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## Involuntary Outpatient Civil Commitment Expanded: The 1983 Changes

In 1983 the North Carolina General Assembly amended the state's involuntary commitment statutes to expand the use of outpatient commitment for the mentally ill.<sup>1</sup> The amended statutes contain three significant changes: a new standard for committing patients to outpatient care,<sup>2</sup> a definition of "outpatient treatment,"<sup>3</sup> and procedural changes for more effective support and enforcement of the outpatient commitment laws.<sup>4</sup> This note examines the constitutionality of the new outpatient commitment standard and the practical effects of the 1983 amendments.

Prior to the 1983 amendments, for a person to be involuntarily committed to either inpatient or outpatient treatment, the court had to find "by clear, cogent, and convincing evidence that the respondent [was] mentally ill or inebriate, and [was] dangerous to himself or others, or [was] mentally retarded, and, because of an accompanying behavior disorder [was] dangerous to others."<sup>5</sup> Although the 1983 amendments do not change the criteria for committing a respondent to inpatient treatment,<sup>6</sup> a new standard is provided for commitment to outpatient treatment:

If the court finds by clear, cogent, and convincing evidence that the respondent is mentally ill; that he is capable of surviving safely in the

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1. See N.C. GEN. STAT. §§ 7A-451, -451.1, 122-8.1, -58.2, -58.3, -58.4, -58.5, -58.6, -58.6A, -58.7, -58.7A, -58.7A:1, -58.8, -58.8A, -58.10A, -58.10B, -58.11, -58.11A, -58.13 (Cum. Supp. 1983). The House Bill was titled "An Act to Expand the Use of Outpatient Involuntary Commitments for the Mentally Ill." 1983 N.C. Sess. Laws 638. Much of the background of the 1983 amendments to the commitment laws can be found in Miller & Fiddleman, *Involuntary Civil Commitment in North Carolina: The Result of the 1979 Statutory Changes*, 60 N.C.L. REV. 985 (1982), which chronicles the changes in the North Carolina commitment statutes through the 1979 amendments and provides an excellent discussion of the historical background of the civil commitment law. For a discussion of the North Carolina outpatient commitment statute from January 1978 through December 1979, see Hiday & Goodman, *The Least Restrictive Alternative to Involuntary Hospitalization, Outpatient Commitment: Its Use and Effectiveness*, 10 J. PSYCHIATRY & L. 81, 84-93 (1982). The 1983 amendments to the commitment law became effective January 1, 1984. 1983 N.C. Sess. Laws 638 § 27.

2. See N.C. GEN. STAT. §§ 122-58.4(c)(2), -58.6, -58.8(a)(2) (Cum. Supp. 1983).

3. See *id.* § 122-58.2(8).

4. See *id.* §§ 7A-451(6) (counsel provided at outpatient commitment hearing for indigent respondents), 7A-451.1 (payment to counsel representing indigent respondent at outpatient commitment hearing), 122-8.1 (disclosure of necessary information), -58.4 (directs examining physician to "give the respondent a written notice listing the name, address, and telephone number of the proposed outpatient treatment physician or center and directing the respondent to appear at the address at a specified date and time"; also directs examining physician to notify designated treatment center and to send the respondent a copy of both the notice and his examination report), -58.6A (procedures for examination and treatment pending hearing), -58.7A:1 (district court hearing procedures for outpatient commitment), -58.8A (immunity from liability for those involved in outpatient commitment), -58.10A (duties for commitment order follow-up), -58.10B (supplemental hearings for outpatient commitments), -58.11 (adding option of outpatient commitment at inpatient commitment rehearing), -58.11A (rehearings for outpatient commitments), -58.13 (release from an inpatient commitment—may request supplemental hearing to determine outpatient commitment need) (1981 & Cum. Supp. 1983).

