

Running head: OUTPATIENT COMMITMENT: A PHILOSOPHICAL DILEMMA

Outpatient Commitment: A Philosophical Dilemma for Families

Thomas H. Pyle

University of Medicine and Dentistry of New Jersey

Abstract

Family members of dually diagnosed psychiatrically disabled individuals sometimes often face a special challenge during the course of their loved ones' recoveries. That challenge is how to reconcile the ideal of individual autonomy with the informed parental instinct to help an ailing or unable child at any age. This challenge becomes a dilemma when a loved one lacks or loses insight to her or her personal mental state due to psychiatric disability or addiction or both. If a loved one is refusing medication or program or support group participation, is it right for a parent to support or even initiate an outpatient commitment for the loved one? The question touches on many sensitive issues within psychiatric rehabilitation. This paper attempts to frame the challenge for family members.

OUTPATIENT COMMITMENT: A PHILOSOPHICAL DILEMMA

The conclusion of celebrated French playwright – and psychiatric “survivor” – Antonin Artaud’s scathing 1925 letter to the “Directors of the Asylum” portended today’s contentious debate about compulsory treatment. “Try to remember,” he admonished the doctors, “that tomorrow morning during your rounds, when, without knowing their language, you will attempt to talk with these people over whom, you must admit, you have only one advantage, namely force” (Agnetti, 2009, p. 33). Forced detention then; compulsory treatment today... The most vexing issue in mental health is still the power to force one with mental illness to treatment against his will. Is it necessary? Can it be justified?

Mental care for the most needy is a social disaster. So says compulsory treatment advocate Dr. E. Fuller Torrey, who calls it “among the greatest calamities” (Torrey, 2008, p. 1). Why? Torrey says that violent crimes by untreated deinstitutionalized individuals are increasing. Four million Americans have severe psychiatric disorders. Ten percent of these (400,000) are the most problematic who, if not treated, tend to be homeless, jailed, or victimized. One percent (40,000) are “overtly dangerous” (Torrey, 2008, p. 5-6). Torrey’s controversial book, *The Insanity Offense*, grimly cites multiple “preventable tragedies” caused by this 1% cohort.

Two villains caused this disaster: deinstitutionalization and legal activism (Torrey, 2008, p. 1). Deinstitutionalization forced thousands needing care to the streets well before American communities were prepared to care for them, causing a small tsunami of seriously problematic victims. Around the same time zealous civil libertarians won more individual rights of the severely mentally ill. California’s Lanterman-Petris-Short Act (“LPS”) in 1967 set the legislative pace. *Lessard v. Schmidt* (1973) in Wisconsin overturned involuntary commitment laws. *Rennie v. Klein* in New Jersey and *Rogers v. Okin* in Massachusetts established rights of patients to refuse treatment, even if they did not know they were sick (Torrey, 2008, p. 4).

OUTPATIENT COMMITMENT: A PHILOSOPHICAL DILEMMA

The result? To cite just one example, by 1985 the seriously mentally ill comprised 30% to 50% of homeless in Los Angeles (Torrey, 2008). Many didn't know they were ill. Five to 10 percent still with severe psychiatric disorders would commit acts of serious violence each year (Torrey, 2008, p. 143). Family members were the most frequent targets. Up to 60 percent of murder victims of mentally ill perpetrators were family members, compared to only 16 percent of family members murdered by non-mentally ill individuals (Torrey, 2008, p. 148). The common thread in such preventable tragedies was lack of treatment. (Torrey, 2008, p. 92).

A devilish detail in this sorry saga is *anosognosia*, a state of mind that does not recognize its own illness. Up to 57 percent of individuals with schizophrenia experience it (Torrey, 2008, p. 112). Most who deny their illnesses also refuse medication; they do not believe they need it. The implication: "Medication refusal occurs commonly among the 400,000 individuals with severe psychiatric disorders who are most problematic and is almost universal among the 40,000 who are overtly dangerous..." (Torrey, 2008, p. 117). The consequence is unnecessary violent behavior, resulting in preventable tragedies (Torrey, 2008, p. 119).

The ultimate devil is society's own "unawareness of unawareness" (Torrey, 2008, p. 120). LPS Act sponsor Frank Lanterman in California, for example, rejected the very idea of anosognosia: "To me this concept is indefensible" (Torrey, 2008, p. 121). The three judges behind the *Lessard* decision were likewise confidently ignorant. Societal unawareness of unawareness ironically defeats society's own self-interest. It drives away those it considers most dangerous from the treatment they most need and society needs them to have.

