

Preface

The articles in this latest volume of *Biomedical Ethics Reviews* focus on three specific issues relative to the general topic heading, *Mental Illness and Public Health Care*. The first of these issues is whether or not the involuntary commitment of mentally ill persons can be said to be morally proper, or even morally permissible, in a society such as ours. The questions arising in connection with this issue are complex. For example, is dangerousness to oneself or others a sufficient ground for committing a mentally ill person to an institution contrary to their will? Are mental health professionals competent to predict dangerousness? Committing a person to an institution for their own good is paternalistic; can this paternalism be justified in a liberal society? In the first two essays in this text, Theodore Benditt and Gerard Elfstrom attempt to answer questions such as these. Although their approaches differ radically, the reader will find that they nevertheless come to quite similar conclusions.

The second topic of discussion in our text is a very broad one: How should we go about determining proper psychiatric care within the parameters of our present health care delivery system? Three articles are devoted to this issue. In the first essay, David Malloy and Thomas Hadjistavropoulos argue that whenever the use of cognitive behavioral therapy (CBT) and pharmacological interventions are both in accord with professional codes of conduct and approximately equal in terms of their effectiveness, CBT should be the treatment of choice because it possesses an ethical advantage. In the essay that follows, Mark Meaney argues that publicly funded managed care for behavioral health services can efficiently and effectively provide benefits for patients. What is needed, he says, is for health services to take care to integrate ethics into their operations. To show how this can be done, Meaney examines an actual case in which a Philadelphia-based public sector managed behavioral health care corporation used the services of an ethics center in Atlanta to implement a system-wide corporate ethics program. In the final essay, Wade Robison expresses concern that our current system of psychiatric care exhibits a shift away from the traditional Freudian model of open-ended, one-on-one therapy to fewer

doctor–patient consultations combined with greater use of pharmacological treatments. Robison acknowledges that this transformation in psychiatric care may have some benefits, but he is extremely troubled by the fact that the principal driving forces behind the change in treatment are economic rather than deliberations concerning what forms of treatment will most benefit patients.

The last issue in our text concerns what should be done when a mental health professional is convinced that one of his or her patients poses a threat to someone else in society. Here the primary concern is whether psychotherapists should break patient confidentiality and warn those whom they believe are in jeopardy at their patients' hands. In 1976, in the case of *Tarasoff v. Regents of the University of California*, the California Supreme Court determined that psychotherapists have a duty of reasonable care to protect those whom they believe could be harmed by a patient. This decision has, in one form or another, been incorporated into most states' laws. In "Tarasoff, Megan, and Mill: *Preventing Harm to Others*," Pam Sailors argues that these laws contain some deficiencies and that the cure for these deficiencies is to modify Tarasoff laws so that they all more closely resemble "Megan's Law"—a law that requires various law enforcement agencies to release relevant information in an attempt to protect the public from sexual offenders.

Mental Illness and Public Health Care is the nineteenth annual volume of *Biomedical Ethics Reviews*, a series of texts designed to review and update the literature on issues of central importance in bioethics today. For the convenience of our readers, each article in every volume of our series is prefaced by a short abstract describing that article's content. Each volume in the series is organized around a central theme; the theme for the next issue of *Biomedical Ethics Reviews* will be *Care of the Aged*. We hope our readers will find the present volume of *Biomedical Ethics Reviews* to be both enjoyable and informative, and that they will look forward with anticipation to future volumes on topics of special concern.

James M. Humber
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Involuntary Outpatient Commitment

Gerard Elfstrom

Shortly after 5:00 PM on January 3, 1999, Kendra Webdale was waiting at the northbound subway stop at 23rd Street and Broadway in New York City. She was approached by a disheveled young man who apparently asked her the time. She turned away from him as the N train pulled into the station. At that instant, the stranger shoved her off the platform and onto the tracks. She was killed instantly.¹ Webdale was the sort of person who elicits intense popular sympathy. Blond haired, blue-eyed, youthful, good-natured, and outgoing, she had a diverse array of devoted friends. Her assailant, Andrew Goldstein, was a pudgy, unkempt loner who had few acquaintances and was unable to hold a job. Worse, he was mentally ill, having suffering from schizophrenia since he was 16 years old. He was first admitted to inpatient treatment at Creedmoor Psychiatric Center in 1989 and was bounced in and out of a variety of institutions and treatment programs until mid-December 1998. By the time he pushed Webdale off the subway platform, his medical files were 3500 pages long.² He also had a well-established history of violent assaults. Most involved only kicking, punching, and shoving, but several of his