5. See N.C. GEN. STAT. § 122-58.8(b) (1981).

6. See *id.* § 122-58.8(a)(1) (Cum. Supp. 1983).

community with available supervision from family, friends or others; that based on respondent's treatment history, the respondent is in need of treatment in order to prevent further disability or deterioration which would predictably result in dangerousness as defined by G.S. 122-58.2(1); and that the respondent's current mental status or the nature of his illness limits or negates his ability to make an informed decision to voluntarily seek or comply with recommended treatment, it may order outpatient commitment for a period not in excess of 90 days.<sup>7</sup>

Thus, a patient who presently is not dangerous to himself or others may be committed to outpatient care if his treatment history indicates that he will become dangerous in the future.<sup>8</sup>

Does commitment based on these new criteria violate the fourteenth amendment's guarantee that a person shall not be deprived of liberty without due process of law?<sup>9</sup> The United States Supreme Court has recognized that "civil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection."<sup>10</sup> The constitutional standard for evaluating civil commitments requires that "the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed."<sup>11</sup> The Court, however, also has acknowledged the state's interest in committing psychiatrically ill people and the state's power to protect its citizens:

The state has a legitimate interest under its *parens patriae* powers in providing care to its citizens who are unable because of emo-

7. *Id.* §§ 122-58.8(a)(2), -58.8(b)(1) (Cum. Supp. 1983). N.C. GEN. STAT. § 122-58.2(1) (1981) defines "dangerous to himself" to mean:

within the recent past: 1. The person has acted in such manner as to evidence: . . . . That he would be unable without care, supervision, and the continued assistance of others . . . to exercise self-control, judgment, and discretion . . . , or to satisfy his need for nourishment, personal or medical care . . . ; or 2. The person has attempted suicide or threatened suicide and that there is a reasonable probability of suicide . . . ; or 3. The person has mutilated himself or attempted to mutilate himself and that there is a reasonable probability of serious self-mutilation.

An individual is defined by the statute as "dangerous to others" if,

within the recent past, the person has inflicted or attempted to inflict or threatened to inflict serious bodily harm on another or has acted in such a manner as to create a substantial risk of serious bodily harm to another and that there is a reasonable probability that such conduct will be repeated.

*Id.*

8. The commitment criteria involve a question of degree. For example, if a mentally ill patient is not taking care of himself, but is not in immediate danger of "serious physical debilitation," whether the patient is dangerous is a question of fact. The outpatient commitment dangerousness criterion, however, does not include the "near-future" element. To be committed to outpatient care, the court must determine that the respondent "is in need of treatment in order to prevent further disability or deterioration which predictably would result in dangerousness." See N.C. GEN. STAT. §§ 122-58.2(1), -58.8(a)(2), -58.8(b)(1) (Cum. Supp. 1983).

9. U.S. CONST. amend. XIV.

10. *Addington v. Texas*, 441 U.S. 418, 425 (1979). See also *Jackson v. Indiana*, 406 U.S. 715 (1972); *Humphrey v. Cady*, 405 U.S. 504 (1972); *In re Gault*, 387 U.S. 1 (1967); *Specht v. Patterson*, 386 U.S. 605 (1967).

11. *Youngberg v. Romeo*, 457 U.S. 307, 325 (1982) (Blackmun, J., concurring); *Jackson v. Indiana*, 406 U.S. 715, 738 (1972).

tional disorders to care for themselves; the state also has authority under its police power to protect the community from the dangerous tendencies of some who are mentally ill.<sup>12</sup>

The Court's test weighs "the individual's interest in liberty against the State's asserted reasons for restraining individual liberty"<sup>13</sup> to determine whether a substantive due process right has been violated.<sup>14</sup>

Since the new outpatient commitment statute deprives a nondangerous individual who has not committed a crime of his liberty, it can be argued that the statute is unconstitutional. Outpatient commitment proceedings deprive the respondent of substantial rights. He is taken into custody, examined by a physician, brought into court, and required to follow his outpatient commitment treatment plan.<sup>15</sup> The treatment plan may include almost any form of treatment that does not take place in an inpatient facility.<sup>16</sup> It may include medication and may require supervision of the patient's living arrangement.<sup>17</sup> The outpatient who fails to follow the prescribed treatment may be returned to custody and reevaluated.<sup>18</sup>

