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# Are They Dangerous Yet?: The Foreseeability of Dangerousness in Oklahoma's Involuntary Outpatient Commitment Law and Its Implications for Patient Due Process Rights

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# NOTES

## Are They Dangerous Yet?: The Foreseeability of Dangerousness in Oklahoma's Involuntary Outpatient Commitment Law and Its Implications for Patient Due Process Rights

At the beginning of November 2017, mental healthcare in Oklahoma was certainly in the news. By declaring that a "fee" on cigarettes was actually an unconstitutional tax, the Oklahoma Supreme Court had blown a $215 million hole in the state budget.[1] As the Oklahoma Legislature proceeded with its special session to fill—or maybe just paper over—said hole, the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) faced a $75 million budget cut[2] from their Fiscal Year 2017 operating budget of about $320,993,000.[3] With only two months left in the year to make these cuts, ODMHSAS feared the only solution outside of new revenue was the cessation of all outpatient services.[4]

The crisis was a perfect example of legislatorial mixed messages. In 2016, the Oklahoma Legislature passed Oklahoma's first involuntary outpatient commitment statutes.[5] The legislature subsequently expanded the law to allow for the involuntary outpatient commitment of certain minors and the updated version of the statute went into effect on November 1, 2017.[6] The overall effect of the simultaneous budget cuts and statute implementation was that the legislature placed a greater demand on outpatient services just as its budget-making policies and squabbles threatened to decimate outpatient services altogether.

Given the recent budget crisis and the existential threat it poses to outpatient services as a whole, it is perhaps no wonder that more people have not been talking about the apparently innocuous provisions the Oklahoma Legislature added to the Mental Health title of Oklahoma's

1. Naifeh v. State *ex rel.* Okla. Tax Comm'n, 2017 OK 63 ¶ 51, 400 P.3d 759, 775; Aaron Brilbeck, *State Could Cut All Outpatient Mental Health & Substance Abuse Programs*, OKLAHOMA NEWS 9 (Oct. 18, 2017), http://www.news9.com/story/36630437/state-could-cut-all-outpatient-mental-health-substance-abuse-programs.

2. Brilbeck, *supra* note 1.

3. STATE OF OKLA., FISCAL YEAR EXECUTIVE BUDGET 2017, at 13 (2016), https://www.ok.gov/OSF/documents/bud17_tagged.pdf.

4. Brilbeck, *supra* note 1.

5. *See* 43A OKLA. STAT. § 1-103(20) (Supp. 2016).

6. 43A OKLA. STAT. § 1-103(20) (Supp. 2017).

statutory code in 2016 and 2017.[7] The new provisions consist of a definition for "assisted outpatient" along with an accompanying procedural statute. While the "assisted outpatient" verbiage may sound tame, these statutes actually permit the use of involuntary outpatient commitment in Oklahoma for the very first time.

Historically, "involuntary commitment" meant inpatient commitment. If a person was mentally ill and dangerous, the state could get a court order to confine that individual in a psychiatric hospital against their will. Today, because mental health care systems across the country increasingly rely on outpatient treatment, states have begun to adopt involuntary outpatient commitment statutes. These laws permit courts to order patients to take psychotropic medications rather than be confined for treatment. Oklahoma's "assisted outpatient" provision is modeled off of the most famous involuntary outpatient commitment statute in the country, a New York statute known as "Kendra's Law."[8]

Although involuntary outpatient commitment might seem like a logical outgrowth of involuntary civil commitment, involuntarily committing an individual to outpatient treatment raises questions concerning patient rights and how imminently dangerous an individual must be to support a commitment order. Individuals eligible for involuntary civil commitment pose an immediate and foreseeable danger to themselves or others.[9] In contrast to such *imminently dangerous* individuals, an individual is more *remotely dangerous* when they are not ill enough to be admitted to an inpatient unit but are simultaneously deemed ill enough to be involuntarily committed to outpatient treatment.[10] For the purposes of this paper, the terms *remotely dangerous* and *imminently dangerous* will be used to distinguish between the foreseeability of dangerousness required to support an order for outpatient commitment in contrast to an order for inpatient commitment. Using these terms, a remotely dangerous individual is not presently dangerous like the imminently dangerous individual because the remotely dangerous individual's mental illness is currently controlled by medication. However, a remotely dangerous individual has a documented history of violence toward themselves or others as well as a history of treatment non-compliance that may reasonably result in mental

7. *See id.*

8. 18 N.Y. MENTAL HYG. LAW § 9.60 (McKinney 2015); *see also NY/Kendra's Law*, MENTAL ILLNESS POLICY ORG., https://mentalillnesspolicy.org/kendraslaw.html (last visited Dec. 20, 2018).

9. *See* 43A OKLA. STAT. § 1-103(13) (2011).

10. *See* 43A OKLA. STAT. § 1-103(20) (Supp. 2017).

deterioration and imminent dangerousness in the *future*. As a result, the danger a remotely dangerous individual poses is less foreseeable and more speculative than the danger an imminently dangerous person poses. Because a person who poses no danger to herself or others has the right to refuse mental health treatment, it is imperative that we ask how remotely dangerous a person ordered to involuntary outpatient treatment must be before the state has violated their due process rights and how far we are willing to stretch the "mentally ill and dangerous" standard in the name of broader societal safety.

This Note will discuss the difficulties inherent in relying on a past history of dangerousness to support an order for the involuntary outpatient commitment of a remotely dangerous person. Part I will detail the constitutional protections individuals have in the involuntary inpatient commitment context as these constitutional standards are also the main protections in the involuntary outpatient commitment process. Part II will discuss the development of involuntary outpatient commitment laws and the particular types of psychiatric patients these laws are intended to target and treat. Next, Part III will analyze specific provisions of Oklahoma's outpatient commitment law, including the scope of the law and the requirements the state must meet in order to obtain an outpatient commitment order. Part IV will consider the legality of outpatient commitment orders that are based on predictions of future dangerousness in light of the fact that individuals who are not dangerous have the right to refuse treatment. Finally, in the context of the individual's right to refuse treatment, Part V will discuss the lack of enforcement mechanisms in Oklahoma's outpatient commitment law and the implications this might have for individuals who wish to refuse treatment.

