Commentary: In Search of Common Ground

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The debate over the use of mandated outpatient psychiatric treatment has been as polarized as any argument in our field. Despite spending much of our careers in the admittedly coercive forensic and correctional mental health systems, we have generally found ourselves at one end of this debate, in opposition to the increased use of outpatient commitment (OPC).

We have always believed that the American social contract guarantees us freedom in the absence of crime. To be coerced after the commission of a crime seems fair. One is told ahead of time the rules of engagement; indeed, it is unconstitutional to punish someone for breaking a law (i.e., *ex post facto*) that was enacted after the fact. Further, there are already several ways to enforce treatment when someone with mental illness commits a crime, including the use of conditions of probation as an alternative to incarceration and mental health diversion programs. Crime is supposed to lead to coercion, and the criminal justice system is the expected agent of punishment in America. In contrast, the mental health system is supposed to provide support, care, and treatment. When we want people to participate in mental health treatment, making it a punishment runs the obvious risk of being counterintuitive, counterproductive, and countertherapeutic.

The debate about OPC has to date focused predominantly on its effects on the individuals who are to be committed. This narrow focus ignores any effects on the hundreds of thousands of Americans with serious mental illness who may view their freedom as potentially at risk if it becomes easier to use coercion. To the extent that the mental health system (as opposed to the criminal justice system) is viewed as an agent of coercive control, we worry that people will be driven away from the treatment they may need because they fear their treaters are agents of coercion. Admittedly, this is an empirical question, but it is one that deserves study before, not after, expanded OPC legislation is enacted.

As Munetz and colleagues[1] observe, the use of coercion is an easy fix for the most visible and frightening problems caused by inadequate and underfunded mental health systems. We share their fear that OPC will become a "cheap fix" and we concur with their statement:

> A major criticism of mandatory community treatment is that it may be promoted as an alternative to a community's provision of adequate voluntary community services. It is clear that before mandatory community treatment can be considered, the community has to offer adequate mental health services to meet the needs of the population of patients with serious mental disorders. Mandatory treatment can in no way serve to fix an underfunded service system in which appropriate services are not available. Before a program of mandatory community treatment is put into place in a community, that community must have an appropriately functional mental health system [Ref. 1, p 180].

If, after implementation of a respectful, adequate, and user-friendly system of community mental health treatment, there remains a handful of stubborn, troublesome, and risk-laden persons with serious mental illness and substance abuse disorders, one would be hard pressed to argue against the need for something more. Munetz *et al.* (1) at this point in their article seem to be headed toward the quite reasonable proposition that we should try to provide services before we try to mandate them. However, the tenor quickly changes; later in the same paragraph they disregard their own warnings:

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> On the other hand, since an ideal mental health system remains a largely unattained goal, it could be concluded that a system will rarely be ready to offer mandatory community treatment. A decision to keep the very sickest individuals in that community stuck in the revolving door would be ethically suspect [Ref. 1, p 180].

The discrepancy in their argument is especially noteworthy for the distinction between their call for an "appropriately functional mental health system" (before implementing OPC) and their immediate discounting of this as a viable option given that ". . . an ideal mental health system remains a largely unattained goal." We certainly agree that it is naïve to anticipate that an ideal mental health system is forthcoming. Since the absence of an adequately functional and funded mental health system is largely responsible for the perceived need for OPC, expansion of OPC will serve as an opiate that will allow this lack to continue.

In short, we agree with Munetz *et al.* that an "appropriately functional" mental health system is a prerequisite for OPC. Thus, before expanding OPC, advocacy efforts should be focused on improvement in overall community mental health services.

With all due respect to the mental health professions, we do worry about the "slippery slope." Mental health professionals have never been reticent to use their coercive power. Prior to the various deinstitutionalization movements of the past four decades, psychiatrists and psychologists were responsible for the long-term confinement of literally millions of Americans. The diminution of this number, while largely enabled by psychiatric research, was advocated and accomplished by rights-conscious lawyers and cost-conscious public officials.[2] Indeed, deinstitutionalization has been decried by many of America's most influential psychiatrists. This is not to say that the manner in which deinstitutionalization was conducted was without serious flaws. In fact, here again, our cumulative failure to provide first an adequate or "appropriately functional" mental health system can be cited as the primary downfall of deinstitutionalization. The failure to keep the promises of community mental health have indeed had tragic consequences. The notion that OPC would be reserved for a select and appropriate few is merely an untested proposition, and one that history would at the very least call into question.

