Ambivalence Codified: California's New Outpatient Commitment Statute

Paul S. Appelbaum, M.D.

California has been a trendsetter in mental health law. In the realm of involuntary commitment, California's 1967 Lanterman-Petris-Short Act, with its emphasis on dangerousness-based criteria and rigorous procedural protections, shaped a generation of commitment statutes across the country (1). The California Supreme Court's decision in *Tarasoff v. Regents of the University of California* in 1976 changed the way the nation—and arguably much of the world—thinks about mental health professionals' liability for their patients' violent acts (2). When California acts, other states tend to follow. Thus it is of particular interest that California is the latest state to adopt legislation permitting outpatient commitment of certain persons with mental illness.

At least 39 states and the District of Columbia now have legal mechanisms for some form of mandatory outpatient treatment, but many of these statutes are antiquated and have fallen into disuse (3). California's new law is one of a modern generation of statutes enacted over the past 15 years that attempts to define carefully a group of patients for whom outpatient commitment may be indicated and to afford these patients strict procedural safeguards. However, the new law also suffers from a profound ambivalence about the legitimacy and value of mandatory outpatient treatment that is likely to restrict its practical impact. If other states follow this lead, the future of outpatient commitment may be dim.

Like so many legal initiatives addressing the problems related to mental illness, California's outpatient commitment law—dubbed Laura's Law—was stimulated in part by a senseless act of violence. Laura Wilcox, a 19-year-old college student, was spending her winter break working at a public mental health clinic in Nevada City, California. In January 2001, a 41-year-old psychiatric patient named Scott Thorpe walked into the clinic in a rage. Convinced that the FBI had been ordering people to poison his food and had compelled him to see a psychiatrist whom he considered to be incompetent, Thorpe had been resisting his family's entreaties to take medications. Thorpe shot and killed Laura Wilcox and another worker at the clinic, then drove to a nearby restaurant, where he killed the manager (4).

The murders in Nevada City provided added impetus in California for a long-discussed effort to adopt an outpatient commitment statute. California's Assembly already had passed a bill sponsored by Assemblywoman Helen Thomson that would have expanded the state's commitment law to allow involuntary outpatient treatment. In response, the California Senate commissioned the Rand Corporation to review the existing data on the effectiveness of outpatient commitment. The National Alliance for the Mentally Ill and local groups of mental health professionals had already lined up behind the effort. But it was the murder of Laura Wilcox, the renaming of the bill in her honor, and the testimony of her parents that apparently put the drive over the top.

Laura's Law begins with a preamble that recites some of the data uncovered by the Rand study (5). Perhaps most impressive is that 37 percent of the persons involuntarily committed in California on 72-hour holds had no record of outpatient service use in the previous year. The implicit suggestion is that, had these persons been compelled to accept outpatient treatment, these hospitalizations could have been avoided. The preamble also cites data from a major study of outpatient commitment in North Carolina (6) that suggested that "people with psychotic disorders and those at highest risk for poor outcomes benefit from intensive mental health services provided in concert with a sustained outpatient commitment order."

Under the new California statute, to be eligible for outpatient commitment—referred to somewhat euphemistically as assisted outpatient treatment—a person must meet nine criteria. Most of the criteria are drawn from New York's recently adopted statute, named Kendra's Law after another young woman who was killed by a person with mental illness (7). As in New York, the mentally ill person must be unlikely to survive safely in the community without supervision; have a history of noncompliance that has led to two hospitalizations or incarcerations in which psychiatric services were provided in the previous 36 months, or at least one act or threat of violence toward self or others in the previous 48 months; and require outpatient commitment to prevent relapse or deterioration that would be likely to result in serious harm to the mentally ill person or to others or in grave disability.

Dr. Appelbaum, who is editor of this column, is A. F. Zeleznik professor and chair in the department of psychiatry at the University of Massachusetts Medical School, 55 Lake Avenue North, Worcester, Massachusetts 01655 (e-mail, appelbap@ummhc.org).

Despite its endorsement of outpatient commitment, the California statute has additional criteria that are more restrictive in several ways than those in the New York statute. Whereas the New York statute requires only that a person be judged unlikely to participate in treatment voluntarily, Laura's Law mandates that the person facing involuntary inpatient treatment must actually have been offered an opportunity to participate in a comprehensive treatment plan and have failed to engage in treatment. Similarly, for a person to be subject to the statute, his or her condition must already be substantially deteriorating, rather than merely likely to deteriorate, as in New York. And assisted outpatient treatment must be "the least restrictive placement necessary to ensure the person's recovery and stability," a provision altogether absent from the New York law. The multiple criteria and rigorous standards will offer many points of attack for attorneys defending commitment cases.

