

# The Ethics of Mandatory Community Treatment

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The authors present three ethical arguments to address the controversy of mandatory community treatment: rights-based versus beneficence, utilitarian, and communitarian. Each approach suggests that mandatory community treatment can be an ethical intervention for individuals with severe mental disorders in well-defined circumstances. It is critical to recognize that such interventions cannot be effective in the absence of an adequately funded, quality mental health service system. Within such a system, the authors believe a program of mandatory community treatment may play an important role. In considering mandatory outpatient treatment, the authors argue that consideration of decisionmaking capacity is preferable to dangerousness criteria, that clinical criteria with some flexibility should be developed so that mandatory community treatment is used only when alternatives have failed, that mandatory community treatment should be implemented long enough to be effective, and that consumers must be involved in the development and implementation of mandatory outpatient treatment programs.

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The appropriate role of coercion in psychiatric treatment remains controversial. In recent years, the locus and focus of the controversy has shifted from hospitals to the community. Involuntary hospital confinement through civil commitment statutes is available in all states in the United States. By the 1970s, most states modified their commitment statutes to emphasize dangerousness as a major criterion for involuntary hospitalization. With such revisions, inpatient civil commitment is generally accepted as a necessary intervention for acutely ill individuals who present an imminent risk of harm to themselves or others because of mental illness. Patients confined as a result of the civil commitment process generally retain the right to refuse treatment in the hospital absent an emergency. Non-emergency treatment of a commit-

ted patient generally can be given only after the patient has been found, through an appropriate judicial or administrative process, to lack decisionmaking capacity and therefore to be unable to give informed consent to treatment.

As patients with serious mental illness have largely moved from institutions to community settings during the past four decades, so too has most of the controversy about mandatory interventions with this population. There are at least three groups of people with serious mental illness who may be confronted with mandates to accept treatment: forensic psychiatric patients, mentally ill offenders, and patients being treated within the community mental health system who have no criminal justice system involvement (i.e., civil patients).

This article confines its consideration to the last group, focusing on patients with serious mental disorders (i.e., schizophrenia spectrum and bipolar and major depressive disorders) who are not necessarily involved with the criminal justice system but who do not voluntarily adhere to treatment and who appear to be unable to live successfully in the community without coercive interventions. Such patients are often referred to as revolving-door patients. For such patients, mandatory community treatment has been

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proposed as an alternative to repeated inpatient hospitalizations in which involuntary treatment with medication is often required. It has been argued that there are patients with serious mental disorders who do not believe they are ill or need treatment, who when ill deteriorate to the point of meeting involuntary commitment criteria, who respond well to treatment when treated in the hospital, but who repeatedly discontinue treatment after discharge and repeat the cycle, again and again. For such patients, mandatory outpatient treatment has been proposed as a less restrictive alternative to repeated inpatient hospitalization. Mandatory outpatient treatment, which depending on the jurisdiction, may be provided under a commitment statute [outpatient commitment (OPC)], through conservatorship or limited guardianship, or through conditional release from a hospital, is a preventive intervention aimed at maintaining stability in a person who otherwise would predictably, based on a well-established history, become ill and commitable.<sup>1</sup>

According to the recent American Psychiatric Association (APA) Resource Document on Mandatory Outpatient Treatment,<sup>1</sup> such treatment is permitted by statute in 40 states and the District of Columbia. While mandatory outpatient treatment is not implemented systematically in many states where it is permitted, a number of states are actively looking at enacting or amending statutes to implement mandatory outpatient treatment. The recent passage of Kendra's Law in New York and the ongoing advocacy of OPC by groups like the Treatment Advocacy Center have brought the debate about OPC to prominence. Position statements representing two sides of the debate nicely highlight the controversy. The National Alliance for the Mentally Ill (NAMI),<sup>2</sup> in its policy statement on OPC states: "Court ordered outpatient treatment should be considered as a less restrictive, more beneficial, and less costly alternative to involuntary inpatient treatment." The Bazelon Center<sup>3</sup> in counterpoint states:

Outpatient commitment laws—statutes authorizing courts to require an individual to accept outpatient mental health treatment—are being proposed as a solution to the problem of people with mental illness in jails, homeless on the streets or engaging in violence. In addition to an unacceptable infringement of individuals' constitutional rights, such laws are a simplistic response that cannot compensate for the lack of appropriate and effective services in the community.<sup>3</sup>

While consumer advocates have been characterized historically as opposing coercive treatment, it is increasingly apparent that individuals with serious mental disorders themselves have a spectrum of opinions similar to those of the community at large.<sup>4</sup> Increasingly, there are vocal consumer advocates in support of mandatory community treatment, along with those who oppose such interventions.

Whether mandatory community treatment can be an ethical intervention for some individuals with a serious mental disorder is the focus of the remainder of this article, along with some specific matters related to the ethics of such treatment.

The authors believe that, when used judiciously, mandatory community treatment is both ethically and clinically sound; but if used casually, coercive interventions can be clinically inappropriate and unethical. There are a variety of ethical approaches to the question of mandatory community treatment. Herein, three arguments will be reviewed in turn.