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attacks sent their victims to the hospital.³ Goldstein gave much the same explanation after each incident of violence, namely that he was inhabited by a superior force that, against his will, forced the acts.⁴ After the assault on Webdale, he used similar language in his confession. He said, "I felt a sensation, like something was entering me. . . . I got the urge to push, shove or sidekick. As the train was coming, the feeling disappeared and came back. . . . I pushed the woman who had blonde hair."⁵

Webdale's death sparked an enormous public outcry in New York City and across the nation. The public was stunned because Webdale was an attractive person, the incident seemed absolutely senseless, and it stoked anxiety about the presence of the mentally ill in local communities. The stir intensified when the public became aware of Goldstein's long history of mental illness and violent assaults. Outrage of this magnitude energizes politicians and prompts them to loosen the public purse strings. So, New York's Governor Pataki and the State Legislature busied themselves with several measures. One pledged an additional \$125 million to expand the system of community-based services for the mentally ill, construct housing for them, and reverse New York State's policy of gradually shutting down its inpatient hospitals. Mental health care advocates and professionals applauded these measures, but they were far less enthusiastic about a second piece of legislation, known as Kendra's Law. Kendra's Law established machinery to identify mentally ill persons in danger of becoming violent, devise a plan of treatment for them, and authorize use of law enforcement personnel to ensure that they hew to the prescribed regimen whether or not they consent to it.⁶ For several reasons, the law does not require that they be placed in an institution. Rather, it allows them to remain in their communities. First, the individuals selected for supervision under this program pose no immediate threat of violence. Second, mental health professionals believe that many benefit from living as near a normal life as is possible. Finally, the mentally ill commonly prefer living independently. The process established by Kendra's

Law is referred to as “involuntary outpatient commitment.” New York is not alone in finding this idea attractive. Some 37 states also have involuntary outpatient commitment laws, although their details commonly differ from New York’s legislation.⁷

Kendra’s Law ignited broad and spirited controversy that focused on several issues posed by involuntary outpatient commitment. First, partisans offer several arguments to support the claim that involuntary outpatient commitment is futile, that is, it is ineffectual. Second, many advocates assert that the effort is misguided because the mentally ill are no more dangerous than the population at large. Third, many claim that it is inept because mental health professionals have consistently proven they are unable to predict which of their patients are likely to become violent. Last, critics assert that involuntary outpatient commitment is morally unjustified because it overrides a fundamental moral and legal right, that of consent to treatment, and it allows the state’s instruments of coercion to be deployed against persons who pose no threat of immediate harm. The first three issues concern matters of fact. Only the last introduces questions of morality and public policy. However, the first three issues address matters that are vitally important to examining questions of policy and moral justification. Hence, each will be examined in turn.

Matters of Fact

Futile

Those convinced that outpatient commitment legislation is futile cite three arguments to support their claim. First, they point out that outpatient commitment machinery would have been completely unnecessary in Goldstein’s case. He had not refused treatment. Instead, he sought it. In the two years prior to his assault on Webdale, he received inpatient treatment on 13 occasions. He voluntarily entered treatment on all 13 admissions.⁸ Critics of outpatient commitment appear to infer from this that all of the mentally ill who are potentially violent would voluntarily accept

treatment if it were available to them. However, although it seems perfectly reasonable to assume that many of them would, it seems unlikely that *all* would do so. In fact, several mental health researchers assert that the most dangerous patients with the most pronounced history of violence are also those most likely to resist treatment.⁹

Second, some commentators assert that Kendra's Law legislation is futile because coerced treatment will prove ineffectual. They state that successful treatment requires the active and voluntary participation of the patient and a relationship of trust and mutual respect between the patient and mental health professionals. However, if patients are coerced into treatment programs, they will not trust their counselors and will not actively participate in treatment plans.¹⁰ These are important and plausible claims. However, although mental health researchers, patient advocates, and policy experts are engaged in a furious debate on the question of whether patients assigned to involuntary outpatient commitment fare better than those who voluntarily enroll in outpatient treatment programs, no empirical data support the conclusion that those assigned to involuntary outpatient commitment programs fare worse than those who enroll voluntarily.¹¹ One administrator has also reported that those selected for outpatient commitment reported feeling no more coerced than members of control groups who voluntarily participated. The key factors determining whether patients felt coerced were those of whether they believed mental health professionals dealt with them honestly and fairly.¹² Hence, the empirical data do not support the claim that outpatient commitment will necessarily be ineffectual.