Even though substantial liberty interests of the individual are affected by the outpatient commitment process, the statute is constitutional. The committed outpatient is not confined in an inpatient facility. Thus, the state's interference with the outpatient's liberty is significantly less than in inpatient commitment. If the patient complies with his treatment plan, he is free to do as he pleases except during the times of actual outpatient treatment.<sup>19</sup>

Two state interests justify the statutes' limitations on the rights of the outpatient. First, the state has an interest in preventing the mentally ill patient from becoming dangerous.<sup>20</sup> Second, the state has an interest in providing treatment to mentally ill individuals who cannot otherwise seek or comply

12. *Addington v. Texas*, 441 U.S. 418, 426 (1979). For a discussion of the state's *parens patriae* and police powers, see S. HALLECK, *LAW IN THE PRACTICE OF PSYCHIATRY: A HANDBOOK FOR CLINICIANS* 126-28 (1980).

13. *Youngberg v. Romeo*, 457 U.S. 307, 320 (1982). See also *Bell v. Wolfish*, 441 U.S. 520, 534 (1979); *Poe v. Ullman*, 367 U.S. 497, 542 (1961) (Harlan, J., dissenting); *Lessard v. Schmidt*, 349 F. Supp. 1078, 1084 (E.D. Wis. 1972) ("The power of the state to deprive a person of the fundamental liberty to go unimpeded about his or her affairs must rest on a consideration that society has a compelling interest in such deprivation."), *vacated and remanded*, 414 U.S. 473, *modified*, 379 F. Supp. 1376 (1974), *vacated and remanded*, 421 U.S. 957 (1975).

14. *Youngberg v. Romeo*, 457 U.S. 307, 320 (1982).

15. See N.C. GEN. STAT. §§ 122-58.4, -58.6, -58.7, -58.8 (Cum. Supp. 1983).

16. See *infra* notes 34-37 and accompanying text.

17. See N.C. GEN. STAT. §§ 122-58.2, -58.10A (Cum. Supp. 1983).

18. *Id.* § 122-58.10A(b).

19. The United States Supreme Court has applied substantive due process protection to civil inpatient commitments because of the loss of liberty involved in confining an individual to an inpatient facility. The Court, however, may be unwilling to extend this protection to the patient committed to outpatient treatment. For example, in *O'Connor v. Donaldson*, 422 U.S. 563 (1975), the Court held that "a State cannot constitutionally *confine* without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends." *O'Connor*, 422 U.S. at 576 (emphasis added).

20. For a discussion of the problems associated with committing a patient under the police power of the state to prevent the patient from becoming dangerous, see S. HALLECK, *supra* note 12, at 127-28.

with necessary treatment.<sup>21</sup> Under the outpatient commitment law, the patient must be mentally ill, must be "in need of treatment in order to prevent further disability or deterioration which would predictably result in dangerousness,"<sup>22</sup> and must be unable to make an informed decision regarding treatment.<sup>23</sup> Thus, in every case of outpatient commitment, both state interests are present.

To balance the state interests with the outpatient's loss of liberty, several points must be considered. Commitment to an inpatient facility, which involves a substantially greater loss of liberty, based on dangerousness to self or others has been found to be constitutional.<sup>24</sup> Although the standard for commitment to outpatient treatment is somewhat lower, it results in a lesser intrusion upon the liberty of the patient.<sup>25</sup> The statutory requirements are designed to limit outpatient commitments to those cases in which the patient would deteriorate to the point of requiring inpatient commitment *but for* the availability of outpatient commitment.<sup>26</sup> Thus, even though outpatient commitment entails a substantial loss of liberty, the patient is spared an even greater loss.

