

## What Would Mary Douglas Do? A Commentary on Kahan et al., “Cultural Cognition and Public Policy: The Case of Outpatient Commitment Laws”

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**Abstract** Involuntary outpatient commitment is a highly controversial issue in mental health law. Strong supporters of outpatient commitment see it as a form of access to community-based mental health care and a less restrictive alternative to hospitalization for people with severe mental illness; vocal opponents see it as an instrument of social control and an unwarranted deprivation of individual liberty. Kahan and colleagues apply the theory of “cultural cognition” in an empirical study of how cultural worldviews influence support for outpatient commitment laws among the general public and shape perceptions of evidence for these laws’ effectiveness. This article critiques Kahan et al. and offers an alternative perspective on the controversy, emphasizing particular social facts underlying stakeholders’ positions on outpatient commitment laws.

**Keywords** Outpatient commitment · Involuntary treatment · Public policy · Cultural cognition

Dan Kahan and his colleagues have written a thoughtful and provocative article that sheds new light on the persistent controversy over outpatient commitment laws (OCLs) and the contested evidence for their effectiveness. These authors implicate opposing “cultural worldviews” in a grand theoretical explanation, coupled with a sophisticated empirical analysis, of why some people support policies of outpatient commitment while others oppose them.

Despite their intriguing and informative study, I think Kahan et al. overstate the case for cultural cognition in their

accounting of the OCLs imbroglio. In their emphasis on overarching cultural worldviews and value schemes as the prime determinants of people’s positions on OCLs, they give short shrift to the particular, and complex, social facts and structures in which these attitudes are rooted. That they attribute their inspiration chiefly to the late anthropologist Mary Douglas and her famous theory of “grid and group” is not without some irony, because for Douglas, these dimensions were essentially about the individual’s position in social structure. These were the cross-cutting scaffolds of social life in which individual identities and cultural values took shape; they were descriptors of rigidity in the boundaries of membership and of complexity in social classification and regulation, as observed in painstaking comparative ethnographies. Grid and group were not, in themselves, intended to mean “preferences [or attitudes or ideas] about how society should be organized,” as Kahan and colleagues would have it.

Douglas, in her classic 1970 book *Natural Symbols*,<sup>1</sup> was interested primarily in the connections between structural features of social life, the symbolic representations of those structural features in elements of culture (especially, at the interface with the natural world), and the links between cultural elements and cosmologies—overarching beliefs and ways of thinking about the world—that characterize particular societies. For example, Douglas showed how social rules and boundaries may be symbolized in a group’s ideas about the human body, which are then reflected in their religious beliefs and rituals, which serve finally to reinforce social structure.

In a subsequent study,<sup>2</sup> Douglas elaborated her theory to describe how different types of social structure gave rise to

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<sup>1</sup> Douglas (1970).

<sup>2</sup> Douglas (1978).

corresponding “cultural biases,” that is, distinctive patterns of constrained thought about the natural, supernatural, and social worlds. The structural configurations were defined by the high and low combinations of *group* (essentially, the strength of social membership ties) and *grid* (essentially, the complexity of social regulation of individual behavior).<sup>3</sup>

Building on Douglas’s insights, her collaborators Michael Thompson, Richard Ellis, and Aaron Wildavsky<sup>4</sup> formally labeled and succinctly described four types of cultures resulting from Douglas’s grid-group combinations. Specifically, where both grid and group were low (i.e., few prescriptions and weak social boundaries), Douglas’s theory predicted a culture of *individualism*. Where both grid and group were traditionally high (i.e., in strongly bounded groups with many rules), the resulting culture was characterized by *hierarchy*. The combination of high group with low grid (i.e., strong sense of membership with few prescriptions) gave rise to *egalitarianism*. And finally, social contexts where low group attended high grid (i.e., weak social ties but extensive regulation) produced a culture of *fatalism*.