Finally, at least one knowledgeable and shrewd observer believes that outpatient commitment legislation will prove ineffectual simply because governments are unlikely to provide sufficient funding to establish these programs and are unlikely to sustain funding for them once moments of crisis slip from public attention.¹³ This is an important and astute observation. However, it is not plausible to presume that such programs will never receive adequate funding. Further, even if they do not, the scraps

and rags of programs in place, such as those in New York State, will continue to function. To the extent that they do, individuals will be pressed into outpatient commitment and the issues generated by Kendra's Law will remain in contention.

Misguided

For many years, patient advocacy groups and mental health professionals have asserted that the mentally ill are no more violent than the population as a whole. If this is the case, legislation such as Kendra's Law is both unnecessary and pernicious. If the mentally ill are no more violent than anyone else, it is unnecessary, because there is no reason for singling them out for special attention on grounds of their violent nature. It is also pernicious because it reinforces the stigma of violence that the mentally ill carry. Mental health advocates assert that those who are mentally ill carry a large stigma simply by virtue of their disease. If they must shoulder the additional stigma of being labeled violent, their lives will become more difficult and the obstacles in the way of their recovery will increase.

In recent years, however, evidence has accumulated that supports the conclusion that the mentally ill as a group are indeed more prone to violence than the general population. One commentator notes, "In the last decade, however, the evidence showing a link between violence, crime, and mental illness has mounted. It cannot be dismissed; it should not be ignored," and the *Harvard Mental Health Letter* reports,

"People with any history of psychiatric treatment are two to three times more violent than average. . . . In a study of 18,000 people conducted by the National Institute of Mental Health, more than half of those who reported committing acts of violence in the previous year, compared with 20% of the general population, met the criteria for a psychiatric disorder in the American Psychiatric Association's current diagnostic manual."¹⁴

The evidence emerges from several major studies. Studies of birth cohort groups (i.e., groups of people born in the same year) in three Scandinavian countries yielded strong correlations between mental illness and violence. In a Swedish study, males with a history of mental illness were 2.5 times more likely than other males in their cohort group to be convicted of crimes and 4 times more likely to be convicted of violent acts. A Danish study revealed that men with a history of mental illness were 2.4–4.5 times more likely to commit violent crimes than men without a history of mental illness, and those with a history of mental illness along with a history of alcohol abuse were 4.2–6.7 times more likely to commit violent crimes than other males. A Finnish study yielded similar results. Schizophrenics were found to be 3.6 times more likely to commit violent crimes than healthy males, whereas those who exhibited other psychoses were 7.7 times more likely to commit violent crimes than others. Mentally ill people who also engaged in alcohol abuse were 25.2 times more likely to commit violent crimes than healthy males. An elaborate and lavishly funded US study also revealed that recently discharged mental patients were significantly more apt to be violent than the healthy populations in the neighborhoods where they lived.¹⁵ Data also show that mental health care workers in the United Kingdom are 3 times more likely to suffer violent assault while on the job than industrial workers and that 1 in 10 hospitalized mental patients commit violent acts.¹⁶

Nonetheless, the picture revealed by the above studies is complex and nuanced. The mentally ill whose symptoms are not active are no more apt to be violent than the population as a whole. However, those who fail to take their medications and whose symptoms become active as a result are more likely to be violent than healthy persons. Worse, mentally ill people whose symptoms are active and who fall prey to substance abuse are significantly more prone to violence than those whose symptoms are active but who do not engage in substance abuse. Further, the mentally ill are more likely than the public at large to fall prey to

alcohol or drug abuse and are more likely to become violent when they do so.¹⁷ Also, the mentally ill often dislike their medications, and, hence, they do not take them. Andrew Goldstein is a good example. Although he had no record of drug or alcohol abuse, he was notoriously lax in maintaining his schedule of medications. He, as do many other patients, reported that the medications made him listless, caused soreness, prevented him from sleeping, and made his mouth dry. So, left to his own devices, he did not take them. When he lapsed, the symptoms of his disease reappeared and the episodes of violent behavior also recurred.¹⁸

As a result of these findings and likely also as a result of the popular belief that something must be done to address violence on the part of the mentally ill, several mental health professionals have determined that it is best to acknowledge the problem and seek to address it honestly and effectively.¹⁹ Paradoxically perhaps, some prominent researchers believe several patient advocates now also embrace the idea, apparently on grounds that they believe the general public is more apt to support increased funding for mental health services if it is persuaded that doing so will reduce violence by the mentally ill.²⁰