We are troubled by the apparently tautological definition of impaired decisionmaking. Munetz *et al.* acknowledge the danger that disagreement with one's doctor might become viewed as evidence of impaired decisionmaking ability, but their answer—that evidence shows schizophrenia to be a biological disease—simply begs this important question. Many patients do not take psychotropic medications because they do not like the side effects.[3,4] While the consequences of this decision (e.g., an exacerbation of a psychosis) might appear dire to a physician, this is as personal and phenomenological a choice as one could imagine. We are confident that most psychiatrists have experienced neither psychosis nor extrapyramidal side effects. It is difficult to imagine why their judgment on this crucial question should supersede that of a person who has experienced both.

There are potentially grave legal problems with OPC. In a recent article focusing squarely on New York's Kendra's Law, Perlin[5] identifies a plethora of potential pitfalls, including the typically short amount of time (three days in the case of New York) in which counsel assigned to a person facing commitment is given to prepare cases; the shaky track record of many states in the creation of outpatient facilities and services; the logistical problems in many jurisdictions that flow from the trial court's ability to hold OPC hearings in the subject's absence; the failure to consider the implications of the Americans with Disabilities Act and the Supreme Court's 1999 decision in *Olmstead v. L.C.*[6] that found a right to community treatment for certain state hospital patients; the question of "blurring" that is raised when a forensic facility becomes the OPC locus; the lack of expertise on the part of, for example, parole officers (again, part of the New York statute) to link inpatient treatment failure to a person's failure to take prescribed medication; the liability implications if a county fails to pursue an OPC order; the resolution of tort liability, especially *Tarasoff*, issues, in such cases; the lack of mental health professionals in many sparsely populated, rural counties to assure that ordered medication is administered; and the complex constitutional questions, especially those that focus on forced treatment.

Finally, freedom matters. The ability to make mistakes is a gift that most of us take for granted. Freedom to choose cannot be contingent upon making "good" choices, for the right to label choices as good and the right to choose are one and the same. Patrick Henry publicly espoused liberty or death. This choice, however, was not demeaned as self-destruc-

tive; he is revered as an American hero. When a homeless person chooses the freedom of the streets instead of the paternalistic protection of a social service agency, why is the choice less deserving of respect? As Munetz *et al.* state: "The literature chronicles frequent reports of the homeless mentally ill being robbed, beaten, and sexually assaulted" (Ref. 1, p 176). Yet, we would add, they stay on the streets. It is certainly possible that this decision is evidence of incapacity, but it is also possible that it is a rational choice of freedom over paternalistic coercion, however well intentioned. There is nothing necessarily crazy about not wanting to be told what to do.

Serious questions of freedom and public welfare are best resolved, in our opinion, by striving toward a community consensus, and polarized debates preclude consensus. Whichever pole wins the debate, well-informed and thoughtful proponents of the other side are left feeling angry and disenfranchised. In that spirit, although we have outlined our rationale against widespread use of OPC, we do not mean to imply that we are unwilling to examine its possible utility. Nevertheless, rather than advocating for the expansion of OPC, we believe that at present, our collective energies are far better directed toward developing adequate community mental health resources. We contend that to have a truly meaningful debate about expansion of OPC, the necessary precondition of adequate voluntary mental health care (as supported by both camps) must first be addressed. Essentially, instead of looking for evidence to win this debate, both sides should be looking for common ground.

In that spirit and to that end, in many ways the article is deserving of praise. Certainly Dr. Munetz and his colleagues have done an excellent job of making the philosophical case for outpatient commitment, or at least that it is not ethically or morally unthinkable. Their article is carefully reasoned and well written, and seems at first blush to pose almost incontrovertible logic in behalf of outpatient civil commitment. Unlike previous advocates for outpatient civil commitment, they seem to understand the importance of liberty, and the seriousness of taking it away. For example, they would require a showing that "alternatives have failed" before initiating OPC.