Whereas Douglas originally focused on group and grid as dimensions of whole societies, she and her disciples elaborated the theory as a way of describing any social organization. This made things much more complicated, because in modern societies that are heterogeneous, fragmented, and mobile, individuals often belong to multiple social groups with different configurations. Moreover, any one organization might exemplify aspects of various cultural patterns at once, e.g., both individualism and hierarchy.<sup>5</sup> Understanding how numerous sources of identity and meaning converge to shape individuals’ attitudes and perceptions—explaining their approach to risk and their posture on public issues, for example—is a topic of increasing interest at the interface of political science, cognitive psychology, and the sociology of culture.<sup>6</sup>

Importantly, however, for Douglas, cultural biases were inherent in the *interaction* of grid with group, not in whether a social entity could be characterized as high or low on either dimension alone. And in any event, the grid and group

continua were descriptors of the actual conditions and constraints of social life, so that the corresponding biases were always linked to *social facts*, in Durkheim’s coinage,<sup>7</sup> and were not free-floating opinions about matters such as individual liberty or community responsibility or equality or risk. At the same time, Douglas did not believe that individual thought was *completely* determined by social structure—only that ways of thinking were patterned, or channeled into a “range of cosmological possibilities,” by people’s group membership and the constraints of social structure. In her words, from *Cultural Bias*:

[*Grid-group analysis provides*] a method of identifying cultural bias, of finding an array of beliefs locked together into relational patterns. The beliefs must be treated as part of the action, and not separated from it as in so many theories of social action ... The interaction of individual subjects produces a public cosmology capable of being internalized in the consciousness of individuals ... This is not an exercise to demonstrate the sociological determination of thought. If I were tempted in that direction I would have to face an insoluble problem of accounting for social change ... What I claim to be stable and determined is not [*people’s*] individual positions but the range of cosmological possibilities in which they can possibly land themselves by choosing to deal with their social problems in one way or another.<sup>8</sup>

Applying Douglas’s ideas to elucidate a contemporary public policy question—such as why people vehemently disagree over OCLs—may indeed be a fruitful and informative exercise. However, if we take Douglas’s theory on its own terms, positing the clash of cultural worldviews as a sort of exogenous explanation would seem to be starting at the wrong place.

In Kahan and associates’ version of grid-group theory, the most important question to ask in order to understand people’s inclination to support or oppose OCLs is: What is their cultural worldview? (What is their basic cultural-value orientation? Specifically, how much do they value *individualism* or *communitarism*, *egalitarianism*, or *hierarchy*?) Once we know people’s level of commitment to these values, we can predict—at least better than chance—whether they will like OCLs or not (assuming they are told what OCLs are.) Not only that, but we can predict how people will elastically perceive the scientific evidence for OCLs’ effectiveness in such a way that it lines up with their inchoate policy position. (So say Kahan and colleagues, and their survey data provide some evidence that they are on to something.)

<sup>3</sup> To elaborate, the “group” dimension is mainly about the strength of social boundaries that define membership and exclude outsiders, forming the basis for individuals’ shared sense of identity. (“Group” answers the question, “Who am I?”) The “grid” dimension captures the amount of regulation and constraint that is placed on individual action by dint of prescribed roles, relationships, and schemes of social classification. (“Grid” answers the question, “What tells me how to behave?”).

<sup>4</sup> Thompson, Ellis, and Wildavsky (1990).

<sup>5</sup> Extensions of grid-group analysis were partly the contribution of Douglas’s political scientist collaborators Thompson and Wildavsky. For a review of these developments, see Caulkins (1999).

<sup>6</sup> Dimaggio (1997).

<sup>7</sup> Durkheim (1897/2006).

<sup>8</sup> Douglas (1978, op. cit., p. 14).

Without minimizing these insights as far as they go, I think Mary Douglas would begin by asking a couple of prior questions about her research subjects: *Who are these people? What are they doing? And why are they acting like this?* She would answer these questions by assembling the necessary ethnographic facts to determine her informants' grid/group coordinates, and then proceed to look for symbolic connections between these structural configurations and people's beliefs, worldviews, and corresponding cognitive biases. To the extent that Kahan and colleagues gloss over the answers to these prior questions, their explanation of the OCLs controversy is, in my view, theoretically out of focus.

In a departure from Douglas's conceptual framework, Kahan and colleagues treat egalitarianism/hierarchy and individualism/communitarianism as two separate sets of preferences—free-floating attitudinal variables—which they equate with grid and group, respectively. For them, attitudes “support” particular ways of organizing society. However, these authors virtually ignore the question of what social structures may underlie and produce the attitudes in the first place, and they fail to explicitly consider the juxtaposition of, or interaction between, the grid and group dimensions of social life. For Douglas, in contrast, that juxtaposition was the core insight of grid and group; it is what creates the kinds of variations in cultural worldview that Kahan and colleagues are interested in. In Douglas's own words, “Cultural theory can ... throw light on *thought style* as a collective product.”<sup>9</sup> That is to say, the framing of thought is the product of the collective, and not the other way around. But in turn, thought styles serve the function of upholding and reinforcing a particular social structure.

