 27–28.

¹⁸⁷ See Steadman et al., *supra* note 185, at 332–35; see also Swartz & Swanson, *supra* note 5, at 27–28.

¹⁸⁸ See Steadman et al., *supra* note 185, at 332–35; see also Swartz & Swanson, *supra* note 5, at 27–28.

¹⁸⁹ Swartz & Swanson, *supra* note 5, at 28.

¹⁹⁰ *Id.*

¹⁹¹ Tom Burns et al., *Community Treatment Orders for Patients with Psychosis (OCTET): A Randomised Controlled Trial*, 381 *THE LANCET* 1627, 1628 (2013).

treatment, “but different lengths of compulsory supervision.”¹⁹² The subjects of the study were all diagnosed with psychosis, deemed capable of providing informed consent, and “considered suitable for supervised outpatient care by their clinical teams.”¹⁹³ Eligible subjects were assigned to two randomized groups, one subject to “Community Treatment Orders” (CTOs) and the other discharged from the hospital pursuant to so-called “Section 17” leaves of absence, a longstanding practice in which released patients remain subject to an inpatient commitment order for “brief periods to assess the stability of a patient’s recovery after or during a period of involuntary hospital treatment.”¹⁹⁴ CTOs, in turn, are a relatively new alternative disposition, having been introduced in England and Wales in late 2008. The introduction of CTOs generated considerable controversy and produced intense resistance from a number of professional and patient advocacy organizations.¹⁹⁵ They “require patients to accept clinical monitoring and allow rapid recall for assessment,”¹⁹⁶ and “last for 6 months, renewable for an additional 6 months, and subsequently for 1-year terms.”¹⁹⁷ Given the differences between these two practices (CTOs versus Section 17 releases), it was no surprise that the OCTET researchers found “the total number of days under compulsion during follow-up was significantly greater in the CTO group . . . than in the Section 17 group”¹⁹⁸

The researchers followed the study subjects for twelve months, measuring rates of hospital readmission, time to first readmission, overall time in the hospital, and clinical and social functioning. They found no differences in primary (rate of hospital readmission), secondary (length to subsequent hospitalization, days in hospital, etc.), clinical, or social outcomes between the groups.¹⁹⁹ They concluded that “[t]he evidence is now strong that the use of CTOs does not confer early patient benefits despite substantial curtailment of individual freedoms,” and urged that “any proposal to either introduce CTOs to new jurisdictions or extend their use would require a commitment to test their effects at least as rigorously as we have done.”²⁰⁰

¹⁹² *Id.* at 1628.

¹⁹³ *Id.*

¹⁹⁴ *Id.* at 1628–29.

¹⁹⁵ *See id.* at 1627.

¹⁹⁶ *Id.*

¹⁹⁷ Burns et al., *supra* note 191, at 1629.

¹⁹⁸ *See id.* at 1631.

¹⁹⁹ *See id.*

²⁰⁰ *Id.* at 1632.

While some have suggested that the OCTET study raises questions about the efficacy of outpatient commitment practices in the United States, critics of the study argue that it is not entirely relevant to the U.S. context because CTOs do not involve a judicial order and thus do not leverage the power of “the black robe.”²⁰¹ Additionally, they argue that the study included some patients with little or no history of treatment non-compliance, the group targeted by U.S. outpatient commitment advocates, and excluded a large number of patients who refused to consent to the research, a group presumably over-represented by individuals hostile to voluntary treatment.²⁰² Finally, critics contend that neither the CTO group nor the Section 17 group spent enough time under mandate (in the case of the CTO group the average length was 170 days) to trigger the greater-than-six-months benefits identified in the Duke study.²⁰³

Notwithstanding these criticisms of the OCTET study, the results do raise serious questions about the relative contributions of coercion versus enhanced treatment and other services in producing favorable outcomes for treatment-resistant mentally ill patients subject to outpatient commitment. Some opponents of outpatient commitment contend that other community-based models, such as Assertive Community Treatment (ACT), which provide coordinated case management, enhanced treatment, and other aggressively delivered services, can be equally effective in reducing hospitalizations, homelessness, and criminal system involvement.²⁰⁴ A number of studies, including several meta-analyses, report that ACT can be effective in reducing the length and frequency of hospitalization and increasing independent living, while moderately improving psychiatric symptoms and quality of life for persons with severe mental illness.²⁰⁵ While ACT is more costly to administer than other models

²⁰¹ See TREATMENT ADVOCACY CENTER, *supra* note 170.