### **Rights-Based Versus Beneficence**

Liberal individualism is one of the most powerful ethics arguments raised against coercive treatment. This rights-based theory provided the impetus in the 1970s to change civil commitment laws from a need-for-treatment standard to a standard of imminent dangerousness. Proponents of this theory declare that (the) right is before the good.<sup>5</sup> Liberalism occupies a near sacred position within Western democracies, and many believe "that no part of the moral vocabulary has done more to protect the legitimate interests of citizens in political states" (Ref. 6, p 77). In this context liberalism does not refer to the current political philosophy but instead refers to a tradition of thought that emphasizes tolerance and respect for individual rights that spans the philosophical tradition from John Locke (17th century England) to John Rawls, a living American rights-based political and social philosopher. Within the framework of liberalism, rights are justified claims that individuals and groups can make on others and the state.

Rights are divided into two categories: positive and negative. Positive rights are best described as entitlements, such as a free public education. Negative rights entail the right of individuals to be left alone. Negative rights, or freedom from interference, are viewed as more powerful claims than positive rights. Rights have been described as "trumps" by the legal philosopher Ronald Dworkin.<sup>7</sup> The powerful

position of rights in the Anglo-American tradition has been bolstered within the past 30 years by the predominance of liberal individualism theories in the fields of ethics, law, and political philosophy.

Two other essential features of the liberal theory of ethics are neutrality and equality. Neutrality describes the condition in which the state must tolerate differing conceptions of the good life or what gives value to life. Liberal neutrality is probably the most challenged aspect of liberalism when considering the ethics of involuntary treatment overall and involuntary outpatient treatment in particular. Equality, the final tenet of liberalism, implies equal access to rights and benefits in a society, as well as the provision that enforcing the law will not unduly burden any particular segment of society.

Clearly, our society greatly values individual freedom. Individuals have the right to make lawful decisions about all aspects of their life without undue intrusion from the state or others. The courts have emphasized the principle that “every human being of adult years and sound mind has a right to determine what shall be done with his own body. . .” (Ref. 8, p 1). The legal doctrine of informed consent essentially elaborates the principle that, with certain exceptions, nothing can be done to one’s body without explicit agreement after a careful review of the risks, benefits, and alternatives, including the alternative of doing nothing. Informed consent must be voluntary, knowing, and competent.<sup>9</sup>

Competence to make decisions (or the clinical term decisionmaking capacity) may be problematic among persons with serious mental disorders. Grisso and Appelbaum<sup>10</sup> in their MacArthur Foundation competency studies looked most systematically at this matter. They describe four tests of competence: evidencing a choice, understanding, reasoning, and appreciation. They found about a quarter of acutely ill, hospitalized patients with schizophrenia failed any one of these three tests: understanding, reasoning, and appreciation. When a compound standard was used requiring adequate performance in all three tests, results showed that over half had impaired decisionmaking capacity. Presumably, after treatment, a portion of these patients will regain decisionmaking capacity by the time of discharge from the hospital. This has not been well studied, but it is apparent that, despite treatment, a portion of patients have a more persistent lack of capacity. In a research context, Carpenter and associates<sup>11</sup> have shown that an educa-

tional intervention can be a remedy for impaired capacity to give informed consent to research in subjects with schizophrenia.

It is likely that a substantial portion of patients with a persistent lack of capacity are the people commonly referred to as lacking insight into their illnesses. Studies have demonstrated that response to treatment for psychosis is independent of insight; in other words, psychotic patients who do not appreciate that they are ill may, with treatment, have substantial improvement in psychotic symptoms such as delusions and hallucinations, but continue to believe that they are not ill.<sup>12,13</sup> Lack of insight into illness appears to overlap substantially with one of the tests for competency developed by Grisso and Appelbaum,<sup>10</sup> the appreciation test. This tests the ability “to appreciate the significance for one’s own situation of the information disclosed about the illness and possible treatments.” It appears that a patient who does not believe he/she is ill (i.e., who lacks insight) would fail the appreciation test and, on that basis, could be found to lack decisionmaking capacity. Recent evidence suggests that this unawareness of illness has a neurobiologic basis inherent in schizophrenia and is therefore more than defensive denial.<sup>14–18</sup> Accordingly, a strong argument can be made that there are patients with schizophrenia who meet the description of the revolving-door patient who cannot make an autonomous refusal. Their brain disorders prevent them from making an informed decision. In such cases, rights-based arguments appear to give way to the notion of beneficence, using the *parens patriae* powers of the state to make decisions on behalf of individuals who are unable to make informed decisions for themselves. A beneficence argument holds that in these circumstances the ethical solution is to develop a mechanism to assure that such patients get the treatment that they need. Without such imposed treatment, a patient is allowed to be a victim of his or her illness. More than two decades ago, in an essay, “The Myth of Advocacy,” Alan Stone argued persuasively that advocating on behalf of such patient’s right to refuse treatment is misguided advocacy at best.<sup>19</sup> Actions based on *parens patriae* are appropriate responses for persons who are unable to make decisions in their own best interest.