### *I. Constitutional Protections in the Involuntary Commitment Context*

To understand the effect involuntary outpatient commitment laws have on mental health law and patient rights, it is first necessary to understand the constitutional requirements governing involuntary outpatient commitment. In a series of cases, the Supreme Court of the United States affirmed that a state must prove by clear and convincing evidence that an individual is both mentally ill and dangerous before it may involuntary commit the individual to an inpatient unit.[11]

11. Although the Court uses the less-specific phrase "involuntary commitment," the cases all concern examples of involuntary inpatient commitment.

In *O'Connor v. Donaldson*, the Court held that proof of mental illness alone was not enough to support an involuntary commitment order.[12] The *O'Connor* case concerned a man named Kenneth Donaldson who had been involuntary committed to an inpatient facility for fifteen years because his father believed he was suffering from "delusions."[13] At trial, Donaldson offered uncontradicted evidence that he had never been a danger to himself or others and that he could have supported himself outside the hospital.[14] Although the Fifth Circuit Court of Appeals suggested that it would be "constitutionally permissible" for the state to involuntarily commit a non-dangerous person for mental health treatment, the Supreme Court disagreed.[15] Instead, the Court held that "[a] finding of 'mental illness' alone cannot justify a State's locking a person up against his will and keeping him *indefinitely in simple custodial confinement*. . . . [T]here is still no basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom."[16]

After *O'Connor* affirmed that "dangerousness" was a necessary element for an involuntary inpatient commitment order, *Foucha v. Louisiana* affirmed that "mental illness" was also an indispensable element for confinement.[17] The case turned on a Louisiana statute that allowed a person found not guilty of a crime by reason of insanity to be confined for dangerousness even after a physician had recommended the person be released from custody because the person was no longer mentally ill.[18] Under the statute, the confined individual had the burden of proving that they were not dangerous.[19] Terry Foucha suffered from a temporary, drug-induced psychosis as well as an "anti-social personality" that was deemed not to be a mental illness.[20] He contended that his confinement under the Louisiana statute violated his due process and equal protection rights.[21] The

12. 422 U.S. 563, 575 (1975).
13. Id. at 565–67.
14. Id. at 568.
15. Id. at 572–73.
16. Id. at 575 (emphasis added). The holding in *O'Connor* leaves open the possibility that a *definite* commitment could be supported on the finding of mental illness without a further finding of dangerousness. However, later cases refashioned the *O'Connor* case as holding that involuntary confinement of a non-dangerous mentally ill person is unconstitutional. *See, e*.g., Foucha v. Louisiana, 504 U.S. 71, 77 (1992).
17. *Foucha*, 504 U.S. at 77.
18. Id. at 73.
19. Id.
20. Id. at 75.
21. Id. at 73.

Supreme Court held that there was no basis for the state to hold Foucha once he was no longer mentally ill.[22] The state had to first release Foucha from custody and then civilly commit him; to do this, the state would have to prove by clear and convincing evidence in a civil commitment proceeding that Foucha was both mentally ill and dangerous.[23]

As *Foucha* suggests, the standard of proof for involuntary inpatient commitment is clear and convincing evidence, rather than the preponderance of the evidence standard more typically required in civil law proceedings. In *Addington v. Texas*, the state of Texas sought to civilly commit a man who had a history of delusions and "assaultive episodes."[24] The Texas trial court applied a clear and convincing evidence standard, but on appeal Addington argued that the correct standard of proof was the beyond a reasonable doubt standard employed in criminal cases.[25] Concerned that it would be impossible to prove a person's future dangerousness beyond a reasonable doubt, the Texas Supreme Court chose neither Addington's nor the trial court's standard.[26] Instead, the court held that the preponderance of the evidence standard of proof would not violate an individual's due process rights in civil commitment cases.[27]

The Supreme Court vacated and remanded the Texas Supreme Court and upheld the trial court's application of the clear and convincing evidence standard.[28] The Court expressed concern about balancing the individual's interest in not being indefinitely confined with the state's interest in the care of "the emotionally disturbed."[29] It reiterated its continued holding that "civil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection."[30] The Court held that due process requires "proof more substantial than a mere preponderance of the evidence" because there is a risk that the factfinder might involuntarily commit an individual for "a few isolated instances of unusual conduct."[31] With loss of liberty on the line, the Court concluded that society should assume the greater risk of error in the judgment.[32] However, the Court also

22. Id. at 78.
23. Id.
24. 441 U.S. 418, 420-21 (1979).
25. Id. at 421-22.
26. Id. at 422.
27. Id.
28. Id. at 428-29, 433.
29. Id. at 425.
30. Id.
31. Id. at 427.
32. Id.

held that it was not necessary for the state to meet the beyond a reasonable doubt standard.[33] It underscored the Texas Supreme Court's concern about the speculative nature of proving future dangerousness and also reasoned that involuntary commitment proceedings were not punitive in nature and so should not require that the state meet a criminal standard of proof.[34]

Taken together, these three cases highlight issues that are at the core of involuntary commitment generally, but which are magnified in importance when it comes to involuntary outpatient commitment, specifically. While the individual is not confined during involuntary outpatient treatment, there is still a liberty interest at risk in the process—the freedom to refuse psychotropic medication. Furthermore, the difficulty of proving future dangerousness becomes central to the discussion because of the very nature of involuntary outpatient commitment and the types of patients who would benefit from such assisted outpatient treatment in the first place.