For these reasons, the state's interests in outpatient commitment outweigh the individual's liberty interests. If the committed outpatient satisfies the statutes' requirements and complies with his treatment plan, the intrusion on the liberty interests of the individual is minimized.<sup>27</sup> The outpatient commitment law, as amended, is constitutional.

Analysis of the 1983 amendment's practical effect indicates that, if applied cautiously, the amended outpatient commitment statutes can have positive results. Properly committed patients who comply with an appropriate treatment plan will not become dangerous to themselves or others<sup>28</sup> and will receive necessary treatment without having to enter an inpatient facility.<sup>29</sup> To

21. See S. HALLECK, *supra* note 12, at 127-28. See also *supra* note 12 and accompanying text.

22. N.C. GEN. STAT. §§ 122-58.4(c)(2), -58.6, -58.8(a)(2) (Cum. Supp. 1983). See Miller & Fiddleman, *supra* note 1, at 989 n.18 (1982):

The United States Court of Appeals for the District of Columbia was among the first to discuss the requirement for dangerousness as a criterion for involuntary commitment. Relying on District of Columbia statutes, the court supported the necessity of a demonstration of dangerousness in *Cross v. Harris*, 418 F.2d 1095 (D.C. Cir. 1968), and in *Millard v. Harris*, 406 F.2d 964 (D.C. Cir. 1968) (sexual psychopath laws). Stronger arguments, basing requirements for dangerousness on constitutional grounds, were soon forthcoming. See *Addington v. Texas*, 441 U.S. 418 (1979); *O'Connor v. Donaldson*, 422 U.S. 563 (1975); *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972).

23. See *supra* note 7 and accompanying text.

24. See *Addington v. Texas*, 441 U.S. 418, 426 (1979) (state "has authority under its police power to protect the community from the dangerous tendencies of some who are mentally ill"); *O'Connor v. Donaldson*, 422 U.S. 563, 576 (1975) ("[A] State cannot constitutionally confine without more a nondangerous individual.").

25. See *supra* notes 6-8, 19 and accompanying text.

26. See *supra* notes 6-8 and accompanying text.

27. See *supra* note 19 and accompanying text.

28. To be committed, the respondent must be "in need of treatment in order to prevent further disability or deterioration which would predictably result in dangerousness." N.C. GEN. STAT. § 122-58.8(a)(2) (Cum. Supp. 1983). Assuming the outpatient treatment is effective, the patient will not become dangerous.

29. See *infra* notes 34-37 and accompanying text.

a great extent, however, the effectiveness of outpatient care depends on the willingness of the patient to comply with the treatment plan. When a patient is involuntarily committed to outpatient care, his therapy is likely to be ineffective because he cannot be compelled to follow his treatment plan. Despite this potential drawback, the statutes' enforcement provisions<sup>30</sup> effectively protect the state's interests. Since the statutes' ability to protect state interests depends on the efficacy of the enforcement provisions, the state should reevaluate psychiatrists' role in enforcement.<sup>31</sup> Psychiatrists should be required to perform police power functions only when outpatients fail to comply with treatment<sup>32</sup> and "the provision of needed and effective treatment for the committed patients"<sup>33</sup> justifies the psychiatrists' enforcement role.

No specific form of outpatient treatment is required by the North Carolina statute. Practical problems may arise involving the availability and quality of the various types of treatment listed in the definition of "outpatient treatment." " 'Outpatient treatment' may include medication; individual or group therapy; day or partial-day programming activities; services and training, including education and vocational activities; supervision of living arrangements; and any other services . . . ."<sup>34</sup> North Carolina General Statutes section 122-58.2(8) identifies three goals of outpatient therapy. Outpatient therapy may be provided (1) to "alleviate the person's illness or disability,"<sup>35</sup> (2) "to maintain semi-independent functioning,"<sup>36</sup> or (3) "to prevent further deterioration that may reasonably be predicted to result in the need for inpatient commitment to a mental health facility."<sup>37</sup>