²⁰² See *id.*

²⁰³ See *id.*

²⁰⁴ Assertive Community Treatment (ACT) is defined as an evidence-based model that provides outpatient treatment, rehabilitation and support services to individuals who are diagnosed with severe mental illness and whose needs have not been well met by more traditional mental health service delivery models. Generally, ACT is used to provide services that are specifically tailored to the individual needs of the patients. It is distinguished from traditional approaches by the following features: a multidisciplinary team; low client/staff caseloads that enable more intensive contact; community-based services that are directly provided rather than brokered to other organizations; and 24-hour coverage by the treatment team. See *About ACT*, N.Y. STATE OFFICE OF MENTAL HEALTH, <http://bi.omh.ny.gov/act/index> (last visited Feb. 7, 2015).

²⁰⁵ In one report covering more than twenty-five randomized controlled ACT trials, three-quarters found that ACT was:

of outpatient treatment, several studies have found that it is more cost-effective because of a reduced utilization of hospitalization and emergency services.²⁰⁶

By far, the most intensive research on outpatient commitment in the United States has been conducted in New York in association with the reauthorization of Kendra's Law. The 2005 reauthorization of the program "required an independent evaluation of its implementation and effectiveness," which led the New York State Office of Mental Health to contract with researchers from Duke Medical School, the MacArthur Foundation Research Network on Mandated Community Treatment, and others to undertake a comprehensive study.²⁰⁷ The researchers reviewed a massive array of administrative data (hospital records, case manager reports, Medicaid claims, arrest records, and so forth) and conducted interviews with "key stakeholders" and "service recipients."²⁰⁸ They reported a number of findings relating to regional variation, service engagement, recipient perceptions, and impact on the State's overall public mental health system, but the findings with respect to outcomes are of central importance to the ongoing debate about the efficacy of mandated outpatient treatment, especially given that New York has provided more new treatment and service resources and set out a "more comprehensive implementation, infrastructure and oversight system" than is to be found in any other state with a program of outpatient commitment.²⁰⁹

Significantly, and consistent with the earlier Duke study, the program

more effective than usual care in reducing hospitalization and increasing client satisfaction with services. Effectiveness in other outcome domains [was] less consistent, however, 8 out of 12 studies found improvement in housing stability among those treated in ACT and 7 out of 12 showed improvements in subjective quality of life.

See Center for Behavioral Health Services & Criminal Justice Research, *Assertive Community Treatment: Intervention Fact Sheet*, PLACER COUNTY NETWORK OF CARE, <http://placer.networkofcare.org/mh/library/article.aspx?id=2436> (last visited Oct. 28, 2014).

²⁰⁶ See, e.g., Craig M. Coldwell & William S. Bender, THE EFFECTIVENESS OF ASSERTIVE COMMUNITY TREATMENT FOR HOMELESS POPULATIONS WITH SEVERE MENTAL ILLNESS: A META-ANALYSIS, 164 AM. J. PSYCHIATRY 393, 398 (2007) (use of assertive community treatment "leads to greater improvement in housing stability and symptom reduction early in treatment. While hospitalization appears similar in assertive community treatment and standard case management, differences in hospitalization rate and duration require further study. These findings provide support for policy makers and community program directors to institute assertive community treatment as a best available practice to improve outcomes for the homeless mentally ill.").

²⁰⁷ See Swartz et al., *supra* note 114, at v.

²⁰⁸ See *id.* at v-vi.

²⁰⁹ See *id.*

evaluation found that service engagement was “comparable” for patients subject to Kendra’s Law and patients receiving outpatient treatment on a voluntary basis for the first six months, but that after twelve months the patients subject to Kendra’s Law were more engaged than were voluntary patients.²¹⁰ The researchers also found “consistent evidence” that outpatient commitment under Kendra’s Law produced a “substantial reduction” in the number of psychiatric hospitalizations and in days spent in the hospital, as well as “moderately strong evidence” that it reduced the likelihood of being arrested.²¹¹ They reported that recipients of mandated care were “far more likely to consistently receive psychotropic medications appropriate to their psychiatric conditions,” and that case managers noted “subjective improvements in many areas of personal functioning, such as managing appointments, medications, and self-care tasks.”²¹²

In a special section of the journal *Psychiatric Services* published in 2010, many of these findings were elaborated in a series of detailed articles on the functioning of Kendra’s Law. In one of these articles, Marvin Swartz and his colleagues describe their analysis of Medicaid claims and other state records indicating that patients subject to outpatient commitment under Kendra’s Law experienced “reduced hospitalization and length of stay, increased receipt of psychotropic medication and intensive case management services, and greater engagement in outpatient services.”²¹³ In another piece, Richard Van Dorn and his colleagues report findings consistent with the earlier North Carolina study that the “[b]enefits of involuntary outpatient commitment, as indicated by improved rates of medication possession and decreased hospitalizations, were more likely to persist after involuntary outpatient commitment ends if it is kept in place longer than six months.”²¹⁴ And a third article by Allison Gilbert and colleagues, which compared arrest rates of patients under Kendra’s Law and those receiving voluntary community treatment, found a relative reduction in the odds of being arrested among those subject to outpatient commitment.²¹⁵

²¹⁰ See *id.* at vii.