Inept

Historically, mental health professionals have vigorously asserted that they have little competence to determine which individuals are likely to cause harm and which not. Since 1984, the American Psychiatric Association has stated as policy that the profession of psychiatry has no expertise that enables it to identify which patients are prone to violence.²¹ Further, it has often been claimed that mental health professional's estimates of the danger of violence posed by mentally ill individuals are no more accurate than random guesses.²² A variety of recent studies yield data that undermine this assertion. The studies do point out that it is difficult to gain solid information about success in predicting when particular patients are likely to become violent.²³ Partly, this is because professionals who have reason to believe a patient

will become violent will likely take measures to prevent an outbreak. Furthermore, some studies have shown that judgments about violence are guided not simply by estimates of probability but also by underlying principles of judgment that will vary from practitioner to practitioner. Some, for example, believe that it is best to err on the side of caution in seeking to prevent violent acts by the mentally ill, whereas others are convinced that it is enormously important to allow patients maximal freedom.²⁴ Despite the difficulties, a number of elaborate research programs have undertaken to identify the factors most closely associated with violent behavior by the mentally ill and to radically increase the accuracy of attempts to predict violent behavior. One study was able to sort some patients into a group that was half as likely to be violent as the group of patients as a whole, and it was able to sort other patients into a group that was twice as likely to be violent as the entire population of patients. They reveal that patients who have a history of engaging in violent acts and have fantasies about violence have a high risk of engaging in violent behavior, whereas those lacking these characteristics are at low risk of engaging in violent behavior.²⁵ Several studies have claimed considerable success in this endeavor, and researchers are working to refine decision protocols in ways that will allow mental health practitioners to quickly and easily determine which of their patients are prone to violent behavior. Further, as reported earlier, patients outside institutions who fail to take their medications and who engage in substance abuse are quite likely to become violent. Of course, none of the studies is able to predict which particular patients will become violent. They can only sort patients into groups of those prone to violence and those unlikely to become violent.

Also, the social and legal contexts in which mental health professionals operate has changed over the years. The landmark Tarasoff Case in California of 1976 gave firm legal foundation to the principle that mental health professionals are legally accountable to third parties likely to be harmed by their patients.²⁶ The

principle of patient confidentiality is overridden in such cases. Subsequent legal decisions and the public's outrage over spectacular acts of violence by the mentally ill have strengthened and broadened the responsibility of mental health professionals to be alert to indications that their patients may harm others and take measures to protect those who are at risk of becoming victims.²⁷ Given continued public interest in this issue, the array of funding available for research on the topic, and their own self-interest, it is likely that mental health professionals will continue to improve and refine their instruments for predicting violent behavior by their patients.

Rights

The above survey of questions of matters of fact reveals that involuntary outpatient commitment is not futile, the mentally ill genuinely are more dangerous than the population as a whole when they fail to take their medications and when they engage in substance abuse, and mental health professionals have far greater resources for identifying those groups of the mentally ill who are likely to become violent than has been previously recognized. Hence, involuntary outpatient commitment legislation cannot be ruled unworkable simply by appeal to matters of fact. Nonetheless, the moral and legal issues remain, and they remain formidable. Involuntary outpatient commitment legislation establishes machinery that allows government officials to override the right of consent to treatment of a group of people who have not been deemed incompetent to consent to treatment and who do not pose an immediate threat of harm to others. Further, the legislation makes provision for employing the state's instruments of coercion to enforce these decisions. The justification offered for violating the rights of the mentally ill in this manner is that public safety will be enhanced, because it is hoped that fewer people will be killed or injured by the mentally ill as a result of these measures.

Public Safety vs the Right of Consent

Balancing fundamental human rights against concern for public safety is a difficult matter. Few are prepared to assert that concern for human rights should completely set aside concerns for public safety. “The Constitution is not a suicide pact,” is a commonplace of legal analysis.²⁸ Even ardent advocates of the rights of the mentally ill agree that the mentally ill who are deemed to pose an immediate danger to others may have their right of consent to treatment overridden.²⁹ Further, the concern for public safety is grounded on recognition of fundamental human rights—perhaps the most fundamental of all—those of the right to life and security. Nonetheless, few in the United States are prepared to sacrifice all other human rights on the altar of public safety. There are many ways to enhance public safety at the cost of overriding human rights, such as trimming rights to due process, privacy, freedom of speech, and freedom of association. Few are likely to agree that public safety concerns are sufficient to outweigh any significant portion of these rights. Furthermore, it is beyond controversy that the right of consent to treatment is one of the fundamental legal and moral rights of citizens of the United States. So, concern for public safety is balanced against other human rights. The difficulty is to strike the balance between the two groups in reasonable and morally justifiable fashion. Several considerations may assist deliberation about whether Kendra’s Law and other legislation like it strike a defensible balance between the right to consent to treatment and the requirements of public safety.