## *II. The Purpose of Involuntary Outpatient Commitment Laws*

Involuntary outpatient commitment is designed for patients whose mental illnesses may be controlled by medication but who struggle with "treatment non-compliance" that results in a cycle of hospital admittances and discharges that can be hard on both the individual and their loved ones.[35] Essentially, the pattern proceeds as follows: At some point, an individual becomes so seriously mentally ill that they are dangerous to themselves or others. Once they meet the "mentally ill and dangerous" standard, they are admitted to an inpatient facility.[36] While there, they receive treatment. Often, this treatment takes the form of prescription medication that will substantially control the symptoms of their mental illness.[37] For some individuals, the medication works so well that

33. Id. at 431.

34. Id. at 428-29.

35. See 43A OKLA. STAT. § 1-103(21) (Supp. 2017). According to the definition of "assisted outpatient treatment," the purpose attributed to such treatment is "to treat an assisted outpatient's mental illness and to assist the person in living and functioning in the community, or to attempt to prevent a relapse or deterioration that may reasonably be predicted to result in suicide or the need for hospitalization." Id.

36. See 43A OKLA. STAT. § 1-103(13) (2011). Oklahoma's definition for "person requiring treatment" incorporates the mentally ill and dangerous standard. An individual must meet the definition of "person requiring treatment" to be admitted to an inpatient facility.

37. *See* Jillane T. Hinds, *Involuntary Outpatient Commitment for the Chronically Mentally Ill*, 69 NEB. L. REV. 346, 367 (1990).

eventually they are no longer a danger to themselves or others. Because the individual no longer meets the "mentally ill and dangerous" standard, the patient is subsequently discharged from the inpatient facility.[38] However, without the structure of the inpatient setting, the individual fails to take their medication for one reason or another and becomes "treatment non-compliant."[39] Without their medication, the individual's symptoms return until, eventually, the individual is ill enough and dangerous enough to be readmitted to an inpatient facility.[40] Patients who struggle with this pattern of admittances and discharges have become known as "revolving door patients."[41] Involuntary outpatient commitment statutes were designed "for compelling treatment for those chronically mentally ill individuals who have a history of failing to continue taking antipsychotic medication voluntarily or consistently and who, without medication, would predictably require inpatient hospitalization again in the future."[42]

Treatment non-compliance can occur for a number of reasons. For example, some individuals simply may not want to take their medication while some may refuse medication for religious reasons.[43] Some individuals may believe they are no longer mentally ill and so no longer need their medication.[44] Additionally, psychotropic medication may cause some individuals to experience adverse side effects.[45] Sometimes those side effects are bad enough that the individual may choose to deal with the symptoms of their mental illness rather than continue their treatment.[46] Furthermore, some individuals experience challenges related to mobility. For some patients, the struggle to get to an outpatient facility, attend appointments regularly, or pick up medication may make treatment compliance a feat not worth the effort.[47] Sometimes individuals simply forget to take their medication, which can start a vicious cycle of mental deterioration and treatment non-compliance.[48] As the individual increasingly experiences symptoms of mental illness, they may also find it

38. See 43A OKLA. STAT. § 1-103(13) (2011).
39. Hinds, *supra* note 37, at 351.
40. *Id.*
41. *Id.* at 350-51; Geraldine A. McCafferty & Jeanne Dooley, *Involuntary Outpatient Commitment: An Update*, 14 MENTAL & PHYSICAL DISABILITY L. REP. 277, 278 (1990).
42. Hinds, *supra* note 37, at 352.
43. Id. at 372.
44. Id.
45. Id. at 372-73.
46. Id.
47. See id. at 352, 373.
48. Id.

increasingly difficult to remember to take their medication.[49] While treatment non-compliance may occur for a variety of reasons, any one of the above reasons could be exacerbated if the individual does not have a support network of family and friends who can help them travel to and from their appointments, remind them to take their medication, and provide stability, encouragement, and understanding.

Managing this treatment non-compliance on an outpatient basis has become especially important for mental health treatment systems because there exists a gap in care between inpatient and outpatient treatment that may endanger individuals receiving treatment as well as the public at large. While today inpatient treatment is reserved for the most acutely mentally ill individuals, this was not always the case. In 1950, Oklahoma had 6059 hospital beds spread across its four state psychiatric hospitals.[50] Griffin Memorial Hospital, the largest of the state psychiatric hospitals and the only one still offering comparable inpatient services, was home to 2936 of those beds.[51] However, beginning around 1960 and accelerating during the 1980s, mental health systems around the country underwent a process called "deinstitutionalizion."[52] Mental health professionals reduced the inpatient populations of psychiatric hospitals and replaced those inpatient services with new outpatient services to varying effect.[53] Today, Griffin Memorial Hospital has only 120 beds—a ninety-six percent reduction in inpatient capacity.[54]

Because there are so few inpatient beds across the state, individuals may experience delays being admitted. Such delays can be especially dangerous when individuals need frequent admissions during a short period of time because delays may exacerbate gaps in their care. Furthermore, because space in inpatient facilities is limited, the standard for what mental health professionals consider "dangerous" enough for admittance may be quite high. For example, if a person hears voices directing them to harm or kill others but the person also appears to be capable of ignoring those voices,

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49. Id.

50. COUNCIL OF STATE GOV'TS, THE MENTAL HEALTH PROGRAMS OF THE FORTY-EIGHT STATES 38 (1950).

51. Id. at 235.

52. See Gerald N. Grob, *From Asylum to Community: Mental Health Policy in Modern America*, 62 PSYCHIATRIC Q. 187 (1991); Sarah Capps, *Continuity in Care: The History of Deinstitutionalization in Oklahoma's Mental Healthcare System,* U. OKLA. HIST. J., Spring 2016, at 31, https://commons.shareok.org/bitstream/handle/11244.46/1251/OUHJ-Issue-5-Spring-2016.pdf?sequence=1&isAllowed=y.

