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The MacArthur Coercion Studies: A Wisconsin Perspective

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THE MACARTHUR COERCION STUDIES: A WISCONSIN PERSPECTIVE

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The Admiral noticed an ominous image on the radar screen of his ship which was clearly on a collision course with what appeared to be another vessel. He radioed ahead: "We are on a collision course; change your direction 10 degrees to the North." A message was radioed back: "Yes we are on a collision course; change your direction 90 degrees to the South." The now irritated Captain radioed a new message: "I am an Admiral; change your direction 10 degrees to the North." The message came back: "I am a seaman second class; change your direction 90 degrees to the South." An even more enraged Admiral radioed back: "This is a battleship; change your direction 10 degrees to the North!" The message came dispassionately back: "This is a lighthouse; change your direction 90 degrees to the South."

The MacArthur Coercion Studies, to me, represent a lighthouse-like reality: that major mental illness, by its intrinsic nature and manifestations, makes the use of coerced care—rather than purely voluntary treatment—necessary in some instances. No matter how earnestly some wish that were not so, or some might argue that it ought not to be so, or some might even legislatively prohibit so it cannot be so, coerced care, in some small number of cases, necessarily exists—like the lighthouse—as an unavoidable reality for both psychiatry and the law. That reality, like the lighthouse, cannot be wished away, argued away, legislated away, or litigated away. Our task as clinicians, attorneys, and advocates is to work together to chart as prudent and reasonable a course as possible that equitably and sensibly balances clinical realities with legal rights.

The MacArthur Foundation Research Network on Mental Health

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and the Law accepts that reality and, in these Coercion Studies, sets out to more precisely define and study coerced care. Then, it makes recommendations as to how coerced care, when necessary, can be best managed to maximize treatment opportunity with patients, while minimizing the detrimental impact on present or future treatment efforts, all the time respecting important rights and liberties. By systematically, dispassionately, and meticulously examining the nature of—and need for—coerced treatment (along with competency standards and violence risk assessment), in an overdue and enlightened fashion, these Coercion Studies provide study in place of slogans, data in place of diatribe, and recommendations in place of recriminations.

There is a Chinese proverb that states: "*If we don't change our direction, we are likely to end up where we are headed.*" The MacArthur Studies help us change our direction so that "where we are headed" in this important search—to balance the right to be sick with the right to be rescued—provides the most prudent, the most sensible, and the most equitable standards and solutions that we can fashion, on behalf of patients, their families, and the public, using to the best advantage our present state of knowledge in both psychiatry and law. These MacArthur Studies provide some data, finally, to help us in that important and vital search. It is with this more objective knowledge, and in this more scientific climate, that the search for the most reasonable midpoint in this delicate equation can be furthered. It is in that spirit that this conference was convened.

I. HOW WE GOT TO WHERE WE ARE

By necessity, psychiatry and law, with respect to the severely mentally ill, have been linked together for a long time in Wisconsin. That interface began benevolently in 1873 when then Wisconsin Governor Barstow sent a committee out to examine the plight of the mentally ill. What it found was a distressing picture indeed. Most of the mentally ill were in jails, untreated, and uncared for. Throughout the counties they visited in Wisconsin, this is what they found:

> Men and women unable to take care of themselves in pens with loose straw for beds and only a blanket to cover their naked bodies. In some jails the straw was changed daily, but in others clean straw was put in only once or twice a week. In one county an insane man and an insane woman were found nude, covered with their own excrement, huddled in a pile of straw above a pig pen. In another county the mentally sick persons were locked in

> a room, which in the opinion of the board had not been cleaned for years.... A sick woman was found in a dark cell in the cellar of a county jail. She received her food through a hole in the floor, much like a wild animal receiving food from its keeper.... Inmates frequently killed each other and black eyes and bruises were evidence of fights and abuse of the keepers.[1]

Dr. Walter Kempster, appointed Superintendent of the Northern Hospital for the Insane, which opened that year, responded to that report thusly:

> Who can think of the number of unfortunate beings now confined in the receptacles of the different counties of this state, and realize in the most remote degree, the sorrowing hearts their misfortunes have created; of hopes once bright now dashed; of the ambitions that lured beyond strength; of life's work begun but left unfinished; of affections ripened only to be blasted—who can consider these calamities of our fellow mortals, rendered insane by perhaps no act of their own, unwittingly thrown upon the charity of the state, bound by the unyielding fetters of a terrible disease .... Who can think of these things, *of the measureless calamity of insanity*, and turn idly away, closing eye and hand, withholding that which is known to be required to make life comfortable? We can conceive of no argument, economical or humanitarian, that can be adduced to show why aid should be postponed; why the sufferer must be compelled to suffer on.[2]

Subsequently, state and county mental hospitals were built, laws were created, and funds appropriated, so that the mentally ill could be separated from the jailed—where they had been to that point incarcerated for the crime of being sick—so that they could instead receive treatment if treatment for their condition was known, or failing that, so that they could at least be in a place of safety and retreat. Even in those early days, many such patients came voluntarily, but some required involuntary commitment. Throughout the ensuing century and a quarter to the present time, clinicians, attorneys, judges, advocates, legislators, and governors have continually interfaced and interacted with each

1. Darold A. Treffert, *The Image of Psychiatry and Its Impact on Patients and Future Patients*, *in* MOOD DISORDERS: THE WORLD'S MAJOR PUBLIC HEALTH PROBLEM 244, 244-45 (Frank J. Ayd, Jr. & Irving J. Taylor eds., 1978) (quoting First Annual Report, Wisconsin State Board of Charity and Reform (1873)) [hereinafter Treffert, *The Image of Psychiatry*).

2. Treffert, *The Image of Psychiatry*, *supra* note 1, at 245.

other, from their respective vantage points, searching to find that reasonable middle ground in the delicate equation of balancing certain rights—the right to be sick with the right to be rescued; the right to be free with the right of the patient and those around him or her to be safely protected; the right to receive treatment with the right to refuse treatment—for those few patients who do, because of severe mental illness, require involuntary, or coerced, treatment.

Which brings us to this conference today, still searching, still dialoguing—"sifting and winnowing" we call it in Wisconsin—because some involuntary or coerced treatment, remains necessary in some small number of cases of major mental illness.

II. WHERE ONE STANDS DEPENDS ON WHERE ONE SITS

For seventeen years I was Director of Winnebago Mental Health Institute, which serves thirty-seven counties in the east and north half of Wisconsin; it was to the mental health system what "University Hospital" or its equivalent is to the general health system—a tertiary care center for specialized treatment for persons with particularly complex conditions. Then for twelve years, I was director of a community mental health system for a county of 90,000 persons providing inpatient, outpatient, transitional, and a wide range of other services for persons with mental illness, developmental disability, alcohol, or drug problems. Throughout those years, and continuing to the present, I was also in private practice with both outpatients in the office and inpatients in a general hospital psychiatric unit when such care was necessary. So my vantage point—where I sit—is that of a clinician and an administrator in a wide variety of public and private, hospital and community, outpatient, and inpatient settings.

