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The paradox of autonomy : mandatory outpatient treatment of those with mental illness

Amanda Cannon Foster

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To the Graduate Council:

I am submitting herewith a thesis written by Amanda Cannon Foster entitled "The paradox of autonomy : mandatory outpatient treatment of those with mental illness." I have examined the final electronic copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Arts, with a major in Philosophy.

Glenn C. Graber, Major Professor

We have read this thesis and recommend its acceptance:

Richard Aquila, John Hardwig

Accepted for the Council:

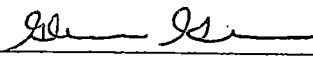
Carolyn R. Hodges

Vice Provost and Dean of the Graduate School

(Original signatures are on file with official student records.)

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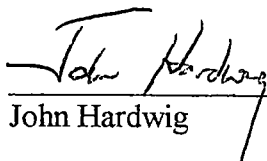


Glenn C. Graber, Major Professor

We have read this thesis
and recommend its acceptance:




Richard Aquila



John Hardwig

Accepted for the Council:



Interim Vice Provost and
Dean of the Graduate School

THE PARADOX OF AUTONOMY:
MANDATORY OUTPATIENT TREATMENT OF THOSE
WITH MENTAL ILLNESS

A Thesis
Presented for the
Master of Arts
Degree
The University of Tennessee, Knoxville

Amanda Cannon Foster
May 2001

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ABSTRACT

This thesis explores the ethical territory charted by a relatively recent development in the treatment of the severely and persistently mentally ill, mandatory outpatient treatment (MOT). MOT is designed to treat patients who make a fair recovery from illness when they take their prescribed medications consistently, but who repeatedly quit taking their medication, only to suffer a series of relapses which result in involuntary commitment in psychiatric hospitals. For these individuals, MOT is believed to be a less restrictive alternative to inpatient commitment, and better method of preventing relapse than current patterns of repeated hospitalization. The thesis explores four areas of significant debate within the context of mandatory outpatient commitment.

First, I address the definition of meaningful rational autonomy and its relationship to coercive treatment of mental illness. I examine how these issues are integrated into the movement for mandatory outpatient treatment of the mentally ill within their communities, and I conclude that MOT is a less restrictive and therefore more desirable treatment method than the forced hospitalization permitted under most commitment standards.

Second, I address the inadequacy of many community resources and the debate over the efficacy of involuntary commitment statutes. I analyze recent research into the effectiveness of mandatory outpatient treatment, and I conclude that, while more research is needed, present findings suggest MOT commitments do improve patient compliance and can help patients lead more stable and productive lives.

Third, I identify limitations of current MOT statutes by presenting a case study of a woman on mandatory outpatient treatment orders. I argue that outpatient commitment

statutes are nothing more than empty rhetoric if they do not have adequate enforcement mechanisms in place, and I conclude that MOT orders need to be strengthened by such enforcement.

Fourth, I look at different definitions of disability and their relevance and impact on the experience of those who have been diagnosed with mental illness. I conclude that certain forms of mandatory outpatient commitment do not constitute a double standard in the treatment of mental disability, and that, far from committing harms against them, conscientious use of coerced community treatment for some individuals with severe and persistent mental illness offers the best hope of restoring their autonomy such that they may live relatively safe and purposeful lives.

The conclusion of this thesis is that mandatory outpatient treatment involves a paradox. That is, for some individuals with severe and persistent mental illness, expanding their autonomy may require temporarily restricting it. This paradox can be best resolved through treatment methods such as mandatory outpatient commitment, since this involves less restriction on autonomy than traditional inpatient hospitalization and offers a better chance for the individual to regain stability within his or her own community.

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LIST OF ABBREVIATIONS

ADA	Americans with Disabilities Act
APA	American Psychiatric Association
B & C	Tom L. Beauchamp and James F. Childress
DOT	Directly Observed Therapy
EEOC	Equal Employment Opportunity Commission
MDR-TB	Multiple Drug Resistant Tuberculosis
MOT	Mandatory Outpatient Treatment
NAMI	National Alliance for the Mentally Ill
NCD	National Council on Disability
TB	Tuberculosis

I. Introduction

While the locked wards of psychiatric hospitals and institutions are not quite a thing of the past, recent years have seen involuntary treatment of mental illness moving from the institution to the community. Mandatory Outpatient Treatment (MOT) is the involuntary, court-ordered treatment of severely and persistently mentally ill individuals in their communities, rather than in psychiatric hospitals. Mandatory outpatient treatment laws are an extension of the laws governing involuntary inpatient commitment for mental health treatment. The primary difference is that on MOT, patients live in the community, not in psychiatric hospitals, and come in to treatment centers to receive medication or other therapy for their mental illness. As is true with any form of involuntary treatment, MOT is susceptible to abuse and is therefore subject to an ongoing debate over the limits of coercion and the sanctity of autonomy.

According to a recent resource report on mandatory outpatient treatment issued by the American Psychiatric Association, the theory behind MOT is that by providing an alternative treatment to forced hospitalization, states can prevent some individuals from repeatedly cycling through decompensation (experiencing a serious relapse of illness) and hospitalization in what has come to be called the "revolving door" (Binder, et al, 2000, p. 2). In most states which have laws permitting MOT, an individual must meet three criteria for civil commitment: (a) the individual must have been involuntarily hospitalized because of a threat or attempt to harm himself or others, *or* as a result of placing others in reasonable fear of being harmed by him, *or* because of an inability to prevent harm or injury to himself, *and* (b) the significant probability that one or more of the above would

occur without a hospitalization. In addition, (c) both of these criteria must be accompanied by a mental illness in the individual which can be and is in need of being treated (Tennessee Code Annotated, 33-6-201).

MOT policies in states like Tennessee have come under the scrutiny of patients' rights groups, especially those which represent the interests of the mentally ill population. Many of these groups believe that MOT constitutes an abridgment of the rights of persons with mental illnesses, whom they believe carry a mental disability. These groups feel that, as persons with disabilities, the severely and persistently mentally ill should not be subjected to forced treatment, since other, non-mentally ill but physically disabled persons do not have treatments for their disabilities imposed upon them (here they ignore the forced treatment of tuberculosis, a point which I will discuss later in the paper). The expression of these views came together in a meeting of mental health professionals, attorneys, advocates, friends and relatives of people with mental illness and mental illness sufferers and survivors themselves before the National Council on Disability (NCD) in November of 1998. The report issued by the NCD following this forum will be cited frequently in this paper, since the voices it highlights eloquently capture the debate over the autonomy and the health needs of those with severe mental illnesses.

Please note that in most of the discussion which follows (excluding a comparison with directly-observed treatment for tuberculosis) I will limit the scope of my arguments to MOT orders for persons who are believed to be a danger to themselves, and I will largely ignore the family of arguments that address MOT order for those who pose risks to others. This latter discussion, while involving many of the same issue as the former, also

requires addressing the police powers of the state, particular duties of health care providers to disclose confidential information to potential victims, and degree of harm as constituted by legal and moral precedents; these issues lie beyond the limited space for detailed discussion available in this paper. I will also assume that those whom I describe as having severe and persistent mental illnesses do in fact have diagnosable and treatable mental illnesses. Modern psychiatry is not without its defects, and surely some emotional disorders are mislabeled as mental illnesses. In the case of illnesses such as schizophrenia, major depression, and bipolar disorder, however, I have faith that psychiatry has a significant degree of insight into these conditions and treatments that improve them. I will argue that mandatory outpatient treatment is one such treatment for some of these illnesses in some individuals.

It should also be noted that I am promoting the view that meaningful rational autonomy should take precedence as a guiding moral principle over the principle of beneficence, a view that has several implications. For a patient who has little or no chance of recovering any degree of meaningful rational autonomy, I support the view that the principle of beneficence requires attempting to treat that patient, even over his or her objections. Thus, for example, a patient who has severe physical damage to the brain that causes an apparently irreversible state of dementia can have her stated wishes to be left alone overridden in the name of acting beneficently toward her. In the case of a patient who has a chance of recovering a degree of meaningful rational autonomy, however, beneficent intervention is justified only insofar as it has the larger aim of restoring and/or facilitating autonomy. Thus, the motivation behind my arguments for mandatory

outpatient treatment for some patients lies in the belief that such coercive intervention is justified only because it aims at preserving, restoring, and enhancing meaningful rational autonomy for those individuals.

The debate over involuntary treatment within the community contains several critical issues which need philosophical explication. This paper will explore the related issues of what constitutes coercion and meaningful autonomy, and how these issues are integrated into the movement for mandatory outpatient treatment of the mentally ill within their communities. I will address the inadequacy of many community resources and the debate over the efficacy of involuntary commitment statutes, and I will examine through a case study how an MOT commitment in Tennessee functioned for a particular patient. I will also look at different definitions of disability and their relevance to the experience of those who have been diagnosed with mental illness. By this discussion I intend to show that certain forms of mandatory outpatient commitment do not constitute a double standard in the treatment of a mental disability, and that, far from committing harms against them, conscientious use of coerced community treatment for some severely and persistently mentally ill individuals offers the best hope of restoring their autonomy such that they may live relatively safe and purposeful lives.

Mandatory outpatient treatment involves a paradox. That is, for some individuals with severe and persistent mental illness, expanding their autonomy may require temporarily restricting it. This paradox can best be resolved through treatment methods such as mandatory outpatient commitment, since this involves less restriction on autonomy than traditional inpatient hospitalization and offers a better chance for the individual to

regain and maintain stability within his or her own community.

II. The Paradox of Autonomy: Restricting Liberty to Facilitate Agency

The debate over mandatory outpatient treatment is really a philosophical debate. Its core issues revolve around our notions of autonomy and self-determination and the role of beneficence and paternalism in regard to those values. Both advocates for and advocates against the involuntary treatment of individuals with mental illnesses center their arguments around the same fundamental belief, that the fact of mental illness in a person's life should not of itself be grounds for limiting his or her right to determine how to live a meaningful existence.

Essentially, the difference between the two camps is that they disagree over what constitutes autonomy. Those who oppose MOT on the grounds that it constitutes unfair discrimination against those with a mental disability do so because they believe even persons with severe and persistent forms of mental illness, such as some cases of schizophrenia and bipolar disorder, are capable, or should be regarded as capable, of making rational decisions as to their welfare and treatment (National Council on Disability Report, 2000). To be capable of making rational decisions regarding one's basic welfare is one component of a capacity I will term "meaningful autonomy", discussed in more detail in what follows. Those who advocate MOT orders for certain mentally debilitated individuals do so because they believe the very nature of the mental illness renders the individual incapable of making such life-sustaining decisions as when and where and how to receive treatment, establish residency, and maintain social contacts (and thus, I will argue, infringes upon their meaningful autonomy).

So what is autonomy, both as a general philosophical concept, and as a moral

component in the lives of persons with mental illnesses? Books have been written to answer the first question.¹ The significance of autonomy in the lives of the mentally disabled has been less discussed, despite its relevance to the ongoing debates over involuntary treatment.