Critics who do not believe in the reality of schizophrenia are quick to point out the apparent circularity of clinician’s reasoning in support of mandatory intervention. Critics argue that saying that a patient

who denies he or she is ill does not have decisionmaking capacity is tantamount to saying that if a patient does not agree with the doctor, then the patient is incompetent. If schizophrenia were not to have a biologic basis and if there were an acceptable alternative explanation (e.g., mislabeled social deviance or an appropriate response to an insane society) then such an argument might carry weight. However, today the evidence that schizophrenia (or the group of schizophrenias) is a brain-based disorder greatly weakens the critics' arguments. The argument is further weakened by the growing evidence that the lack of awareness of schizophrenia itself has a biologic basis, similar to the anosognosia in stroke patients.<sup>18</sup>

A beneficence approach supports the appropriateness of intervention for an individual who lacks decisionmaking capacity. In creating a process for an alternate decisionmaker, the question remains as to what standard should be used to make decisions on the impaired individual's behalf. Two approaches are possible: a substituted-judgment approach and a best-interest approach. A substituted-judgment approach requires that the assigned decisionmaker consent to the decision that the incapacitated individual would have made if he or she were competent. A best-interest approach requires only consideration of what the decisionmaker deems to be in the incapacitated person's best interest. The substituted-judgment approach appears to provide the possibility of maintaining greater autonomy. In cases in which the individual's values and opinions about his or her illness and treatment options were known during a time that the person clearly was a capable decisionmaker, the use of a substituted judgment comes closest to a rights-based approach. Unfortunately for the patients who are most often candidates for mandatory outpatient treatment, their lack of decisionmaking capacity is commonly long-standing. Therefore, it is extremely difficult to know what they would have wanted if competent. In such cases a best-interest standard appears to be the preferable option.

### Utilitarianism

Utilitarianism, a consequentialist theory of ethics, has one basic principle, that of utility. It is most often defined as the greatest good for the greatest number. The effective use of a utilitarian argument in the instance of outpatient commitment requires appreciation that it is not used as a common sense, expedient approach to what some see as a social ill. Such

an approach, sometimes termed hedonistic utilitarianism, does not appropriately inform the practice of mental health professionals in general or in a case-specific context. For example, the use of outpatient commitment solely for convenience or resource management at the cost of individual freedom is not acceptable. Nevertheless, the type of direct utilitarian approach that seeks to produce agent-neutral or intrinsic good, the type of good that rational people value, can legitimately inform public health policy positions. The utilitarian requirement of an objective assessment of overall interest and reasoned, fair choice to optimize good results for all involved parties is an acceptable alternative to a totally rights-based versus beneficent position.

There is evidence that delay of treatment of persons with severe mental illness may negatively affect recovery.<sup>20,21</sup> In addition, reports of the lifetime suicide rate, among those with major mental illnesses, range from 10 to 17 percent, compared with 1 percent in the general population.<sup>22</sup> Persons with chronic mental disorders are also more likely to neglect medical treatment for co-occurring illnesses, significantly reducing the length and quality of their lives.

Recently, there has been much discussion concerning the frequency of violence in the mentally ill and there have been several high profile cases that have intensified the interest in the use of outpatient commitment in the prevention of violence. The relationship of violence to mental illness is complex, but recent studies support the argument that the two are at least somewhat positively correlated. Torrey<sup>22</sup> notes three risk factors that increase the likelihood of violence in the mentally ill: a history of violence, substance abuse, and noncompliance with medication. To the extent that outpatient commitment could decrease the likelihood of noncompliance with medication and substance abuse, it might decrease the risk of violent behavior in committed individuals with such histories. It is likely that more mentally ill persons are victims of violence rather than perpetrators. The literature chronicles frequent reports of the homeless mentally ill being robbed, beaten, and sexually assaulted. Cognitive disorganization can leave such individuals particularly unable to defend themselves. Using a utilitarian framework of balancing goods would appear to favor the beneficent/paternalistic course. Because of the seriousness of the possible harms, the utilitarian is likely to believe that avoid-

ance of those harms is preferable to preserving autonomy. When the risk of harm is slight, then it is likely the utilitarian would opt to preserve autonomy, because in most situations, self-determination promotes the greatest good. It is important to remember, in this instance, that the utilitarian is likely to favor the more intrusive beneficent option only if the results of the use of outpatient commitment indeed significantly reduce the risk of harm. That implies that outpatient commitment must demonstrate, on average, more positive outcomes to continue to be considered an appropriate utilitarian option. The APA Resource Document reports that a growing body of research demonstrates that the “Use of mandatory outpatient treatment is strongly and consistently associated with reduced rates of rehospitalization, longer stays in the community, and increased treatment compliance among patients with severe and persistent mental illness” (Ref. 1, p 23). However, a recent Rand review of the empirical literature and the experience of eight states on the effectiveness of involuntary outpatient treatment conducted for the California legislature was more circumspect. The Rand researchers acknowledged that there “is some evidence that the combination of court orders and intensive treatment” may reduce rates of hospitalization, violent behavior, and arrests but considering the complexity of an underfunded California mental health system they did not believe there were enough data to determine whether “the development of an involuntary outpatient treatment system in California is worth the additional cost to mental health treatment systems, the courts, and law enforcement” (Ref. 22, p xx).