What must change? Torrey (2007) has several ideas. Laws that perpetuate the system's problems should be modified. The 1% cohort should be better identified through screening. Antipsychotic medications and substance abuse measures must be more available. And,

OUTPATIENT COMMITMENT: A PHILOSOPHICAL DILEMMA

treatments should be “enforced” through personal finances managed by representative payees, access to housing, mental health courts, and “assisted” outpatient treatment.

But the shrill alarm sounded by Torrey rings harshly in the ears of consumer activists worldwide. To them, compulsory treatment is anathema, a fundamental, flagrant violation of human rights. So declared several psychiatric survivor groups in their statement at the World Psychiatric Association’s Conference entitled “Coercive Treatment in Psychiatry: A Comprehensive Review” in Dresden, Germany in 2007: “We stand united in calling for an end to all forced and coerced psychiatric procedures and for the development of alternatives to psychiatry...” (European Network et al., 2007). Consumer pioneer and “psychiatric survivor” Judi Chamberlin claims that psychiatric diagnoses are actually not clear about the nature of psychiatric disabilities (National Empowerment Center, n.d.). Evidence is also scant that neuroleptic medications improve outcomes and in fact actually cause damaging long-term brain changes. And psychiatrists are not truly able to predict violent behavior in their patients, nullifying justifications of such coercion based on doctors’ opinions about individuals’ dangerousness. (National Empowerment Center, n.d.).

A major question in compulsory treatment is capacity determination. Although the individual recovery model continues to gain respect, in compulsory treatment the medicine model still seems fully in charge: “...the fundamental features of mental health legislation remain the same: imposed medical authority supported by a legal framework which gives priority to medical expertise” (O’Brien, 2010). Capacity determination is a moral and social minefield. Its stakes are so high because the ancillary consequences of compulsory treatment are so vexing, for several reasons:

- *Compulsory treatment is discriminatory.* The psychiatrically disabled can be forced to treatment without consent; those with other medical problems cannot. Racial

OUTPATIENT COMMITMENT: A PHILOSOPHICAL DILEMMA

minorities are also more likely to be deemed “dangerous” than whites (Sheehan, 2009).

- *It is stigmatizing.* Laws which allow forced treatment of the “dangerous” surely do nothing to abate stigmatized perceptions of people with mental illness as dangerous (O’Brien, 2010).
- *It is imprecise.* Is capacity ever confused with cooperation? Clinicians tend to equate acceptance of treatment with capacity and refusal of it with incapacity (O’Brien, 2010).

For all its vexing questions, compulsory treatment seems to get results. Involuntarily committed outpatients have been shown to have better outcomes, fewer hospitalizations and arrests, and greater quality of life (Swanson et al., 2003). Long-term outcomes after New York’s 1995 Kendra’s Law, a mandatory treatment law, show that incarcerations, arrests, rehospitalizations, and homelessness were reduced by 70% or more in all categories (Geller, 2006).

The debate about compulsory treatment is hampered by hidebound views which seem to skew the issue to look like involuntary commitment to inpatient hospitalization. Outpatient commitment offers more flexibility in local contexts which ought to help soften ideological rigidity that too often ossifies the discussion. Nevertheless, compulsory treatment might benefit—and the debate about it might modulate—from several improvements in policy and practice, such as more adequate service availability, better criteria for capacity determination, better legal criteria for its use, more professional accountability, and more evidence based practice.

OUTPATIENT COMMITMENT: A PHILOSOPHICAL DILEMMA

References:

- Agnetti, G. (2009). The consumer movement and compulsory treatment: A professional outlook. *International Journal of Mental Health* 37(4), 33-45. doi: 10.2753/IMH0020-7411370403
- Ashcraft, L. & Anthony, W.A. (2006). It's time to end forced treatment. *Behavioral Healthcare*, 26(12), 8-10.
- Bosek, M.S.D., Ring, M.E. & Cady, R.F. (2008). Do psychiatric advance directives protect autonomy? *JONA's Healthcare, Law, Ethics and Regulation* 10(1), 17.
- Burns, T. and Dawson, J. (2009). Community treatment orders: how ethical without experiential evidence? *Psychological Medicine* 39(10), 1583-6.
- European Network of (ex-)Users and Survivors of Psychiatry, World Network of Users and Survivors of Psychiatry, MindFreedom International, & Bundesverband Psychiatrie-Erfahrener (2007). Declaration of Dresden against coerced psychiatric treatment. Retrieved from <http://www.enusp.org/dresden.htm>.
- Deegan, P.E. & Drake, R.E. (2006). Shared decision making and medical management in the recovery process. *Psychiatric Services*, 57, 1636-1639. doi: 10.1176/appi.ps.57.11.1636
- Drake, R.E. & Deegan, P.E. (2009). Shared decision making is an ethical imperative. *Psychiatric Services*, 60(8), 1007.
- Drake, R.E., Deegan, P.E. & Rapp, C. (2010). The promise of shared decision making in mental health. *Psychiatric Rehabilitation Journal*, 34(1), 7-13.
- Fears, S.C. & Hackman, A. (2009). Outpatient commitment: A treatment tool for the mentally ill? *American Medical Association Journal of Ethics* 11(1), 6-12.
- Geller, J.L. (2006). The evolution of outpatient commitment in the USA. *International Journal of Law and Psychiatry* 29(3), 234-248. doi:10.1016/j.ijlp.2005.09.003
- Lawton-Smith, S, Dawson, J. & Burns, T. (2008). Community treatment orders are not a good thing. *The British Journal of Psychiatry* 193, 96-100. doi: 10.1192/bjp.bp.107.049072
- Link, B., Castille, D.M. & Stuber, J. (2008). Stigma and coercion in the context of outpatient treatment for people with mental illnesses. *Social Science & Medicine*, 67, 409-419.
- Monahan, J., Bonnie, R.J., Appelbaum, P.S., Hyde, P.S., Steadman, H.J., & Swartz, M.S. (2001). Mandated community treatment – beyond outpatient commitment. *Psychiatric Services*, 52(9), 1198-1205.
- Monahan, J., Swartz, M., & Bonnie, R.J. (2003). Mandated treatment in the community for people with mental disabilities. *Health Affairs*, 22(5), 28-38.

OUTPATIENT COMMITMENT: A PHILOSOPHICAL DILEMMA

- National Empowerment Center, Inc. (n.d.). Should forced medication be a treatment option in patients with schizophrenia? (Judi Chamberlin debates E. Fuller Torrey, MD on involuntary treatment). Retrieved from <http://www.power2u.org/debate.html>.
- Oaks, D.W. (2008). Prospects for a nonviolent revolution in the mental health system during a time of psychiatric globalization, presented as a plenary lecture at Madness, Citizenship and Social Justice: A Human Rights Conference, Simon Fraser University, 12 June 2008. Retrieved from <http://www.mindfreedom.org/about-us/david-w-oaks/madness-citizenship.pdf/view>.
- O'Brien, A.J. (2010). Capacity, consent, and mental health legislation: time for a new standard? *Contemporary Nurse*, 34(2), 237-247.
- Petrila, J. et al. (2008). Florida's outpatient commitment law: A lesson in failed reform? *Psychiatric Services*, 59(1), 21-23.
- Ridgely, M.S., Borum, R. & Petrila, J. (2001). The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States. Santa Monica, CA: RAND. Retrieved from http://www.rand.org/pubs/monograph_reports/2007/MR1340.pdf
- Sheehan, K.A. (2009). Compulsory treatment in psychiatry. *Current Opinion in Psychiatry*, 22, 582-586.
- Swanson, J.W., Swartz, M.S., Elbogen, E.B., Wagner, H.R. & Burns, B.J. (2003). Effects of involuntary outpatient commitment on subjective quality of life in persons with severe mental illness. *Behavioral Sciences and The Law*, 21, 473-491. doi: 10.1002/bsl.548
- Swanson, J.W., Borum, R., & Swartz, M.S. (2001). Can involuntary outpatient commitment reduce arrests among persons with severe mental illness? *Criminal Justice and Behavior* 28, 156-189.
- Swartz, M.S., Swanson, J.W., Steadman, H.J., Robbins, P.C. & Monahan, J. (2009). New York State Assisted Outpatient Treatment Program Evaluation. Durham, NC: Duke University School of Medicine. Retrieved from http://www.macarthur.virginia.edu/aot_finalreport.pdf
- Swartz, M.S., et al. (2006). Use of outpatient commitment or related civil court treatment orders in five U.S. communities, *Psychiatric Services*, 57(3), 343-49.
- Swartz, M.S., et al. (2008). Outpatient commitment: When it improves patient outcomes, *Current Psychiatry*, 7(4), 25-35.
- Torrey, E.F. (2008). *The Insanity Offense: How America's Failure to Treat the Seriously Mentally Ill Endangers Its Citizens*. New York: W.W. Norton & Co., Inc.

OUTPATIENT COMMITMENT: A PHILOSOPHICAL DILEMMA

Wortzel, H. (2006). The right to refuse treatment. *Psychiatric Times*, 23(14), 1-4.

In addition:

Various resources from the MacArthur Research Network on Mandated Community Treatment.

Retrieved from www.macarthur.virginia.edu.