The most prominent definition of autonomy in the world of bioethics comes from Tom Beauchamp and James Childress in their book, Principles of Biomedical Ethics. In their view, personal autonomy is “personal rule of the self that is free from both controlling interferences by others and from personal limitations that prevent meaningful choice, such as inadequate understanding” (B & C, p. 121). They also assert that two conditions are necessary for meaningful autonomy, “(1) *liberty* (independence from controlling influences, which includes external as well as internal coercion) and (2) *agency* (capacity for intentional action) (B & C, p. 121). What is unique about the autonomy of some individuals with mental illness (and what has caused so much controversy) is that, paradoxically, agency cannot occur without the temporary restriction of liberty.

The significance of this specific kind of autonomy has a long history in Western liberal thought. One of its greatest champions was the utilitarian philosopher John Stuart Mill. In his treatise on the principle of utility, Mill discussed why humans seem to value their freedom of thought and action so devoutly, noting that it is better to be a

1

A few, in particular, come to mind: Gerald Dworkin’s influential The Theory and Practice of Autonomy, Grace Clement’s ethic of care approach in Care, Autonomy, and Justice: Feminism and the Ethic of Care, and Carolyn Ells’ dissertation, Autonomy and Chronic Impairment, in which she explores autonomy from the standpoint of chronic disability (Dworkin, 1988; Clement, 1996; Ells, 2000).

discontented but wise individual than to be a blithe fool (Mill, 1967, p. 397). This view reflects the two prerequisites for meaningful autonomy as given by Beauchamp and Childress, with “freedom of thought” corresponding in part to liberty, and “action” corresponding to agency. Mill viewed the essence of man as an endeavor in self-creation. His work, On Liberty, makes this view explicit. In describing how childhood experiences shape our values as adults, he says, “[I]t is the privilege and proper condition of a human being, arrived at the maturity of his faculties, to use and interpret experience in his own way” (Mill, 1974, p. 122). Mill goes on to say, “The human faculties of perception, judgment, discriminative feeling, mental activity and even moral preference, are exercised only in making a choice” (Mill, 1974, p. 122). We are given the tools of decision-making in childhood — observation of the distinction between right and wrong, of consequences and inducements, and the development of logical reasoning — and are then free to use them in adulthood to make our way in the world as best we can.

A person suffering from a severe mental illness, however, often lacks these tools and has limited means to reason and to navigate his way through the challenges of even ordinary life. He cannot always freely choose among directions for his life, because the capacity for rational choice — that is, choice beyond mere reflex — is diminished by the mental illness. A comprehensive report on mental illness issued by the Surgeon General in 2000 defines mental illness as “all diagnosable mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning.” In its discussion of mental disorders as disabling (using “disability-adjusted life years” as

measuring standard), the Surgeon General's report notes that, "Major depression is equivalent in burden to blindness or paraplegia, whereas active psychosis seen in schizophrenia is equal in disability burden to quadriplegia" (Office of the Surgeon General). The disabling effects of severe mental illnesses are especially limiting because the illnesses often attack and handicap a person's ability to reason through his or her actions and appreciate a quality of life lived autonomously.

Other things being equal, a person's own beliefs, opinions, and feelings, combined with an adequate knowledge of choices available to him, enable him to define his life through action. Such an ability involves one of the two prerequisites for meaningful autonomy, agency. The other, liberty, is just as integral. It is not the action alone that counts, however, as Mill explains: "It really is of importance, not only what men do, but what manner of men are they that do it" (Mill, 1974, p. 123). Thus it is that an act is best judged not as an isolated event, but as a reflection of the moral attitude and personal beliefs of the actor.

How are we to judge the actions of those who are severely disabled by mental illness? Let's take an example. If a man chooses to stand, poorly clad, in the winter cold throughout a night of freezing temperatures, how should we react to his choice? If we ask him why he is standing in the weather instead of coming inside to shelter, and he replies that he stands there because the voices in his head have told him the cold weather will cure his headaches, how do we evaluate that response? Is it simply the result of well-reasoned deliberation regarding the advice of voices he hears in his head? Does it reflect an autonomous choice, one made free of both external coercion and the internal coercion that

poses limitations restricting personal choice? Is it even appropriate for us to be asking these questions, or do we have a duty to let him make his choices free from any judgment on our part, acting out of what we might call the “live and let live” (or, sometimes, “let die”) philosophy?

I answer that we not only have the right to ask these questions, we have a moral duty to do so. And not only are we compelled to ask these questions, we are compelled by the demands of beneficence to act upon our evaluation of the answers the individual gives. In their discussion of the principles of biomedical ethics, Beauchamp and Childress formulate the principle of beneficence in these terms: “Beneficence refers to an action done for the benefit of others; benevolence refers to the character trait or virtue of being disposed to act for the benefit of others; and *principle of beneficence* refers to a moral obligation to act for the benefit of others” (B & C, 1994, p. 260). Notwithstanding the truism that many acts of beneficence are not as morally or legally obligatory as refraining from committing harm, it remains that there are some demands placed upon us to act for the good of others. Especially when the beneficent action poses little risk to us and portends great benefit to the recipient, we should strive to act from the principle of beneficence.

Keeping this view of beneficence in mind, let’s return to our queries about the man standing in the perilous cold. It might be tempting, from a “live and let live” perspective, to frame the choice as one between letting the man freeze to death out of respect for his autonomy, or forcing him in to shelter out of concern for his welfare. This would set the situation up as a choice between two differing moral goods — autonomy and beneficence.

This would be a false dichotomy, however, for the following reasons: if the man is severely mentally disabled such that he cannot perceive the danger in his exposing himself to the elements, then he does not possess meaningful autonomy in the sense of being rational. If the man is being coerced, in the sense of being unduly influenced, by internal voices to put himself at undue risk, then he does not possess meaningful autonomy in the sense of being free from limitations that prevent meaningful choice (such as inadequate understanding). If the man does not know or recognize that he has the opportunity to seek shelter from the life-threatening cold, then he does not possess meaningful autonomy in the sense of appreciating live choices.

Beauchamp and Childress address the supposed conflict between the "live and let live" perspective and the principle of beneficence:

The debate between proponents of the autonomy model and the beneficence model...has often been confused by a failure to distinguish between a principle of beneficence that *competes* with a principle of respect for autonomy and a principle of beneficence that *incorporates* the patient's autonomy (in the sense that the patient's preferences help to determine what counts as a medical benefit). (B & C, 1994, p. 272)

It is important to keep this distinction in mind when evaluating the role and value of autonomy in the life of a person with a severe and debilitating mental illness. Our man in the cold certainly has rights which must be respected, but these rights should be incorporated into a view of what will benefit him, particularly since meaningful autonomy is precisely what seems to be disabled in his case. If the man does not possess meaningful autonomy, then there is no such autonomy to be respected by leaving him out in the cold. There is no relevant conflict between autonomy and beneficence, since meaningful autonomy exists only potentially right now, and may be best facilitated by acting from the

principle of beneficence. The beauty of the value of beneficence in this situation is that it not only allows us to act morally by removing the man from the cold and into protection, but it also allows us to act to restore his autonomy by administering care for his mental illness. By intervening in his condition by providing therapy and rehabilitation we have a chance of restoring his *liberty* through *meaningful agency*.

Let me first address those three levels of autonomy mentioned above with the example of the man in the cold -- rationality, freedom from internal coercion, and appreciation of choices. The first criterion for determining if he possessed meaningful autonomy depended on his ability to perceive danger to himself (and thus take means to protect himself from it). This criterion stems from the belief that rational persons are able to care for themselves and to act in what is generally their best interests. Mill, for example, specifically excludes from the entitlements of independence and full self-determination those whose rational capacities are diminished by age or illness. His statement of the libertarian position, "The only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant," is followed by the exception to the rule: "It is perhaps, hardly necessary to say that this doctrine is meant to apply only to human beings in the maturity of their faculties" (Mill, 1974, pp. 68-9).

Quite apart from any particular conception of autonomy, just as parents decide what is best for their children, the *parens patriae* power of the state, of course, allows it to act to protect its citizens from themselves if they put themselves in undue danger (Winick, 1997, p. 1149). In terms of mandatory outpatient commitment, this could mean

temporarily placing those who have been found incompetent to make some treatment decisions for themselves in the custody of the state. Some form of commitment orders, including outpatient commitment, could be ordered to preserve the welfare of the mentally disabled individual. According to philosopher Joel Feinberg, this legal paternalism is in any case backed up by a staunchly libertarian position such as that of Mill, since Mill only wants to apply the right of non-interference by others in one's actions to the actions of persons whose choices appear by and large to be voluntary (Feinberg, 1980, p. 117).

Mill believes the capacity for voluntary choices is vital to an individual's expression of meaningful autonomy, defining and facilitating as it does the values and goals of the individual actor. In On Liberty, he provides justification for outside interference in actions which are non-voluntary, either because they are the result of ignorance, external force, or internal coercion. Feinberg cites the following passage from On Liberty in his discussion of justified harms:

If either a public officer or anyone else saw a person attempting to cross a bridge which had been ascertained to be unsafe, and there were no time to warn him of his danger, they might seize him and turn him back, without any real infringement of his liberty; *for liberty consists in doing what one desires*, and he does not desire to fall into the river. (Feinberg, 1980, p. 117) (Emphasis added)

We are justified in presuming certain choices to be involuntary (in the sense of not being expressions of meaningful choice), so long as we also respect the right of the person to override our presumption by then asserting his desires openly. Yet Mill, that bastion of libertarian values, believes even this can be justifiably overridden. Feinberg notes Mill's view that "on other occasions a person may need to be protected not from his ignorance but from some other condition that may render his informed choice substantially less than

voluntary” (Feinberg, 1980, p. 117).

The problem in determining whether or not interference in the life of a person with a mental illness is justified is that for many patients with mental disorders, the limitations that prevent meaningful choice are mostly internal. The cause may be invisible, and those wishing to intervene may only see its effects. An intervention may be justified, at the very least in order to get a clearer idea of what is really going on with the individual. We have a duty to try to figure out why the man is standing in the cold, and to intervene in his actions if we feel they are the result of internal factors (which may render his actions involuntary).

As Feinberg explains,

It may be that there is no kind of action of which it can be said, “No mentally competent adult in a calm, attentive mood, fully informed, etc., would *ever* choose (or consent to) *that*.” Nevertheless, there are actions of a kind that create a powerful *presumption* that any given actor, if he were in his right mind, would not choose them. The point of calling this hypothesis a “presumption” is to require that it be completely overridden before legal permission be given to a person, who has already been interfered with, to go on as before. ...The point of [this legal] procedure would not be to evaluate the wisdom or worthiness of a person’s choice, but rather to determine whether the choice really is his. (Feinberg, 1980, p. 118)

We are at the least required by the principle of beneficence to inquire into the origins of the man’s decision, since a decision made because of internal or external interference with meaningful choice does not carry with it all the liberty rights granted by the possession of meaningful rational autonomy.

This line of argument leads naturally to the second criterion for determining autonomy, which concerns the question of coercion, defined here as limitations, either internal or external, that restrict meaningful choice. In order to assess the moral import of

coercion in mandated community treatment it is necessary to examine both our commonly held and legally defined notions of coercion. Bruce Winick, a professor of law at the University of Miami School of Law, writes, "In its most basic meaning, the term coercion connotes force or duress, or at least the threat of force" (Winick, 1997, p. 1146). Winick makes the point that coercion is not merely an objectively defined state of force or threat of force; it also has a significant subjective component which is determined by the individual's perception of the force being applied to him. The criteria of coercion are often applied only to the actions of the one imposing the force or threat of force. Winick observes, "...[T]his exclusive focus on the coercer seems artificial. The same actions may be perceived as coercive by one patient, but not coercive by another. ... Thus patient perceptions of coercion are often incongruent with their official legal status" (Winick, 1997, p. 1146).