²¹¹ *Id.*

²¹² *Id.*

²¹³ Marvin S. Swartz et al., *Assessing Outcomes for Consumers in New York’s Assisted Outpatient Treatment Program*, 61 PSYCHIATRIC SERVS. 976, 976 (2010) (discussing Gilbert article).

²¹⁴ Richard A. Van Dorn et al., *Continuing Medication and Hospitalization Outcomes After Assisted Outpatient Treatment in New York*, 61 PSYCHIATRIC SERVS. 982, 983 (2010).

²¹⁵ Marvin S. Swartz, *Introduction to the Special Section on Assisted Outpatient Treatment in New York State*, 61 PSYCHIATRIC SERVS. 967, 968 (2010).

A largely consistent set of outcomes was reported by researchers from Columbia University and the New York State Psychiatric Institute who were funded by the New York State Office of Mental Health to conduct a “quasi-experimental” longitudinal study comparing seventy-six patients mandated to outpatient treatment in Queens and the Bronx and 108 patients with similar characteristics who were not assigned to outpatient commitment.²¹⁶ The researchers found little difference between the two groups in the extent to which they experienced psychotic symptoms, but the group subject to outpatient commitment was “less likely to perpetrate serious violent behavior ($p < .05$), had a lower risk of suicide ($p < .05$), and had better illness-related social functioning ($p < .05$).”²¹⁷ Ultimately, the researchers concluded that “people’s lives seemed to be modestly improved along several dimensions by outpatient commitment as enacted in New York State under Kendra’s Law.”²¹⁸

The finding of reduced serious violent behavior is especially significant, given the larger debate in Congress and elsewhere concerning the need to prevent violence and reduce the number of seriously mentally ill persons who become enmeshed in the criminal system.²¹⁹ The controlled studies of outpatient commitment in North Carolina and New York “yielded contradictory findings” on this score,²²⁰ and other research on the question has also produced inconsistent results. The Duke study found that “assignment to the outpatient commitment group did not reduce violence, [but] a combination of extended outpatient commitment and frequent service use was associated with less violence.”²²¹ Other researchers have found no association between outpatient commitment and violence,²²² but such a link was central to another study using longitudinal data of 262 patients placed on outpatient commitment in the Piedmont region of North Carolina.²²³

The Piedmont region study uncovered an association between extended mandatory community treatment and reduced rates of arrest for individuals with a history of “dual-system recidivism, that is, a history of both arrest and hospitalization,” and concluded that this association was

²¹⁶ See Phelan et al., *supra* note 59.

²¹⁷ *Id.* at 140–41.

²¹⁸ *Id.* at 142.

²¹⁹ See *supra* text accompanying notes 6–13.

²²⁰ Swartz & Swanson, *supra* note 5, at 28.

²²¹ See Phelan et al., *supra* note 59, at 142.

²²² See Virginia A. Hiday & Teresa L. Scheid-Cook, *The North Carolina Experience with Outpatient Commitment: A Critical Appraisal*, 10 INT’L J. L. & PSYCHIATRY 215 (1987).

²²³ See Swanson et al., *supra* note 81, at 156.

mediated by the variable of violent behavior.²²⁴ Building on the findings of the earlier Duke study, these researchers hypothesized that, while outpatient commitment might not reduce the risk of arrest for all persons with serious mental illness, it could be effective for those with dual-system recidivism whose criminal system involvement would more likely be related to their mental illness.²²⁵ They focused on three variables, violent behavior, substance misuse, and medication compliance, “as likely intervening factors that might explain the effect of [outpatient commitment] in reducing arrest in prior dual-system recidivists.”²²⁶ The researchers found that extending outpatient commitment reduced violent behavior, and this was primarily responsible for the lower rates of arrest they observed in this population.²²⁷ Although the study was not a controlled randomized design, and the authors conceded that the relationships between outpatient commitment, violent behavior, and rates of arrest are complex and uncertain, they concluded that their data did suggest the potential for effective collaborations between criminal justice and mental health agencies and for the potential benefits of outpatient commitment when “judiciously applied.”²²⁸

CONCLUSION

The proposed Murphy Bill and calls by others for the increased use of outpatient commitment implicate a broader debate about the foundations of civil commitment law and practice. For advocates who assert that the restrictive approach to involuntary treatment adopted throughout the United States in the 1970s undermined legitimate *parens patriae* objectives, imposed unnecessary costs on the families of chronic mentally ill individuals, and left too many treatment-resistant patients disconnected from the public mental health system, the adoption of a more effective system of outpatient commitment, along with other reforms designed to bring patients into care before they decompensate into dangerousness or grave disability, is long overdue.²²⁹ The adoption of these reforms,

²²⁴ See *id.* at 160, 183–84.