53. See Grob, *supra* note 52; Capps, *supra* note 52.

54. Capps, *supra* note 52, at 34.

that individual might not be considered dangerous enough to be admitted to an inpatient facility because auditory hallucinations alone might not prove that an individual is dangerous at all, let alone imminently dangerous.[55]

Given the lack of inpatient space available and the high standard for dangerousness in the inpatient setting, it is important that Oklahoma's mental healthcare system provides outpatient treatment options for individuals who still pose some danger but who do not yet meet the more stringent inpatient standard. In theory, involuntary outpatient commitment statutes help patients who are treatment non-compliant by ordering those patients to attend their outpatient treatment and to take their medication. This should prevent the cycle of deterioration as well as provide a treatment solution when a person has begun experiencing symptoms due to treatment non-compliance but is not yet dangerous enough to be admitted to an inpatient facility.

### *III. The Structure and Scope of Oklahoma's Involuntary Outpatient Commitment Statutes*

Oklahoma's involuntary outpatient commitment statute is located in two separate places in title 43A of the Oklahoma Statutes. The first part of the law is the definition of "assisted outpatient," which provides the scope of the law's application.[56] The technical aspects of the law, including procedural requirements, are located in a separate section of the title.[57]

According to the definition of "assisted outpatient," an individual must meet certain statutory requirements relating to their medical history and needs.[58] To begin, they must be mentally ill.[59] They must also be "unlikely

55. This example is based on the author's own experiences. The final determination concerning whether an individual is imminently dangerous will depend on the opinion of an examining mental health professional.

56. 43A OKLA. STAT. § 1-103(20) (Supp. 2017).

57. 43A OKLA. STAT. § 5-416 (Supp. 2016).

58. 43A OKLA. STAT. § 1-103(20)-(21) (Supp. 2017).

> 20. 'Assisted outpatient' means a person who:
>
> a. is either currently under the care of a facility certified by the Department of Mental Health and Substance Abuse Services as a Community Mental Health Center, or is being discharged from the custody of the Oklahoma Department of Corrections, or is being discharged from a residential placement by the Office of Juvenile Affairs,
>
> b. is suffering from a mental illness,
>
> c. is unlikely to survive safely in the community without supervision, based on a clinical determination,

to survive safely in the community without supervision, based on a clinical determination."[60] The statute does not define "safely," and for this reason the word could conceivably encompass a wide variety of dangers, including suicidality, mental deterioration that leads to physical deterioration, physical harm to others, or possibly even behaviors that do not involve physical harm to anyone if those behaviors threaten a negative change in status, such as incarceration. The individual also must be "unlikely to voluntarily participate in outpatient treatment that would enable him or her to live safely in the community" as a result of their mental illness.[61] Additionally, the individual must require involuntary outpatient treatment "to prevent a relapse or deterioration which would be likely to result in serious harm" to themselves or others.[62] The individual must also be "likely to benefit from assisted outpatient treatment."[63] This requirement creates

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> d. has a history of lack of compliance with treatment for mental illness that has:
>
> (1) prior to the filing of a petition, at least twice within the last thirty-six (36) months been a significant factor in necessitating hospitalization or treatment in a hospital or residential facility, or receipt of services in a forensic or other mental health unit of a correctional facility, or a specialized treatment plan for treatment of mental illness in a secure juvenile facility or placement in a specialized residential program for juveniles, or
>
> (2) prior to the filing of the petition, resulted in one or more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others within the last twenty-four (24) months,
>
> e. is, as a result of his or her mental illness, unlikely to voluntarily participate in outpatient treatment that would enable him or her to live safely in the community,
>
> f. in view of his or her treatment history and current behavior, is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to the person or persons as defined in this section, and
>
> g. is likely to benefit from assisted outpatient treatment; and
>
> 21. 'Assisted outpatient treatment' means outpatient services which have been ordered by the court pursuant to a treatment plan approved by the court to treat an assisted outpatient's mental illness and to assist the person in living and functioning in the community, or to attempt to prevent a relapse or deterioration that may reasonably be predicted to result in suicide or the need for hospitalization.

*Id.*

59. *Id.* § 1-103(20)(b).
60. *Id.* § 1-103(20)(c).
61. *Id.* § 1-103(20)(e).
62. *Id.* § 1-103(20)(f).
63. *Id.* § 1-103(20)(g).

some sense that the treatment should be in the best interest of the individual or at least that an individual should not be involuntarily committed to outpatient treatment unless it will have some positive effect.

However, before a person can be involuntarily committed to outpatient treatment, the individual must first meet the institutional requirements in the definition of "assisted outpatient."[64] To begin, the individual must be "currently under the care of a facility certified by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) as a Community Mental Health Center," be in the process of being "discharged from the custody of the Oklahoma Department of Corrections," or be in the process of being "discharged from a residential placement by the Office of Juvenile Affairs."[65] Effectively, before an individual may qualify as an "assisted outpatient" the individual must either be someone who is already a consumer of Oklahoma's outpatient mental health services—specifically at a community mental health center—or the individual must qualify for assisted outpatient treatment because of their history with either the Department of Corrections or the Office of Juvenile Affairs.

Because of this first requirement, the definition of "assisted outpatient" does much to limit the scope of involuntary outpatient commitment in Oklahoma. If the individual must have a history at an ODMHSAS community mental health center or with either the Department of Corrections or the Office of Juvenile Affairs, it is unlikely that courts will order the involuntary outpatient commitment of an individual who has never been treated for mental illness before. Additionally, a court may not order the involuntary outpatient commitment of an individual who has had no prior contact with the state of Oklahoma. Individuals who have a history of treatment at community mental health centers or comparable agencies located in other states must establish a history of treatment or interaction with Oklahoma's mental health system or state agencies before a court can order that they be involuntarily committed to outpatient treatment.