Attention to coercive factors in a decision-making process reflects the emphasis Mill gave to the "manner" of the person making the decision. Decisions, especially those concerning our health, are not made in a vacuum. They are the product of many considerations and contingencies beyond even our own basic wishes, taking into account the effect our choices may have on our families and the community to which we belong. "Very few choices in life are wholly free of at least some degree of coercion," Winick notes. "In addition to the compulsion of the law, a variety of economic, social, familial, occupational, and psychological pressures inevitably impinge on individual decision making, sometimes leading individuals to experience their choices as coerced" (Winick, 1997, p. 1148).

Robert D. Miller discusses the role of internal coercion in the lives of persons with mental illness, a factor that is not often acknowledged in the court system or even by mental health advocates (Miller, 1997, p. 1200). Clinicians are trained to be more attuned to these internal forces than are others involved in decisions about the patient's welfare, in part because informed consent operates on a sliding scale with many mental patients. An understanding of facts, such as the ability to recite the risks and benefits of a course of treatment, is not a sufficient proof that true informed consent has taken place. Miller explains,

This approach assumes great significance because the clinical research demonstrates that denial of illness is the most common reason for refusal of clinically appropriate treatment by psychiatric patients. Thus, serious mental disorders — which are the ones for which psychiatric medications are prescribed — rob patients not only of their abilities to function autonomously, but also of their capacities to make truly informed choices about treatments that would restore their capacities and autonomy. (Miller, 1997, p. 1200)

This debilitation of the capacity for informed consent is what makes severe and persistent forms of mental illness so pernicious. And it is what makes the arguments of some mental health advocates, who would prevent interference in the decision-making process of many persons with mental illness for any reason, so ill-founded. Internal coercion, in the form of auditory and visual hallucinations, diminished appreciation of consequences of action and inaction, and deeply rooted denial of illness, can work to rob the patient of his autonomy. If a person is ignorant of the choices available to her either because she cannot understand the content of the choices, or because the choices are presented by a health care provider the individual deems threatening, or because of any of a number of other reasons stemming from the presence of a mental illness in the person, then the individual may

experience internal coercion. The frequently invisible quality of this kind of coercion does not render it less potent a force in limiting the liberty of the patient by incapacitating his agency.

The issue of coercion within mental health treatment can be somewhat clarified through a look at the moral distinctions between acts of beneficence (“an action done for the benefit of others”) (B & C, 1994, p. 260) and obligations of nonmaleficence (“obligations not to harm others”) (B & C, 1994, p. 190). Beauchamp and Childress assert, “Generally, obligations of nonmaleficence are more stringent than obligations of beneficence; and, in some cases, nonmaleficence overrides beneficence when the best utilitarian outcome would be obtained by acting beneficently” (B & C, 1994, p. 191). In other words, beneficence can sometimes go only so far. When a beneficent act, as judged perhaps by the utility of the act, would involve committing a moral harm against someone, the principle of nonmaleficence may dictate refraining from performing the act. In the case of MOT, an example comes to mind: if committing an individual to inpatient or outpatient treatment will likely prevent that individual from harming another person and/or himself, the principle of beneficence seems to recommend such treatment. If, however, the individual is not incompetent and would have his liberties unjustly curtailed by such a commitment, the principle of autonomy may demand respecting that individual’s right to refuse treatment.²

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There is a difference, of course, between *harms* and *wrongs*, a difference which has particular relevance to the debate over involuntary treatment. If a person consents to having his liberty restricted, he may be harmed by that restriction, but not necessarily wronged by it. The restriction of liberty in and of itself does not constitute a moral wrong.

In order to know whether to engage in beneficent intervention or to walk away out of concern that interference would commit a harm against the person's liberty, however, it is essential to know what degree of autonomy the individual possesses. This third criterion for determining autonomy is the one upon which I wish to focus most attention. I have contended that if the man does not know or recognize that he has the opportunity to seek shelter from the life-threatening cold, then he does not possess the capacity for meaningful choice, and so no meaningful rational autonomy. This is because meaningful choice does not depend merely on the ability to recognize and weigh options in making a choice; it also depends on the extent of the agent's knowledge of all the options available to him.

What is meant by the capacity for meaningful choice, or "rational autonomy", is notoriously difficult to agree upon. Rem Edwards' definition of rational autonomy makes rationality a "function of how we know, not of what we know" (Edwards, 1997, p. 55). He construes rationality as demonstrated by the ability to identify goals and reasonable means of achieving them, the possession of beliefs that are supported by empirical evidence, and the ability to give logical reasons for one's actions in the light of consciously-acknowledged goals, among other things (Edwards, 1997, p. 55). Being rationally autonomous, by virtue precisely of one's rationality, means being able to decide

Consent can mediate the moral responsibility of the actor by removing coercion from the situation (when we take "removal of coercion" in the sense of the restricted person's understanding of the live options available to him and his freedom from internal and external forcing unduly influencing his choice). If a person was not coerced into treatment and freely chose to be placed in a locked psychiatric ward, he may be harmed if he has no medical need to be there, but the attendant who locked the door to the ward behind him was not committing a wrong against him (Feinberg, "Legal Paternalism", in Rights, Justice, and the Bounds of Liberty).

for oneself what is best for oneself. This definition allows for the fact that others may disagree with you about what is best for you. Competency tests are designed to approximate an evaluation of one's ability to make decisions or to draw conclusions that others would likely also reach in their deliberations (Drane, 1997, p. 208). This "other-regarding" component, while problematic in one sense, may still be the best way we have for "seeing" mental illness.

I would add something to Edwards' definition, however. If we apply Edward's definition to the experiences of persons with mental illness, "meaningful" rational autonomy should really be the goal of interventions aimed at helping them. Paul S. Appelbaum writes,

Meaningful autonomy does not consist merely in the ability to make choices for oneself. Witness the psychotic ex-patients on the streets, who withdraw into rarely used doorways, rigidly still for hours at a time, hoping...that immobility will help them fade into the grimy urban background, bringing safety and temporary peace from a world which they envision as a terrifying series of threats. Can the choices they make, limited as they are to the selection of a doorway for the day, be called a significant embodiment of human autonomy? Or is their behavior rather to be understood on the level of a simple reflex -- autonomous only in a strictly formal sense? (Appelbaum, 1997, p. 547)

Mental illness is not just the same as any physical disability. In the case of the severely and persistently mentally ill, the disability involves the erosion of what many people, including persons with mental illness, regard as what makes them distinctly human -- the possession of meaningful rational autonomy.

Even within purposeful, self-determining, rational autonomy in this sense there are gradations to consider. Alfred D. Beasley and Glenn C. Graber expand Edwards' view of rational autonomy by introducing the notion of life plans, which demonstrate that

autonomy varies in degree. Meaningful, rational autonomy involves the formulation of “life plans” which can differ from person to person and even from day to week to year in the person to whom they belong. Life plans, of course, depend on the knowledge the planner possesses and the kind of person he or she is. Some life plans may also be more comprehensive than others; taking account, for instance, of specific goals the planner has in mind. Plan also may vary in terms of their coherence — some goals may conflict with other possibilities, thus putting limits on the options available to the planner. Graber and Beasley provide an example involving two students considering careers in medicine:

Andrew...may have chosen only one life-goal — to practice medicine, without having decided about whether to marry and have a family; whereas Bonnie has already decided on two goals — medicine and motherhood. This means that, other things being equal, Bonnie will be more autonomous than Andrew with respect to relevant specific choices. (Beasley and Graber, 1984, p.32)

Bonnie will be more autonomous in this respect because she has a clearer idea of what she wants and may have learned to develop strategies for achieving it. Another way to explain Bonnie’s greater autonomy would be to say that she will be living more *intentionally* than Andrew, thus perhaps bringing in an “existentialist” aspect of autonomy. When we are simply carried along by a general aim, such as to get into medical school, we are less likely to be making choices with the intention of fulfilling a specific and self-chosen goal.

Whereas Andrew might be easily swayed by his parents or teachers to choose a school they like but that in truth does not open his talents to their best potential, Bonnie may consider a vast number of medical schools and choose one that she knows will hone her best skills and give her a chance to work in the areas she is most interested. Bonnie will then be making more intentional choices and have greater autonomy than Andrew in this

regard.

So how might the autonomy of a person with mental illness be limited? A person with a severe mental disability, such as our man standing in the cold, may in the most florid stages of his ailment be too confused to be more than superficially aware of choices available to him. Will he know, for instance, that there are several medicines which could help control his symptoms? Will he know that his disability could qualify him for subsidized housing? Will he be familiar with the community resources in his area, such as the drop-in center operated by his local mental health center? And, most importantly, even if he knows these things, will he know what he wants well enough to make an informed choice that is in line with his personal goals?

If the answer to any of these questions is no, then our mentally disabled friend's autonomy is limited by his lack of knowledge. Either he doesn't know what options are available to him, or he doesn't know how to decide whether he wants to take advantage of them, or, in many cases, both. The only meaningful autonomy he possesses at this time is his *potential* autonomy. At this point, he may be able to decide whether to stand on this street corner or that one in the freezing cold, but this does not amount to meaningful autonomy, or at least to the kind of autonomy to which every individual is entitled as a human being. We have a duty to respect his potential for autonomy, and to do that, we may need to override temporarily some of his stated wishes.

In light of these considerations, it is accurate to conclude that the goal of MOT is precisely restoration of the patient's autonomy. Yet despite the existence of mandatory outpatient treatment statutes in every state, the real aim of outpatient commitment — the

restoration of autonomy — is largely not being realized. This is possibly due to a weak commitment standard in most states, together with a lack of adequate enforcement mechanisms (Isaacs and Jaffe, 1996). Patients can be treated under such statutes but they cannot be forced to accept treatment until they meet the requirements for commitment, which usually means reaching the point of imminent harm to self or others (Isaacs and Jaffe, 1996). The danger of harm needs to be clear and present, which usually means that the individual is already in a florid state of the particular disease causing the dangerous behavior. Persons exhibiting such behavior — threatening to kill themselves or others, committing bodily harm to themselves or others, or even perhaps only committing acts of vandalism — while under the stress of a severe psychosis are usually hospitalized or incarcerated until their conditions can be brought under control. Advocates note, however, “This defeats the whole purpose of outpatient commitment, which is to prevent the individual from getting to that point in the first place” (Isaacs and Jaffe, 1996). The legally relevant issue of mandatory outpatient commitment revolves around changing the threshold for commitment.

The proposal for such a change, of course, elicits concern from advocates who warn that the current threshold exists to prevent the abuse that would result (and has, in the recent past, resulted) if persons who are not appropriate candidates for mandatory inpatient or outpatient treatment are forced to submit to treatment against their wills. This is a valid concern, and one which is especially grave given this country’s recent history of over-institutionalization. The alarm of advocates is perhaps premature, however, when we consider the legal procedural standards in place to safeguard the liberties of persons with

meaningful rational autonomy, to which I shall turn shortly. Setting aside such concerns for the moment, however, proponents of MOT are frustrated that many outpatient commitment statutes are not tough enough to fulfill the purpose for which they were designed: the prevention of relapse of illness in patients with a history of such decompensation.