In each of those settings, including the Institute, the vast majority of patients were voluntary. But mental illness being what it is, in some relatively few instances, involuntary or coerced treatment becomes necessary. The circumstance of a patient who goes into the Emergency Room with chest pain, and to whom it is recommended he or she should stay in the hospital, but decides to go home instead is not the same as another patient in that same Emergency Room, cowering in the corner, hissing but otherwise mute, acting on delusions and responding to hallucinations. That latter patient, severely ill with a psychotic disorder, simply cannot, because of a disorder of the brain itself, make the same clear-headed judgment that the non-psychotic, but probably nonetheless still anxious, cardiac patient can make. Fortunately, the number of patients who require coerced treatment among the mentally ill is small

compared to those entirely competent to choose whether or not to receive treatment. With the increasingly effective, well-tolerated, and safe treatments now available for major mental illness such as severe depression, manic-depressive disorder, and schizophrenia—along with increasing community resources and support systems which make such treatments even more accessible—the number of patients requiring involuntary treatment is being reduced even further.

From the public defender's vantage point, the issues look somewhat different than they do to me as a clinician. The task for the public defender is to see that all due process is provided, legal rights are fully protected, and the least restrictive alternative used. To the civil libertarian, the issue is broader still: to make sure civil commitment does not become applicable to merely odd or eccentric behavior, or be substituted too easily or too casually in those persons who, even though mentally ill, maintain the capacity to make choices whether we agree with those choices or not.

But for each of us—clinician, attorney, advocate—from our respective vantage points, the task, it seems to me, is identical: to find, given what knowledge we have about mental illness *and* the law, that best and most reasonable midpoint in the delicate equation of balancing clinical realities and legal rights. Finally, these MacArthur Studies provide some data to help us in that task.

III. THE PENDULUM SWINGS—BOTH WAYS

I visited my first institution for the mentally ill when I was a junior medical student in 1957. There were no antidepressants, no anti-psychotics, no MRIs or CAT scans. Length of stay was measured in years. Insulin therapy was popular; the only medications available were sedatives and hypnotics. The total population in state and county mental hospitals nationwide was 560,000 persons, having increased each of the previous 100 years. But about that same time, in the search for a less sedating antihistamine, "tranquilizers" were accidentally discovered and chlorpromazine, the first anti-psychotic and the first definitive remedy for some forms of major mental illness, began to be widely used. Its impact on psychiatry in the 1950s and beyond was as dramatic as the impact of penicillin and other antibiotics in the rest of medicine beginning a decade earlier.

Almost simultaneously, antidepressants were discovered. Definitive treatments were now available for two of the most common forms of major mental illness. With the use of those medications, psychiatric hospital populations began to decrease in the same manner as happened

with TB sanitoria census after the introduction of streptomycin.[3] For the first time in a century, state and county mental hospital populations began to *decrease* because of these new anti-psychotic and antidepressant medications. Today, 77,000 persons, a decline of eighty-seven percent, reside in such hospitals nationwide.[4] Length of stay began to shorten first to months, then to weeks, and now to days. Treatment foci changed from inpatient to community settings. Mental health teams began to make house calls; storefront clinics existed right in the patient's neighborhood. Some of the stigma of mental illness began to decline, and more optimism, acceptance, and hope emerged. The pendulum swung optimistically toward more effective treatment for the mentally ill, and availability and access to such treatment improved markedly in the 1950s and 60s.

But a disquieting backward swing of that pendulum began about that same time as well. Prior to 1970, civil commitment criteria, in Wisconsin and throughout the nation, were constitutionally too vague, due process provisions were too few, and standards for civil commitment too broad. Mental Health Acts in all the states overemphasized *parens patriae* powers and too easily invoked police powers. Those statutes were deficient not only in substantive due process, but in procedural due process as well. For example, in Wisconsin the statutes stated simply that involuntary commitment could occur when a mentally ill person "require[d] care and treatment for his own welfare, or the welfare of others, or of the community" and that person was "a proper subject for custody and treatment."[5] Mental illness was much too loosely defined, and due process was scant. There were no requirements, for example, for prompt hearings, notice of the allegations, the right to an attorney, the right to remain silent, and the right of making the state bear the burden of proof beyond a reasonable doubt.

While there had been efforts underway in Wisconsin by a number of persons, including me, to revise that statute in the late 1960s and early 1970s, the law was challenged in a class action suit in 1972 when those revisions did not occur through the legislative process. In response to the challenge that the law was unconstitutionally vague, a federal district court handed down the *Lessard* decision involving due process rights of

3. *See* Treffert, *The Image of Psychiatry*, *supra* note 1, at 247.

4. *See* Leona L. Bachrach, Ph. D., *The State of the State Mental Hospital in 1996*, 47 PSYCHIATRIC SERVICES 1071, 1073 (Oct. 1996).

5. Mental Health Act, WIS. STAT. § 51.75, Art. II (f) (1971).

the mentally ill.[6] Instead of merely finding the statute to be unconstitutionally vague, however, the court, in a rather sweeping move, went one step further and construed the statute to imply a finding of dangerousness—inserting the exceedingly narrow language that for involuntary civil commitment to occur, there had to be "an extreme likelihood that if the person is not confined, he will do immediate harm to himself or others based on a finding of a recent overt act, attempt or threat to do substantial harm to oneself or others."[7] In so doing, the *Lessard* decision inappropriately—in my view and in the view of others as well—converted *parens patriae* powers in the Wisconsin civil commitment statute into police powers without ever specifically addressing the constitutionality of *parens patriae* absent the vagueness which admittedly was present in that statute.[8] The case ultimately made its way to the United States Supreme Court, which vacated and remanded it twice in 1974 and 1975.[9] Eventually, the Wisconsin Legislature responded to the *Lessard* decision by creating a statute with imminent physical dangerousness, to self or others (homicidal or suicidal), as the only two criteria for civil commitment. In addition to limiting civil commitment to these narrow imminent physical dangerousness requirements, significant new due process provisions were also added, including prompt probable cause hearings, thorough judicial review before final commitment, enumeration of patient's rights, provision of least restrictive alternatives, a specified length of commitment, and clearly delineated emergency detention provisions.[10]

Many other states, acting on cases within their own jurisdiction or patterning laws after *Lessard,* revised their commitment statues as well, embodying commitment criteria based on imminent physical risk—danger to self, danger to others—also including, as well, new due process provisions.[11] It soon became apparent, however, in Wisconsin and around the country, that this abrupt swing of the pendulum—from the

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6. *See* Lessard v. Schmidt, 349 F. Supp. 1078 (1972), *vacated,* 414 U.S. 473 (1974), *on remand to,* 379 F. Supp 1376 (1974), *vacated* 421 U.S. 957 (1975), *on remand to* 413 F. Supp. 1318 (1976).