Although the requirement that the individual have a history with an Oklahoma state agency substantially narrows the application of the law, the fact that one of those agencies is the Office of Juvenile Affairs broadens the application of the law where minors are concerned. Kendra's Law, the New York statute on which Oklahoma's definition of "assisted outpatient" is based, originally required that the individual be "eighteen years of age or

64. *Id.* § 1-103(20).
65. *Id.* § 1-103(20)(a).

older."[66] When the bill was originally passed in Oklahoma in 2016, the legislature simply adopted New York's age requirement.[67] However, after the 2017 amendments to the statute, Oklahoma now allows certain minors to be involuntarily committed to outpatient treatment where other jurisdictions reserve outpatient commitment for adults.[68]

The institutional limitations on the scope of Oklahoma's involuntary outpatient commitment law serve a double function. First, they protect individuals from being involuntary committed to outpatient treatment when those individuals have had no contact with the state of Oklahoma concerning their mental health so that, presumably, the state knows relatively little about their illness. Second, limiting involuntary outpatient treatment to individuals who are already consumers of certain state services should save money in the already cash-strapped state budget when compared to an involuntary outpatient commitment law that does not contain such institutional limitations. Managing Oklahoma's finite resources with institutional limitations became increasingly important after the legislature amended the law to remove the minority limitation.[69]

In addition to these institutional limitations, to qualify as an "assisted outpatient" the individual must experience one of two possible triggering events. The first possible triggering event occurs when the individual's treatment non-compliance necessitates "hospitalization or treatment in a hospital or residential facility, or receipt of services in a forensic or other mental health unit of a correctional facility, or a specialized treatment plan for treatment of mental illness in a secure juvenile facility or placement in a specialized residential program for juveniles" at least twice within the last thirty-six months before the petition for involuntary outpatient commitment is filed.[70] In other words, a person can qualify for involuntary outpatient commitment when they have failed to take their medication and, because of this failure, needed some form of inpatient treatment twice within the last three years. The second possible triggering event occurs when the individual's treatment non-compliance "resulted in one or more acts of

66. 18 N.Y. MENTAL HYGIENE LAW § 9.60(c)(1) (McKinney 2015).

67. 43A OKLA. STAT. § 1-103(20) (Supp. 2016).

68. 43A OKLA. STAT. § 1-103(20) (Supp. 2017).

69. See Brilbeck, *supra* note 1.

70. 43A OKLA. STAT. § 1-103(20)(d)(1) (Supp. 2017). The Oklahoma Forensic Center is a psychiatric hospital for individuals who are acquitted not guilty by reason of insanity or who are adjudicated incompetent to stand trial. *Oklahoma Forensic Center (OFC)*, OKLAHOMA DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES (Feb. 19, 2019, 6:56 PM), https://ok.gov/odmhsas/Mental_Health/Oklahoma_Forensic_Center.html.

serious violent behavior . . . or threats of, or attempts at, serious physical harm" to themselves or others in the twenty-four months before the petition for involuntary outpatient commitment was filed.[71]

### *IV. The Problem of Predicting Future Dangerousness*

These triggering events are important because they provide evidence that the individual poses a foreseeable risk of danger. If the individual, as a result of failing to take their medication, experienced past deterioration that required inpatient treatment, then this displays a pattern of behavior that will likely continue. The definition of "assisted outpatient" predicts that an individual who fails to take their medication will continue to do so and will deteriorate until they are a danger to themself or others. For example, the individual must be "*unlikely* to survive in the community without supervision," "*unlikely* to voluntarily participate in outpatient treatment," "*likely* to benefit" from outpatient treatment, and be in need of such treatment to prevent relapse "in view of his or her *treatment history* and current behavior."[72] Surprisingly, nowhere in either the definition of "assisted outpatient" or in the procedures for involuntary outpatient commitment is there a requirement that the state demonstrate that the individual is currently refusing to take their medication or that the individual is currently deteriorating.[73] While there is a suggestion that the individual's current behavior will be considered during the process of ordering involuntary outpatient commitment, the statute does not elucidate what type or degree of behavior should satisfy a court that such an order is necessary and proper.[74] When it comes to how foreseeable it is that an individual will pose a danger to themselves or others, there is quite a difference between an individual whose current behavior consists of statements that indicate their wish to refuse medication and current behavior which threatens immediate violence. Oklahoma tries to confront the foreseeability issue by requiring that the individual have a medical history that establishes a pattern of either inpatient treatment or violence because it appears to establish a pattern of dangerousness that echoes the "mentally ill and dangerous" standard without actually meeting it.[75]

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71. *Id.* § 1-103(20)(d)(2).

72. *Id.* § 1-103 (emphasis added).

73. *Id.*; 43A OKLA. STAT. § 5-416 (Supp. 2016).

74. 43A OKLA. STAT. § 1-103 (considering eligibility for assisted outpatient treatment "in view of his or her treatment history and current behavior").

75. *Id.* § 1-103(20)(1)-(2) (Supp. 2017).

While using a past history of violence and inpatient admittances seems like a reasonable way to predict dangerousness, the difficulty is that an individual has the right to refuse medical treatment as long as that person is not a danger to themself or others. In *Washington v. Harper*, the United States Supreme Court held that "the Due Process Clause permits the State to treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will, if the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest."[76] While this articulation appears to set out the familiar "mentally ill and dangerous" standard of involuntary inpatient commitment with the additional requirement of "medical appropriateness," the Supreme Court altered the test slightly only two years later. In *Riggins v. Nevada*, the Court held that due process would have been satisfied if "treatment with antipsychotic medication was medically appropriate and, considering less intrusive alternatives, essential for the sake of [petitioner's] own safety or the safety of others."[77] Under the *Riggins* formulation, the state must show that it was "medically appropriate" to involuntarily administer the medication, that doing so was "essential" for the safety of the mentally ill individual or for the safety of others around them (implicitly because the individual is dangerous to some unspecified degree), and that the state considered less intrusive alternatives but found them to be insufficient.[78] Although both *Harper* and *Riggins* involved criminal proceedings, they provide guidance concerning what due process requires in the context of civil commitment.