Whether one agrees with this Durkheimian-functionalist formulation or not (and it is a bit of a chicken-and-egg problem), I think Douglas *was* committed to it. Indeed, one way of seeing her whole theoretical project is that she was trying to bring a sort of Durkheimian sociology of knowledge to the enterprise of cultural-anthropological analysis.<sup>10</sup> In that light, I do not think one can accurately claim to apply Douglas's theories without properly accounting for the role of *social facts* (i.e., in the way that Durkheim in *Suicide* went beyond the abstract doctrinal proscriptions against suicide among Protestants and Catholics, and honed in on social-structural differences in their ways of life, in order to explain group variation in suicide rates.)

Theoretical infidelity isn't always a bad thing; theories should, of course, be revised when warranted to account for new data, and indeed Douglas revised her own theory in later writings (revamping, in particular, what she meant by

the “grid” dimension.) In Kahan et al., though (as I have already suggested), the deviation from Douglas seems to downplay the key sociological insight underlying grid-group analysis, which Douglas would have attributed largely to Durkheim.<sup>11</sup>

Let us imagine asking Mary Douglas what she would most like to know in order to explain the following (stipulated) facts: (1) The Treatment Advocacy Center (TAC) strongly advocates for outpatient commitment laws while the Bazelon Center for Mental Health Law works to defeat them; (2) The National Alliance on Mental Illness (NAMI) members generally (if somewhat reluctantly) favor OCLs while Mental Health America (MHA) members tend to oppose them; and (3) lawyers working for the 1st Judicial Department of the Mental Hygiene Legal Service (MHLS) in Manhattan favor “Kendra's Law” while their counterparts with the 2nd Judicial Department a few miles away in Long Island largely oppose the law in its prevailing form.<sup>12</sup>

<sup>11</sup> To illustrate the point another way: In order to explain what people believe and how they think about *anything*—e.g., what the girls in a British convent school think about Christian doctrine and how their theological beliefs might differ from those of a millennialist Christian sect in America; what the tribespeople in a small African village think about animals and food and the human body; what stockbrokers think about risk and taxes; or what university professors think about nuclear power and global warming—Mary Douglas would not begin by asking whether these people think society *should* be hierarchal or egalitarian, or whether they are inclined to put the interests of individuals ahead of the common good. Rather, she would look at the organization and function of life *in the convent, the sect, the village, the financial district, and the university faculty*. She would also look at any other salient sources of belonging—for Durkheim “*social solidarity*”—that define these individuals' sense of themselves. Here, she might investigate the range of social ties, from families to political party affiliations. Only then, in my opinion, would she work out an explanation of the grooves worn by cultural habits of thought—the worldviews—that *emerge from*, and reinforce, those ties and group boundaries.

<sup>12</sup> The public positions taken by the respective directors of the two MHLS judicial departments illustrate, and set the tone for, the very different approaches that each department has adopted with respect to Kendra's Law. On the one hand, Dennis Feld, Deputy Director of Appeals and Special Litigation for the 2nd Judicial Department MHLS, was the attorney who represented the plaintiff in the *Matter of K.L.*, a Constitutional challenge to Kendra's Law that was heard and ultimately rejected by the New York Court of Appeals. Feld argued that it was unconstitutional to detain patients for evaluation without a hearing when they are refusing to take their prescribed medication. He also argued that patients should be declared mentally incapacitated before being ordered into assisted outpatient treatment—a position that the appellate court said “would have the effect of eviscerating the legislation” (Santora, 2004). On the other hand, Marvin Bernstein, Director of the 1st Judicial Department MHLS, has publicly taken the position that Kendra's Law functions as a less-restrictive alternative to involuntary hospitalization. From the *Gotham Gazette*: “‘Virtually no [Kendra's Law] applications are made for people living in the community,’ Bernstein said, adding that most people in his district do not contest the orders, as they are eager to be released from the hospital. Cases in the Brooklyn and Queens [represented by the 2nd Judicial Department], however, are contested more often, Bernstein said” (Adame, 2005).

<sup>9</sup> Douglas (1970/1996).

<sup>10</sup> Fardon (1999).