### Communitarianism

A serious challenge to a rights-based argument against outpatient commitment can be derived from communitarian ethics. Communitarian ideals are rooted in the philosophical and political traditions of the 18th century Scottish philosopher David Hume, through the writings of Thomas Jefferson, to the present day in the works of Michael Sandel and Michael Walzer. Communitarians oppose the fundamental positions of liberalism, especially neutrality, as well as the current societal network of structures that support those ideals. Briefly, communitarians propose that ethical decisionmaking should be based on promoting communal good, traditional practices,

and cooperation. Another common thread among communitarians is the necessity of involvement in public life signified by increased participation in micro- and macrocommunities.

As noted earlier, part of the liberal objection to all types of involuntary treatment is based on the preservation of negative rights through noninterference. However, it is also based on the liberal notion of neutrality, described as the presumption that government or institutions must not presuppose any conception of the good life. The embodiment of policies, based on the liberal notion of neutrality, has ill served revolving-door patients. The affront that episodic, crisis-oriented treatment has caused the community of families, treating professionals, and society at large forces communitarians to point to this situation as another example of how unrestrained liberalism has promoted moral harms. In challenging the exercise of the negative right to refuse treatment, the communitarian would be likely to note that an infringement (not a violation) of that right would be justified to promote the communal values of humanity, safety, and health promotion. Without question, the communitarian would require the community to develop an adequate treatment plan and resources as a response to those same values.

Communitarians continue their skepticism of liberalism, particularly neutrality, by questioning the impossible liberal ideal of the unencumbered self. This term refers to the position that ethics decisions must be made with a conscious effort to assure freedom from the influence of values that often inform such decisions, notably cultural, religious, social, or even professional values. Michael Sandel, a prominent communitarian, criticizes this idea noting: “Despite its powerful appeal, the image is flawed. It cannot make sense of our experience nor account for commonly recognized obligations such as solidarity, family ties etc. . . . Such loyalties are not as some liberals contend, matters of sentiment rather than morality” (Ref. 24, p 13). Sandel also correctly notes that liberal notions of neutrality are also based on values. They are based on the values that liberals hold dear such as tolerance, freedom, and fairness. It is an equal violation of the principle of neutrality to promote liberal values in preference to communitarian values.<sup>24</sup> Descriptions abound in the literature describing the dire circumstances into which revolving-door patients sink between episodes of intensive involuntary treatment. They are often accompanied by

incredulous accounts of lawyers defending the individual's rights to remain in such situations.<sup>25</sup> Sandel criticizes the liberal position on neutrality and equality noting: "We have seen how problems in theory show up in practice. . . . Treating persons as freely choosing independent selves may fail to respect persons encumbered by convictions or life circumstances that do not permit the independence the liberal self image requires" (Ref. 24, p 116).

Communitarians, based on their convictions regarding traditional roles, are also likely to criticize mental health professionals for their reluctance to involve themselves in the care of persons requiring more legally intrusive interventions. They would be likely to view a reluctance to pursue individual treatment options that include the additional burdens of involuntary outpatient treatment as not fulfilling one's obligation as helper and healer. Based on the value of community participation, mental health professionals would be expected to pursue policies to facilitate the availability of effective treatment options that might include involuntary outpatient treatment. Finally, communitarians believe the route to true liberty does not begin with the defense of rights but in civil engagement in one's political and social community. Engagement in recovery, described later in this article, is one sphere of common interest in which persons with mental illness may choose to participate if afforded opportunities.

Having considered three ethical arguments about the appropriateness of mandatory community treatment we now turn to several specific issues when implementation of such interventions is considered.

### How Long Should Mandatory Community Treatment Be Maintained?

In a recent large scale, methodologically sound study of outpatient commitment, the investigators found that for outpatient commitment to be effective, the commitment order must be maintained for more than 180 days, a longer duration than that required simply to stabilize the person.<sup>26</sup> However, based on a traditional interpretation of the concept of least restrictive alternative, a well-established value within rights-based theories, such lengthy interventions could not be supported. Some ethicists would challenge that such an interpretation of rights-based theory is superficial and not totally accurate.