### *V. "Assisted Outpatients" and Enforcing Treatment Compliance Without Imminent Dangerousness*

One of the most striking features of the Oklahoma involuntary outpatient commitment statute is how it acknowledges and affirms the right of individuals to refuse medication even as it creates a framework to force individuals to take medications when they are, by definition, not dangerous enough to meet the "mentally ill and dangerous" standard. A court "shall not order hospitalization" without considering the individual's competency to refuse court-ordered treatment, "including, but not limited to, the rights of the consumer . . . [t]o refuse medications."[79] However, "[a] court may order the patient to self-administer psychotropic drugs or accept the

76. 494 U.S. 210, 227 (1990).
77. 504 U.S. 127, 135 (1992).
78. Id. at 135-37.
79. 43A OKLA. STAT. § 5-416(A) (Supp. 2016).

administration of such drugs by authorized personnel," and the order "may specify the type and dosage range of such psychotropic drugs."[80]

While the language of the statute does not track the requirements set out in *Riggins*, its requirements speak to each of the *Riggins* requirements. To begin, the licensed mental health professional who files the petition for assisted outpatient treatment must create a written treatment plan for the individual and "state facts which establish that such treatment is the least restrictive alternative" available for treating the individual.[81] The definition of "assisted outpatient" tries to establish that the forced administration of medication is necessary for the safety of the individual or the safety of those around them by showing that the individual committed or threatened violence against themselves or others within the last two years or that the individual must have recently been found to be imminently dangerous because they were admitted to inpatient care twice within the last three years.[82] The definition of "assisted outpatient" also seeks to establish that such treatment is "medically appropriate" by requiring evidence of the individual's mental illness, history of treatment non-compliance, and need for outpatient treatment in which they are otherwise unlikely to voluntarily participate.[83] The procedural statute also tries to ensure that the treatment is medically appropriate by limiting the temporal scope of the treatment; "[t]he initial order for assisted outpatient treatment shall be for a period of one (1) year."[84] While a licensed mental health professional may file a petition to extend the order beginning thirty days before the end of that year, the court considering the petition for extension must determine if the individual continues to meet the "criteria for assisted outpatient treatment" and if "such treatment is the least restrictive alternative."[85]

The initial one-year order and subsequent petition to extend does not sufficiently address the possibility that an individual who meets the definition of "assisted outpatient" may never become treatment compliant. It is not outside the realm of possibility that an assisted outpatient treatment

80. *Id.* § 5-416(K).

81. *Id.* § 5-416(F), (I). While the statute merely says that this task falls to the "petitioner," section 5-410(C) mandates that "[p]etitions filed to determine if an individual should be ordered to assisted outpatient treatment . . . shall only be filed by a licensed mental health professional employed by the Department of Mental Health and Substance Abuse Services or employed by a community mental health center certified by the Department." *Id.* § 5-410(C).

82. *See* 43A OKLA. STAT. § 1-103(20)(d)(1)-(2) (Supp. 2017).

83. *Id.* § 1-103(20).

84. 43A OKLA. STAT. § 5-416(M) (Supp. 2016).

85. *Id.*

order might extend for years, or for much of an individual's life. If an individual who fits the pattern of a "revolving door patient" refuses take their medication or attend outpatient treatment, it is likely that they will continue to experience symptoms of mental illness. Based upon the fact that an individual must have experienced cyclical deterioration in the past in order to meet the definition of "assisted outpatient," it is entirely possible that these symptoms will continue to cause the individual to relapse or deteriorate until they are dangerous.[86] Although the statute requires ongoing evaluation of the appropriateness of the treatment, nothing in the statute prohibits the order for treatment to become what is effectively a standing outpatient treatment order that extends over the lifetime of the individual.[87] While the statute creates some procedural safeguards against this possibility, it contains no clear and enforceable limitations. Because the statute lacks such limitations, it elevates societal safety and normalizing notions of the assisted outpatient's best interests over individual autonomy and the freedom to refuse medical treatment.

Additionally, the statute does not contain adequately clear provisions for enforcing the involuntary administration of medication when the individual is not presently dangerous. The standards set forth by the United States Supreme Court in *Riggins* suggest that an individual should be a danger to themselves or others before the state orders medication to be forcefully administered.[88] The requirement that the administration of medication be *essential* to protect the safety of the individual or the public suggests that the Court was referring to an imminently dangerous individual, but this is up for debate.[89] For this reason, involuntary outpatient commitment statutes proceed into uncharted territory by allowing the forced medication of remotely dangerous individuals. Such statutes order the administration of medication as a preventive measure based on a pattern of behavior which suggests that the individual will become dangerous in the future. At the heart of the involuntary outpatient commitment statutes is a conflict between the right of non-dangerous mentally ill individuals to refuse medication and the overall goal of the statutes, which is to force individuals to become "treatment compliant" when the danger they pose is still remote.

Oklahoma's solution to this conundrum is, essentially, to give courts the power to order involuntary outpatient treatment but take away their most powerful enforcement mechanisms. The statute expressly says that

86. *See* 43A OKLA. STAT. § 1-103(20)(1)-(2) (Supp. 2017).
87. See *id.* § 1-103; 43A OKLA. STAT. § 5-416 (Supp. 2016).
88. *See* Riggins v. Nevada, 504 U.S. 127, 135 (1992).
89. *Id.* at 135-37.

"[f]ailure to comply with an order of assisted outpatient treatment shall not be grounds for involuntary civil commitment or a finding of contempt of court."[90] In other words, an individual shall not be deemed to meet the "mentally ill and dangerous" standard simply because they refuse to comply with the involuntary outpatient commitment order. Refusal to comply with an assisted outpatient treatment order will lead to an individual's involuntary inpatient commitment only when an "assisted outpatient appears to be a person requiring treatment."[91] A "person requiring treatment" is a technical term, essentially meaning an individual that is mentally ill and dangerous.[92] Therefore, if the individual continues to refuse to comply with treatment even after the treatment has been ordered by the court, the court cannot find them in contempt and the individual cannot be moved to an inpatient treatment unit before they have relapsed or deteriorated to the point that they meet the "dangerous" criteria required for inpatient admission.