7. *Id.* at 1093.

8. *See* Darold A. Treffert, *The Obviously Ill Patient in Need of Treatment: A Fourth Standard for Civil Commitment,* 36 HOSP. & COMMUNITY PSYCHIATRY 259, 260 (Mar. 1985).

9. Schmidt v. Lessard, 414 U.S. 473 (1974); 421 U.S. 957 (1975). *See also* RAEL JEAN ISAAC & VIRGINIA C. ARMAT, MADNESS IN THE STREETS: HOW PSYCHIATRY AND THE LAW ABANDONED THE MENTALLY ILL 127 (1990).

10. *See* WIS. STAT. ANN. §§ 51.001-51.95 (1997-98).

11. Darold A. Treffert & Richard W. Krajeck, *In Search of a Sane Commitment Statute,* 6 PSYCHIATRIC ANNALS 56-81 (June 1976).

standard for civil commitment being far too broad to now so narrow ("imminent physical dangerousness only")—was too restrictive and far too harsh, ignoring some obvious clinical realities. I began to collect a series of cases of what I called "dying with your rights on"—situations in which scrupulous concern for the patient's rights overshadowed reasonable concern for the patient's life.[12] This tragic catalog of cases has continued to grow.[13]

Along with these cases, there also was an increase in admissions of mentally ill persons into jails and prisons (a step a century backward to 1873) because of dangerousness criteria too narrowly defined.[14] Due to civil commitment criteria now too stringent, criminal observation provisions in the law were being used instead of civil commitment procedures for some of the mentally ill. Some mentally ill persons, having been arrested for minor offenses such as vagrancy, shoplifting, disorderly conduct, or failure to pay a restaurant bill, for example, would either be directly jailed—if for no other reason than their own safety—or in some instances such persons would be sent to psychiatric facilities for criminal observation under the Wisconsin Statute Chapter 957 provisions. In tabulating criminal observation commitments at three Wisconsin state institutions after the *Lessard* decision, there was an increase of seventy-eight percent in criminal observation cases at Winnebago, Mendota and Central State Hospital, rising from 200 such cases annually pre-*Lessard* to 367 such cases in 1977, two years after that decision.[15] However, this number represents only the tip of the iceberg, as the vast majority of "arrests" for minor offenses of obviously mentally ill persons, as an admitted effort on the part of law enforcement persons to get needy persons into a safe environment and hopefully even into a stream of treatment, occurred at the city and county level with incarceration being handled locally.

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12. *See* Darold A. Treffert, *Dying with One's Rights On*, 224 JAMA 1649 (1973). *See also* Darold A. Treffert, *The Practical Limits of Patient's Rights* 5 PSYCHIATRIC ANNALS 91-96 (1975); Darold A. Treffert, *Dying with Their Rights On*, 2 PRISM 49-52 (Feb. 1974) (hereinafter Treffert, *Dying with Their Rights On*].

13. *See* Darold A. Treffert, Dying With Your Rights On, Still, (paper presented at the 140th annual meeting of the American Psychiatric Association, Chicago, May 9-14, 1987).

14. *See* Marc F. Abramson, *The Criminalization of Mentally Disordered Behavior: Possible Side-Effects of New Mental Health Law*, 23 HOSP. & COMMUNITY PSYCHIATRY 101, 104 (1972). *See also* Jennifer Caldwell Bonovitz & Edward B. Guy, *Impact of Restrictive Civil Commitment Procedures on a Prison Psychiatric Service*, 136 AM. J. OF PSYCHIATRY 1045, 1046-47 (1979).

15. *See* Darold A. Treffert, *Legal "Rites": Criminalizing the Mentally Ill*, 3 HILLSIDE J. CLINICAL PSYCHIATRY 123-37 (1982) [hereinafter Treffert, *Legal "Rites"*].

This criminalization of the mentally ill, ironically at a time when society had de-criminalized alcoholism and drug abuse, has continued. Nationwide, in 1998, as many as six to fifteen percent of persons in city and county jails, and ten to fifteen percent of persons in state prisons, had severe mental illness.[16] And those percentages do not include a whole new influx of persons—sexual predators now being defined as "mentally ill"—into jails, prisons or some hybrid institutions specially created for that purpose. Since the law went into effect in 1997, 188 persons have already been detained under observation or committed status under Wisconsin Statute 950 provisions at either the Wisconsin Resource Center or the Mendota Mental Health Institute.[17] It is projected there will be forty-eight such new commitments annually.[18] In other states, as well, the new mentally ill sexual predator classification is creating a large population of such persons either in existing prisons, new special facilities, or even worse, filling beds in already overburdened mental hospitals.

One additional element of this harsh pendulum swing warrants mention—substitution of what might be called legal "rites" for patient rights.[19] From a time when due process was woefully lacking, the pendulum swung rather drastically in the opposite direction—in some instances, toward providing now more process than is due or necessary. One example of the extreme to which the legal "rites" pendulum overcompensated occurred in a Milwaukee courtroom in 1981.

The patient was in jail, had a prior diagnosis of schizophrenia, was obviously ill to anyone viewing him, and refused to eat, bathe, or communicate. He stared blankly at the ceiling. A jailor saw him eating feces from a toilet bowl. A psychiatric evaluation was ordered and a court proceeding occurred:

> [Public Defender]: "Would the eating of fecal material on one occasion by an individual pose a serious risk of harm to that person?"
>
> [Doctor]: "It is certainly not edible material . . . . It contains elements that are considered harmful or unnecessary."
>
> [Public Defender]: "But doctor, you cannot state whether the

16. *See* H. Richard Lamb & Linda E. Wienberger, *Persons With Severe Mental Illness in Jails and Prisons: A Review*, 49 PSYCHIATRIC SERVICES 483-84 (1998).

17. Interview with Phillip Macht, Director, Wisconsin Resource Center, Oshkosh, Wisconsin (Dec. 7, 1998).

18. *Id.*

19. *See generally* Treffert, *Legal "Rites,"* *supra* note 15.

consumption of such material on one occasion would invariably harm a person?"
[Doctor]: "Certainly not on one occasion."[20]

The Public Defender then moved to dismiss the action on the grounds that the patient was in no immediate danger of physical injury or dying. The case was dismissed. That patient, after two subsequent arrests, was sent to a state hospital for observation on a charge of disorderly conduct—failure to pay a restaurant bill—and was finally given medication to which he had responded well previously. He was successfully treated and released.[21]

As a reaction to some of these trends, an additional standard—gravely disabled—was added to Chapter 51, Wisconsin's Mental Health Act as a third standard for involuntary commitment.[22] However, this third standard also was predicated only on *physical* harm. Many other states added such a third standard also.[23] Wisconsin added an additional criteria in 1996—the so-called "obviously ill" or "need-for-treatment" standard—wherein a patient with a documented history of mental illness, who was deteriorating but not *yet* dangerous, could be detained for a thirty-day period if a petition for such detention was approved by the Attorney General's office within twelve hours of filing. This provision is generally referred to as the "Fifth Standard" in Wisconsin because there are two gravely disabled standards in Wisconsin law; nationwide this is generally referred to as the fourth standard.[24] Eight other states have added such an "obviously ill" or "need-for-treatment" fourth standard to add to the generally available three other standards existent in all states: (1) danger to self; (2) danger to others; and (3) gravely disabled.[25] Experience with this Fifth Standard in Wisconsin will be discussed in more detail later in this paper.

