Temple University Beasley School of Law | Center for Public Health Law Research

FROM: **LEGAL ASSOCIATE**
TO: **LEGAL SUPERVISOR**
DATE: **JUNE 5, 2015**
RE: **BACKGROUND MEMO ON OUTPATIENT COMMITMENT LAWS**

Background Memorandum

Introduction

Over the past several decades there have been many debates about outpatient commitment and how it relates to patient and community safety as well as patient rights. Outpatient commitment is the legal process that forces a mentally ill patient to accept treatment while still interacting with the community in an outpatient setting.[1] This memo will discuss the history of involuntary outpatient commitment, the criteria for commitment, the commitment process, some hotly debated topics on the subject and how outpatient commitment relates to firearm possession.

HISTORY

Outpatient commitment originated from inpatient commitment and was a result from rising concerns about patients' rights and care. In the 1960s, there was an increase in public concern about the treatment of patients in inpatient commitment facilities.[2] The increase in concerns first resulted in stricter inpatient laws that created a shift in commitment criteria.[3] Originally, the commitment criterion was a broad focus on patient incompetency which shifted to a narrower benchmark of proving the individual poses a threat to themselves or others.[4] Furthermore, the courts became the primary decision makers when determining if the individual met the criteria for commitment.[5] The concern for patient care was balanced with the concern for patients not voluntarily following their medical treatment orders, which led to

[1] Gerry McCafferty & Jeanne Dooley, *Involuntary Outpatient Commitment: An Update*, 14 Mental and Physical Disability Law Reporter 277, 277 (May-June 1990).
[2] Richard C. Boldt, *Perspectives on Outpatient Commitment*, 49 NEW ENG. L. REV. 39, 43 (2014).
[3] Id.
[4] Id.
[5] Id.

jurisdictions adopting outpatient commitment laws.[6]

A civil commitment bill in the District of Colombia led the way for the involuntary commitment reforms.[7] The bill created two changes in incompetence hearings. First, there was a shift from assuming all individuals were incompetent to make their own medical decisions to an assumption that the patients were competent until proven otherwise by the court system.[8] Second, there was a narrowing of the standards the state must meet before committing a patient.[9] The new standard stated the state must prove the patient is dangerous to themselves or others.[10]

Today, forty-five states and the District of Columbia have a statute permitting outpatient commitment.[11] The five states that do not permit outpatient commitment are Connecticut, Maryland, Massachusetts, New Mexico, and Tennessee.[12] The general goals of outpatient commitment statutes include the reduction of patient hospitalization, homelessness, arrests and incarcerations, violence and crime, and caregiver stress and the improvement of treatment compliance.[13]

CRITERIA FOR COMMITMENT

While there is a lot of variance between states, most of the outpatient commitment statutes have similar patient criteria as the inpatient commitment statutes.[14] Many states require that a judge must find

[6] *Mandatory Outpatient Treatment*, American Psychiatric Association, Dec. 1999, at 2.
[7] *See Supra* note 2 at 43.
[8] Id. at 44.
[9] Id.
[10] Id. at 44-45.
[11] *Assisted Outpatient Treatment Laws*, Treatment Advocacy Center (2011), http://www.treatmentadvocacycenter.org/solution/assisted-outpatient-treatment-laws.

[12] *Id*.; Tennessee's outpatient commitment law is debated because the state's law mandates the patient first be given an inpatient commitment order and then switched to outpatient commitment if advised by the hospital superintendent, which many say more parallels a conditional release rather than outpatient commitment, E. Fuller Torrey & Robert J. Kaplan, *A National Survey of the Use of Outpatient Commitment*, 46 Psychiatric Services (Aug. 1995), http://www.treatmentadvocacycenter.org/legal- resources/legal-articles/357; New Mexico is currently working on its own bill for outpatient commitment. The bill passed the house on March 21, 2015 and is currently being reviewed by the Senate, 2015 Bill Text N.M. S.B. 53.

[13] Id.
[14] *Involuntary Outpatient Commitment*, Harvard Medical School (Aug. 1, 2008), http://www.health.harvard.edu/newsletter_article/Involuntary_outpatient_commitment

the patient had 1) one or more prior hospitalizations or arrests within a set time period in the recent past and 2) those hospitalization and arrests show the patient is unlikely to voluntarily adhere to the medical treatment prescribed and will deteriorate.[15] Other states necessitate the judge to find the individual lacks the capacity to make rational, informed decisions with regards to their medical treatment.[16] A few states require a finding that the patient is likely to deteriorate if they are not treated.[17]

While the original movement in the 60s stepped away from the focus on patient incompetency and towards the dangerousness determination of the patients to find a need for commitment, some states are beginning to broaden their standards again. A handful of states allow for outpatient commitment when there is a prediction of patient deterioration that can result in the patient becoming dangerous or becoming gravely disables if they do not receive treatment.[18] Many of these states focus on five triggers to make their determination including the ability of the patient to make rational, informed decisions about their treatment and the patient's ability to survive safely without supervision.[19] The most common combination of triggers are focused on the individual's history of mental illness that has resulted in hospitalization, mental services in a correctional facility, or acts, attempts or threats violent behavior on multiple occasions in a set period of time, the individual's likelihood of volunteering for treatment when they would benefit, and the individual's potential of deterioration to a imminently dangerous or dependent state without treatment.[20]

---

[15] Richard C. Boldt, *Perspectives on Outpatient Commitment*, 49 NEW ENG. L. REV. 39, 55-56 (2014).