The statute's lack of enforcement power suggests that states are uncertain about what due process requirements constrain their involuntary outpatient commitment laws, given that such laws are relatively new creations and that the United States Supreme Court has yet to hear a case on one.[93] While the Supreme Court has ruled on the standards for involuntary inpatient commitment, the Court has not provided any guidance about how remotely dangerous an individual can be before the forced administration of medication becomes a violation of their liberty interest. To avoid violating the Fourteenth Amendment, states like Oklahoma and New York have adopted involuntary outpatient commitment laws with a compromised enforcement power.

Although one may argue that designing statutes this way errs on the side of caution, such compromised enforcement power may still lead to due

90. 43A OKLA. STAT. § 5-416(Q) (Supp. 2016).

91. *Id.* § 5-416(P).

92. 43A OKLA. STAT. § 1-103(13) (2011).

93. In addition to Oklahoma, New York, and other states that have modelled their involuntary outpatient commitment statutes on Kendra's Law, states like North Carolina and Hawai'i have expressly stated that individuals subject to an outpatient commitment order may not be forcibly medicated or forcibly detained for treatment. 43A OKLA. STAT. § 5-416(Q) (Supp. 2016); 18 N.Y. MENTAL HYGIENE LAW § 9.60(n) (McKinney 2015); N.C. GEN. STAT. § 122C-273(a)(3) (2004); HAW. REV. STAT. § 334-129(b) (2017). In these cases, the individual who refuses treatment must be involuntary committed to inpatient treatment before they may be forcibly medicated. This means that they must be imminently, rather than remotely dangerous. N.C. GEN. STAT. § 122C-273(a)(3) (2004); HAW. REV. STAT. § 334-129(b) (2017).

process issues. If an individual complies with a court order for involuntary outpatient commitment only because they incorrectly believed that the court or other authority had the power to enforce compliance, is it possible that the individual's due process rights have still been violated? An individual's effective exercise of their right to refuse treatment may be premised on the individual's understanding that they have such a right in the first place.[94]

Because issues of competency and financial dependence loom large in mental health law, it is necessary to consider what role involuntary outpatient commitment statutes give to the family and friends of the "assisted outpatient." Simply because of the nature of some mental illnesses, some individuals may experience symptoms which may interfere with their ability to understand the legal and medical issues facing them.[95] Additionally, those same symptoms may make it difficult for the individual to maintain employment or to support themselves, thereby increasing their reliance on family and friends for support.[96] When combined, this means that an individual may depend significantly on their family both to explain and to enforce their legal rights during an involuntary outpatient commitment proceeding.

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94. Consider, for example, what is almost certainly the most famous case to find a 5th Amendment violation due to a failure to warn individuals of their rights: Miranda v. Arizona, 384 U.S. 436, 445 (1966) ("[T]he defendant was questioned by police officers, detectives, or a prosecuting attorney in a room in which he was cut off from the outside world. In none of these cases was the defendant given a full and effective warning of his rights at the outset of the interrogation process. In all the cases, the questioning elicited oral admissions, and in three of them, signed statements as well which were admitted at their trials.").

95. This is especially true for those illnesses which are most likely to lead to discussions of involuntary outpatient commitment.

96. Maintaining steady employment while controlling one's mental illness is a common struggle and many organizations have resources to help individuals understand their options and legal rights. *See, e.g.*, *Depression, PTSD, & Other Mental Health Conditions in the Workplace: Your Legal Rights*, U.S. EQUAL EMP. OPPORTUNITY COMM'N (Feb. 17, 2018, 4:32 PM), https://www.eeoc.gov/eeoc/publications/mental_health.cfm; *Mental Health Conditions in the Workplace and the ADA*, ADA NAT'L NETWORK (Feb. 17, 2018, 4:32 PM), https://adata.org/factsheet/health; *Succeeding at Work*, NAT'L ALLIANCE ON MENTAL ILLNESS (Feb. 17, 2018, 4:32 PM), https://www.nami.org/Find-Support/Living-with-a-Mental-Health-Condition/Succeeding-at-Work. Because individuals that meet Oklahoma's definition of "assisted outpatient" either needed inpatient care in the last thirty-six months or acted violently one or more times in the last twenty-four months, individuals that meet the definition of "assisted outpatient" are more likely than many other individuals with mental illness to struggle to maintain steady employment. *See* 43A OKLA. STAT. § 1-103(20)(d) (2011).

Oklahoma's statute on patient rights in the mental health context explicitly outlines a "right to counsel, including court-appointed counsel . . . to represent the person at no cost if the person is an indigent person and cannot afford an attorney."[97] However, the statute unfortunately limits this right to "persons requiring treatment," which is defined to refer specifically to a person who meets the criteria for inpatient commitment.[98] Therefore, a person who meets the criteria for involuntary outpatient commitment only has a statutory right to a court-appointed attorney once they have deteriorated to the point that they may be involuntarily committed to inpatient treatment. Because the individuals who are the prime focus of Oklahoma's involuntary outpatient commitment statute do not have a statutory right to a court-appointed attorney, and these same individuals have experienced cyclical periods of hospitalization or violence that likely reduced their ability to hold steady employment, it is very likely that these individuals may be forced to rely on their family to provide them with legal counsel—if they obtain legal counsel at all. Because these individuals may struggle with mental deterioration, have no right to court-appointed counsel, and may feel quite differently about their treatment than their family and friends do, questioning the way Oklahoma's involuntary outpatient commitment statute allocates power between the "assisted outpatient" and their family and friends is essential.