Waithe<sup>27</sup> challenges the notion quite effectively in examining the writings of John Stuart Mill, a 19th century philosopher and an exemplar of rights-based theorists. She examines his consideration of the conditions that justify paternalism within his classic work, *On Liberty*, originally published in 1859.<sup>28</sup> Waithe's use of Mill's ideas in justifying a beneficence-based approach is particularly relevant because his work is often quoted by liberal individualists seeking to limit coercive forms of treatment. For example, Mill is cited in the *Lessard* decision, one of the most prominent cases in the change of commitment criteria from need for treatment to dangerousness.<sup>29</sup>

Briefly, Waithe<sup>27</sup> presents Mill's position as follows: The potentially paternalized must be morally nonresponsible for actions in the specific circumstances in which paternalism is contemplated. Mill references the mentally ill in the category of the morally nonresponsible. The second condition of morally defensible paternalism is that such individuals are about to cause harm to their own interests, notably those involving their ability to exercise their rights fully. The third condition is that the potentially paternalized will experience an enhancement in his or her capacity to self-govern or that further deterioration is prevented. The final condition is that the potential paternalization takes place in the least restrictive manner. Waithe believes that, based on the sum of the conditions outlined by Mill, he (Mills) would champion the form of treatment that, while the least restrictive, would be most conducive to the restoration of the paternalized person to the fullest capacity for self-government. In light of the research noted earlier, Mill's conditions, considered together, seem to permit the use of more restrictive but restorative treatment (i.e., longer term outpatient commitment) even if the less restrictive treatment regimen would be sufficient to stabilize the person. Waithe also believes that Mill's third condition clearly supports legal decisions concerning the right to treatment and wider latitude in choice of treatments. If there is good evidence that repeated but insufficient treatment episodes are not as effective as a prolonged period of outpatient commitment following stabilization, Mill would be likely to deem such repeated brief interventions as unjustified paternalism. Considering this, the current practice of repeated, brief, intense treatment for stabilization of revolving-door patients

would appear less morally defensible than maintaining a more lengthy outpatient commitment.

### **What Are Appropriate Criteria for Mandatory Community Treatment?**

The use of dangerousness as the primary criterion for mandatory community treatment is problematic.<sup>30,31</sup> While dangerousness criteria are appropriate when considering the need for involuntary confinement, their appropriateness is much less clear when considering outpatient treatment. If a person is imminently dangerous, a strong argument can be made for involuntary confinement. However, such a person, unless determined also to lack decisionmaking capacity, can still refuse treatment. Confinement without treatment, for the protection of self or others, appears ethically justifiable only for short periods. For community treatment, in which treatment rather than confinement is the fundamental goal, there are three critical problems with a dangerousness approach: it contributes to stigma, it is an unsustainable argument over time, and it fails to permit mandatory treatment.

Requiring dangerousness in order for someone in need to receive mandatory outpatient treatment is at odds with efforts to reduce the stigma associated with serious mental illness. The dangerousness argument with outpatients, what might be called the “but for treatment” argument, is hard to sustain for the length of time that a person needs mandatory treatment. The following is a typical scenario:

A patient with a well established history of repeated decompensations resulting eventually in dangerous behavior and inpatient commitment has been treated, stabilized, and discharged into the community under an outpatient commitment order. The treating psychiatrist believes the patient’s continued success in the community is contingent on maintaining an outpatient commitment order. A request for continued commitment is filed with the court, and during the hearing the psychiatrist testifies that while the patient is not imminently dangerous, he would predictably become dangerous again “but for treatment.”

While this argument may be appropriate shortly after an acute episode, as time passes it becomes increasingly difficult to sustain the argument that such a person remains dangerous.

With dangerousness as a criterion for commitment, whether inpatient or outpatient, there is not generally a finding of decisionmaking incapacity and, accordingly, mandatory treatment (e.g., with medication) is not included in the court order. This

results in paradoxical and potentially deceitful court orders in which a patient is ordered for outpatient treatment that can be refused. The court and clinicians may imply, for example, that the patient must take medication, but that is not actually part of the commitment. An outpatient commitment order that is essentially a bluff, while often effective, is ethically suspect.<sup>31–33</sup> In such cases, no actual harm is done, but in light of the clinician’s role obligation to be truthful, moral harm is perpetrated by such a bluff. Such actions create a sense of moral regret for the clinician acting in good faith. Demarco<sup>34</sup> notes that moral regret in such circumstances may be interpreted as a sign of a need for reform within the circumstances, obligations, or social/professional roles creating the dissonance.

For these reasons, capacity-based criteria for mandatory outpatient treatment appears to be a better alternative than dangerousness. Capacity-based approaches seem to be less stigmatizing, are sustainable over whatever period of time the individual is determined to lack decisionmaking capacity, and directly result in a substitute decisionmaking process to obtain consent for needed treatment. A capacity-based approach also appears to address another important concern that critics of mandatory community treatment raise—what is referred to as the “problem of the slippery slope.”

### **The Problem of the Slippery Slope**

There is great concern of how widely mandatory approaches to treatment will be used for individuals with serious mental disorders and how the concept of mandatory outpatient treatment might be expanded to other populations. Regarding individuals with serious mental disorders, the question of what proportion of the population is appropriate for mandatory treatment is a serious public policy issue for which there is not yet a clear answer. A mainstream view of ethics appears to be that it is that portion of the population with a serious mental disorder who persistently lack decisionmaking capacity beyond an acute episode of illness and who, without coercion, refuse needed treatment. The size of that population is unknown but is certainly open to empirical investigation. Studies to date, most prominently the MacArthur Foundation competency studies, provide data on the lack of capacity during an acute episode. Studies extending the methodology over time in the community, to our knowledge, have yet to be done.