[16] Id. at 56.
[17] Id. at 57.
[18] Id. at 61; North Caroline states that proof of either the dangerousness of the patient or the prediction that the patient will deteriorate can be used as proof that outpatient commitment is necessary, *see*, N.C. Gen. Stat. Ann. §122C-261.
[19] Id. at 61-62.
[20] Id.; Kendra's Law requires the three most common triggers for a court to order outpatient commitment, N.Y. C.L.S. Men. Hyg. §9.60.

PROCESS FOR COMMITMENT

Since the commitment reforms in the 60s, the outpatient commitment process has become heavily reliant on the judicial system. Individuals now have the right to due process as well as the right to counsel before they can be committed.[21] Furthermore, the court must find the commitment is required by clear and convincing evidence.[22] Still, while the current statutes aim to mitigate past exploitations of mental health patients by giving them more rights in the courtrooms, many hearings are treated as a formality more than as a process to protect the patient's rights.[23]

There are four reasons a patient will generally be given outpatient commitment by a court. First, a mentally ill patient who commits a crime may be given the option to go to mental health court where the judge will order outpatient commitment for the individual if they are found guilty.[24] Second, the patient may be switched to outpatient commitment from inpatient commitment.[25] Third, the patient may meet the criteria for inpatient commitment and the court may give the individual a choice between inpatient and outpatient commitment.[26] Fourth, the court may find a patient does not meet the criteria for inpatient commitment, but the individual is a risk for decomposition to the point that they will meet the criteria.[27]

The types of services provided to outpatient commitment patients ranges between states. Some states only require a focus on the treatment and management of the patient's mental illness.[28] Other states promote services to look at the entire range of factors that contribute not only to the individual's

[21] *See*, *Lessard v. Schmidt*, 349 F. Supper. 1078, 1093 (E.D. Wis. 1972).
[22] *See*, *Addington v. Texas*, 441 U.S. 418 (1979).

[23] Candice Teri-Lowe Player, *Outpatient Commitment ad Procedural Due* Process, 38 INTERNATIONAL J. OF L. AND PSYCHIATRY 100, 104 (2015).

[24] John Monahan, et. al., *Mandated Community Treatment: Beyond Outpatient Commitment*, Psychiatric Services, 7-8 (Sep. 2002).
[25] Id. at 9.
[26] Id.
[27] Id.
[28] Richard C. Boldt, *Perspectives on Outpatient Commitment*, 49 NEW ENG. L. REV. 39, 56 (2014).

mental illness, but also their functionality in the community and their criminal behaviors.[29] A third set of states provide services to patients who have the "potential-for-deterioration" based on past chronic relapses.[30]

Furthermore, a handful of states discuss forced medication as part of the treatment program assigned to outpatient commitment patients. Specifically, anti-psychotic drugs have been specifically listed in the types of treatment allowed with outpatient commitment programs.[31] Some argue the forced medication is a violation of the patient's right to refuse medical treatment.[32] Others say any other forms of treatment such as therapy are ineffective without medication.[33]

States also vary on their enforcement policies and what punitive actions can be taken if a patient does not comply with their outpatient commitment order. Some states do not have a statute addressing enforcement.[34] Other states return a patient to inpatient commitment if they are not compliant with their outpatient commitment order.[35] When patients are returned to inpatient commitment facilities though, some jurisdictions require another hearing to determine if the patient actually meets the inpatient commitment criteria[36] while other states allow for "continuing jurisdiction," which allows a judge to modify the sentencing without another hearing.[37] Furthermore, there are currently debates as to whether

[29] Id.
[30] Id. at 57.
[31] Id. at 57.
[32] *Mandatory Outpatient Treatment*, American Psychiatric Association, Dec. 1999, at 8; many of these arguments rely on U.S. Supreme Court cases that state there is a fundamental right to medical treatment unless patient is presently dangerous or lacks the capacity to make informed decisions about their medication, *see Washington v. Harper*, 494 U.S. 210 (1990) and *Riggins v. Nevada*, 504 U.S. 127 (1992).
[33] *Mandatory Outpatient Treatment*, American Psychiatric Association, Dec. 1999, at 8.
[34] Id. at 69.
[35] Id. at 68.
[36] Id. at 69; In North Dakota, if a patient is found to not comply with the treatment or the treatment is not sufficient, an appeal must be made and the court must hold a hearing within seven days to determine if the current treatment is sufficient or if an alternative should be ordered, N.D. Cent. Code, § 25-03.1-21.
[37] Gerry McCafferty & Jeanne Dooley, *Involuntary Outpatient Commitment: An Update*, 14 Mental and Physical Disability Law Reporter 277, 281 (May-June 1990); Michigan is an example of a state that allows for "continuing jurisdiction" though the patient retains the right to object and must be informed of the right by the hospital at the time of transfer, M.C.L.S. § 330.1475.

