Outpatient Commitment
Helpful Treatment Tool, Unnecessary Deprivation of Liberty or Merely a Distraction?

Mark J. Heyrman
Clinical Professor of Law
University of Chicago Law School
1111 East 60th Street
Chicago, Illinois 60637
773-702-9611
Email: m-Heyrman@uchicago.edu
What is outpatient commitment?

• A court order for involuntary treatment in the community issued as an alternative to or at the end of a period of inpatient commitment (commitment to a hospital).

• The standards and procedures for imposing outpatient commitment vary widely from state to state.

• The mechanisms for enforcing outpatient commitment vary widely from state to state.
The goals of outpatient commitment

- Insure continuity of care for persons with serious, treatable, but incurable mental illnesses—usually focused on insuring continuity of psychotropic medication
- Reduce recidivism
- Improve quality of life for persons with mental illnesses and their families and communities
The Identified Problem to Be Solved by Outpatient Commitment

• Since the 1950s we have reduced the number of inpatient psychiatric beds by 95% (from 35,000 to 1,200 state operated beds in Illinois).
• The vast majority of persons with serious mental illnesses are now living in the community.
• Some persons with very serious mental illnesses (schizophrenia and bipolar disorder) often cycle in and out of hospitals (and prisons and jails and homelessness).
• After a partial recovery during brief inpatient stays, these persons leave the hospital, stop taking psychotropic medications and relapse.
• If only we could keep these persons on medication, we could break this cycle.
• Outpatient commitment will force patients to continue their medication and all will be well
Kendra’s Law: The Foundation Myth of Outpatient Commitment

- Outpatient commitment was not available in the United States
- A person with a serious mental illness was prematurely discharged from a New York State hospital due to our excessive concern with civil liberties and our restrictive commitment laws
- He refused treatment in the community.
- He pushed Kendra to her death under a subway train in New York City
- New York State responded by enacting an outpatient commitment law—named Kendra’s Law.
- That law has succeeded in breaking the cycle of repeated hospitalizations in New York.
- Other states should follow New York’s example.
Kendra’s Law: an alternative view

• Outpatient commitment had been on the books in the many states long before Kendra’s Law.
• The man who pushed Kendra to her tragic death in NYC was discharged against his will due to a lack of hospital beds.
• The man who pushed Kendra to her tragic death was not offered even reasonably adequate community mental health services after his discharge.
• New York State enacted an outpatient commitment law which was accompanied by a massive increase in community mental health funding.
• The research on Kendra’s Law and other outpatient commitment laws is inconclusive.
• States wishing to improve the treatment of persons with serious mental illnesses would be wise to study the research carefully to determine whether, and under what circumstances, the use or increased use of outpatient commitment will improve the care of persons with serious mental illnesses.
The Research on Kendra’s Law

• First take: Bellevue Hospital study found that the enactment of Kendra’s law improved the treatment outcomes of persons under outpatient commitment, but that persons not under such orders had a similar improvement in outcomes.

• Second Take: Persons under outpatient commitment orders did better than those not under outpatient commitment orders. Study warned that this result could not be generalized to states that had not increased the availability of community mental health services to both groups.
Outpatient commitment in Illinois: The legal arrangements

• Outpatient commitment in the MHDDCode of 1978.
• New system for outpatient commitment created in 1991 authorizing involuntary medication orders in the community.
• Agreed outpatient commitment orders authorized in 2006
• Law spelling out explicit standards and procedures for outpatient commitment enacted in 2010.
1978 Outpatient commitment law (405 ILCS 5/3-811)

• Since 1978 Illinois law has required a court considering involuntary commitment on an inpatient basis to consider commitment to a less restrictive alternative.

• Outpatient commitment only authorized for persons meeting the “subject to involuntary admission” standard in 405 ILCS 5/1-119.

• Court empowered to commit respondent to the “care and custody” of a person, including a family member or an institution.
Agreed orders for outpatient commitment under 405 ILCS 5/3-801.5

• Allows persons facing involuntary inpatient commitment to agree to outpatient commitment in order to avoid hospitalization.
• Outpatient commitment order may include psychototropic medication
• Order may last up to 180 days and may be extended by agreement.
• A person who violates the order can be hospitalized but may immediately request discharge under the same terms as a “voluntary patient” under 405 ILCS 5/3-400, et seq.
• Continued confinement beyond few days is permitted only if a petition for inpatient commitment is filed with the court.
Outpatient medication orders under 405 ILCS 5/2-107.1

• Court can order involuntary medication on an outpatient basis following a hearing.