Outpatient commitment proceedings, like inpatient commitment proceedings, begin with the filing of an affidavit and a petition with the clerk or magistrate for an order to take an individual into custody for examination by a qualified physician.<sup>38</sup> Although amended section 122-58.8 permits the state to commit individuals involuntarily to outpatient care if they presently are not dangerous but may become dangerous, the statutes relating to the affidavit's sufficiency and the magistrate's findings have not been amended to reflect this

30. N.C. GEN. STAT. §§ 122-58.10A, -58.10B, -58.11A (Cum. Supp. 1983).

31. See *infra* notes 58-62 and accompanying text.

32. See *infra* notes 61-62 and accompanying text.

33. Miller & Fiddleman, *supra* note 1, at 988 n.10 (1982).

34. N.C. GEN. STAT. § 122-58.2(8) (Cum. Supp. 1983).

35. *Id.*

36. *Id.*

37. *Id.*

38. N.C. GEN. STAT. § 122-58.3(A) (1981) provides:

Any person who has knowledge of a mentally ill or inebriate person who is dangerous to himself or others, or who is mentally retarded and, because of an accompanying behavior disorder, is dangerous to others may appear before a clerk or assistant or deputy clerk of superior court or a magistrate of district court and execute an affidavit to this effect, and petition the clerk or magistrate for issuance of an order to take the respondent into custody for examination by a qualified physician. The affidavit shall include the facts on which the affiant's opinion is based. The respondent must be found in or be a resident of the same county as the clerk or magistrate.

new dangerousness standard.<sup>39</sup> Both provisions currently require a finding that the respondent is *presently dangerous* to himself or others.<sup>40</sup> Thus, a literal reading of the involuntary commitment statute yields the following illogical rule: a respondent must qualify for *inpatient* commitment under the higher dangerousness standard before he may be committed to *outpatient* therapy under the lower dangerousness standard. The remedy for this problem is simple. The General Assembly should amend section 122-58.3, which prescribes the petitioning procedure and magistrate's fact-finding standard, to comport with the new standards in section 122-58.8.

Assuming that the problem posed by the mismatched statutes is overcome by legislative action, magistrates will be authorized to require that a respondent be taken into custody and examined by a qualified physician if they reasonably believe that the respondent is mentally ill and will become dangerous without treatment. Following the physician's examination, a court could order the respondent to be committed to outpatient therapy if it found that the respondent satisfies four criteria. He must be mentally ill, capable of surviving safely in the community, in need of treatment to prevent his predictable deterioration into a dangerous person, and unable to make an informed decision to seek or comply with treatment voluntarily.<sup>41</sup> The third criterion requires the court to make a very difficult factual determination.

How is a court to determine when a patient is not dangerous but is "in need of treatment in order to prevent further disability or deterioration which would predictably result in dangerousness?"<sup>42</sup> As a practical matter, the court will rely on the examining physician's evaluation. North Carolina General Statutes section 122-58.4 requires the physician to determine whether the respondent is presently dangerous<sup>43</sup> or predictably will become dangerous without treatment.<sup>44</sup> One criticism leveled at the dangerousness standard is that it is difficult to predict dangerousness in individual cases.<sup>45</sup> The type of patient who will be found to satisfy the outpatient commitment criteria is one who has not attempted suicide, mutilated himself, or inflicted or threatened serious bodily harm on another in the recent past, and who is not in danger of serious

39. See *id.* (affidavit statute). See also *id.* § 122-58.3(b) (1981 & Cum. Supp. 1983) (magistrate's findings). Section 122-58.3(b) provides:

If the clerk or magistrate finds reasonable grounds to believe that the facts alleged in the affidavit are true and that the respondent is probably mentally ill or inebriate and dangerous to himself or others, or is mentally retarded and, because of an accompanying behavior disorder, is dangerous to others, he shall issue an order to a law-enforcement officer . . . to take the respondent into custody for examination by a qualified physician.