At the 140th Annual Meeting of the American Psychiatric Association in 1987, Dr. Darold A. Treffert, a psychiatrist from Wisconsin and long-time proponent of involuntary outpatient treatment programs, spoke of the need for stronger outpatient commitment statutes with adequate enforcement mechanisms. Since the early 1970s, when the Wisconsin legislature defined the criterion for commitment as the likelihood of immediate harm to self or others, Dr. Treffert has been tracking 109 outcomes in the lives of mental patients who he believes should have been subject to a more stringent commitment standard, namely, to one that includes a likelihood of deterioration to the point of danger. Of these 109 cases, he reports that there were 42 deaths — 31 due to violence by the mental patient upon another individual, and 11 suicides. “Some will argue that this is merely anecdotal reporting,” Treffert admitted. “These instances, however, are not anecdotes to the families of the patients and the families of the innocent victims and the victims themselves” (Treffert, 1987).

In his push for stronger, more inclusive commitment laws such as MOT, Treffert countered the claims of civil liberty advocates:

[T]he freedom to be wandering the streets psychotic, deteriorating and untreated in the face of effective treatment that ought to be given, is not freedom; it is abandonment... The right to be able to die with one's rights inviolably observed but obvious illness overlooked, and to cause others to die who happen to be nearby,

that is not a right, that is insensitivity, purism and lack of true psychiatric sophistication cruelly presented as concern. (Treffert, 1987)

Treffert's point is profoundly simple: individuals with mental illnesses which severely debilitate their capacity for rational decision-making are not likely to be exercising meaningful autonomy when they refuse treatment. Their refusal is more likely a symptom of their illness, a sign that they need help, rather than an assertion of self-determination. When autonomy is limited in this way, and when there are means to restore it to a fuller capacity, those with the power to do so — physicians, nurses, legal advocates, and family and friends — are obligated to help the individual in this regard.

The concern attending changing the threshold for commitment to outpatient treatment, of course, is that such coercive state intervention can be abused. The push for deinstitutionalization in the 1960s and 70s was precipitated by just such widespread abuse. Many advocates fear that if we change the commitment standard to one *predicting* decompensation, we will swing the pendulum of institutionalization back toward unjustified coercion. Treffert is frank about this concern. He notes, "major mental illness, by its intrinsic nature and manifestations, makes the use of coerced care -- rather than purely voluntary treatment -- necessary in some instances" (Treffert, 1999, p. 759). Yet, care delivered under coercion does not have to be abusive to the patient's liberties. In describing the case of a severe alcoholic who was forced into treatment against his will, recovered, and later thanked the clinicians for initiating coerced care, Treffert writes,

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 [MacArthur Foundation Coercion 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

persuasions and inducements rather than legal maneuvers and force. With those elements in the persuasion process, coerced care need not be an oxymoron. (Treffert, 1999, p. 773)

Coercion is a serious concern for both patients and clinicians. Coercion can vary by degree, however, and careful attention to legal procedures protecting the patient's rights, together with treatment decisions made with as much of the patient's and patient's family's cooperation as possible, can act as a safeguard against abuse of personal autonomy. Waiting until a person is dangerous to himself or others is the least compassionate way to encourage and support personal autonomy. In order to really help certain individuals suffering with mental illness, we need an approach that prevents deterioration to the point of dangerousness and that is comprehensive in its approach to reinforcing the decision-making skills that lead to meaningful self-determination. To return to my original position on the issue, restoring autonomy may involve limiting liberty in order to facilitate agency.

III. The Context of MOT: Public Positions on Research and Aims

In January of 2000, the American Psychiatric Association issued what was titled the "APA Resource Document on Mandatory Outpatient Treatment" (Binder, et al, 2000, p. 2) (hereafter referred to as the APA Document). The stated purpose of this document is to identify and to clarify some of the issues surrounding MOT for the various branches of the APA and other psychiatric societies which are working on drafting legislation regarding involuntary treatment in their communities. The APA Document includes specific conclusions about and recommendations for the drafting and implementation of mandatory outpatient treatment statutes, as well as an overview of research from the past twenty-five years as to the effects of involuntary outpatient treatment programs in different areas of the country.

Among the conclusions and recommendations most relevant to our present discussion, the APA Document specifically calls for those individuals who do not yet meet the criteria for inpatient hospitalization to be included in the target population for MOT. This is in keeping with the main purpose of MOT, which is to reduce hospitalizations by preventing individuals with mental illness from decompensating to the point where inpatient care is necessary. In the APA's opinion, allowing MOT to be ordered for those who have been deemed to pose a *very likely probability* of relapse to the point of dangerousness is the best way to prevent such a relapse and subsequent hospitalization from occurring (Binder, et al, 2000, p. 2). The predictive nature of this recommendation has been met with much criticism and some caution by those who approve of MOT, as we will see later.

The Document very precisely delineates what the APA sees as the goals of MOT. These aims are “to improve compliance, reduce rehospitalization rates, and decrease violent behavior among a subset of the severely and chronically mentally ill” (Binder, et al, 2000, p. 2). It should be remembered that outpatient (and inpatient) commitment orders are only believed to be necessary for a small, seriously and persistently ill portion of the population with mental illness. It is also important to note that the APA Document places MOT’s role within a broader scheme of comprehensive and assertive community treatment programs. We will observe in what follows how the relative significance of this array of intensive services is debated by advocates and providers alike again and again in the discussion of research into the causes and effects of MOT.

The APA Document emphasizes the greater role clinicians will be called to play under MOT statutes, ranging from an increased pressure to accept difficult patients who are ordered on MOT by the courts, to a possibly greater liability risk by basing their treatment and release of patients on predictions of future violence or harm. The APA argues that clearly defined roles within the treatment program, such as a division of responsibility between clinicians, case managers, probation officers, and the courts, will eliminate some of this liability (Binder, et al, 2000, pp. 15-16). Among the other 11 recommendations are provisions regarding what to do in the case of noncompliance with the treatment orders, a proposal that the average length of commitment to treatment be at least 180 days, and the suggestion that patients be involved in the formation of their treatment plan as much as is reasonably possible (Binder, et al, 2000, p. 3).

It is helpful to view the APA’s position on MOT in the context of other

organizations' public positions on involuntary community treatment. The most visible participant in the forum on mental health issues is often the National Alliance for the Mentally Ill (NAMI). NAMI was formed in 1979 by a group of parents and friends of persons suffering from severely debilitating mental health conditions such as schizophrenia. The Alliance was motivated largely by a sense of betrayal and frustration toward the field of psychiatry, which NAMI's members felt had shied away from looking toward purely biological causes of such illnesses and had come to rely instead upon environmental factors such as the roles of families in contributing to the conditions. Perhaps in reaction to this focus, NAMI has pushed for public and health care provider awareness that mental illnesses are brain diseases which have biological causes and should be treated with medication and appropriate therapy.

In NAMI's "Policy on Involuntary Commitment and Court Ordered Treatment" they assert the need for involuntary treatment when persons with "biological brain disorders (also known as severe mental illnesses) such as schizophrenia and manic-depressive illness" lack insight into their need for treatment. While they acknowledge that improved community services will reduce the need for involuntary commitment and that such a commitment should only be used "as a last resort and only when it is believed to be in the best interests of the individual in need," they also advocate the use of mandated outpatient treatment when necessary because of its benefits over involuntary hospitalization: "Court ordered outpatient treatment should be considered a less restrictive, more beneficial, and less costly treatment alternative to involuntary inpatient treatment" (NAMI). NAMI's overall recommendations for commitment policies regard

the need for continuity of care and an integrated approach to mental health care.

There is little in NAMI's position statement or in the APA's Resource Document, however, that addresses the role of coercion within mandatory outpatient treatment. It seems to be assumed that because the very nature of mandatory treatment involves coercion, few distinctions need to be drawn between acceptable levels of coercion and the significance of differences in patients' perception of coercion. We have seen, however, how much internal coercion caused by mental illness can influence behavior. The fact that coercion is a primary mechanism in mandatory outpatient treatment does not diminish the fact that there are ethically appropriate ways of working with and minimizing the effects of coercion.

The area in MOT where coercion comes under the most scrutiny involves the issue of forced medication. Because the APA Document does not endorse forced medication, it seeks to find a middle ground where threats of hospitalization are enough to ensure compliance with psychotropic medication. The Document states,

Successful mandatory outpatient treatment programs need some coercive power to enforce compliance. Even if statutes do not authorize forced medication, all techniques short of force should be used to promote compliance. ...If the patient does not comply with court-ordered medication, that fact should be sufficient evidence of lack of compliance with the treatment plan to cause the patient to be taken to the outpatient treatment facility for treatment. ...It is likely that the prospect of repeated involuntary visits to the treatment facility would result in medication compliance for many patients. (Binder, et al, 2000, p. 18)

This approach to coercion walks a fine ethical line. On the one hand, it is because of a lack of insight caused by their condition, accompanied by a prediction of harm to themselves or to others, that persons are ordered on MOT in the first place. Once on MOT, forced treatment (excluding, in the APA's view, forced medication) is begun in order to stabilize

the person and hopefully restore insight into the need for treatment. On the other hand, if we suppose the person does regain stability and no longer poses a threat of harm, are clinicians and courts then justified in forcing the individual to continue treatment? These questions arise largely out of the predictive approach to MOT the APA Document advocates.

Leonard Stein and Ronald Diamond, both psychiatrists active in the community treatment movement, have written a response to the APA's Resource Document. Their response will be published in the Journal of the American Academy of Psychiatry and the Law under the title, "Involuntary Treatment in the Context of a System of Care." Besides criticizing the APA Document for uncritically accepting the conclusions of present research, ignoring a possible deterrent effect MOT orders may have for other patients who might otherwise seek community treatment, and downplaying concerns that appropriate funding will not be provided for adequate care, Stein and Diamond also point out the paucity of consideration given to ethical issues such as the degree of coercion and paternalism such statutes may permit. They note, "The suggestion seems to be that coercion is ethically justified because it is effective" (Stein, et al, 2000).

Coercion has to be evaluated not only as a treatment tool but as a moral act. Coercion can be seen as both an act of beneficence and an act of nonmaleficence, depending on the relative moral weight of the respective benefits and harms. On one hand, the very purpose of mandatory treatment in the community, according to proponents, is to maximize benefits for everyone — the patient receives treatment in the least restrictive setting, and the community is ostensibly protected from potential harm by one of its

members. The coercive nature of MOT, then, is just an unfortunate necessity for the process to work. On the other hand, to take the position of some patient advocates, the coercion that is part of forced treatment may be an immoderate application of the state's police power that results in no benefit to the patient and actually commits a grave harm against him.