• Hearing procedures are substantially similar to those for involuntary inpatient commitment.

• Seven-part standard includes requirement of proof by clear and convincing evidence that the respondent lacks decisional capacity and that the medication is in her or his best interest. But no proof of dangerousness to self or other is required.

• Involuntary medication can begin for someone in an inpatient setting and continue if and when the person is released.

• Orders last for 90 days but may be renewed.

• Enforcement is not specified in the statute.
Elaborate Outpatient Commitment Law Enacted in 2010

• Explicit standard for outpatient commitment set forth in 405 ILCS 5/1-119.1
• New Article VII-A added to MHDDCode detailing procedures for outpatient commitment.
• Outpatient commitment procedures are identical to inpatient commitment procedures.
• Outpatient commitment orders last for up to 180 day, but may be renewed following another hearing.
• A person who violates an outpatient commitment order may be placed in a mental hospital for no more than 24 hours unless a petition for inpatient commitment has been filed. 405 ILCS 5/3-812.
Outpatient commitment in Illinois: The History of Its Use Since 1978:

• No organized effort to use outpatient commitment until the 1990s.
• Brief and unsuccessful Chicago-Read MHC experiment tried in the 1990s.
• Sporadic use by private practitioners since the 1990s
• Extremely rare use of agreed orders for outpatient commitment under Section 3-801.5.
• Extremely rare use of involuntary medication orders under Section 2-107.1, but only when the respondent is confined at the outset of the order and released during its duration.
• Extremely rare use of outpatient commitment procedures created in 2010.
Reasons why outpatient commitment is not used in Illinois:

• Lack of treatment resources
• Lack of infrastructure
• Opposition by (or lack of support from) necessary participants
  • Community providers
  • State’s attorneys
  • Judges
  • Hospitals (public and private)
• Opposition by necessary participants primarily due to lack of resources and infrastructure
Claims of opponents:

• Enactment of outpatient commitment laws will dramatically increase coercion and loss of autonomy for persons with mental illnesses.

• Outpatient commitment has a “net-widening” effect which will subject to involuntary treatment many people who would otherwise not be so burdened.

• The primary treatment ordered will be psychotropic medications which have serious and sometimes irreversible side effects.

• Without more services, outpatient commitment will reduce the services available on a voluntary basis.
Response to opponents:

- Outpatient commitment laws have existed in most states for decades
- Most states are unwilling to invest in the infrastructure needed to implement outpatient commitment laws
- Most states are unwilling to invest in the treatment services needed to implement outpatient commitment laws
- Because of scarce resources, outpatient commitment is usually restricted to very tiny percentage of persons with mental illnesses—those with the most serious symptoms
- Since outpatient commitment is less restrictive than inpatient commitment, if focused on a narrow population it may reduce the need for more coercive inpatient commitment.
More arguments for outpatient commitment:

• Could be used to convince the state to spend more money—that’s what happened in New York with Kendra’s Law
• We should focus on the sickest people first because they are most at risk and impose the largest costs on the system
• We will never have the money to offer all of the services needed to engage people in the mental health system—coercion is much cheaper
• The sickest people can never be engaged, only coerced
More arguments against outpatient commitment:

• We have never actually tried to engage people in the mental health system by offering them the services they need and want
• Engagement has been shown to work with some of the sickest people
• It is morally wrong to use coercion unless engagement has been tried first and failed
• Engagement is actually cheaper because we do not need to waste money on enforcement infrastructure.
Let’s Change the Subject: It’s the Money, Stupid!!!

• Mental health services have always been underfunded.
• The mental health system in this country is broken.
• There aren’t enough mental health advocates.
• We can’t afford to fight with each other.
• We should focus all of our energy on issues that unite us rather than divide us.
• Mental health advocates will never agree on the wisdom of outpatient commitment
• We should focus all of our energy on increasing mental health funding