The first place to look for a clue is the circumstance where all agree that the right of consent to treatment may be overridden on grounds of public safety; this is when the mentally ill pose an immediate threat of harm to others. If mental health professionals have the resources to determine which individuals are likely to do harm to others, there seems little reason to defer action until a crisis is at hand. No prudent professional group or office of policy-makers waits until crisis erupts to take preventative mea-

asures. They seek ways to anticipate threats to public safety, and they devise plans to forestall disaster. Those who insist that the right to consent to treatment can never be overridden for those who are not an immediate threat to others put public officials in a difficult position. They may be able to identify individuals who are highly likely to become an immediate danger to others if they do not take their medications and may be well aware that these individuals have a record of failure to take their medications, but they cannot take measures to assure that these individuals take their medications. Hence, strictly hewing to the policy of honoring the right to consent to treatment for those not an immediate threat to others forces officials to wait until the crisis erupts and lives are endangered before they take coercive action.

So, if the mentally ill identified as potentially dangerous are relevantly like those who are an immediate danger to others, there is little justification for honoring the right to consent to treatment for the former group but not the latter. However, there are three vitally important differences between the two groups. First, those who pose an immediate threat to others have created an emergency situation, and it is a commonplace that many important rights and restrictions can be set aside in emergencies, as the US Supreme Court's "clear and present danger" test illustrates. Vitally important constitutional rights, such as those of freedom of speech, can be set aside in emergencies, but not otherwise. Those who only pose the danger of becoming violent have not created the emergency conditions that would justify setting aside fundamental rights. More importantly, protecting the right to consent to treatment does not imply that public officials are barred from taking any measures at all to prevent violence. Certainly formulating plans to identify those most at risk of becoming violent and working to get them enrolled in programs of effective treatment are both prudent and justified. However, overriding important individual rights in a nonemergency situation is unjustified. Second, when individuals pose an immediate threat of harm, officials have no difficulty knowing with precision that

these individuals are dangerous. Mental health professionals are working to improve their techniques for identifying individuals at risk of becoming violent, and they have achieved considerable success in doing so. The difficulty is that even the best of these measures can identify only those most likely to become dangerous. No matter how refined and sophisticated the techniques become, they will never be able to identify individuals who certainly will become dangerous. Furthermore, there is no legally or morally justifiable means of establishing the accuracy of these techniques, as responsible authorities will take measures to prevent the condition of those identified as potentially violent from deteriorating to the point where they pose an immediate threat of danger to others. United States law does not allow individuals to be punished by law or forfeit fundamental rights simply because they are at risk of violating the law or causing harm to others. There is no justification for setting aside this principle for a group of people who differ from the general population only by being mentally ill. Finally, when individuals pose an immediate risk of harm, their likely victims can also be identified with precision and measures can be taken to protect them. When the risk of violence is only potential, this effort is vastly more complicated. Therefore, those mentally ill who pose an immediate threat of harm are not relevantly like those who are only identified as being potentially violent, and there is no justification for overriding the right of consent for both groups. Because the mentally ill who pose an immediate threat of harm to others are relevantly different from those who do not, public officials and public policy are not justified in treating the two groups alike.

One issue that has thus far been overlooked is that of the degree of threat to public safety the mentally ill pose. The violence that most completely captures the public's attention is homicide, as the Goldstein case illustrates. Patient advocates for the mentally ill have been quick to cite data. An average of 19,431 homicides were committed in the United States in the 10 years from 1989 to 1998. Of that number, it is estimated by one author-

ity that less than 1000 are committed by people who are mentally ill, a small fraction of the total.³⁰ Hence, even if the entire group of homicides committed by the mentally ill were eliminated, the number of homicides committed in the United States each year would decrease very little. The United States, in other words, would not be made significantly safer even if all the Andrew Goldsteins and potential Andrew Goldsteins were removed from the population or treated successfully. The difficulty is that violence by the mentally ill is like airplane crashes. Both capture the public's attention and stir its anxieties, even though airplane crashes account for a miniscule portion of the accidental deaths in the United States each year, and homicides by the mentally ill account for a small fraction of the homicides in the United States each year.³¹ They are alike because a public response of this magnitude makes these cases important. Because they disturb the public, government officials must take measures to address these deaths. The question is whether the public outrage has sufficient moral weight that public officials are justified in endorsing the violation of individual rights that occurs when an individual's right of consent is overridden and individuals are subjected to coercion by state agencies. The obvious answer to this question would appear to be "No." Public outrage creates practical problems for public officials, but the mere fact of outrage has no moral weight. In fact, among the most basic principles of government in the United States is that those persons whose moral and legal rights are vulnerable need to be protected against popular dislike and suspicion.