Overall, then, between 1972 and 1996 the pendulum swung clearly in the direction of more restrictive commitment criteria, more attention to legal rights (what in some instances have deteriorated into what I call

20. Dan Patnnos & Mary Zahn, *Man Moves In, Out of System*, MILWAUKEE SENTINEL, Aug. 19, 1981, at 16.

21. *See id.*

22. *See* WIS. STATS. § 51.20 (1997-98).

23. *See* Treffert & Krajeck, *supra* note 11, at 56.

24. Darold A. Treffert, *1995 Wisconsin Act 292: Finally, the Fifth Standard*, 95 WISC. MED. J. 537-40 (1996) [hereinafter Treffert, *Fifth Standard*].

25. Robert D. Miller, *Our Seriously Ill Patients Need This Legislation*, 32 WISC. PSYCHIATRIST 14-19 (1991).

"legal rites"), essentially prohibiting *parens patriae* interventions by requiring instead that narrowly defined imminent *physical* dangerousness be used as the sole basis on which involuntary intervention was permitted. The irony in this is that at a time when definitive treatment for major mental illness did *not* exist—from the 1850s until the 1950s—the authority to intervene was then too broad, the standards too liberal, and statutes constitutionally too vague. Yet beginning in the 1950s, after prompt, safe, and effective treatments became available for many forms of major mental illness, mental health statutes too stringent and too cumbersome and prevented, or unnecessarily delayed, such treatment. Thus, at a time such as now, when civil commitment for "care and treatment" would not be a euphemism for the ability to merely to confine, the right to *refuse* treatment cancels out the right to *receive* treatment in many instances. The MacArthur Studies should help in that regard by making right to refuse treatment determinations more uniform, more standardized, and more readily definable.

There is some evidence that the pendulum, which did swing so vigorously backward beginning with *Lessard*, has already begun a correction from permitting only police powers toward a return to some *parens patriae* considerations once again in a counterbalancing manner.[26] Outpatient commitments, protective placements, and limited guardianships have been newly forged, or creatively adapted, that allow outpatient treatment for persons with severe mental illness without having to meet more stringent *inpatient* involuntary commitment criteria.[27] By 1995, thirty-five states and the District of Columbia had such *outpatient* commitment provisions.[28]

Indeed, even when those are not available or applicable, there is ample evidence that clinicians, attorneys, and judges—when apparent and indicated—incorporate *parens patriae* and patient welfare concerns into existing civil commitment criteria when only "imminent physical dangerousness" criteria, on the surface, are too harsh. A recent study confirms previous findings that some judges, faced with various statutory and non-statutory considerations, in certain individual circum-

26. *See generally* Paul S. Appelbaum, *Civil Commitment: Is the Pendulum Changing Directions?* 33 HOSP. & COMMUNITY PSYCHIATRY 703 (1982). *See also* John Q. LaFond, *Law and the Delivery of Mental Health Services,* 64 AMER. J. OF ORTHOPSYCHIATRY 209-22 (1994).

27. *See generally* E. Fuller Torrey & Robert J. Kaplan, *A National Survey of the Use of Outpatient Commitment,* 46 PSYCHIATRIC SERVICES 778 (1995). *See also* ISAAC & ARMAT, *supra* note 9, at 313-16.

28. *See* Torrey & Kaplan, *supra* note 27, at 778.

stances can go "beyond the black letter of the law." The study also demonstrates that the *parens patriae* model more closely describes the individual judge's decision making process than the "police powers" model. Contextual variables such as the patient's family favoring commitment, can be influential as well.[29] In an even wider international context, Paul S. Appelbaum also argues that the pendulum may be swinging back again, in that reforms toward police powers, away from the "health and safety" needs of the patient, are resisted and have *not* dominated reform in most other nations.[30] When the law fails to reflect such patient health, safety, and treatment concerns, it is "molded" in practice to better incorporate "treatment needs" over narrow physical dangerousness criteria and stringent procedural rights.

Thus, the pendulum—in this ongoing search for a reasonable midpoint in the delicate balance between clinical realities and legal rights—has, these past 125 years, swung forward, then back, and then forward again. But rather than remaining constant, each time the pendulum goes back, however far, the next time it moves forward a bit further, progress-wise, than it had ever been before. It is with that awkward gait that this search, like all of man's inquiries, is propelled along, letting us adjust our direction slightly each time, so eventually we end up in that place to which we properly ought to be headed. These MacArthur Studies help in adjusting properly this particular journey's direction.

IV. DEFINING "COERCION"—THE FIRST, NECESSARY STEP

This MacArthur Study begins right where it should, by defining coercion. My tendency, both as a clinician and administrator, when I first read these Studies, was to page ahead to the end of the report to see what effect coercion had on the *outcome* of treatment efforts. While impact on treatment effectiveness may be an ultimate bottom line question with respect to coercion—does it help or hinder?—this early report correctly points out that before trying to assess whether coerced treatment "works," it is necessary to determine what makes people feel coerced as a prerequisite to meaningfully studying the impact of coercion. So I commend the researchers here for reminding us to carefully define terms before leaping to studying outcome. It is clear from these Studies,

29. *See* Harold J. Bursztajn et al., *Beyond the Black Letter of the Law: An Empirical Study of an Individual Judge's Decision Process for Civil Commitment Hearings*, 25 J. AM. ACAD. PSYCHIATRY L. 79, 89-90 (1997).

30. *See* Paul S. Appelbaum, *Almost a Revolution: An International Perspective on the Law of Involuntary Commitment*, 25 J. AM. ACAD. PSYCHIATRY L. 135, 138 (1997).

and our general observations in practice, that equating coerced care with civil commitment status is too crude a standard. Some persons enter the hospital "voluntarily" because they have been told unless they do so they will be involuntarily committed. Others "volunteer" as a condition of probation, or as a condition of licensure in the case of some professional persons, or to save a marriage "by getting some help."

While "voluntary" in terms of the letter of the law, threats and intimidation at worst, and persuasion at best, can make the voluntary nature of some admissions coerced care. Contrariwise, as these Studies point out, sometimes an "involuntary" process is used on paper, with full consent of the patient, to achieve some transportation, fiscal, jurisdictional or other purpose. Any attempt to define coercion by legal status alone becomes even more problematic in Wisconsin when one remembers that this state had, in its statutes—until the 1970s—a "voluntary commitment" (a real oxymoron) provision for persons with alcoholism under which the person would voluntarily commit (not admit) himself or herself to the hospital for at least a thirty-day stay during which time such persons could be detained on this "voluntary commitment" even if they asked for their release. It truly was a "voluntary commitment."