To resolve this issue it would seem we would need to know whether mandatory outpatient treatment works; that is, are the possible benefits — reduced hospitalization rates and less violence by the severely mentally ill — realized and do they outweigh the possible harms? This is much more difficult to establish than it might seem. Research into the effectiveness of MOT has been less than conclusive. The numerous studies that have been performed try to use the same standards for determining effectiveness, but the nature of mental illness and the way its impact varies depending on the individual has made concrete conclusions difficult to come by. Most studies define effectiveness in terms of a reduction in hospitalizations or compliance with treatment during and/or after the period of MOT commitment. Most researchers define compliance as showing up for appointments at the community center and adhering to the required medication regimen. These criteria stem from the founding principle that is usually the motivation when MOT statutes are enacted — the belief that requiring outpatient treatment will prevent patients from cycling in and out of involuntary hospitalizations, and will allow them to create and maintain stable lives within their communities (Binder, et al, 2000, p. 1). It is this motivation that I am defending in this paper, though the endorsement of the motivation does depend on some evidence of its achieving its aims.

The APA research document discusses the findings of several of these studies, concluding that the overall perception in the research field is that MOT is effective in reducing hospitalizations and in encouraging ongoing community treatment. "...These studies, taken as a group, suggest that mandatory outpatient treatment can be effective in reducing rehospitalization rates and increasing compliance when adequate services are included and the programs have the support of the treatment providers" (Binder, et al, 2000, p. 5). Looking at each study individually, however, I have observed a repeated caution on the part of researchers: the nature of MOT makes any definitive assessment of the available empirical evidence difficult to establish. This observation has been repeated both by watchdog groups, such as the Bazelon Center for Mental Health Law, and proponents of MOT, such as Stein and Diamond. The latter, in their overview of the Resource Document, write that though they themselves "feel that mandatory community based treatment may well be useful for some clients" they caution that "the research base for this contention is not as strong as [the authors of the Document] imply. Many readers of the available literature would disagree with the authors' conclusion that currently available research supports the use of mandatory community treatment orders" (Stein, et al, 2000).

The Bazelon Center has been even more dismissive of the research which the APA's Document cites. In its report, "Studies of Outpatient Commitment are Misused," the Center critiques the methods and conclusions of many of the studies of MOT to date, and asserts, "[A]rguments that involuntary outpatient commitment is a panacea in the treatment of individuals with mental illness are specious. The more scientific the study, the

less evidence it offers that outpatient commitment orders have any effect beyond providing increased access to effective services” (Judge David L. Bazelon Center for Mental Health Law, “Studies of Outpatient Commitment Are Misused”). The reason for this, in part, may be that any study that sets out to prove efficacy will be facing a number of variables beyond scientific control which are an inherent part of the nature of mental illness.

It is vital when examining the ethical as well as empirical issues surrounding MOT to remember that a commitment to treatment for psychological disorder affects not “patients”, but persons. Patients are people, not simply units of measure in a statistical endeavor. As James and Hilde Lindemann Nelson explain in their book, The Patient in the Family, “It’s not an illness that must be treated, but an embodied, desiring, thinking, and feeling person.” Doctors, they warn, “will make serious mistakes if they don’t understand that illness occurs in a human being with a history and a set of life-circumstances” (Nelson and Nelson, 1995, p. 50). When researchers focus only on missed medication appointments, duration of court orders, and rehospitalizations, they may overlook the most significant factor in determining the impact of mandatory outpatient treatment -- the experience of illness in a *person*, beyond his or her status as a patient. Rehospitalizations can occur for a number of reasons, not least of which may have to do with changing social circumstances and the patient’s evolving coping mechanisms. Even when grouped by “severity of illness,” patients can have very different experiences with their conditions. The research pairing of two diagnosed schizophrenics who have each had twenty hospitalizations in the past two years for the purpose of comparing their “success” with MOT does not mean that their own perceptions of the condition, their family and social

supports, or even treatment regimens, are the same.

Nevertheless, in terms of the factors each study measures, most studies do in fact suggest a trend in those who undergo MOT commitments. These persons, overall, seem to fare better than their non-MOT counterparts in terms of reduced hospitalization rates and compliance with treatment in the months following the end of their commitment. The Resource Document divides the MOT studies to date into two groups, first and second generation studies. The Document reiterates a common criticism of these studies, which is that “most did not attempt to establish whether the legal mandate for treatment was causally linked to the improved outcomes observed” (Binder, et al, 2000, p. 5). These early studies did, however, gather some convincing evidence that intense treatment seems to improve hospitalization rates for some severely mentally ill persons. The question remains whether or not the success is due to the intensity of treatment, or the coerced nature of the treatment, or perhaps both.

North Carolina has had MOT statutes for a long enough period to have been studied several times by several different research teams. The most prominent research has been conducted by Virginia Hiday and her colleagues, who have been studying MOT in that state since 1978. In their first published study (1982), Hiday and R. R. Goodman found that of 408 patients committed to MOT in North Carolina, only 29% were rehospitalized during the MOT period. The Resource Document notes, “Half those patients were returned because they had not complied with their required treatment plans,

not necessarily because they had again become dangerous” (Binder, et al, 2000, p. 5).³

This study did not compare these reduced rates with the rates of individuals released against medical advice but without commitment orders. Such a comparison would perhaps have provided more conclusive evidence of the efficacy of MOT. The Resource Document notes that additional research into the correlations between court orders and compliance is needed.

At St. Elizabeth’s Hospital in Washington, D.C., Guido Zanni and Leslie deVeau studied patients who went from being voluntary outpatients to undergoing outpatient commitment orders. Their sample consisted of 42 patients, of whom all but eight were under court orders for outpatient commitment for a full year after being discharged from an inpatient ward of the hospital. The study revealed a trend toward shortened recommitment stays — from an average 55 days before the outpatient orders to 38 days in the year of the outpatient commitment — but the authors noted that this difference was not statistically significant. Zanni and deVeau concluded that, “Because treatment efficacy involves complex interactions between patient characteristics, treatment intervention, treatment setting, and staff characteristics, future studies of outpatient commitment should focus on some of these issues besides further investigation of the efficacy of the intervention” Zanni, et al, 1986, p. 942).

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This raises a significant philosophical issue, namely, is it appropriate to restrict/violate a person’s civil rights for failing to follow a treatment plan, when the patient had not deteriorated to meet medical criteria for hospitalization as a result of not following that plan? The answer(s) to this question lies beyond the scope of this paper, but the issue bears further critical discussion.

It may be that the nature of MOT will always preclude hard and fast causal links to be drawn between coerced treatment and the increased likelihood of a patient's mental and social stability. A truly randomized sample would involve liberty restrictions and infringements on confidentiality that could probably not be justified. Perhaps because of these research limitations, in none of the many studies I reviewed did I find any evidence the respective researchers deemed conclusive enough to establish the use of mandatory outpatient treatment as a definitively effective treatment tool.

Perhaps such decisive evidence is not necessary, however, in order for such treatment to be justified. Most studies do demonstrate a trend toward reduced hospitalizations, and most researchers emphasize the role that social supports, often in the form of intensive community treatment programs, may play in the success of commitment orders. Some advocates see this role as predominantly the reason why MOT seems to work for some patients. That is, it may be that the coercion of the patient is not the cause of success, but rather the efforts of community services to provide assistance to the committee that is rallied by court mandated orders.

This point has been made by the Bazelon Center for Mental Health Law in its warning concerning the conclusions that can be appropriately drawn from some of the research I have cited. They see the existence of a court order as secondary to the real reason committed patients sometimes do well under MOT. The real reason, the Center believes, is the improved access to a continuous care approach these individuals receive when their communities are forced through the order to offer them aggressive treatment.

Involuntary outpatient commitment appears to increase the use of services because

it forces the system to make those services available for people for whom a court has ordered treatment. Expanding service options would accomplish the same ends without coercion, without the trauma of a court appearance and without violating the individual's right to make decisions about his or her own health care. (Judge David L. Bazelon Center for Mental Health Law)

Many advocates such as those of the Bazelon Center see the failure of individuals to follow through on voluntary outpatient treatment as due to failings within the system of mental health care itself. They view it as patently unfair to punish a person for not complying with treatment when there are so many challenges to their receipt of such treatment. Stein and Diamond devote most of their response to the APA's Document to attacking the issue they see as central to the success of any mandated community treatment program — an integrated system of services so that no patients are “lost in the cracks.” In what they call “this fragmented non-system of public mental health care,” Stein and Diamond say patients are often turned down, over treated, under treated, or simply lost to community tracking when they are admitted and then discharged from hospitals (Stein, et al, 2000). They recommend a “systems” law for MOT, much like that currently in place in Wisconsin. Under Wisconsin law, both the hospital and the community services are held responsible for the treatment of the individual, and they coordinate efforts to treat and release patients. “Because the law applies to both the hospital and the community,” write Stein and Diamond, “the degree of coercion applied to an individual can be titrated easily, since people committed under the law can still be released from the hospital rapidly with many of their civil rights largely intact” (Stein, et al, 2000). Extending the coerced care beyond hospital discharge also means that there is more time for strong relationships between the individual and his or her health care providers to form, increasing the chances

of long term stability for the patient (Stein, et al, 2000). Stein and Diamond feel a systems approach, which was not addressed by the Document, would improve the chances of a patient's success with MOT, as well as limiting the amount of coercion the person may undergo. "The more options that are available, the more likely a client is to avail him or herself of one of them, and the more choices that a person has the less coerced the person is likely to feel. Integrating the hospital and community expands the choices available while increasing the ability to tailor an intervention to the need of each person" (Stein, et al, 2000).

It is undeniable that community mental health services are severely lacking for many patients because of lack of funding, limited access to affordable transportation within the community, the reluctance of many health care providers to treat recalcitrant patients, and the bureaucratic hurdles many patients face in becoming eligible for reduced-cost care. More than a generation after deinstitutionalization, furthermore, these problems seem to more entrenched than ever, with little sign of improving (Mosher, et al, 1994). Yet, as Stein and Diamond and other provider-advocates have concluded, the fact that "commitment laws coerce staff almost as much as they do patients" can mean a great benefit to patients (Stein, et al, 2000). Though it will undoubtedly rankle some mental health advocates, mandatory outpatient treatment orders may be the best way under the circumstances for many persons with severe and persistent mental illness to receive quality care and improve their chances for attaining stable lives.

This is a philosophically tricky argument to make; however, real solutions to the problems of the mentally ill must take into account how much the very nature of their

illness affects the manner in which they receive their care. Mandatory outpatient treatment statutes have come into existence largely to meet the needs of the severely and persistently mentally ill more effectively and more conscientiously than entirely voluntary systems have done. The traditional voluntary approach may have failed in part because the lack of involvement, both in terms of monetary means and personnel limitations, of community services. Advocates may jump to the seeming higher ground, then, by blaming poor delivery of community services for the noncompliance of some patients. This ground may be shaky, however, once one takes into account just how many challenges community organizations face in even staying financially afloat in order to even exist to offer care, much less achieve a high standard of care. So does the blame then pass to the state and federal governments, which have often ignored pleas for greater financial support and have come to rely on private health care companies to administer care? Should the blame be borne by these private companies, which seem to favor profit margins over meeting the needs of the mentally ill in their care? In truth, all parties seem to share some blame for the current state of mental health services in this country. In such a situation, however, blame is only useful insofar as it points out paths for change.