I think Douglas would mainly want to know more about these social entities—TAC, Bazelon, NAMI, MHA, and the two different MHLS departments; what they are about, who belongs to them, how salient these affiliations are to their members, how they are organized and how they function, and (importantly) how they relate to other groups with an interest in OCLs. She would probably also want to know about the specific life experience of the proponents and detractors of OCLs vis-à-vis severe mental illness: Do they have a personal stake in OCLs by having a mental illness themselves, perhaps being a parent of a person with mental illness, or being a mental health professional? (Kahan et al. do ask this question, but their analysis makes no distinctions among different types of relationships to people with mental illness, e.g., a friend vs. a family member, which could lead to opposite positions on OCLs.) And how do those personal entanglements, with all of their baggage—of asymmetries in power and social status and ambivalent affective ties—get recapitulated symbolically in the OCL wars?

#### WHY THE OCL CONTROVERSY IS LESS THAN THAT MEETS THE EYE ... AND MORE

It is important to recognize that this controversy, in its polarized and polarizing form, has consisted largely of a symbol-laden dispute among elites and vocal advocates, not rank-and-file stakeholders in the population. But for many people, outpatient commitment just is not that important or salient; they have not developed strong opinions about it and probably won't. Kahan and colleagues recognize this, and take some trouble to measure knowledge of OCLs and incremental support for them, but their analysis doesn't tell us how important the issue is to people, or compared to what.

Survey respondents often say they “strongly agree” with statements about things that do not matter to them very much; being certain is not the same as caring. And their responses might differ if they were queried about some concrete, contextualized alternatives to OCLs, or if asked to consider various outcome scenarios.<sup>13</sup> Many other people who *are* in a position to be affected by OCLs, and do have opinions about them, nevertheless think OCLs are a mixed bag or would qualify their support based on the type of outpatient commitment we are talking about (e.g., conditional discharge from an otherwise-longer involuntary hospitalization vs. preventive OPC initiated in the community; the nature and size of the target population; and the accessibility and quality of care to be provided under court-ordered treatment.)

<sup>13</sup> Swartz et al. (2003).

With respect to elites, in order to explain why E. Fuller Torrey and Mary Zdanowicz<sup>14</sup> have championed OCLs while Robert Bernstein<sup>15</sup> and Michael Allen<sup>16</sup> have opposed them, I do not think we need to understand much about any differences in these individuals' basic worldview, or their attitudes about communitarianism or egalitarianism. Rather, their positions on OCLs are to be understood first by reference to the groups they belong to. These elites are closely and publically identified with prominent associations that are virtually *organized around* their respective positions on OCLs, and for whom opposition to, or support for, OCLs thus serves an important social-boundary function. (E. Fuller Torrey does not go around preaching the gospel of outpatient commitment *because* he has the determining worldview of a *communitarian hierarch*—though that may play some role; rather, I think he does so because he is the famous founder of a tightly run organization that is all about promoting outpatient commitment, and prior to that, perhaps, because he is a psychiatrist with a sister who has schizophrenia.)

To consider a slightly more problematic example, that of the two MHLS Judicial Departments serving the New York City area: It is public knowledge that the lawyers with the 1st Department (covering Manhattan and the Bronx) generally support Kendra's Law while those with the 2nd Department (covering Brooklyn, Queens, Long Island, and Staten Island) tend to oppose the law in its current form.<sup>17</sup> In my view, and having interviewed the directors and some of the lawyers in both offices, these differences of opinion over Kendra's Law have little, if anything, to do with variations in basic cultural worldview, or cultural bias in perceptions of risk and appraisal of the research evidence for OCLs' effectiveness. Indeed, the lawyers in both MHLS departments appear to share very similar worldviews, and I suspect the departments would be indistinguishable on average scores measuring attitudes of individualism vs. communitarianism, or egalitarianism vs. hierarchy, among their respective legal staff.

Rather, it seems that the differences are rooted in the leadership and established conventions of the respective departments; in the ways in which the departments relate to the local psychiatric hospitals where most Assisted

<sup>14</sup> Torrey and Zdanowicz (2001).

<sup>15</sup> Robert Bernstein is Executive Director of the Bazelon Center for Mental Health Law, which, as Kahan et al. make clear, officially opposes outpatient commitment (<http://www.bazelon.org/issues/commitment/positionstatement.html>). In a speech in 2000 to the Consumer Movement Summit, Bernstein said, “Kendra's Law has polluted the system by introducing the very coercion that characterized the psychiatric institutions of the past into the community, where it was not supposed to be part of the picture.” ([www.mhselfhelp.org](http://www.mhselfhelp.org))

<sup>16</sup> Allen and Smith (2001).