The beginning of wisdom is to call things by their right name. I commend the MacArthur Group for beginning the study of coercion in mental health care by first carefully defining it, and then by expanding and refining that definition to include *perceived* coercion as a valid area of inquiry in this important topic area rather than simply equating "coercion" with involuntary commitment status. Coercion can occur with voluntary admission status as well, as these Studies convincingly point out, and on occasion the committed patient may have experienced little or no coercion in spite of the "involuntary" status.

A. Coerced Care—Beyond Inpatient Status

Actual or perceived coercion can be measured differentially between inpatients on a voluntary versus committed status. This is a good starting point, as in present day practice "coerced care" increasingly occurs on an outpatient, in-community basis. Outpatient commitment exists in many states now, sometimes with criteria identical to inpatient standards, but sometimes with criteria somewhat less stringent. In even wider use than outpatient commitment, is an adaptation of Wisconsin's Chapter 55, the "Protective Services or Placement Act." This Act had been originally intended to apply principally to the elderly and developmentally disabled. In Dane County, Wisconsin, for example, with its

integrated system of community care, the mechanism of a limited guardianship under Chapter 880 and Chapter 55 has been used to appoint a guardian limited to consenting or refusing medication. In 1989, 350 of Dane County's approximately 1500 chronic mentally ill—almost twenty-five percent—were under some sort of compulsory medication order including protective placement, regular commitment orders, or ninety-day "settlement agreements."[31]

Because of some curtailments in the use of protective placements for medication compliance, due to several court decisions, 1996 data for Dane County still showed twenty-four percent (373 of 1537 seriously ill patients) under an involuntary court finding that provided compulsory medication administration, but the distribution was somewhat different among those orders: One hundred and nineteen civil commitments, seventy-five settlement agreements, one hundred and fifty-eight protective services or placements, and twenty-one conditional releases.[32]

Therefore, in attempting to define "coerced care" as the first step in evaluating its impact on care and outcome of care, the MacArthur group will need to go beyond the more traditional voluntary versus committed inpatient populations—where that distinction is already blurred as noted above—to include "coerced care" among "involuntary" outpatient populations who are under either specific outpatient commitment statutes or creatively tailored protective placements.

B. Coerced Care—an Oxymoron?

The term "coerced" is defined as "to cause a person to yield to pressure." Coerced treatment sounds like it would, on the face of it, be a failure. Yet some of my most grateful patients received coerced care:

> He was a middle aged professional man with a severe alcohol problem. His wife accompanied him to the appointment. He had already lost his position with his company, had largely dissipated the family savings, had severely compromised his reputation and was now about to lose his family as well. The bottom line, the spouse insisted, was that unless he signed himself into the hospital for detoxification and treatment, she and the children were moving out. The promises of stopping drinking on his own, going to A.A., getting outpatient help, and generally

31. *See* ISAAC AND ARMAT, *supra* note 9.

32. Personal communication, David LaCount, Administrator, Dane County Mental Health System, Dec. 2, 1998.

"shaping up" were no longer good enough. They had all been tried. They all had failed—repeatedly. I pointed out his professional license was likely next to go, after his family, then his health. He reluctantly agreed. He signed himself into the hospital. It is now seventeen years of sobriety, success at work, and fulfillment at home later. He stops by once a year to let me know how well he is doing and how grateful he is we all insisted—we all "coerced"—him into care, and then recovery.

In reading these MacArthur Studies, I realize now that "coercion" worked in this case because we—family, clinician, employer—used a generous amount of what is usefully and appropriately defined and outlined in these Studies as "procedural justice"—genuine concern, good faith, respect, listening to his side of the story, involving important persons in his life in the decision making process, and using persuasion and inducements rather than legal maneuvers or force. With those elements in the persuasion process, coerced care need not be an oxymoron. Or consider this case:

A catatonic patient, hissing and spitting in the Emergency Room, obviously psychotic now that he has gone off his medications, which have so well controlled his symptoms in the past, cannot be detained, in spite of the pleas of who have seen this all before with Dad when he stopped taking his meds, because the police officer says hissing and spitting is not against the law, and the patient is threatening no one. It is obvious to all, though, that hallucinations and delusions are rampant and out of control. The patient, otherwise mute, simply stares blankly at the voluntary admission form. The patient should return home, the family is advised, "until he gets worse." He does, of course, get worse. After several days of not eating or drinking, floridly psychotic but still mute, he develops a fever. An ambulance is called; he is admitted to a medical unit of a general hospital because it is thought, he might have had a stroke. His catatonia resembled those symptoms. Then, after a four-day delay on a medical unit during which the family watches Dad deteriorate further, he finally legally qualifies for transfer to a psychiatric unit where a treatment order is obtained.

The patient responds within hours, promptly and dramatically, as he always had before, to the medication. The voices disappear; the bizarre behavior ceases. A hospitalization, which could have taken a few days if prompt treatment had been given, takes several weeks. That patient—and his family too—are

> grateful for the "coerced care" that finally came, late as it was. The patient asked me, when he recovered, why we didn't do something sooner. "Because we were protecting your liberties", I replied. "Being sick like that, Doc, isn't 'liberty' at all," he retorted.

C. Is No Care Preferable To Coerced Care?

Few would argue that voluntary treatment with a fully consenting patient is preferable to any sort of coerced care. The cases above point out that in some instances, even coerced care can be effective, and, in retrospect, appreciated. The MacArthur Studies intend to more carefully define the nature, extent, and effect of coercion on mental health treatment and that inquiry is welcome. Nevertheless, I would submit that if one is to look *fully* at the impact of voluntary versus coerced care on the mentally ill, one has to study that with one other crucial variable at risk as well—the impact of *no* care at all. Admittedly, that is difficult to achieve. But if one is looking at the outcome of treatment, it would be truly comprehensive only if one compared and contrasted the effects of voluntary care, coerced care (including but not limited to involuntary commitment) and *no* care on similar populations.

Let me provide an example of no care. Two young women in a university community were observed standing on a street corner in the campus area, staring in catatonic fashion at each other for over an hour. A crowd gathered creating considerable confusion at the busy intersection. Eventually, the police were called and took the pair to a nearby precinct for questioning, but the women would give nothing more then their names; they refused to speak and sat mutely staring into space. The police concluded that some type of psychiatric observation was indicated, but when they contacted the city attorney's office and the prosecuting attorney's office, the opinion from both was the same. State law allowed persons to be held for observation only if they appeared obviously dangerous to themselves or others. In this case, while the overall behavior was clearly bizarre, they were, after all, only staring at each other, and were not voicing any threats against themselves or others. Since neither homicidal nor suicidal tendencies were apparent, it was the opinion of both attorneys that the women did not qualify for observation. Reluctantly, the police released them.