Their call for consumer involvement in such programs is similarly well intentioned. Equally important is their observation that mental health consumers are themselves diverse. This is a reminder that cannot be repeated too often. Indeed, we agree that consumers may line up strongly on both sides of this question. Finally, though we do not agree with all of the opinions presented, these authors clearly appear to come to this question from a position of kindness and altruism.

Dr. Munetz and colleagues also seem to understand the necessity that OPC be used for a select few, highly appropriate individuals. They argue that OPC should be used "judiciously," and we agree. To their credit, they acknowledge that "casual" use of coercive interventions can be "clinically inappropriate and unethical." If one were willing to accept that those requirements would be met, their ethical defense of OPC would seem reasonable.

It is less clear how they would guarantee that these infringements on people's liberty would be used in such a careful and judicious fashion. Munetz *et al.* would coerce those patients with impaired decision-making ability, a feature that they themselves attribute to more than half of "acutely ill, hospitalized patients with schizophrenia." By their logic, then, one might expect half of all involuntarily committed patients to be candidates for community-based coercion. Even if one thinks all of these people need OPC, such use could hardly be described as "judicious."

We also appreciate the authors' admonition that OPC not be tried prematurely, "before a person has had an opportunity to enter recovery on a voluntary basis," and agree that "such interventions (as OPC) complicate the therapeutic relationship." We eagerly await an explanation of how these authors would avert these problems with OPC; nevertheless, we respect and admire their integrity and respect for consumers in raising the questions. We also agree with the article's stated belief that OPC should be an alternative to involuntary inpatient treatment. To the extent that this is true, it would actually represent less coercion and would seem to placate the interests of consumer libertarians quite nicely. If only it were true.

In contrast, the treatment that Munetz and colleagues describe does not appear to be an alternative to inpatient treatment. On the contrary, they appear to aim OPC directly at those Americans who would otherwise be free, albeit perhaps homeless and mentally ill. The entire movement toward increased use of OPC, in fact, is in response to people who are currently not civilly committable. Whether they

should be or not is a discussion for another day, but it must be acknowledged that, at least in the short run, more OPC means less freedom.

Similarly, Munetz *et al.* argue that dangerousness is the wrong criterion for coercion. In fact, they take issue with dangerousness precisely because it is used only for short periods. It is clear that their proposal would result in coercion for more people over much longer periods than is currently the case.

They argue instead that impaired ability to make decisions ought to be the standard for OPC. This standard has utility for advocates of OPC. For example, if danger to self or others were the sole criterion, it would be impossible to exclude many Americans (including mental health professionals) who engage in the most serious health-destructive behaviors. Munetz *et al.* make facetious reference to mandatory treatment for nicotine addiction, obesity, and diabetes, conditions that are epidemic and often eventually fatal in America. It is not clear, however, why this reference is facetious. How is it that a decision to refuse psychotropic medications with strong side effects is viewed as self-evidence of an inability to make decisions, yet decisions with far more lethal consequences are deemed to be the appropriate province of individual autonomy? Perlin[7] has characterized such distinctions as "sanism" and reflective only of a bias against people with mental disabilities.

The authors point to *parens patriae* as the justification for these abridgements of freedom, but even parents must let their children make decisions; otherwise, the child will never learn to do so. The point at which parents can, should, and generally do step in is when there is serious risk. Although Munetz *et al.* do not outwardly acknowledge a risk-based scheme, the interventions they advocate are nevertheless designed to prevent some type of harm to the person they wish to commit—and well they should, for in the absence of risk, what right does a free society have to take away the freedom of its citizens? Munetz *et al.* defend paternalism when "such individuals are about to cause harm to their own interests, notably those involving their ability to exercise their rights fully" (Ref. 1, p 178). But what are their interests? And who is to say?