40. See *id.* § 122-58.3.

41. *Id.* § 122-58.8.

42. *Id.*

43. *Id.* § 122-58.4(c)(1) (Cum. Supp. 1983) (examination by qualified physician—one criterion for inpatient commitment is dangerousness to self or others).

44. *Id.* § 122-58.4(c)(2) (examination by qualified physician—respondent must be in need of treatment to prevent further disability or deterioration which would predictably result in dangerousness to be committed to outpatient care).

45. S. HALLECK, *supra* note 12, at 130-32 (section entitled "Is Dangerousness Predictable, and are Psychiatrists any more Equipped to Predict it than Anyone Else?").

physical debilitation within the near future,<sup>46</sup> but who has been committed to inpatient treatment in the past and who shows signs of deteriorating. Judges should recognize that psychiatrists' predictions may not be accurate in individual cases.

Another potential problem is determining the length of the respondent's commitment to outpatient treatment. By statutory limitation, the period of initial commitment may not exceed ninety days.<sup>47</sup> Upon rehearing, "[i]f the respondent continues to meet the criteria" for outpatient commitment, "the court may order outpatient commitment for an additional period not in excess of 180 days."<sup>48</sup> The court may order additional periods of outpatient commitment for as long as the patient continues to meet the criteria for commitment.<sup>49</sup> The practical problem is that "[a]t any time that the outpatient treatment physician finds that the respondent no longer meets the criteria [for outpatient commitment], the physician shall notify the court and the case shall be dismissed."<sup>50</sup> This provision will require dismissal of a patient's case as soon as the patient does not satisfy any one of the criteria. In particular, the patient's case must be dismissed as soon as he becomes fully able "to make an informed decision to voluntarily seek or comply with recommended treatment."<sup>51</sup> Although this criterion protects an important right of the respondent,<sup>52</sup> it does not appear in the standard for commitment to an inpatient facility.<sup>53</sup> Under the amended outpatient commitment statutes, physicians and the courts will face the difficult task of determining when the respondent is able to make an informed decision about his treatment. The physician should not assume that the patient should be treated for the entire length of the commitment ordered by the court, and should be prepared to release the patient when he no longer meets all four criteria for outpatient commitment.

Finally, practical problems may arise with regard to the availability and quality of the various treatments listed in the statutes' definition of outpatient treatment.<sup>54</sup> The definition is very broad—it is not clear what services actually will be available to patients committed under the statute.

How well will outpatient commitment work? Will it further the specified

46. *Cf.* N.C. GEN. STAT. § 122-58.2 (1981). If the patient is in danger of serious physical debilitation within the near future, or has threatened or attempted suicide or bodily harm on another, then the patient should be committed to an inpatient facility. Outpatient commitments are "intended for the revolving door patient, not [the] first admission with no treatment history." Memorandum to Screening Staff at Dorothea Dix Hospital, Raleigh, North Carolina, February 21, 1984.

47. N.C. GEN. STAT. §§ 122-58.8(a)(1), -58.8(a)(2), -58.8(b)(1) (Cum. Supp. 1983).

48. *Id.* § 122-58.11A(c).

49. *See id.* § 122-58.11A.

50. *See id.* § 122-58.10A(b)(4).

51. *See id.* § 122-58.4(c)(2) (criteria for outpatient commitment). N.C. GEN. STAT. § 122-58.10A(b)(4) (Cum. Supp. 1983) requires dismissal as soon as any one of the criteria is no longer satisfied by the respondent.

52. This criterion protects the patient's right to determine his own treatment. This right may be taken away only if the patient is dangerous, as is the case in inpatient commitments, or if the patient is unable to make this decision for himself.

53. *See* N.C. GEN. STAT. § 122-58.4(c)(1) (Cum. Supp. 1983).