Some hours later the police were called to a campus apartment where the two women were found on the floor screaming in pain, their clothes ablaze from a self-made butcher paper pyre they had lit oblig-

ingly for each other in a suicide pact. Both women were taken to hospitals in critical condition. One recovered; the other died. She died with her rights on.[33]

This is one example from my tragic catalog of over 200 cases of persons who, what I call, "died with their rights on." I have hundreds of such cases previously reported in different articles. Civil libertarians and other critics refer to these cases as Treffert's "anecdotes." They dislike them. The cases are jarring. They are "out-liers," not common, and do not represent the mainstream circumstance, these critics say. They interfere with philosophical musings. But the instances are real. They do exist. These persons, with such tragic outcomes, are not "anecdotes" to their families and loved ones, or to innocent persons or bystanders sometimes harmed by them. So I continue to track and report them.

It is curious to me that these "dying with your rights on" cases are viewed so dismissively by critics because they are mere "anecdotes"—a single instance from which one draws much broader conclusions. Comparatively, a class action suit, such as *Lessard*, is also a single instance from which broader conclusions are drawn and sweeping remedies are applied. Clinicians call them cases; attorneys call them class action suits.

So what have the courts said in these legal cases? On the issue of involuntary treatment, and the requisite criteria for such confinement, in *Addington v. Texas*,[34] Chief Justice Burger of the United States Supreme Court stated that "[t]he state has a legitimate interest under *parens patriae* powers in providing care to its citizens who are unable, because of emotional 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."[35] It is not, then, either *parens patriae* or police powers, as the *Lessard* decision ruled in throwing out *parens patriae* concerns entirely, but rather, that there is a legitimate role for both *parens patriae* and police powers in appropriate circumstances, as the decision in *Addington* allows. In a footnote to *O'Connor v. Donaldson*,[36] the United States Supreme Court echoed that finding, stating that involuntary treatment may sometimes be necessary "if for physical or other reasons he is helpless to avoid *the hazards of free-*

33. *See* Treffert, *Dying with Their Rights On*, *supra* note 12, at 49.
34. 441 U.S. 418 (1979).
35. *Id.* at 426.
36. 422 U.S. 563 (1975).

dom."[37]

Many of these "dying with your rights on" cases demonstrate graphically, and tragically, that freedom can be a hazard—or another form of imprisonment—for persons who are obviously ill and in need of treatment; who are not *yet* dangerous but well on their way to being so, and who, because of that obviously and permeating illness, are unable to care for themselves. The Group for the Advancement of Psychiatry (GAP) report, which the MacArthur Studies cite in the introduction to their work, concluded that "sometimes involuntary psychiatric treatment is necessary, can be effective, and can lead to freedom from the constraints of illness. Conversely, tight restrictions against coercive treatment can have disastrous consequences."[38]

The bad news is that some disastrous consequences continue to occur in some cases. The good news is that the addition of the third—"gravely disabled"—standard and now the fourth "need for treatment" standard in some states for the "obviously ill" but not *yet* dangerous patient, along with outpatient commitment, protective placements, and limited guardianships alluded to above, have reduced that number. Yet in spite of those alternatives, there remain some instances of *no* treatment or intervention, when such treatment and intervention clearly ought to occur. Sometimes that is because of the law, sometimes it is because of lack of facilities or resources, and sometimes it is because of advocacy too strident, or in my view, misapplied.

One of the reasons I find these MacArthur Studies so useful and promising is that now *data* can be collected on the whole spectrum of voluntary treatment, involuntary treatment, and no treatment at all. The data can be compared and contrasted with respect to impact, outcome, and, eventually, even costs. Data can put anecdotes in perspective, and it can put philosophical musings in perspective as well. That would be a welcome substitution for both anecdotes and musings.

In order to accomplish that, though, these MacArthur Studies, as they proceed, when studying the spectrum of care from entirely voluntary to entirely coerced, and all the hybrid variations between those two alternatives that have developed now, will need to include "*no* care," along with voluntary and coerced care, as a part of the study and control groups. "No care" is a legitimate, realistic, and actual part of the full

37. *Id.* at 574 n.9 (emphasis added).

38. COMMITTEE ON GOVERNMENT POLICY, GROUP FOR THE ADVANCEMENT OF PSYCHIATRY; FORCED INTO TREATMENT: THE ROLE OF COERCION IN CLINICAL PRACTICE, No. 137 at 43 (1994).

spectrum of possibilities when assessing or examining the total spectrum of care—or lack thereof—for the mentally ill today. While setting up such a research protocol *pro*spectively would pose difficult if not impossible ethical problems (randomly assigning seriously ill persons to no treatment) certainly there should be much *retro*spective data that can be analyzed, comparing and contrasting outcome for reasonably matched persons between voluntary care, coerced care, and no care at all. For example, if one were comparing success rates of surgical versus medical approaches to coronary artery disease, in order to honestly assess the relative effectiveness of those treatments, one would necessarily have to include a group of patients in which there was no intervention at all. It is no different with mental illness, it seems to me, and I hope and recommend, that the MacArthur Studies include "no treatment" as one of the dependent variables in assessing treatment outcome and effectiveness with these populations.

Certainly with involuntary treatment and coerced care there is much to be cautious about. Such interventions cannot be allowed to be arbitrary, capricious, casual, or employed merely for convenience or economies. Painstaking protection of patients' civil rights and use of the least restrictive alternative in each and every case is essential to be sure. But equally important—no more, no less—is the task of ensuring reasoned, restrained but appropriate care and intervention for the seriously mentally ill patient when severe and tragic consequences will ensue to the patient or those around him or her in the absence of treatment. The MacArthur Studies provide some direction and guidance in proportioning out that delicate equation.

V. THE MACARTHUR STUDIES TO DATE: MEANINGFUL FINDINGS TO THE CLINICIAN

Each person, looking at the MacArthur Studies to date, again depending on one's vantage point, is probably struck by different findings. To me, as a clinician and administrator, the following are particularly significant:

A. The Vast Majority of Psychiatric Admissions are Voluntary

Of 1.1 million civil inpatient admissions in 1980, seventy-three percent (broadly construed) were voluntary although that proportion varies depending on the type of facility. For example, the voluntary admission percentage in state and county facilities was 38.4%; Community Mental Health Centers 53.9%; General Hospital Psychiatric units 85.2%; and

VA units 94.4%. While some adjustments need to be made for the fact that "voluntary" and "involuntary" designations are not entirely accurate for a variety of reasons discussed above, the fact is that the vast majority of inpatient and outpatient treatment is *not* coerced and occurs as a voluntary contract between patient, facility or agent, and therapist.