Thus, while Munetz *et al.* argue that dangerousness is not the appropriate criterion, their entire argument is replete with such references to various kinds of risk. They speak of consumers who "appear to be unable to live successfully in the community." They speak of "revolving-door patients." Clearly, they would act to avert the risk of some type of bad outcome, but therein lies the problem. How is a bad outcome defined? What constitutes success? Suppose a person can receive more money from disability payments than at a minimum wage job. Would it be good or bad judgment to eschew treatment? It depends on the values of the person making the decision. For some people, success may be measured largely in terms of the amount of autonomy they can retain. For them, coerced treatment may represent a failure so great that no treatment gains can overcome it.

Once we agree that risk is the appropriate yardstick, it is fair to ask if OPC is the best way to mitigate the risks in question. We think not. The literature on OPC, virtually without exception, ascribes many of the benefits of OPC to improvements in the services provided (see for example, Refs. 8–10). Perhaps it is not the patients who need coercion, but the mental health systems that are supposed to serve them. Ironically, Munetz *et al.* cite New York's so-called Kendra's Law. This case, of course, is a dramatic example of substituting coercion for treatment. It was not the offending patient who was noncompliant, but the mental health system that was unwilling or unable to provide him the level of service he wanted and apparently required.

Clearly, the authors have succeeded in placing OPC into philosophical context, in arguing that OPC can be an ethical intervention in the life of a person with serious mental illness. But just because we can do something does not mean that we should.

The mental health professions and the systems that fund most mental health treatment must make it their business to reduce (and perhaps one day remove altogether) the need for restrictions of liberty solely because of mental illness. The best way to do that is to increase the willingness of people with mental illness to engage in treatment, by making treatment challenging, interesting, understandable, user-friendly, and individualized. Disagreement with one's doctor, by itself, may not be evidence of a lack of insight, nor ought it to be justification for a loss of freedom. This disagreement must first be a clinical matter, resolved by the very best clinical interventions, such as empathy, active listening, and patient education.

If, as some have argued, a lack of insight is part of the illness, then it is the job of the mental health

professions to offer treatment for it, by educating people about their illnesses. If people lack the ability to make good decisions, then it is the job of the mental health professions to teach them decision-making skills, not necessarily to make decisions for them. If people do not want to participate in treatment, before mandating it, we should at least look at the nature and quality of the treatment they refuse and make it as desirable as possible. Most of all, the mental health professions must fight to ensure that there are enough resources to provide mental health treatment to those who need it most and for long enough to do some good.

If these measures were to be implemented, if mental health systems were respectful and accessible to the people who need them, we suspect that most of our objections to expanded use of OPC would be eroded. Numbers would cease to be a fear, since very few people would be likely to require coercion. With any luck, one day this will happen, and we will all have to find something else to debate.

In America, the most common form of punishment is the restriction of liberty. To suggest that coercion is not punishment flies in the face of over 200 years of American law and values. When patients have an inadequate mental health system, punishing them by restricting their liberty is adding insult to their injury. Psychiatric and psychological treatments require real treatment alliance to work, and even the proponents of OPC agree that punishment is not the best the way to achieve it.

If the goal is getting patients to accept the treatment they are deemed to need, coercion is only one strategy. By the admission of the advocates of OPC such as Munetz *et al.*, it will not work in the absence of an adequately funded community mental health system, and such systems are widely believed to be nonexistent. If we all agree that more and better mental health services are needed and that the consequences of our currently underfunded system are expensive, both in dollars and in human lives, then why would we not work on that first? Widespread use of OPC will take the heat off our currently inadequate system by greasing America's squeakiest wheels. By doing so, it runs a serious risk of perpetuating the real problem instead of fixing what is truly broken.

In conclusion, despite our admitted bias against increased use of OPC, we found a good deal of thought-provoking and innovative thinking in this article. Unlike some articles advocating OPC, these authors demonstrate a sincere respect for consumers and their wishes and an appropriate hesitancy to take away liberty without the most convincing justification. We believe that this article has the potential to advance the debate in a positive direction, beyond polarization and toward some sensible consensus that adequately accounts for the legitimate concerns of both camps. If in fact one could fashion a scheme for OPC that truly represents an ounce of coercion that could prevent a pound of involuntary inpatient commitment, what sensible libertarian could oppose it?

We are yet a long way from consensus, but there is common ground on which to build. For now, at least, we applaud the thoughtful efforts of these authors to move the debate forward.

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