Moreover, no more than ten days before the filing of the petition for outpatient commitment, a licensed mental health professional must have personally examined the patient and then must be available to testify in person at the court hearing to follow. Should the person to be committed not go along with an evaluation after "appropriate attempts" to elicit cooperation, the mental health professional must so state and must indicate that there is nonetheless reason to believe that the criteria are met. In such a case, the court can order the person to be taken into custody and transported to a hospital for an evaluation. Assuming the court determines that the criteria have been met, assisted outpatient treatment can be ordered for an initial period of up to six months.

What happens if the patient fails to comply with the terms of an outpatient commitment order? Patients could not be compelled to take medication unless found incompetent in a separate proceeding, and even then the statute lacks procedures for involuntary administration of medication. If the mental health professional who is providing treatment to the person believes that he or she may be in need of involuntary admission to a hospital for evaluation, the patient may be transported by law enforcement officers to a facility for up to 72 hours. But if at any point the evaluators determine that the person does not meet the dangerousness-based criteria for an involuntary commitment, he or she must be released. When patients who are noncompliant are not yet so dangerous to themselves or others that they would qualify for an inpatient commitment under the usual criteria, their families and treaters would appear to have no recourse under the law. Thus a statute ostensibly designed to enable patients to be stabilized in the community and avoid hospitalization precludes enforcement of the court order until patients are in such poor condition that they already qualify for involuntary hospitalization. Moreover, failure to comply cannot in itself be used as grounds for involuntary hospitalization or for a finding of contempt of court.

Perhaps most illustrative of the ambivalent feelings about outpatient commitment that lie behind this statute are the provisions that place significant burdens on any county that undertakes to provide assisted outpatient treatment—and that give each county the right to opt out of the system. If they want to buy in to Laura's Law, counties must develop mobile mental health teams with low staff-to-patient ratios, develop plans for outreach services to families and others who come into contact with persons with severe mental illnesses, provide services for persons with physical disabilities, offer parenting support and self-help options, focus on psychosocial rehabilitation and recovery, create services specifically aimed at homeless persons under the age of 25 years, have services that reflect the needs of women from diverse cultural backgrounds, develop services for persons who have been suffering from mental illness for less than a year, and meet a range of other requirements. All these services must be made available to persons seeking voluntary treatment as well as to those committed for outpatient treatment.

These options, of course, are all desirable elements of a complete, well-funded mental health system. But it is no secret that California's system is far from well funded. By requiring elaborate planning and service provision to all patients, not just those committed—and by providing not an extra dollar for the purpose—the California legislature has created a sham system of outpatient commitment. Even if a county signs up and pays the cost of creating the services required by the statute, the commitment criteria are so narrow that, fairly applied, few patients are likely to meet them. And, of course, even if a person is committed, there is essentially no means of enforcing the law.

What lies behind this anomaly? Many explanations might be offered, and there is likely truth to all of them. Like most people who must stand for reelection, the California legislature's instinctive desire was to offend neither side of the debate, even if they didn't entirely satisfy them either. While the advocates of outpatient commitment can claim victory, their opponents can rest secure knowing that the statute's requirements are sufficiently burdensome that counties will think twice before going along. Given the state's current financial woes—and the traditional position of people with mental disorders at the end of the queue even when times are good—the reluctance to spend more money on mental health services probably played a role as well.

In addition, part of the problem may be that the California legislature found itself pressed to use the right tool for the wrong purpose. Outpatient commitment makes sense as part of the therapeutic armamentarium of a mental health system for patients who have demonstrated that they cannot or will not seek outpatient treatment and who then deteriorate substantially or require repeated hospitalization. These are the patients who are caught in the mental health system's revolving door, or who have dropped out of the system altogether and live in homeless shelters or on sidewalks. They are probably incapable of making competent decisions about their treatment, and

they suffer grievously as a result. An outpatient commitment statute with teeth—one that allows meaningful enforcement of treatment orders—seems likely to change the lives of many of these people for the better.

But like many states, California fell into the trap of looking to outpatient commitment to solve a different problem: violence by persons with mental illness. Despite the statute's use of deterioration criteria, its history makes clear that the legislators had Laura Wilcox's murderer in mind as they crafted the law. As I have argued elsewhere (8), the difficulties in predicting and preventing violence—especially the uncommon acts of brutality that galvanize the media and the public—make outpatient commitment a mediocre tool for the purpose. Perhaps sensing this difficulty, and displaying traditional American reluctance about the use of coercive interventions to prevent crime, the California legislature pulled its punches. It created a statute that spoke to the public demand for safety in the streets but that is so hemmed with restrictions that it is unlikely to be widely used. Had the legislators in fact been thinking of the incompetent psychotic patient living in a box or under a bridge, they might have been less restrictive in designing the outpatient commitment criteria and better able to recognize the need for additional resources to deal with the problem.

The future of outpatient commitment remains uncertain. If pressed into service largely as a tool for public safety, its failings in that role will likely lead to its demise. At this point, in California, as in many other jurisdictions, outpatient commitment remains an approach in search of patients who are likely to benefit from its application. ♦

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