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Back to table of contents Previous ArticleNext Article

ETHICS CORNER

Ethics Considerations of Involuntary Outpatient Treatment

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In the 19th and first half of the 20th centuries in America, involuntary psychiatric treatment was the domain of psychiatric hospitals, and prolonged commitments were easily obtained with few rights retained by patients. Over time, civil commitment laws were changed to reflect a greater emphasis on patient autonomy.

With the deinstitutionalization movement in the 1950s, many chronically mentally ill patients who had been institutionalized were released to outpatient mental health clinics. It was around this time that civil commitment laws were developed to mandate participation in outpatient treatment for mentally ill individuals who lacked sufficient insight into their illness to access treatment voluntarily and whose condition deteriorated dangerously without treatment.

There are many variations between states in the legal pathway to involuntary outpatient treatment, and these differences will not be addressed here. Regardless of a state's legal handling of involuntary treatment, the relevant ethical concepts remain the same. This article highlights the ethical concepts most relevant to involuntary outpatient treatment and calls attention to an APA resource offering guidance on the topic.

In December 2015, the APA Board of Trustees adopted a position statement on involuntary outpatient commitment, defined as "a civil court procedure wherein a judge orders a person with severe mental illness to adhere to an outpatient treatment plan designed to prevent relapse and dangerous deterioration. Persons appropriate for this intervention are those who need ongoing psychiatric care owing to severe illness but who are unable or unwilling to engage in ongoing, voluntary, outpatient care."

Involuntary outpatient treatment pits two important ethical principles against each other, creating a tension between beneficence and autonomy. Beneficence, an ethical principle that dates from the Hippocratic Oath, holds that a physician's efforts shall be focused on providing treatment that helps a patient. In involuntary outpatient treatment, beneficence derives from the belief that treatment will mitigate symptoms of illness that are so severe that they place the patient or others in danger. Patients who are court-ordered to involuntary outpatient treatment have demonstrated past failures to participate in outpatient treatment, subsequent clinical deterioration, and a return to

involuntary inpatient treatment once the patient's symptoms create an imminent risk of harm once again.

Autonomy is a more modern ethical principle, added to the medical ethical lexicon in the mid-20th century, which stresses the right of the individual to make independent decisions. To order a patient to participate in treatment reduces that person's autonomy, and to order that patient to receive a medication involuntarily is an even more extreme encroachment on autonomy. It is because of concerns about such violations of a patient's autonomy that a civil process is required to ensure that the magnitude of beneficence to the patient justifies their loss of autonomy.

Ideally, involuntary outpatient treatment is a temporary condition. One hopes that after six months or longer of enforced adherence to treatment, a patient will experience sufficient improvement in symptoms and/or functioning that the individual recognizes that treatment is helpful and worth continuing. In some cases, this insight never develops, and involuntary treatment may need to be continued. Thus, insight into the effect of treatment on the illness may be considered the hinge point in transitioning away from involuntary treatment. In other words, if a patient recognizes the benefits of treatment, his or her ability to make independent treatment decisions may be restored, and then the principles of beneficence and autonomy are once again in alignment.

A criticism of this view is that the treatment team and the judicial review process get to determine that treatment is beneficent. One might see a tautology in an arrangement whereby we allow only patients who recognize that treatment helps to make independent treatment decisions. However, keep in mind that only the most severely ill patients, those whose symptoms create grave disability or dangers to self or others, are involuntarily ordered into treatment.

The APA's position statement articulates the conditions under which involuntary outpatient treatment is justifiable, including an assessment of likelihood of relapse or deterioration without treatment, the presence of adequate treatment resources, a sufficient duration of time to realize treatment-related improvements, the involvement of patients and families in treatment planning even though treatment is involuntary, and

clearly articulated procedures to follow if a patient does not adhere to involuntary treatment recommendations.

In summary, although involuntary outpatient treatment restricts patient autonomy, it is still considered ethical if the benefits of treatment and the potential harms of foregoing treatment are adequately established under a civil system that includes sufficient resources to render the treatment worthwhile. ■

APA's Position Statement on Involuntary Outpatient Commitment and Related Programs of Assisted Outpatient Treatment can be accessed here .

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