54. *See supra* text accompanying note 34.

goals in the statute?<sup>55</sup> A study of North Carolina's previous outpatient commitment statute was conducted in 1978 and 1979.<sup>56</sup> The patients studied had been committed under the stricter standard for dangerousness.<sup>57</sup> The results of the study were promising:

[O]utpatient commitments appear to be working very well, since more than two-thirds did not become dangerous enough within 90 days to invoke legal action to have them involuntarily hospitalized. . . . Of all respondents committed to outpatient treatment, only 15.7% in 1978 and 9.5% in 1979 were involuntarily hospitalized within 90 days by the court.<sup>58</sup>

All persons involved in administering the outpatient commitment law should be interested in having the statute evaluated further. Long-term studies should evaluate whether and when patients require inpatient commitment after release from the outpatient treatment program.

One factor that will influence the success of the outpatient commitment law is the support given by the physicians who examine and treat the respondents. At each stage in the commitment process, the physician is placed in a difficult and potentially unpleasant position. The physician must examine the patient and determine whether the patient meets the commitment criteria.<sup>59</sup> If the respondent is committed to outpatient treatment, the outpatient treatment physician must "make all reasonable effort to solicit the respondent's compliance."<sup>60</sup> If the outpatient fails to comply with his treatment plan, the treating physician may request that the respondent be returned to custody for reexamination and possible commitment to an inpatient facility.<sup>61</sup> Thus, the physician will be placed in an adversarial relationship with the patient and may have to perform the function of a police officer for the state.

Since "[c]linicians do not relish the role of incarcerators, an inevitable part of involuntary commitment; that role becomes tolerable only when there is justification in the provision of needed and effective treatment for the committed patients."<sup>62</sup> So long as the statute results in "needed and effective" treatment, treating physicians should support the law. If a large percentage of

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55. See *supra* notes 35-37 and accompanying text.

56. Hiday & Goodman, *supra* note 1, at 84-93 (1982).

57. *Id.* at 85. The 1983 amendment incorporated the lower standard for outpatient commitments and did not become law until January 1, 1984. See *supra* note 1 and accompanying text.

58. Hiday & Goodman, *supra* note 1, at 89-90. The study further concluded:

Without the use of outpatient commitment, all of the respondents of this present study would have been removed from their communities, separated from their social support systems, and involuntarily confined to the strange, abnormal environment of a mental hospital. Outpatient commitment has been effective in providing treatment and control of dangerousness while enabling respondents to maintain their roles and networks in familiar surroundings. Outpatient commitment not only is more rational in terms of human costs, but also is more rational in terms of financial costs to the taxpayer.

*Id.* at 91.

59. See N.C. GEN. STAT. § 122-58.4 (1981 & Cum. Supp. 1983). See also *supra* notes 44-46 and accompanying text.

60. N.C. GEN. STAT. § 122-58.10A(b)(1) (Cum. Supp. 1983).

61. *Id.* § 122-58.10A(b)(2).

62. Miller & Fiddleman, *supra* note 1 at 988 n.10.

the patients committed under the law do not comply with their treatment plans, however, the statute should be reexamined since the effectiveness of outpatient care depends on the willingness of the patient to comply with the treatment plan.

North Carolina's amended outpatient commitment statutes should prove beneficial to properly committed patients who comply with their outpatient treatment plans. It will provide them with necessary treatment without exacting an unreasonable loss of personal liberty. The statutes' provisions for handling cases in which the patient fails to comply or refuses to comply with treatment ensure that, whether the patient complies or not, other citizens will be protected from the patient becoming dangerous. Furthermore, the 1983 amendments to the outpatient commitment law should result in greater use of outpatient commitment for the mentally ill. The amendments expand the class of persons who may be committed to include patients whose mental illness will lead predictably to dangerousness. Proper application of the new law will benefit both the state and the patients committed under the law. The state should be aware of potential problems with the statute, however, and reevaluate its use and effectiveness in the years to come.

MARY JOY O'MEARA