When in the course of a patient's illness should mandatory interventions be tried? If mandatory treatment becomes readily available, might it be tried prematurely, before a person has had an opportunity to enter recovery on a voluntary basis? This appears to be a valid concern and requires that careful clinical consideration be given to criteria for mandatory community treatment. While elsewhere we have argued that mandatory treatment is not incompatible with a recovery paradigm, such interventions may complicate the therapeutic relationship and the recovery effort early in the course of a person's illness.<sup>35</sup> Geller<sup>36</sup> promulgated clinical guidelines that suggested mandatory outpatient interventions should be considered only when a person has demonstrated repeatedly an inability to live independently in the community. According to such guidelines, a person would not be a likely candidate for a court-ordered intervention following a first or second psychotic episode. Such determinations almost certainly must be made on a case-by-case basis, using clinical criteria with some flexibility. Lack of decisionmaking capacity may be necessary but not sufficient as a criterion for an involuntary community intervention.

A major criticism of mandatory community treatment is that it may be promoted as an alternative to a community's provision of adequate voluntary community services. It is clear that before mandatory community treatment can be considered, the community has to offer adequate mental health services to meet the needs of the population of patients with serious mental disorders. Mandatory treatment can in no way serve to fix an underfunded service system in which appropriate services are not available. Before a program of mandatory community treatment is put into place in a community, that community must have an appropriately functional mental health system. An ethical society must fulfill its obligation to provide sufficient support, both financial and political, to assure that an adequate and accessible system of services is available to meet the needs of its citizens with serious mental illness. Too often this obligation remains unfulfilled. On the other hand, since an ideal mental health system remains a largely unattained goal, it could be concluded that a system will rarely be ready to offer mandatory community treatment. A decision to keep the very sickest individuals in that community stuck in the revolving door would be ethically suspect.

If our society becomes comfortable with mandating treatment of people with serious and persistent mental illness, will this lead to expansion of mandated treatment into other populations? The concern that we will slide down such a slippery slope is widespread, especially if we are not careful with the criteria used for such interventions. If dangerousness, especially over the long term, and refusal of treatment are the primary criteria for mandatory treatment, can we not argue for inclusion of alcohol and other substance abusers, for which there may be effective interventions,<sup>37</sup> and sex-offenders, for whom the effective intervention may essentially be quarantine.<sup>38</sup> Taken to the extreme, it has been facetiously suggested that it is only a matter of time before mandatory treatment is required for nicotine addiction, obesity, diabetes, or any number of chronic medical conditions. While many non-mentally ill people with chronic conditions fail to comply with recommended interventions, often for no good reason, thereby putting themselves at long term health risk, few could be considered to lack the capacity to make an informed decision about such interventions. Careful use of decisionmaking incapacity as a primary criterion for mandated intervention appears to reduce the basis for concern about sliding into overuse of mandatory interventions.

### ***The Importance of Consumer Participation: Nothing About Us Without Us***

The recovery approach to treatment of persons with serious mental illness has become increasingly influential during the past decade.<sup>39-42</sup> Indeed, states such as Wisconsin and Ohio have started to redesign their mental health systems so as to incorporate recovery values.<sup>41</sup> While there are various facets to the recovery model, one of the more salient features is that of empowerment of the consumer. Empowerment has been described as having many aspects. Some have suggested that, consonant with empowerment precepts, "Consumers should play a key role in the development, implementation, and evaluation of all services" (Ref. 40, p 10).

As the mental health field increasingly embraces the recovery paradigm, consideration should be given to affording consumers a role in the decision-making procedures of the involuntary treatment process (as well as other aspects of the mental health delivery system). Such consumer involvement would have the effect of increasing the collective experien-

tial base of those participating in the process, helping to insure that decisionmakers remain sensitive to the various possible consequences of their actions for those most affected by their mandates.

However, in that consumer views on involuntary treatment are not monolithic,<sup>42</sup> care must be taken to ensure consumer input is representative and responsible. Frese<sup>43</sup> has reviewed the evolution of consumer advocacy activities during the past few decades. He points out that consumer advocates who have been primarily interested in increased consumer rights and liberties have tended to focus their advocacy efforts on opposing the use of forced treatment. In developing this stance, they have forged relationships with consumer rights attorneys and others who place a particularly high value on these considerations.

On the other hand, consumer advocates who place high value on the need for psychiatrically disabled persons to receive effective treatment, tend to be supportive of delivering such treatment, even in those circumstances in which such persons' disability interferes with their ability to appreciate that they have the disability.

Because the libertarian consumer advocates and their attorney allies have been so successful, the no-forced-treatment stance has been perceived as that of consumers as a whole. This is an unfortunate circumstance, one that fails to reflect the view and opinions of the growing number of consumer advocates who feel strongly that such a rights-oriented perspective tends to do serious injustice to those with the most severe psychiatric disabilities.

Consumer advocates in this latter category often find themselves comfortable working with the consumer/family advocacy organization NAMI. NAMI has many thousands of consumer members. Currently, such members make up fully one-fourth of the members of the NAMI Board of Directors.