B. Patient Interviews are a More Accurate Measure of "Coercion" than Legal Status

In interviewing 157 newly admitted patients, forty-nine percent of *voluntary* patients indicated someone other than themselves had initiated coming to the hospital; four percent were in some form of custody at the time of presentation; twenty-five percent felt there were reasonable alternatives to hospitalization and ten percent perceived themselves to have been coerced using the perceived coercion scales. On the other hand, twenty-two percent of the *involuntary* patients indicated it was their idea to come to the hospital and forty-seven percent felt there were no reasonable alternatives to hospitalization. Thirty-five percent did not perceive themselves as having been coerced into the hospital; fifty-six percent said they would have entered the hospital voluntarily if they had been given that opportunity. Therefore, patient interviews, using the MacArthur tools, in the present and any future studies, to measure coercion provide a much more meaningful assessment of those factors than looking at legal status alone.

C. Involuntary Commitment is not Synonymous with Denial and Protest

Involuntarily committed patients do not invariably deny their illness and protest the hospitalization process. Thirty-four percent believed they were mentally ill; twenty-two percent indicated it was their idea to come to the hospital and twenty percent stated they had initiated the admission. Approximately one half (forty-seven percent) agreed there was no reasonable alternative to hospitalization and, in a process that one might automatically assume involves pressure and force, thirty-five percent of patients who were legally committed did *not* perceive themselves as having been coerced into the hospital. Of particular concern, however, is the fact that fifty-six percent of these committed patients indicated they would have entered the hospital voluntarily if they had been given the opportunity. An obvious question arises—why wasn't voluntary admission used? There was some suggestion that in some cases legal status determined transportation arrangements. Involuntary commitment just to achieve that purpose seems cumbersome—and inappropriate.

D. The Need for Hospitalization—A Retrospective View by the Patient

Two hundred seventy of the patients in one sample of this study were re-interviewed between four to eight weeks after discharge. More than fifty percent of the re-interviewed patients who said initially that they did *not* need to be hospitalized reported that, in retrospect, the decision for their hospitalization was the correct one. Less than five percent of those who said at the time of admission they needed such care now said, in retrospect, such care was unnecessary. Thus, the patient's view of hospitalization, even when coerced, can change in a positive direction over time and need not be a lingering deterrent to future care, should that become necessary.

E. Procedural Justice—An Eminently Useful Concept and Term

These Studies show that in some instances, coerced care is a reality with major mental illness. That being the case, the most valuable lesson—the bottom line or take home message—from this work for anyone involved in patient or client care, whether coerced or not, in my view, is the concept, and term, *procedural justice.* While in this study that term was applied to the patients' perceptions of the ways they were treated by others during the process of coming to and being admitted to the *hospital,* including the nature of pressures and coercion in that admission process, the key elements in procedural justice are just as applicable to care in outpatient settings where, for example, protective placements or outpatient commitments are used as least restrictive alternatives to inpatient care.

The findings here usefully show that there is a low level of perceived coercion if: persuasion and inducement are used rather than threats or force; others, including friends and family, are involved in the decision making as a form of caring; the patient believes others acted out of genuine concern; the patient believes he or she was treated respectfully and in good faith; and the patient was afforded a chance to tell his or her side of the story. Those elements of including of the patient/client in the decision-making process are universally applicable to the treatment transaction wherever, and whenever, it occurs. That they should be a part of coerced care particularly, when it is necessary to use such, is certainly worthy of mention and emphasis and these Studies usefully do that. Those elements remind me of the inscription above the door of a mental hospital in Europe: "To cure sometimes—to help often—to comfort always." These Studies, and the concept of procedural justice, usefully remind everyone involved in the coerced care transaction that

there is a vital human dimension to that stringent legal process.

VI. THE "FIFTH STANDARD" IN WISCONSIN—EXPERIENCE TO DATE

I mentioned the so-called "fifth standard" earlier and a brief review of its provisions, and experience to date, with that new need-for-treatment provision might be useful here. In 1996, Act 292 went into effect, establishing the so-called "fifth standard" for civil commitment in Wisconsin. This was a culmination of a fourteen-year effort by the Wisconsin State Medical Society and the Alliance for the Mentally Ill of Wisconsin to pass such a law.[39] It provides for earlier intervention in some instances of persons with a documented history of mental illness *before* deterioration to physical dangerousness required in the four other commitment criteria in Chapter 51, Wisconsin's Mental Health Act. Key provisions include the following:

> A substantial probability, as demonstrated by both the person's treatment history and his or her recent acts and omissions, of all of the following: a) The person needs care and treatment to prevent further disability or deterioration; b) He or she will, if left untreated, lack services necessary for his or her safety and suffer severe mental, emotional or physical harm that will result in the loss of a person's ability to function independently in the community or loss of cognitive or volitional control over his or her thoughts or actions. The probability of suffering severe mental, emotional or physical harm is not substantial if reasonable provision for the person's care or treatment is available in the community and there is a reasonable probability that the person will avail himself or herself of these services or if the person is appropriate for protective placement; and c) an incapability of expressing an understanding of the advantages and disadvantages of accepting medication or treatment and of the alternatives to the particular medication or treatment offered, after the advantages, disadvantages and alternatives have been explained to the person.
>
> Emergency detention can occur using this standard but the attorney general or designee is required to review and approve, prior to or within 12-hours after filing, any petition using this standard.
>
> Inpatient treatment under this standard is limited to 30 days. If the person is subsequently treated on an out-patient basis and

39. See Treffert, *Fifth Standard*, *supra* note 23 at 537.

> there is a violation of conditions established by the county or the court, the patient may be transferred to an inpatient facility for up to an additional 30 days.
>
> Medication or treatment may be administered without the consent of the person if, at or after the probable cause hearing the court finds that there is probable cause to believe the person meets the standard....
>
> Prior to or at the final hearing the county must provide a recommended treatment plan for goals, type of treatment, expected providers or inpatient care, and community case management services to be used after release; [and]
>
> When a law enforcement officer or other person so authorized plans to detain a child under this standard, he or she must first consult with a mental health professional.[40]

During the legislative struggle to enact this legislation, civil liberty opponents were concerned that such a new standard would be used as a first, rather than last, resort and that the mental health system would be overrun with inappropriate admissions. Ms. Dianne Greenley of the Wisconsin Coalition for Advocacy, my co-discussant on this panel, wrote in 1991, when she and I debated this topic in print, that such a standard, if enacted

> will cause personal pain and loss to those subject to unnecessary commitments, will create enormous fiscal consequences for the counties, and will undoubtedly lead to protracted litigation over its constitutionality.... The probability that commitment will be used as a first and not a last resort is significantly increased.... This will inevitably lead to greater hospital costs for the county 51.42 boards and human service departments. It may also lead to the expansion of the number of beds at the state hospitals.[41]

Fortunately, I can report, none of those dire consequences have occurred. The "Fifth Standard" went into effect on December 1, 1996. In the twenty-two months since that time there have been thirty-five requests for commitment under this new standard (1.6 requests per month). Thirty requests have been approved for an average of 1.4 approvals per month since the enactment of this new standard. Eighty-six

40. *Id.* at 538.