If the degree of public outrage is not a reliable instrument for establishing a morally justifiable balance between public safety and human rights, the answer must be sought elsewhere. Considerations of equity may serve the purpose. Any morally justified balance between public safety and human rights must be equitable. An equitable balance would not unjustly harm one group of people, and it would not impose greater burdens on one group of people than all the members of society would be willing

to shoulder. This approach derives from a fundamental principle of moral philosophy, namely that all person's interests have equal weight and no one's interests should be cast aside in favor of the interests of the majority. So, to address the question of how to balance the concern for public safety against the concern to protect the right to consent to treatment, the search for an equitable policy must discover what rights the public at large has been willing to yield or to what degree it has proven willing to sacrifice them in order to protect public safety. Firearms and automobile travel serve as useful test cases. Automobile accidents claim far more lives and cause vastly more injury than do mentally ill persons. Every person in the United States is at far greater risk of being killed or injured by an automobile than harmed by someone who is mentally ill. According to the US Centers for Communicable Disease, 43,501 Americans died in automobile accidents in 1998, and 4,277,000 people in 1997 received injuries in automobile accidents that were sufficiently serious to require visits to hospital emergency rooms.³² Hence, the threat to public safety and the welfare of each individual is far greater than the threat posed by the mentally ill. However, Americans resist paying significant amounts of money to make automobiles and highways safer. They have proven willing to accept legislation requiring them to wear seat belts and pay modest sums of money to make automobiles safer. However, they have certainly not been willing to accept the sacrifice of any right that comes near the importance of the right to consent to treatment. The case of firearms is also illuminating. Firearms are responsible for vastly more death and injury each year than are the mentally ill. The Centers for Communicable Disease states that 30,708 US citizens died as a result of injuries from firearms in 1988.³³ Each individual American faces a far greater risk of being harmed by a firearm than someone who is mentally ill. Further, few Americans can claim they need firearms to meet their life's needs. Yet, American citizens have proven unwilling to accept more than modest restrictions on the purchase and possession of firearms.

Hence, in the cases of automobiles and firearms, Americans have proven unwilling either to accept any significant restriction on their rights or pay any great cost either in money or inconvenience to gain increased safety for themselves. This is despite the fact that firearms and automobiles cause far more harm to them than do the mentally ill. Hence, because they have proven unwilling to accept far more modest restrictions on their lives to enhance public safety in the cases of automobiles and firearms, Americans would be unjustified to ask the mentally ill to sacrifice their right of consent to treatment for the sake of increased public safety. Overriding the right of the mentally ill to consent to treatment in order to enhance public safety is therefore unjustified on grounds that it violates equity.

The above does not imply that American citizens and mental health professionals either can or should be sanguine about the dangers to public safety posed by the mentally ill. Although 1000 deaths each year is a small fraction of the tally of fatalities, it is a significant number of lives. Further, it is roughly the same as the average number of number of lives lost in airplane crashes each year.³⁴ Yet, following an airplane crash, governmental authorities undertake an exhaustive investigation of the incident. Often these investigations cost millions of dollars. Once the investigation is complete, officials commonly make recommendations designed to prevent similar accidents in the future. These recommendations commonly stipulate changes in equipment on airplanes or air traffic control units, modified flight procedures, or alterations in pilot training. Such measures are often costly and impose considerable burdens on pilots, the airline industry, or the Federal Aviation Agency. In the case of the mentally ill as in the case of airplanes, Americans can enhance public safety without violating anyone's rights simply by spending money. Thus far, once the public outcry over a particular incident has died down, they have proven unwilling to do so.