One path is mandatory treatment of the mentally ill. Not because the ill themselves are necessarily to blame for their relapses, but because such laws force a concerted effort on the part of health care providers, insurance companies, government bodies, and, yes, patients, to work for improvement. A well-integrated mandatory community treatment program can be "sensitive to the clinical reality that the best way to decrease the need for future episodes of coercion may be to continue the current period of coercion long enough

to allow stability and community integration to occur” (Stein, et al, 2000). The patient is one of the beneficiaries, though the patient also often has the most at stake in terms of personal liberty and well-being (excluding cases in which the patient poses a severe threat to the health and safety of others). These high stakes are the reason so much oversight is needed in the administration and enforcement of MOT orders; beneficence must maintain a delicate balance with the obligations of nonmaleficence. When conscientiously applied, MOT orders may force community services to look at ways to help a population of patients whose needs may have been easy to ignore when such services could choose whom they wished to serve. The success of MOT laws may focus the government’s attention on looking at what factors may have helped reduce expensive hospitalizations and may urge short-term thinkers to examine the long-term benefits of improved voluntary community care.

Perhaps most importantly, however, a program of mandatory treatment in the community may give patients who have previously cycled in and out of hospitals, with little continuity of care, the experience of sustained health while undergoing treatment. Individuals who have not, for whatever reasons, believed that their disorders could be managed such that they could attain stable lives may experience that stability for the first time. Living successfully with their illnesses may be the best treatment possible, since it may provide an incentive for continued treatment, and a renewed sense of hope in what may otherwise have seemed an endless and unwinnable battle. No one welcomes without great reservation any law or program which curtails an individual’s freedoms. Many of those who have studied MOT laws and who have worked with patients under both

voluntary and involuntary outpatient systems have concluded, however, that MOT laws hold enough promise if not clear evidence of the successful treatment of severe and debilitating illness to justify its use. Let's now turn our attention to mandatory outpatient treatment in practice by examining a case study.

IV. Ethical and Practical Issues in Enforcement: A Case Study

Marilyn Davis hasn't shown up for her appointment. It's a drizzly October day, and the nurse sighs as she notes Marilyn's absence in her chart. "This is the fourth medication clinic appointment she's missed in a row," she says. "I guess we'll have to send another letter." Marilyn is a patient at an outpatient mental health center. She is scheduled to come in for an appointment with a nurse once every two weeks, to receive an injection of psychotropic medication. Unlike most patients at the center, however, Marilyn is under court orders to receive her injection. She is on what her state calls Mandatory Outpatient Treatment (MOT).

A second nurse looks over Marilyn's chart. "When was the last time Dr. Peters saw her?" he asks. "It says here she's been on chemotherapy?" The other nurse explains that Marilyn was receiving treatment for a cancer that was detected about six months ago. The psychiatrist at the mental health center, Dr. Peters, saw Marilyn three months previously. Marilyn complained then that the injections she was on for her mental illness were interfering with the chemotherapy treatment, and so Dr. Peters suspended her psychotropic medication injections until after her chemotherapy was completed. According to the date she had told him, that would have been two months ago.

"We've sent letters warning her, but she's still not coming in," the nurse continued. "She called once, after the first letter was sent to her, and she said she was done with chemo and would keep her next appointment. That was three appointments ago..." The other nurse asks what will happen now. "Probably nothing," the first nurse replies with another long sigh.

Tennessee's legal code specifically mandates that MOT is appropriate for persons who, because of a history of noncompliance with treatment and subsequent decompensation when released from the hospital, are not expected by their treating professionals to be compliant after release. Marilyn fit the traditional criteria for involuntary community treatment because she was a "revolving door" patient — she repeatedly went off her medication and became unable to care for herself, thus meeting the dangerousness component of the criteria. When she was on her medication she lived in an apartment with her beloved cat and worked part-time at a fast food establishment, where she had twice won the "Part-time Employee of the Month" award. When she stopped taking her medication, which she did every few months for unknown reasons, she became confused and forgetful to the point of neglecting to feed herself, not showing up for work, and often ending up in the psychiatric hospital after ranting at her neighbors. She is part of a small but significant portion of the severely and persistently mentally ill -- those who have a pattern of hospitalization and decompensation -- who find themselves ordered to accept treatment for their illness as an outpatient.

The Tennessee statutes on MOT do provide for procedures to enforce the treatment orders, which include summoning the patient back into court for noncompliance. If the court believes the patient again will not comply with treatment unless forced, MOT orders can be reissued or the patient could be rehospitalized (Tennessee Code Annotated). In practice, however, this kind of enforcement rarely occurs in civil commitment cases, for at least a couple of reasons. First, there is evidence that for treatment to be effective a trust must be developed between the treating professional and the patient (Winick, 1997,

p. 1162). When Marilyn's nurses and psychiatrist must double as monitors of her compliance it is likely that she will see them more as adversaries than as advocates for her good. Many treating professionals decline the watchdog role because they fear creating a potential barrier to effective treatment. Second, the reality of getting Marilyn back into treatment or into court may prove tough to stomach for her mental health workers. Police officers may have to force her physically to appear before the judge. In the face of these drastic measures, many treating professionals send out letters of entreaty and warning to patients out of compliance with MOT in the hopes that this will convince them to return for treatment. If this fails, however, many patients on MOT, like Marilyn, will not be forced by their treating professionals to comply with treatment.

"We have to just wait until she decompensates and does something to make people mad or scared, and we'll see her back here again," the nurse says as she reaches for another chart. "You can almost bet on it."

Marilyn's case is not unique in states, like Tennessee, which have laws providing for some form of mandatory outpatient treatment. These cases raise difficult questions for providers, patients, and the legal system under which such treatment operates. Is it ethical to force a person to receive mental health treatment, especially pharmacological treatment? What role does the patient play in his or her treatment and will treatment be effective if it is coerced? Is it appropriate for treating professionals to be placed in a watchdog role over their patients on MOT orders? Finally, what impression of respect for their personhood is the state giving to mentally ill individuals who are ordered on MOT and then allowed to slip back into their cycle of decompensation?

It is important to remember that MOT is needed for only a small portion of the mentally ill (Tennison). This minority poses a challenge, however, to many traditional notions of respect for autonomy. In much of the discussion surrounding MOT, the autonomy of the patient has come to be seen as more important than beneficence toward the patient. Many mental health advocates speak of "self-determination" as a fundamental right of mentally ill individuals without addressing the fact that the population specifically targeted by MOT laws are precisely those individuals who seem unable to make meaningful choices or to exercise their rights to self-determination (National Council on Disability, 2000). In fact, deciding that autonomy should always trump paternalistic beneficence can sometimes result not in genuine respect for the personhood of the person with mental illness but in rationalized apathy toward them by others in society (Appelbaum, 1997). If it is the intention of the state to act benevolently toward the patient by attempting to restore his or her autonomy through treatment, then this intention should be carried out, and not turned into a pattern of empty threats as a result of inaction.

Paternalism may be justified at least when it arises out of a genuine concern for an individual's welfare and when it is accompanied by respect for the individual's personhood. Surely the important status awarded autonomy does not demand that we allow our fellow human beings to "choose" a mode of living in which they cycle in and out of psychoses that prevent them from enjoying even the basic pleasures of personhood -- the comforts of a home, the fulfillment of meaningful work, and the support of lasting friendships. Autonomy is valued because it allows us to pursue those things. As Paul S. Appelbaum writes, "Far from impinging on their autonomy, treatment [of the severely

mentally ill], even coercive treatment, would not only hold out some hope of mitigating their condition but might simultaneously increase their capacity for more sophisticated autonomous choices" (Appelbaum, 1997, p. 544). This reasoning is the primary basis for the paternalistic beneficence legislated by MOT.

Yet even granting that MOT may in certain cases be justified, there is still the issue of adequate enforcement. If the restoration of autonomy is truly the purpose behind MOT, then those who deem it necessary to mandate treatment should also see to it that the goal of that mandate is realized. This is not only because allowing noncompliance prevents patients from getting the treatment they have been deemed to need, but because it implies a more general disregard for the individuals' well-being and dignity as a person. When the state ignores the situation of individuals ordered on MOT who develop a pattern of noncompliance, the state is sending the individuals a message which contradicts the claim that concern for their personhood and autonomy was truly the motivation behind the MOT. It may suggest to patients that the violation of their rights in the name of care was really only a superficial attempt to placate a society filled with misconceptions and fears about the mentally ill. Unless the statutes are being abused, this is not the intention of MOT orders, and the state should attempt to make clear to individuals ordered on MOT that the intervention is an effort to help them, not hurt them. In a perverse way, the state's inability to follow through on enforcing compliance may be the most uncaring and disrespectful thing it could do to a person who may already feel forgotten and undervalued by his or her community.

Orders for mandatory outpatient treatment should come from a sincere respect for

personhood and the desire to restore the autonomy of individuals like Marilyn. For a severely and persistently mentally ill person, treatment in the name of beneficence and non-treatment in the name of autonomy both become only so much empty rhetoric when they do not encourage positive change in the person's life. States with MOT laws need to decide how far they are willing to go to prevent self-harm by citizens. Either they need to be willing to enforce MOT by calling on the police and the courts and the hospitals to ensure that patients are getting treatment, and thus put some bite into MOT laws; or they need to decide that it is not the place of the state to force treatment upon those who lack insight into their conditions, and make MOT laws obsolete. Walking a fine line in the gray area between paternalism and apathy only compounds a mistaken perception all too prevalent in our society, that mental illness is a label that implies lack of self-worth, a propensity for dangerousness, and an absence of hope.

V. Mental Illness as Mental Disability: Is Mandatory Outpatient Treatment a Double Standard?

In November of 1998, mental health professionals, attorneys, advocates, friends and relatives of people with a mental illness and individuals who had suffered or were suffering from a mental illness met in New York State at a hearing of the National Council of Disability (NCD), a federal agency composed of 15 members who are appointed by the President and approved by the Senate. The hearing was an attempt by the Council to hear from as many perspectives as possible on the status of the mentally ill in this country. As a result of this hearing, a report entitled From Privileges to Rights: People Labeled with Psychiatric Disabilities Speak for Themselves (National Council on Disability, 2000) was issued by the NCD to The President of the United States and to both houses of Congress.

Many of the views expressed in the report came not only from individuals who consider themselves “survivors” of mental illness and the medical and social system designed to treat it, but also from groups which aim to represent the interests of the mentally ill population, such as NAMI. This group and others who spoke at the hearing tend to come from a platform that favors distancing the label of “mental patient” from the public perception and the personal identity of persons who are dealing with or who have recovered from a mental illness. As Loren Mosher and Lorenzo Burti describe them in their book, Community Mental Health: A Practical Guide,

The focus of these groups is not so much on bashing psychiatry as it is on developing a viable alternative to psychiatry’s authority and control. Psychiatric (or other professional) help can be used so long as it is by choice. However, because of their experiences at the hands of psychiatry and the mental health system, ex-patients are very concerned about preservation of their integrity. They worry that cooperation *with* the mental health system will turn into co-optation *by* it. (Mosher and Burti, 1994, p. 26)

It is important to note this orientation of these groups not simply because their views are prominent in the NCD report cited in this paper but because these views pose a significant challenge to the use of mandatory outpatient treatment. Most of the people who have been most vocal in their opposition to MOT are people who have an experience of mental illness, either in their own person or in the life of someone close to them.