Oklahoma's involuntary outpatient commitment statutes evidence the central support role family and friends have in mental health treatment. During the process of obtaining an outpatient commitment order, a licensed mental health professional must create a written treatment plan.[99] The statute expressly states that the mental health professional must allow certain people to participate in the development of the treatment plan, including the assisted outpatient, the treating physician, the treatment advocate, and "[a]n individual significant to the assisted outpatient, including any relative, close friend, or individual otherwise concerned with the welfare of the assisted outpatient, upon the request of the assisted outpatient."[100]

Although an individual may request that their family member or friend be involved in developing their treatment plan, it does not necessarily follow that the individual being ordered to outpatient treatment and their friends or family will always agree on what type of treatment is appropriate.

97. 43A OKLA. STAT. § 5-411(A)(2) (2011).
98. *Id.* § 5-411(A); *id.* § 1-103(13).
99. 43A OKLA. STAT. § 5-416(G) (Supp. 2016).
100. Id. § 5-416(G)(4).

After all, involuntary outpatient commitment was developed to treat individuals with a history of both violence and treatment non-compliance who are *unlikely* to voluntarily participate in outpatient treatment.[101] It is understandable that the family and friends surrounding these individuals might desire more legal and medical options that give them the power to intervene before their loved one becomes imminently, rather than remotely dangerous. Therefore, it is perhaps unsurprising that "family-oriented advocacy groups generally favor an approach to [involuntary outpatient commitment] that loosens the commitment criteria, thereby expanding the number of persons subject to commitment."[102] However, using involuntary outpatient commitment to prevent an individual from deteriorating to the point that they meet the "mentally ill and dangerous" inpatient criteria might mean forcibly medicating an individual who is not imminently dangerous.

This power dynamic raises issues concerning the criteria that family and courts should use to determine when forcible medication is in the best interest of the individual ordered to involuntary outpatient treatment. Theoretically, an individual who is not imminently dangerous may be able to refuse medication for reasons that elevate personal desire or fulfillment over adherence to social norms. For example, an individual with a mental illness might find that their mental illness enables them to be more creative or that their mental illness is somehow a part of themselves that they do not wish to suppress.[103] If the person is not dangerous, they have the right to weigh these considerations and decide whether to refuse medication. However, when an individual with mental illness does not have counsel and is being represented by family or friends who weigh these considerations differently than the individual does, laws like Oklahoma's that purport to confer more enforcement power than they actually do may become problematic. Under such involuntary outpatient treatment statutes, states lack enforcement power when patients violate court orders. As a result, when an individual wishes to refuse treatment these statutes may allow

101. 43A OKLA. STAT. § 1-103(20) (2011).

102. Geraldine A. McCafferty & Jeanne Dooley, *Involuntary Outpatient Commitment: An Update*, 14 MENTAL & PHYSICAL DISABILITY L. REP. 277, 277 (1990).

103. See Humans of New York, *Escaped Again*, FACEBOOK (Dec. 28, 2017, 5:51 PM), https://www.facebook.com/humansofnewyork/videos/2082415631832526/. This video contains an interview with a woman who was involuntarily ordered to inpatient treatment for schizophrenia, according to herself. Because of her religious beliefs, she did not wish to be treated and even "escaped" from the hospital to avoid treatment. In her opinion, schizophrenia is a fabricated disease and, as such, receiving treatment for it merely discredits her religious beliefs.

courts and family members that support involuntary treatment to create the sense that the individual has fewer options open to them than they actually do.

## *VI. Conclusion*

Generally, involuntary outpatient commitment statutes subordinate the individual's right to refuse treatment to society's desire to prevent possible tragedy. The main benefit of these statutes is that they may reduce gaps in the care that "revolving door patients" experience by mandating medical treatment. The hope is that, by doing so, these statutes will prevent individuals from meeting the "mentally ill and dangerous" standard for inpatient commitment. The problem involuntary outpatient commitment statues run into, however, is that the constitutionality of such preventative measures appears uncertain when one considers Supreme Court precedent. If forced medication is not "essential" to prevent danger to the individual or to the public, then the individual has the right to refuse treatment.[104] If the individual is imminently dangerous and meets the "mentally ill and dangerous" standard, it is more foreseeable that forced medication is "essential" to prevent harm. However, when the individual is only remotely dangerous, their mental illness might be currently controlled. Whether court-ordered medication is "essential" to prevent harm is more uncertain. By the very nature of involuntary outpatient commitment statues, deciding whether it is "essential" to forcefully medicate remotely dangerous individuals involves a prediction about future behavior. Because the danger is not imminent, it is less foreseeable. As a consequence, it is less clear that such statutes are constitutional under the standard set out in *Riggins*.[105]

States appear to be aware that involuntary outpatient commitment statutes walk a fine line between ordering the medication of presently dangerous individuals and ordering the medication of individuals who have the constitutional right to refuse medical treatment. For this reason, states have adopted statutes with limited enforcement mechanisms that allow individuals to refuse treatment without consequence. As long as states must operate without guidance from the United States Supreme Court, involuntary outpatient commitment statutes will continue to permit court-ordered medication without permitting courts and mental health providers to enforcement treatment orders.

104. Riggins v. Nevada, 504 U.S. 127, 135 (1992).
105. *See id.*

While Oklahoma's involuntary outpatient commitment statutes will likely give struggling families another option for treating difficult symptoms of mental illness, Oklahoma could certainly take steps to protect the rights of individuals who meet the definition of "assisted outpatient." Although it will require money the state simply does not have, the Oklahoma Legislature should add "assisted outpatient" to the statute on patient rights so that those facing involuntary outpatient commitment have the right to court-appointed counsel.[106] Doing so will ensure that individuals with mental illness have someone advocating for their wishes as well as someone who will explain the enforcement limitations of the statutes. While inpatient treatment is still the last safety net for Oklahoma's most ill individuals, outpatient treatment has increasingly become the foundation of mental healthcare in Oklahoma and across the country. It is past time that we consider the constitutional protections due individuals facing forced outpatient treatment.

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106. 43A OKLA. STAT. § 5-411(A)(2) (2011).