Recently, consumers with these more treatment-oriented views have become active as both board and staff members of the Treatment Advocacy Center (TAC). The TAC is a legal advocacy organization that has recently been established for the purpose of ensuring that effective treatment can be made available to those who are most seriously disabled with psychiatric conditions.

However, even consumer advocates who recognize the value of selected use of mandated treatment seldom argue that decisions concerning the employment of such an approach to treatment should be left

entirely in the hands of mental health professionals or attorneys who have not themselves personally experienced these conditions.

Increasingly, the often-repeated refrain of the more treatment-focused consumer advocates has been, "Nothing about us without us." More recently, leaders of the rights-oriented consumer advocates have also begun to recognize the value of this position,<sup>44</sup> which demands consumer representation at all levels of the decisionmaking process, including those decisions concerning the use of forced treatment.

Mechanisms for possible consumer involvement in the mandatory treatment decisionmaking process have been described.<sup>31,35</sup> Such mechanisms include the establishment of a consumer review panel and the possibility of employing persons who are in recovery from mental illness as guardians for those with similar but more severe disabilities.

Briefly described, a capacity review panel could be established that might, for example, consist of three members from the mental health community, with at least one member being a person who has personally experienced serious mental illness. The primary duty of such a panel would be to review decisions concerning mandatory treatment, perhaps before the issue of decisionmaking incapacity is presented at a formal hearing. Such inclusion of a recovered person ensures that these decisions are not made without the involvement of members of the class of persons who are, or have been, the recipients of treatments similar to those that could be mandated.

Likewise, involving a recovered consumer as the appointed guardian of an impaired person would serve a similar purpose. In this case, however, recovered persons could have even more direct and ongoing influence concerning mandated care. In such a role, a consumer guardian may help disabled persons accept treatment that they might otherwise refuse.

In any event, either of these two approaches serves a critical function by ensuring that decisions concerning mandated treatment are not left entirely in the hands of persons who have no direct personal experience as recipients of such treatments.

## Conclusions

The authors have presented three ethics arguments that support the use of mandatory community treatment in appropriate circumstances for individuals with serious mental disorders. Mandatory out-

patient treatment can never serve in place of a comprehensive, quality mental health service system and is not an effective solution for inadequately funded or structured systems. With an adequate system in place, however, we believe a program of mandatory community treatment may play an important role. In considering mandatory outpatient treatment, the authors argue that a capacity-based approach to determining the appropriateness of mandatory community treatment is preferable to a dangerousness-based approach; that clinical criteria with some flexibility should be developed so that mandatory community treatment is only used when less intrusive alternatives have failed; that mandatory community treatment should be implemented long enough to be effective; and that consumers must be involved in the ongoing development and implementation of mandatory outpatient treatment programs.