The Americans with Disabilities Act defines disability in terms of three components: an impairment that “substantially limits a major life activity, a history of such impairment,” or the perception that a such an impairment exists in the person (Office of Technology Assessment). The Equal Employment Opportunity Commission (EEOC), an agency which regulates employment practices, expands this definition to include explicitly mental illness as a disability, and it even defines as a disability those conditions that are effectively controlled by medication or other therapies or devices (Office of Technology Assessment). By “substantially limited” is meant that the individual is “unable to perform a major life activity that the average person in the general population can perform” or that he or she is “significantly restricted as to the condition, manner or duration under which [he or she] can perform a major life activity” as compared to the general population standard (Office of Technology Assessment).

The definition of “major life activity” has evoked some debate among mental health advocates and legal scholars. The EEOC’s guidelines define such an activity as “caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.” The American Psychological Association has noted

that “working” in the case of many mentally ill persons may be the only “major life activity,” as defined by the EEOC, in which they are substantially disabled (Office of Technology Assessment). Yet many mentally ill persons are unable to maintain social relationships, communicate effectively, or engage in logical reasoning, all of which can significantly disable an individual from living as would the average person in the general population. The EEOC has stated that it does not in fact view the inability to work as the most important criterion of disability. It has also made it clear that being treated as if you have a disability can constitute a disability, since in our society mental illness is often seen as an obstacle to work (Office of Technology Assessment).

Part of the reason mental illness can be difficult to classify as a disability is because it can often be invisible to others. One woman who was being screened for visual hallucinations at an outpatient mental health center was asked if she saw things “other people don’t see.” She replied gravely that she could not answer that question since she couldn’t see through other people’s eyes so she could have no way of knowing if what they saw was in fact different from what she saw (personal observation, Helen Ross McNabb Outpatient Mental Health Center, April 7, 2000). While advances are being made in finding demonstrable biological evidence for mental illness, at present, and perhaps always, the experience of mental illness is by its nature often removed from direct observation by clinicians or others. Clinicians, and often even ordinary bystanders, can observe the symptoms of the illness -- such as the individual speaking to persons whom we do not see before us, or expressing an understanding of the world which is radically different from our experience of it, or emotionally collapsing in a fit of tears and panic for

no apparent reason -- but we cannot see a scar or hemorrhage or failed heartbeat as we often can in cases of physical illness.

The “invisible” quality of many mental illnesses should not prevent us from considering some cases of mental illness to be debilitating. It may, however, give us pause to consider exactly how mental illness may be different from other, physical disabilities. To examine this point, I will borrow a case from Jonsen, Siegler, and Winslade’s book, Clinical Ethics. In this case, “Mr. Cure”, a 24-year old patient, has been brought to the ER by a friend. He complains of a stiff neck and a severe headache, but is in generally good health otherwise. His doctor determines that Mr. Cure has symptoms of bacterial meningitis, a condition which can be fatal if untreated. The doctor informs Mr. Cure that he needs to be hospitalized immediately so that he can undergo a regimen of antibiotics. After explaining the severe risks of going untreated and the low risks of undergoing treatment, the physician is taken aback when Mr. Cure refuses to be hospitalized. Jonsen, et al, note that Mr. Cure “exhibits no evidence of mental derangement or altered mental status” other than this enigmatic refusal (Jonsen, et al, 1992, pp. 15, 47). What should the doctor do?

What Mr. Cure’s case presents is an ethical dilemma revolving around the issue of mental competency. Following his refusal, the physician questions Mr. Cure in detail in an attempt to determine the man’s capacity to make an informed, rational decision. Such questioning, which may come in the form of a formal competency exam, is warranted because Mr. Cure does not appear to be making a rational decision based on the choices

before him.⁴ In this case, probing investigation fails to elicit a clear reason from Mr. Cure concerning his refusal, though he remains apparently competent and aware of the risks/benefit ratios of consent and refusal. Jonsen, et al, then reluctantly propose overriding Mr. Cure's stated wishes and performing the intervention against his will. The authors explain,

Given both this enigmatic refusal and the urgent, serious need for treatment, the patient should be treated, even against his will...In offering this counsel, we reluctantly favor paternalistic intervention at the expense of personal autonomy. Our reluctance stems from the unwillingness to violate the liberty of another. It is overcome by the consideration that something essential is missing in this case. It is difficult to believe this young man wishes to die. The conscientious physician faces two evils: to honor a refusal that might not represent the patient's true preferences, thus leading to the patient's death, or to override the refusal in the hope that, subsequently, the patient will recognize the benefit. This is a genuine moral dilemma: The principle of beneficence and the principle of autonomy seem to dictate contradictory courses of action. (Jonsen, et al, 1992, pp. 62-3)

Violating Mr. Cure's liberty in this difficult case is the only way to avoid what would surely be a greater evil: the possibility of his untimely death. Such a drastic measure is taken in the belief that the patient lacked the ability to decide what was best for him -- in this example, the matter of assenting to a low-risk, high benefit intervention to save his life. His mental capacity to deliberate rationally was thought to be disabled and so his stated wishes were overridden. There appears to be something unique, then, about how

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Note, however, that the physician is not immediately justified in overriding Mr. Cure's refusal to consent to treatment. As Jonsen, et al, caution, "The physician might *presume* altered mental status...but mere presumption, in the absence of affective and behavioral clues, is inadequate to justify a conclusion that he is incapacitated...Refusal of treatment should not, in and of itself, be considered the act of an incapacitated person" (Jonsen, et al, 1992, p. 47).

we approach mental capacity as opposed to physical capacity. We think it inappropriate to question the decision-making capacity of those who are in wheelchairs simply because they are in wheelchairs; we do question the decision-making capacity of the mentally disabled simply because of their particular disability.⁵ This difference is largely because of Western society's emphasis on rational autonomy as the most revered human quality. As John Stuart Mill noted, "It is better to be a human being dissatisfied than a pig satisfied; better to be Socrates dissatisfied than a fool satisfied" (Mill, 1967). We value our ability to make meaningful decisions for ourselves based on a rational understanding of the options before us even more, it seems, than we value pleasure or any other human good.

Do we then apply a double standard when we force persons with mental illness to accept certain treatments if we do not force persons with physical ailments to accept treatments?⁶ The NCD's report notes, "As Congress stated when it passed the ADA, disability is a natural part of the human experience that in no way should limit the ability of people to make choices, pursue meaningful careers, live independently, and participate

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Two comments about the inappropriateness of questioning the decision-making capacity of someone in a wheelchair simply because he or she is in a wheelchair are in order: one, many people do, in fact, treat the physically-handicapped as less than competent simply because of their disabilities; this does not, of course, change the impropriety of such discriminatory treatment. Two, it may be appropriate to question the competence of someone who has just been handicapped by sudden injury or illness. Such persons may be in a state of shock that renders them less than competent. For the purposes of this discussion, however, I am speaking of the inappropriateness of questioning the decision-making capacity of most physically handicapped individuals, whose disabilities do not render them incompetent to make treatment decisions.

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Excluding the case of Directly-Observed Treatment for tuberculosis, to which I shall turn shortly.

fully in all aspects of American society” (National Council on Disability, 2000). While not necessarily disagreeing with this view of disability, it seems to me that there is a conflict between what the Council and the participants who spoke before it claim to be the goals of the ADA as it pertains to mental disability, and what they believe to be most wrong about mandatory outpatient treatment. The thrust of the report is that MOT and other, more restrictive forms of involuntary treatment, constitute an unjustifiable impingement on self-determination. In its core recommendations to Congress and the President, the NCD writes that “laws that allow the use of involuntary treatments such as forced drugging and inpatient and outpatient commitment should be viewed as inherently suspect, because they are incompatible with the principle of self-determination” (National Council on Disability, 2000). The report recommends that the goal of public policy on mental health treatment should be toward a completely voluntary system of treatment “that safeguards human dignity and respects individual autonomy” (National Council on Disability, 2000).

Nowhere in the one hundred-plus page report, however, does the NCD or the hearing participants spell out what constitutes self-determination or individual autonomy. The absence of a distinction between meaningful autonomy and simple, reflexive autonomy such as Appelbaum described is also noted in the position statement on involuntary commitment of The Bazelon Center for Mental Health Law. Their statement proclaims, “The Bazelon Center supports the right of each individual to fully participate in, and approve, a treatment plan and to decide which services to accept” (Judge David L. Bazelon Center for Mental Health Law). Such a position assumes that those who qualify for MOT are capable of participating in, approving, and deciding on a plan for their

treatment. If this capacity is not present to a degree adequate for such decision making, what immediate significance does such a right to self-determination really have?

Studies report that nearly 40% of the homeless population suffers from a severely debilitating mental illness (Appelbaum, 1997, p. 544 and Mosher, et al, 1994, p. 32). Many of these individuals were formerly patients in mental hospitals who found themselves on the streets when policies of deinstitutionalization swept the nation in the 1970s and 80s (Mosher, et al, 1992, pp. 13-18). They scavenge for food, sleep in parks or homeless shelters, and receive minimal medical care and/or community support. Other severely and persistently mentally ill individuals are repeatedly hospitalized for their mental illness, stabilized through medication, and released to their communities over and over again in what has come to be called the "revolving door" of hospitalization. For some patients this revolving door can open and shut ten or twenty times in the space of a year (personal observation of patient charts at Lakeshore Mental Health Institute, March 28, 2000).

Most of those who go through the revolving door lack what psychiatrists call "insight" into their conditions. They are "too sick to know they are sick" (National Council on Disability, 2000, comments of Rael Jean Isaacs). MOT is appropriately applied only to those who not only do not remain compliant with treatment after release from the hospital but who also decompensate to the point of needing hospitalization again as a result of not taking their medications (Binder, et al, 2000, pp. 2-4). When conscientiously applied, MOT is not an instrument of social control over people whom the medical establishment and the individuals' communities have decided are annoyingly "crazy," as

some mental health advocates claim (National Council on Disability, 2000). Craziness in and of itself is never a justifiable reason for restricting someone's freedoms. It is only when mental illness is accompanied by a threat or actual harm to the person or to others around him that the value of autonomy might yield to the value of beneficent intervention.

If we do not attempt to treat the severely and persistently mentally ill because of concern for protecting their autonomy, it is possible that we will be denigrating their integrity, not respecting it. The paradox of much of mental health treatment is that it restricts autonomy in order to restore it. The nature of some psychiatric disabilities is that they prevent the individual from even being aware of his or her disability. Herein arises much of the difficulty surrounding determinations of when such restriction is justified. Certainly forcing people to accept treatment they claim not to want is a violation of autonomy, and certainly those who wish to impose such a treatment bear the burden of proof in establishing its necessity and moral and legal justification in each and every case.

We also need to look critically at the arguments of some mental health advocates, however. Many advocates for those with mental disabilities seem to accept at face value the claim that any form of involuntary treatment constitutes an unjustified infringement upon personal liberty. The rallying cry of such advocates carries a flavor of ideological higher ground. Isaac and Jaffe describe one group of advocates, an informal mental health bar formed in the late 1960s and early 1970s by several public interest lawyers. Bruce Ennis, widely regarded as the founder of that bar, spoke candidly of his target: "My personal goal is either to abolish involuntary commitment or to set up so many procedural roadblocks and hurdles that it will be difficult, if not impossible, for the state to commit

people against their will” (Isaacs and Jaffe, 1996). It seems to be assumed that involuntary treatment is by definition a moral wrong, and any means necessary are justified to impede and eradicate its use.