41. Darold A. Treffert & Dianne Greenley, *Face Off*, 53 WIS. COUNTIES (June 1991), at 24 25.

percent of those requests have been approved. A recent letter to me from the Assistant Attorney General states: "I can state with confidence that the law works the way it was intended by the legislature. The fifth standard is a valuable tool in the treatment of those individuals with mental illness who do not meet the other four standards of dangerousness in Chapter 51 of the statutes."[42]

Thus, there was no flood of patients to hospitals; the counties were not bankrupted; there was no massive shift of resources away from community mental health programs; and there has been no constitutional challenge. Instead, a small number of persons with a documented history of major mental illness who were deteriorating toward more severe disability, usually because they had gone off medication which had been effective to that point, and who were so ill as to be incapable of understanding the need for or advantages and disadvantages of treatment, were prevented from having to suffer further severe mental, emotional, or physical harm *before* treatment intervention could occur. If medication was to be administered without the patient's consent, the court was required to issue an order to treat using standard criteria for such a finding.

In these instances, not only were patients helped before further deterioration, but the families were spared watching their loved one deteriorate when, based on prior experiences, effective treatment was close at hand.

Nevertheless, the "Fifth Standard" falls short of what many supporters of that legislation would have liked to have seen enacted. Those persons with first-time psychotic episodes, who can also rapidly deteriorate to dangerousness narrowly defined, are not subject to this legislation. While some supporters (including myself) were dubious about the Attorney General's office being immediately available twenty-four hours per day seven days a week for approval of these petitions in a timely fashion, such availability has in fact been afforded to all the counties in the state within the strict timelines of the legislation. Not all counties have used filed petitions under this standard; some find it too restrictive or too cumbersome. Others adapt the four dangerousness standards to specific patient circumstances in a less rigid, more flexible manner. They "adapt" the present statutory language in a manner used in other states and other jurisdictions. That, however, is a sporadic justice and depends on the cooperativeness, and flexibility, of the district

42. Letter from Joseph Thomas, Assistant Attorney General, State of Wisconsin Department of Justice (Sep. 28, 1998) (on file with author).

attorney or corporation counsel, the patient's attorney or public defender, and the judge in any particular county. Prompt treatment of mentally ill persons, it seems to me, to the extent legal processes help determine such access, should not depend upon which county the person happens to be in. Some of these problems with the present Fifth Standard provisions perhaps can be rectified with future revisions of that particular section of the law.

VII. BANDWAGONS AND ANOTHER GLANCE BACK

In summary, these MacArthur Studies on coercion in mental health care are welcome and overdue. They begin by first carefully defining coerced care, and then usefully point out that equating involuntary treatment (civil commitment) with coerced care and voluntary treatment with non-coerced care is a far too narrow and out-dated paradigm. Likewise, equating civil commitment with traditional inpatient status is also an out-moded model given outpatient commitment statutes that exist in many states along with other creatively adapted statutes that permit modified guardianships, protective placements, conditional releases, and settlement agreements to maintain some form of "coerced" treatment status. Coercion is not always harmful, these Studies demonstrate, and in some instances, major mental illness being what it is, coerced treatment is simply a stark clinical reality, and it can be a useful necessity.

Coerced care need not be an oxymoron. To achieve that, however, coercion, whenever it is used, must be the least intrusive possible, and should always contain elements of procedural justice such as genuine concern, good faith, respect, listening to the patient's side of the story, and involvement of important persons in the patient's life in the decision-making process. Persuasion and inducements should supersede legal maneuvers or force. For an assessment to be accurate and inclusive regarding the effects of coercion on outcome, it will be necessary to compare and contrast not just carefully defined coerced care versus voluntary care, but situations of "no care" with voluntary care and coerced care. The work to date already confirms that the majority of mental treatment occurs on a voluntary, not coerced, basis; that patient interviews are a more accurate measure of "coercion" than legal status; that involuntary commitment is not synonymous with denial and protest and that procedural justice is an eminently useful concept. Further work will produce many more useful findings for wide application by both psychiatry and law, muting, hopefully, some of the more strident polarization that has characterized the debate between some clinicians, some at-

torneys, and some advocates.

Part of that strident debate has been based on all-or-nothing approaches to an interface between clinical realities and legal rights that are not so easily divisible. Part of that debate has been fueled by a bandwagon mentality, and subsequent pendulum swings, first too liberal, then too narrow and back again. These more objective studies will mute that stridency somewhat, hopefully, and produce fewer bandwagons. Looking back in time a bit, to provide some perspective, may help. In 1870, there was a raging debate in mental hospital circles about the usefulness of and necessity of restraint for mentally ill persons (a debate that rages still). Dr. Kempster wisely viewed it, in 1887, thusly:

> I am reasonably suspicious of all physicians who advocate in their reports and in conventions the system of absolute non-restraint. We know . . . that in . . . some instances, the use of restraint was abused, and its application resorted to when milder and more appropriate remedies would have done better. But because a remedy has been abused, we must not go to the other extreme and refuse to use it at all when we know in a few instances it is the best of all remedies. The world moves by extremes, by popular enthusiasm. Just now it is fashionable to be a reformer, and the fashion in hospital reform is to abandon the camisole and put on another garment, called non-restraint. Ever and anon, men in the magnitude of their inexperience are popping up here and there, ablaze and bristling with new theories, proclaiming them to the world as superior to all established laws, and the tried old custom of their fathers fed and grew prosperous. Yet we can hardly do without them. They stir up the old and sluggish blood and set new brains to thinking. The true man of science never goes off on tangents.[43]

These MacArthur Studies, done by men and women of true science, do not go off on tangents and they do stir up sluggish blood and set new brains to thinking. They provide a lighthouse of reality from which we can embark to search, as best we can, together, to find that reasonable middle ground between the right to be sick and the right to be rescued. And they can help us to be sure scrupulous concern for legal rights does not overshadow reasonable concern for the patient's life. And if we come away with better implementation of procedural justice—respect,

43. Darold A. Treffert, *Psychiatry Revolves as It Evolves*, 17 ARCH. GEN. PSYCHIATRY 72, 73 (1967).

listening, dignity—we all, whatever our role in these efforts, will be the better for it.

How to judge our success? One final look back. In 1873, Dr. Kempster, looking a century back at efforts over that previous one hundred years, provides a yardstick we can apply to our efforts in 1998, even at this conference.

> The results attained in the past one hundred years are certainly gratifying, and should stimulate us to carry forward the good work, constantly endeavoring to advance the interest of the people in whose cause we are engaged, so that, when the record of the next one hundred years shall be written up, it [can] be said of us, that our eyes were not altogether blinded, or that, with the light we had, our opportunities [did not go unimproved].[44]

Hopefully, whoever might look back at our efforts and our enlightenment a century from now, in 2098, will say of us, at this conference on Competency, Coercion, and Risk of Violence at the Renaissance Place in Milwaukee, Wisconsin in 1998, that our eyes were not altogether blinded, or that with the light we had, we did pretty well.

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44. *Id.* at 74.