However, if public safety is genuinely as important to the population at large as is claimed, it should be willing to increase

the funding. The reason is simple and straightforward. A variety of informed commentators on the Andrew Goldstein case agree that a program of assertive outreach would have sufficed to motivate him to continue his medications and help move him into a productive life—and thus would have prevented his attack on Kendra Webdale. Under programs of assertive outreach, patients live in the community but are assigned a case worker who checks in on them at least once a day, is available to the patient 24 hours a day, and is sufficiently well acquainted with the patient to be able to detect subtle changes in behavior or circumstances of living that indicate that the patient's condition has changed or that the patient has failed to maintain his or her schedule of medication. These case managers typically have no more than 10–12 patients to oversee, so they are able to monitor their patients carefully and gauge their progress. Although the cost is significant, it is less than the cost of inpatient treatment in an institution or of imprisonment—which is where many mentally ill end up. Further, experts in such matters assert that these programs can be sufficiently well designed that they will be attractive to patients. In other words, patients will want them.³⁵

It is reasonable to believe that many of the mentally ill at risk of violent behavior would consent to participate in such programs if such were made available to them. Certainly, there is ample reason to believe Andrew Goldstein would have been a willing participant. Hence, there is good reason to believe that a large portion of the harm caused by the mentally ill could be avoided without violating their right of consent to treatment and there are substantial arguments to support the claim that the public is obligated to do so.

The Recalcitrant

An important difficulty remains. As mentioned earlier, it is unreasonable to expect that all of the mentally ill who are potentially violent will consent to treatment, even when serious attempts are made to make the programs of treatment attractive

to them. Worse, those who are most prone to violence are also least likely to accept treatment. Thus, it is likely that some fraction of the group of mentally ill who are competent to make choices about their lives but at risk of becoming violent will refuse treatment and eventually cause harm to innocent people. Note that this group will be comprised of people who are competent and are not presently dangerous, but have qualities which make them prone to violence. However, a number of identifiable groups of non-mentally-ill people also share these characteristics, including young males, the poor, and those who have suffered abuse as children. These latter groups nonetheless enjoy the same rights as the population at large, and the institutions of law and government do not allow their rights to be overridden. Hence, because there are no relevant differences between the groups, there is no justification for treating them differently—at least with regard to overriding their rights. Further, because those who refuse an offer of treatment will be only a subset of those mentally ill who are prone to violence, the threat they pose to public safety will be small. So, once again, because the public at large is unwilling to accept significant restrictions on its rights in return for enhanced public safety, it is unjust to demand that this group suffer impingement on its rights. Overriding their right to consent to treatment is therefore unjustified even for this group.

This does not imply that public officials have no reasonable response to make to this group. There is useful precedent in law governing behavior while intoxicated. Under British–American common law, voluntary intoxication does not absolve individuals from guilt for actions committed under the influence. Although some jurisdictions do not allow any appeal to voluntary intoxication as a defense, most allow defendants to present evidence concerning voluntary intoxication to mitigate guilt. A defendant may appeal to voluntary intoxication to address issues of intent, although an appeal of this sort would not suffice to absolve the defendant of guilt altogether.³⁶ Similarly, the law could stipulate that those mentally ill who are deemed prone to

violence but refuse an offer of therapy would be held legally accountable for any acts they performed as a result of their disease. For them, the insanity defense would not be available, although they might introduce evidence of their disease to address issues of intent. It is reasonable to believe that this possibility would suffice to change the mind of some of the competent but reluctant mentally ill who are deemed prone to violence and prompt them to seek therapy after all. The remainder will need to understand that they are to be held responsible for their choice and its consequences. Public officials are not justified in imposing any further restrictions on them, no more than they would for the population of those who are not mentally ill but are prone to violence.

The Claims of Public Safety

The above does not imply the claims of public safety, and potential victims make no claims on the mentally ill or the mental health practitioners who treat them. Programs that are both morally justified and meet the requirements of public safety have several characteristics: They are designed to vigorously search out those patients who are prone to violent acts, make competent programs of treatment available to them, and provide means to direct them into these programs. Mental health professionals are obliged to sensitize themselves to the potential for violence in their patients, continue to work to improve their ability to read portents of violent behavior, and devise more effective programs of treatment for them. Governmental authorities, for their part, are obliged to insist that competent programs of treatment be established for such patients and, more to the point, provide the funding necessary for these programs to function effectively. Further, they are obliged to alter public laws regarding the criminal insanity defense to strike it as an option for those mentally ill who are offered the option of treatment but refuse. The violence-prone mentally ill who refuse treatment are properly in the same category as the voluntarily intoxicated, that is, they have freely cho-

sen their circumstances and shall be legally liable for their acts. If they are competent to give or withhold consent to treatment, they should also be competent to grasp the implications of this additional commitment. Further, this revision of law would introduce in the legal context an element that mental health advocates insist be present in the treatment of the mentally ill, that is, a vitally important element of responsibility for their own fates and for the consequences of their actions.