Upon critical examination, the arguments of such mental health advocates fall flat on several grounds. One of the arguments proposed by advocates is that mental disabilities are not significantly different from physical disabilities as regards freedom of the will and the right to refuse treatment. To this end, mental health advocates are passionate about achieving equality under the law for the mentally disabled. The NCD report notes, “People with psychiatric disabilities are the only Americans who can have their freedom taken away and be institutionalized or incarcerated without being convicted of a crime and with minimal or no respect for their due process rights. They are the only Americans who can be routinely forced to submit to medical treatments against their will” (National Council on Disability, 2000). This is only partly true, however.

While we are not necessarily accustomed to seeing the forced treatment of persons with what are believed to be purely physical illnesses, forced psychiatric treatment is not without its parallel in the world of physical medicine. The treatment and prevention of tuberculosis, one of the most deadly and most highly contagious diseases known, has often involved some form of detention and/or forced treatment (Rothenberg, et al, 1994, pp. 722-23).

Tuberculosis (or TB) is an infectious disease of the lungs that is transmitted via airborne bacteria and can be deadly if not treated rigorously with a combination of antibiotics for a period of at least six months. Patients are considered contagious until after

the first two weeks of therapy are completed, but the treatment regimen must be continued in order to prevent a relapse of the disease. Relapses of tuberculosis in which the disease has become resistant to treatment (a form of the disease called MDR-TB, or Multiple Drug Resistant TB) can be particularly dangerous, since the bacteria may have grown resistant to the antibiotics and the chance that the patient can no longer be successfully cured is greatly increased.

In the past, the most common approach to treating TB was to isolate the infected individual, either through detention in a specialized facility or in his or her home. Forced detention can severely curtail the liberty interests of the individual, however, so recent years have seen the development of what is called Directly Observed Therapy, or DOT. Writes one medical observer, “‘Supervised swallowing’ sums up directly observed therapy (DOT),” a process in which medical personnel witness the patient taking his medications either in a clinic or in the patient’s home or work (Garner, 1998, pp. 1326-27).

Not unlike the general population, which has about a 35% completion rate for any particular prescribed regimen, patients with TB often cease taking their medications when they begin to feel better (Rothenberg, et al, 1994, p. 730) Because of the danger of relapse, this noncompliance with treatment poses significant health risks, not only to the infected individual, but to larger society. Directly observed therapy is seen as less restrictive than detention and/or isolation in a hospital or other health care facility, and so it is the preferred method of treating TB. The World Health Organization has even included DOT in its recommendations for treatment around the globe (Garner, 1998, p. 1326).

There are a number of similarities between directly observed therapy for tuberculosis and mandatory outpatient treatment for psychiatric illnesses. The first is that both are considered less restrictive alternatives to detention in a hospital. They are viewed as less coercive because more of the individual's freedoms are preserved. They are also both touted as less costly alternatives to hospitalization (Rothenberg, 1994, pp. 729, 733).

Perhaps the most significant similarity between DOT and MOT, however, is that both rely on an assumption of dangerousness and the need to balance society's interests and the interests of the dangerous individual. The use of DOT and MOT is based on past behaviors, not present merely danger. The Center for Disease Control has issued guidelines regarding when it is appropriate to detain individuals in order to ensure their completion of treatment:

The CDC has called for renewed exercise of state police powers in ordering long-term institutionalization of TB patients (especially those with MDR-TB), court-ordered DOT, the use of "emergency isolation" powers by local health officers to detain individuals for TB evaluation, quarantine and detention, and the use of "penalties" with non-compliant TB patients. This approach relies on criteria for detaining individuals based on evidence of past, not present danger to the public in the form of contagion. (Rothenberg, 1994, p. 731).

Court-ordered DOT generally does not occur until the person has demonstrated a lack of commitment to following through with medications. Thus, even though the individual does not at the present moment pose a danger of contagion, the court judges his or her past behavior in terms of compliance and takes this into consideration in determining that the person is dangerous and must accept observed, and if need be forced, treatment.

This is very similar to the standards used in mandatory outpatient treatment orders. The criterion is not the present dangerousness of the individual; if that were the issue at

hand, the judgment likely would be for some period of restraint or hospitalization, or whatever the least restrictive means of preventing harm to the patient and/or others may be. The criteria are instead the past behavior of the individual (decompensation after noncompliance with medication) coupled with a prediction of future dangerousness.

It is only recently, through MOT statutes, that persons with mental illness who exhibited behaviors that had been documented in the past to be precursors to a deterioration to the point of dangerousness to themselves or others — such as not attending therapy appointments and/or not taking medications — could be legally mandated to comply with their treatment regimens. The idea is that even though the person is not *presently* dangerous, his present behavior indicates the very likely probability that he will become dangerous in the near future. For noncompliant patients with TB, the danger is the return of the infection and subsequent contagion. In the case of psychiatric disorders, the danger can be violence towards himself or those around him. In these cases, the State has seen fit to empower the courts, upon the recommendations of health care personnel, to force individuals to comply with treatment (Winick, 1997).

For most of this paper, I have been concerned with harm to self; attempts by the State to prevent such harm originates in the *parens patriae* power of the government. The legality of criteria for preventing harm to others stems from the “police powers” of the government. In a case involving smallpox vaccinations in 1905, the Supreme Court ruled that “the state may subordinate an individual’s liberty right to be freed from restraint to the rights of the public in matters of safety and health” (Rothenberg, 1994, p. 734). The subordination of these rights, however, should be done in the least restrictive manner

possible, preserving as much of the liberty of the individual as is feasible. This consideration makes DOT and MOT, on their faces, appear attractive to those hoping to achieve this balance of private and public rights.

In addition to the argument that there is no parallel forced treatment for physical disabilities and ailments, a second argument often employed by advocates against MOT is that such forced treatment constitutes discrimination against the mentally disabled. There certainly have been too many instances of unfair treatment of those with mental illness. Many human rights violations against the mentally ill have occurred both because of the “behind closed doors” nature of much mental health treatment and because of the stigma attached to mental illness. During the hearing, Janet Foner, a mental health care consumer, described one origin of this stigma: “We are the scapegoats of society...If people can say it is our fault and we are the defective ones, then they don’t have to face the issues that are happening in society that are oppressing people” (National Council on Disability, 2000). The prejudice faced by the mentally ill is disturbing and hearings like that of the NCD on the experience of those with psychiatric disabilities should be a call to arms for Congress and the citizens of this nation to stop unfair discrimination against them.

Mandatory outpatient treatment, however, does not necessarily constitute unfair discrimination against those with mental illness. To discriminate can mean “to recognize as being different” (Funk and Wagnall’s, 1983). Those who use wheelchairs to get around have their difference recognized and accommodated in the form of ramps into buildings and mechanical doors. They are treated differently, according to their need, in order to have their experience be as close to the same as that of other, non-disabled persons. A

person with a psychiatric condition that causes him to believe he doesn't need to come in from the freezing cold because his skin is impervious to frostbite will be treated according to his need. He will be treated not only so that he doesn't freeze to death but also so that hopefully he can understand that he is subject to frostbite and that he does need to seek shelter in the future. The fact that he may not think he needs treatment may be all the more reason why he should be treated, since the treatment is to restore the capacity for rational deliberation. This may be perfectly fair discrimination, and such involuntary treatment does not of itself constitute a double standard.

As much as many forms of mental illness deserve to be considered debilitating, it is not the case that all forms of mental illness are debilitating to an individual in the same way as the loss of a limb or the impairment of a sense may be. Some severe and persistent forms of mental illness strike at the very heart of what many of us consider to be our humanity -- our ability to act on our own will with an accurate understanding of our circumstances and possibilities. They disable our rational autonomy in such a way that we can no longer exercise it in a meaningful way. Unlike the loss of a leg, which may disable the ability to walk, the loss of meaningful rational autonomy may disable our other physical and emotional abilities. It may prevent us from seeking help that we would seek if we were not mentally disabled, and it may prevent us from following through with treatment. When it is conscientiously administered, MOT is not a double standard. It is rather a single standard of concern for others applied differently toward those with different disabilities.

VI. Conclusion

Mental illness presents a puzzle which operates in several dimensions and of which it is difficult ever to get a cohesive picture. The experience of mental illness occurs within a context: it occurs within a society that often still betrays a lingering suspicion that mental disorders are somehow, at least in part, the fault of the afflicted individual; it occurs within the context of a health care system which is badly fragmented and overburdened with bureaucracy and competing demands; and it occurs within the context of a philosophical debate over the principles of autonomy and beneficence and their import for the legitimacy of coercive treatment measures. This puzzle raises perplexing practical and ethical questions: Is mental illness a disability? If so, how can we as an enlightened liberal society best accommodate it? What treatments seem to work best? And is it acceptable if a treatment seems to work but involves coercion and restrictions on liberty? What are the limits of beneficence, and how can the sometimes fragile autonomy of those with mental illness be preserved and enhanced?

The dilemmas posed by mandatory outpatient treatment are but a fraction of the ethical quagmires faced by providers and patients alike in the current mental health care system. The debate over involuntary outpatient commitment does, however, highlight some of the most contentious issues. In particular, it crystallizes a paradox of autonomy: in certain cases, it is only possible to attain meaningful rational autonomy through restrictions on liberty. The demands of libertarianism cannot in these few cases be met without meeting at least some of the demands of paternalistic beneficence.

In this paper I have stressed the delicate balance that must be maintained between

claims for autonomy and claims for beneficence in order for some individuals with mental illness to receive effective treatment. Despite the indeterminacy of current research, I believe mandatory outpatient treatment has at least been found effective enough to warrant its continued use during a period of ongoing research into the purported correlation between a court order and efficacious therapy. The coercive nature of MOT renders it subject to scrutiny, but does not of itself justify its abandonment. More research, particularly into the long-term effectiveness of court-ordered and non-court-ordered treatment on patients' understanding of their illnesses and their coping mechanisms for living with them, is necessary.

Involuntary outpatient treatment of mental illness is neither without its parallel in the world of "physical" medicine (note the discussion of directly-observed therapy for TB) nor does it impose a double standard on those with mental disabilities. Just as the treatment regimen for a (perhaps) more purely biological disease such as cancer is tailored to meet the symptoms of the disease, so too is the therapeutic approach to mental illness geared toward ameliorating the particular problems posed by the mental illness.

Mandatory outpatient treatment has much to recommend it, not least of which is the fact that it allows more liberty than traditional forms of involuntary treatment for mental illness.

The tragedy of some severe and persistent forms of mental illness is that they strike at what many of us hold to be our most valuable qualities — our abilities to reason for ourselves, to take care of our own needs, and to engage in meaningful interaction with the world around us.

The goal of mandatory outpatient treatment is not to further stigmatize or to exploit those with mental illness, but to extend to them some hope of restoring their autonomy such that they may live relatively safe, stable and self-affirming lives.

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