outpatient commitment noncompliance can be used as evidence to support the need for inpatient commitment.[38]

OUTPATIENT COMMITMENT AND FIREARM POSSESSION

Federal law requires licensed gun dealers to perform background checks on customers and prohibits the sale or transfer of firearms to people who have been adjudicated as having a mental illness, which includes people who have been involuntarily committed, but states must voluntarily participate in reporting mental illnesses that would disqualify a person from owning a gun.[39] Background checks are run through the National Instant Criminal Background Check System (NICS) and the database updates rely in part on state reporting.[40] Currently, forty states authorize reporting for the NICS.[41]

In addition to the federal laws, thirty-three states and the District of Columbia have statutes that restrict or prohibit the sale or transfer of all firearms to dangerous, mentally ill patients, which includes patients who have been given outpatient commitment.[42] Michigan and North Carolina only restrict the sale or transfer of handguns to dangerous, mentally ill patients.[43] Most states do have statutes that allow law enforcement to seize firearms from prohibited possessors when they are discovered and a handful of states have procedures for removing firearms from a person who becomes a prohibited possessor after already owning a firearm.[44] The surrender laws for a person who

[38] *See Supra* note 28 at 69.

[39] *Federal Law on Mental Health Reporting*, Law Center to Prevent Gun Violence (May 21, 2012), http://smartgunlaws.org/federal-law-on-mental-health-reporting/.

[40] Id.

[41] *Summary of State Law*, Law Center to Prevent Gun Violence (Sep. 18, 2013), http://smartgunlaws.org/mental-health-reporting-policy-summary/#state.

[42] *Categories of Prohibited People Policy Summary*, Law Center to Prevent Gun Violence (Sep. 29, 2013), http://smartgunlaws.org/prohibited-people-gun-purchaser-policy-summary/; *See generally*, A.R.S. § 13-3101(A)(7)(a), Arizona is an example of a state that prohibits firearm possession by dangerous, mentally ill patients.

[43] *Id.; See*, MCLS § 28.422 Sec. 2(3)(a) and N.C. Gen. Stat. § 14-404(c); North Carolina's law specifies "one who has been adjudicated mentally incompetent," which may or may not cover all outpatient committed patients.

[44] *Id.*; *See*, Mass. Gen. Laws ch. 140, § 129B(4).

becomes a prohibited possessor ranges from immediate surrender by court order to a sixty-day period in which the person must sell their firearm to someone outside of their home.[45]

LONGITUDINAL STUDY OF OUTPATIENT COMMITMENT LAWS

Creating a longitudinal study of state outpatient commitment statutes is probably worth the effort. There are several waves of outpatient commitment statute adoptions, which could be interesting to study. The first waves of statute adoptions stemmed from the 60s and 70s worry about patient rights and started with North Carolina's outpatient commitment statute in 1973.[46] In 1995 though, a study concluded that outpatient commitment laws were underutilized.[47]

In the late 90s and early millennium, a second wave of statute adoptions occurred and shows some correlation with tragic events.[48] The second wave's association with tragedies might create an interesting longitudinal study because the outpatient commitment laws originated as a balance between patient rights and community safety and the tragedy responses seem to be working to reflect that balance still. Furthermore, the second wave was a time in which many states began to adopt and amend outpatient commitment statutes showing a lot of legal activity over a short period of time.

Conclusion

State laws about outpatient commitment have a wide variation based on criteria for committing a patient, the process of committing a patient, and how the process is enforced. The majority of states though focus on the dangerousness and reasoning ability of the patient to some extent. Additionally,

---

[45] Id.
[46] 1973 N.C. Sess. Laws, Ch. 1408 §1.
[47] E. Fuller Torrey & Robert J. Kaplan, *A National Survey of the Use of Outpatient Commitment*, 46 Psychiatric Services (Aug. 1995), http://www.treatmentadvocacycenter.org/legal-resources/legal- articles/357.
[48] In 1999, New York adopted Kendra's Law in response to the death of Kendra Webdale, who was pushed in front of a train by a community member who was not being treated for his mental illness at the time, *An Explanation of Kendra's Law*, Office of Mental Health (Nov. 1999; revised May 2006) http://www.omh.ny.gov/omhweb/Kendra_web/Ksummary.htm; in 2002, California adopted Laura's Law in response to the death of Laura Wilcox who was a mental health clinic volunteer who was shot by a patient who refused his treatment, The Assisted Outpatient Treatment Demonstration Project Act of 2002, Cal. Wel. & Inst. Code Div. 5, Pt. 1, Ch. 2, Art. 9.

there are still many debates about the rights of the patients as well as why the patients deteriorate in the first place.

Furthermore, firearm laws in relation to mentally ill patients vary heavily. While there are federal laws restricting the ownership of guns by mentally ill patients, the states have a lot of control over medical history reporting. Not all states report and those that do have authorized different levels of medical record use as well as different required time periods in which reporting is required.