References

1. Gerbasi JB, Bonnie RJ, Binder RL: Resource document on mandatory outpatient treatment. *J Am Acad Psychiatry Law* 28:127-44, 2000
2. National Alliance for the Mentally Ill: Policy on involuntary commitment and court-ordered treatment. Arlington, VA: Author, October, 1995
3. Judge David A. Bazelon Center for Mental Health Law: Position Statement on Involuntary Commitment. Washington, DC: Author, 1999 (available at <http://www.bazelon.org/involcom.html>)
4. Frese FJ: The mental health consumer's perspective on mandatory treatment, in *Can Mandatory Treatment be Therapeutic?* New Directions for Mental Health Services. Number 75. Edited by Munetz MR. San Francisco: Jossey-Bass, 1997, pp 17-26
5. Rawls J: *A Theory of Justice*. New York: Oxford University Press, 1971
6. Beauchamp TL, Childress JF: *Principles of Biomedical Ethics*. New York: Oxford University Press, 1994
7. Dworkin R: *Taking Rights Seriously* (ed 4). Cambridge, MA: Harvard University Press, 1977
8. *Schloendorff v. Society of N.Y. Hosp.*, 105 N.E. 92 (N.Y. 1914), overruled, *Bing v. Thunig*, 143 N.E.2d 3 (N.Y. 1957)
9. Appelbaum PS, Lidz CW, Meisel A: *Informed Consent: Legal Theory and Clinical Practice*. New York: Oxford University Press, 1987
10. Grisso T, Appelbaum PS: Comparison of standards for assessing patients' capacities to make treatment decisions. *Am J Psychiatry* 152:1033-7, 1995
11. Carpenter WT, Gold JM, Lahti AC, *et al*: Decisional capacity for informed consent in schizophrenia research. *Arch Gen Psychiatry* 57:533-8, 2000
12. McEvoy JP, Apperson LJ, Appelbaum PS, *et al*: Insight in schizophrenia: its relationship to acute psychopathology. *J Nerv Ment Dis* 177:43-7, 1989
13. McEvoy JP: The relationship between insight in psychosis and compliance with medications, in *Insight and Psychosis*. Edited by Amador XF, David AS. New York: Oxford University Press, 1998, pp 289-306
14. Lysaker PH, Bell MD, Bryson G, *et al*: Neurocognitive function and insight in schizophrenia: support for an association with impairments in executive function but not with impairments in global function. *Acta Psychiatry Scand* 97:297-301, 1997
15. Flashman LA, McAllister T, Andreasen NC, *et al*: Smaller brain size associated with unawareness of illness in patients with schizophrenia. *Am J Psychiatry* 157:1167-9, 2000
16. Young DA, Zakzanis KK, Bailey C, *et al*: Further parameters of insight and neuropsychological deficit in schizophrenia and other chronic mental disease. *J Nerv Ment Dis* 186:44-50, 1998
17. Mohamed S, Fleming S, Penn DL, *et al*: Insight in schizophrenia: its relationship to measures of executive functions. *J Nerv Ment Dis* 187:525-31, 1999
18. Keefe RSE: The neurobiology of disturbances of the self: auto-noetic agnosia in schizophrenia, in *Insight and Psychosis*. Edited by Amador XF, David AS. New York: Oxford University Press, 1998, pp 142-73
19. Stone AA: The myth of advocacy. *Hosp Community Psychiatry* 30:819-22, 1979
20. Edwards J, Maude D, McGorry PD, *et al*: Prolonged recovery in first-episode psychosis. *Br J Psychiatry (suppl)* 172:107-16, 1998
21. Harrow M, Sands JR, Silverstein ML, *et al*: Course and outcome for schizophrenia versus other psychotic patients: a longitudinal study. *Schizophr Bull* 23:287-303, 1997
22. Torrey EF: *Out of the Shadows: Confronting America's Mental Illness Crisis*. New York: John Wiley & Sons, 1997
23. Ridgely MS, Borum R, Petrila J: *The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and Experience of Eight States*. Santa Monica, CA: RAND Health, RAND Institute of Civil Justice, 2001
24. Sandel MJ: *Democracy's Discontent: America in Search of a Public Philosophy*. Cambridge, MA: The Belknap Press of Harvard University Press, 1996
25. Isaac RJ, Armat VC: *Madness in the Streets: How Psychiatry and the Law Abandoned the Mentally Ill*. New York: The Free Press, 1990
26. Swartz MS, Swanson JW, Wagner HR, *et al*: Can involuntary outpatient commitment reduce hospital recidivism?—findings from a randomized trial of severely mentally ill individuals. *Am J Psychiatry* 156:1968-75, 1999
27. Waithe ME: Why Mill was for paternalism. *Int J Law Psychiatry* 6:101-11, 1983
28. Mill JS: On liberty, in *On Liberty* (original work published in 1859). Norton critical edition: annotated text sources and background criticism. Edited by Spitz D. New York: Norton Co., 1975
29. *Lessard v. Schmidt*, 349 F.Supp. 1078 (E.D. Wis. 1972)
30. Goldman HH: Book review of *Coercion and Aggressive Community Treatment: A New Frontier in Mental Health Law* (edited by Dennis DL, Monahan J). *Psychiatr Serv* 47:1270-1, 1996
31. Munetz MR, Geller JL, Frese FJ: Commentary: capacity-based involuntary outpatient treatment. *J Am Acad Psychiatry Law* 28:145-8, 2000
32. Geller JL: The quandaries of enforced community treatment and unenforceable outpatient commitment statutes. *J Psychiatry Law* 14:149-58, 1986
33. Borum R, Swartz M, Riley S, *et al*: Consumer perceptions of involuntary outpatient commitment. *Psychiatr Serv* 50:1489-91, 1999
34. Demarco J: *Moral Theory: A Contemporary View*. Boston: Jones and Bartlett, 1996
35. Munetz MR, Frese FJ: Getting ready for recovery: reconciling mandatory treatment with the recovery vision. *Psychiatr Rehabil J* 25:35-42, 2001
36. Geller JL: Clinical guidelines for the use of involuntary outpatient treatment. *Hosp Community Psychiatry* 41:749-55, 1990

37. Maynard C, Cox GB, Krupski A, *et al*: Utilization of services by persons discharged from involuntary chemical dependency treatment. *J Addict Dis* 19:83–93, 2000
38. LaFond JQ: The future of involuntary civil commitment in the U.S.A. after *Kansas v. Hendricks*. *Behav Sci Law* 18:153–67, 2000
39. Anthony W: Recovery from mental illness: the guiding vision of the mental health system in the 1990's. *Psychosoc Rehabil J* 16: 11–23, 1992
40. Beale V, Lambric T: The recovery concept: implementation in the mental health system, in A Report by the Community Support Service Advisory Committee. Columbus, OH: Ohio Department of Mental Health, August 1995, pp 1–20
41. Jacobson N, Greenley D: What is recovery?—a conceptual model and explication. *Psychiatr Serv* 52:482–5, 2001
42. Frese FJ, Stanley J, Kress K, *et al*: Integrating evidence-based practices and the recovery model. *Psychiatr Serv* 52:1462–8, 2002
43. Frese FJ: Advocacy, recovery, and the challenges of consumerism for schizophrenia. *Psychiatr Clin North Am* 21:233–49, 1998
44. Pelka F: Shrink rap. *Mainstream*. June/July, 1998, pp 22–7