Objections

These proposals are likely to be met by several objections, all of which deserve comment. The first is a response that mental health advocates have made to schemes for involuntary outpatient commitment. It is that they are unnecessary because the law and mental health care already contain provisions for emergency commitment, conditional release from commitment, and directed living in the community.³⁷ These options are all important and useful. However, they fail to address the claims of public safety. If maximal public safety is to be sought that is compatible with carefully respecting the rights of the mentally ill, a concerted and organized effort must be made to identify and seek to provide appropriate treatment to those at risk of becoming violent. Further, such programs provide an important benefit for the mentally ill and for mental health professionals. Both groups have expressed concern that the mentally ill be stigmatized as being violent and therefore suffer a considerable burden in addition to their disease.³⁸ In the eyes of the public at large, the failures of the mental health care system rather than its successes bring stigma to the mentally ill. Simply continuing to insist that most of mentally ill are not violent and that the violence caused by the mentally ill is a small fraction of the total violence in the United States will not erase the stigma or calm the anxieties of the public. Hence, it behooves all parties to take active measures to seek to reduce the failures of the system to a minimum. Only in this way is the stigma attached to the mentally ill likely to be eased and the

credibility of and public confidence in mental health professionals likely to be enhanced.

Another objection waits. It is that inevitably some number of the competent but violence-prone mentally ill will harm others and be brought to trial for their acts. If they are not able to employ the criminal insanity defense, they may be found guilty of their acts and sent to prison. The very important difficulty is that they will be placed in institutions not equipped to offer them appropriate treatment. It is inappropriate to treat them as, and house them with, ordinary prisoners. It is bad for the mentally ill because they will not receive the treatment they need and bad for ordinary prisoners because they will be housed with those who are unstable and possibly violent. However, the matter is complicated by the fact that, as a number of studies have demonstrated, a considerable number of ordinary prisoners show distinct symptoms of mental illness or have been treated for mental illness in the past. Hence, there is a considerable number of prisoners who are in need of treatment.³⁹ The proper solution is simple and obvious: Adequate mental health treatment facilities should be established in prisons, just as prisons have facilities to treat physical maladies. In some cases, it is likely that separate units designed to address the needs of mentally ill prisoners will be most suitable. If so, the proper response is to construct them.

The final objection is perhaps the most troubling and the least tractable. It is that the United States has proven unwilling to provide adequate funding and support for mental health treatment in the past and is unlikely to do so at any time in the future.⁴⁰ Because this is so, extra funds are unlikely to become available to address the needs of, and the threats posed by, the mentally ill who are potentially dangerous. Programs established to address these problems would therefore only stretch a threadbare system yet further, deplete its inadequate fund of resources, and, worse, remove resources from equally deserving but nonviolent patients. This is an important and troubling difficulty and it should not be overlooked or belittled. However, concerns of public safety and

the welfare of potential victims do matter. One thousand homicides, although small in relation to the total, is a considerable number. Further, the number of victims of nonlethal but harmful violence is likely to be several times larger than the number of homicides. Mental health professionals, as do all citizens, share the obligation to enhance public safety. In fact, their obligation is weightier than that of ordinary citizens because they are able to undertake policies to reduce the potential for violent behavior by their patients. In addition, successful programs aimed at reducing the violence of mental health patients would both increase the public's confidence in mental health professionals and the institutions they operate and reduce the stigma of violence that attaches to all the mentally ill and not simply those who are potentially violent.

Conclusion

It is true that the mentally ill whose symptoms are active are more violent than the population as a whole, and their propensity to violence is significantly enhanced if they also engage in substance abuse. It is also the case that mental health professionals have the means to identify which groups of mentally ill people are most apt to become violent. Finally, outpatient commitment programs are not necessarily ineffectual. However, these matters of fact do not suffice to justify overriding the right to consent to treatment enjoyed by mentally ill in order to enhance public safety. Overriding is unjustified because it is inequitable. The examples of automobile travel and possession of firearms demonstrate that the American population is unwilling to accept restrictions on its own activity equivalent to those it would impose on the mentally ill in order to bring about a greater gain for public safety.

The above does not imply that the public has no options available for responding to the threat posed by the potentially

violent mentally ill or that the public has no responsibility in this matter. It certainly can and ought to support assertive management programs that will allow the competent mentally ill to reside in the community but under effectual supervision. Further, the public and mental health professionals are obliged to devise machinery to seek to identify those groups of mentally ill who are prone to violence and make opportunities for treatment available to them. Those mentally ill who are competent to give consent to treatment but do not should be placed in the same legal category as the voluntarily intoxicated; that is, they should be held responsible for their condition and legally accountable for acts performed while under its influence.

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