²²⁵ See *id.* at 183–84.

²²⁶ *Id.*

²²⁷ See *id.*

²²⁸ See *id.* at 184–86.

²²⁹ See generally E. FULLER TORREY, *THE INSANITY OFFENSE; HOW AMERICA’S FAILURE TO TREAT THE SERIOUSLY MENTALLY ILL ENDANGERS ITS CITIZENS* (2008) (noting the deinstitutionalization movement “emptied the nation’s psychiatric hospitals without ensuring that patients would receive care once they left the hospitals”).

however, raises difficult questions of funding, implementation, and enforcement.²³⁰

In addition, there are legitimate questions about the benefits of mandated outpatient treatment relative to the costs that the use of government coercion may impose in terms of diminished patient autonomy and in chilling the willingness of mentally ill persons to seek treatment voluntarily.²³¹ The most promising outcome studies, providing the strongest evidence of the upside potential of outpatient commitment, are from New York, the state that has most aggressively addressed the funding and implementation issues.²³² Significant uncertainty remains, however, regarding the potential for enforced community-based treatment to reduce subsequent hospitalizations, arrests, homelessness, and distress in jurisdictions that do not put into place either adequate treatment and service resources or the administrative structures needed to ensure success. Moreover, even in New York the great majority of patients subject to Kendra's Law have come under court order as a step-down measure upon their discharge from inpatient care.²³³ Presumably, the costs to individual self-determination and autonomy inherent in enforced treatment are lower for these patients, given that they are transitioning from inpatient confinement, than for the smaller number of individuals subject to outpatient commitment as a front-end measure. Challenging questions about the relative costs and benefits of mandated outpatient treatment remain, therefore, in other jurisdictions that may choose to deploy this intervention prospectively, especially if they offer fewer dedicated resources and less coordination of care than has been present in New York.

Finally, the difficulty of enforcing outpatient commitment orders, given states' reluctance to hold noncompliant patients in contempt or to impose other punitive measures, suggests that the practice must rest

²³⁰ See *supra* text accompanying notes 112–76.

²³¹ See Richard J. Bonnie et al., *supra* note 49, at 801–02.

[T]he coercion-centered reforms might deepen stigmatization of people with mental illnesses and impede progress toward a voluntary, recovery-oriented system of services. The perceived link between violence and mental illness leads people to frame the policy choices in mental health law as trade-offs between individual liberty and privacy, on one side, and greater security, on the other. However, although such a trade-off is sometimes posed in certain cases, a climate of coercion drives people away from services. The right prescription is to draw people into services by protecting privacy, mainstreaming mental health treatment, and destigmatizing mental illness.

Id.

²³² See Swartz et al., *supra* note 114, at 3–4.

²³³ See *id.* at vi.

primarily on either the “black-robe effect”²³⁴ or on a recognition that the true object of the court’s mandate is the network of community service providers, case managers, and others who presumably offer more focused and coordinated care as a consequence of the judicial involvement inherent in outpatient commitment. The former rationale is controversial at best and raises difficult questions of professional ethics and fairness.²³⁵ The latter rationale may well be the better ground for increasing the use of outpatient commitment, although an alternative effort on the part of state legislatures and public mental health policymakers to increase the use of Assertive Community Treatment without judicial involvement might well accomplish the same ends. Whether ACT and other policy and funding innovations that carry fewer costs to individual liberty can provide an equivalent stimulus to providers and others to offer effective and coordinated care to this difficult population of patients is a question that warrants further experimentation and study.²³⁶ The willingness of individual states or communities to undertake these alternative projects in lieu of an increasing use of outpatient commitment is likely to turn on the broader perspectives concerning civil commitment law and practice, already evident in the national debate over the Murphy Bill, which decision-makers bring to these deliberations.²³⁷ It is only with conscious attention to these background assumptions that an effective evaluation of relative costs and benefits can be accomplished.

²³⁴ See TREATMENT ADVOCACY CENTER, *supra* note 170.

²³⁵ See Hoge & Grottole, *supra* note 171, at 167.

²³⁶ See Coldwell & Bender, *supra* note 206, at 398.

²³⁷ See *supra* text accompanying notes 99–112.