<sup>17</sup> See footnote 12.

Outpatient Treatment (AOT) orders originate; in the somewhat different roles that the MHLS attorneys from each department play in the court proceedings when AOT petitions are heard; and, importantly, in certain features of the local patient populations being petitioned for AOT, which correspond to subtle differences in the socially defined functions of AOT orders.

In Manhattan, the MHLS lawyers attempt to have a collaborative and, whenever possible, a non-adversarial relationship with the hospitals' clinical staff, who are mostly using AOT orders as a tool to obtain early discharge for patients involuntarily committed to long stays in psychiatric facilities. In these cases, the attorneys representing patients in AOT hearings typically do not oppose outpatient commitment; as Marvin Bernstein told the *Gotham Gazette*, "most people in [Bernstein's] district do not contest the orders, as they are eager to be released from the hospital."<sup>18</sup> In this scenario, the lawyers may raise legal objections when warranted, but otherwise help facilitate the process by which their clients may leave the hospital sooner via an AOT order, and thereby obtain the outpatient services needed in the community. At the same time, they are using the supervision of the AOT order as a form of risk management for the (few) patients who have a history of violence. Thus, they see the AOT order as serving both the patients' and society's best interests.

In contrast, the 2nd Department MHLS lawyers tend to have a more adversarial relationship with the local hospitals and AOT petitioners, partly because the respondents themselves—the patients petitioned from the areas the 2nd Department represents—are more likely to contest AOT orders.<sup>19</sup> Consequently, as illustrated in the aforementioned *Matter of K.L.*, these lawyers see their role as raising objections and trying to quash AOT orders—either by challenging AOT's legal basis or undermining the psychiatric testimony and other evidence presented to show that the respondent meets AOT criteria. Failing that, the 2nd Department lawyers perceive their task as representing their clients' own wishes by trying to limit the scope of individual outpatient treatment plans that are specified under AOT. However, their goal is not to limit services per se, but to curtail the amount of coercion attached to those services.

Again, I think, it would be a mistake to suggest that these lawyers are behaving in such different ways because they have distinct overarching cultural worldviews determining their respective positions on OCLs. Rather, their beliefs about OCLs are a function of what they are doing; of the traditions and leadership of the Departments they are

working in, and the strength of their affiliations within those Departments.

All that said, trying to understand why people take the positions they do about outpatient commitment is an inherently complicated task, as Kahan and colleagues clearly realize, for several reasons: (1) outpatient commitment, legally and in practice, is more than one thing; (2) outpatient commitment means different things to different people, depending on their experiences and point of view; and (3) arguments that appeal to some of the same principles and ideals can be used to support opposite positions with respect to OCLs. This is not to say that "cultural cognition" plays no role in these opinions; indeed, what Douglas referred to as "thought styles" may mediate the association between people's location in social structure and their behavior in supporting public policies and laws like outpatient commitment.

Does any of this matter? Yes. By whatever means they arrive at the opinions they hold, the general public—taxpayers and voters through the elected state representatives—may have a strong say in the fate of outpatient commitment laws: how broadly or narrowly these laws will be targeted and implemented; what forms of coercive treatment will be considered acceptable in the community; what consequences of untreated mental disorder will be tolerated in the name of individual autonomy; and what resources will be allocated for "leveraging" services on behalf of people with mental illness in the community.

Because it does matter, continuing to examine the puzzle of people's attitudes toward OCLs is a long-term project worth the trouble. Kahan and colleagues deserve a great deal of credit for tackling this (even if their best empirical model, in the end, left unexplained the large majority of the variance—about 89%—in why people support or oppose OCLs.) But to get beyond these small explanatory gains, I would argue, requires the application of something else that Mary Douglas was famous for: comparative ethnographic analysis that situates people and events not only within the interaction of culture and social structure, but historical moment.

### AN ALTERNATIVE TELLING OF THE OCLS STORY<sup>20</sup>

In the remainder of this article, I offer some observations about the outpatient commitment controversy, animated by a bit of armchair ethnography and social history. There is an important "story on the ground" that is easily missed

<sup>18</sup> Adame (2005).

<sup>19</sup> Ibid.

<sup>20</sup> Adapted from Swanson (2005). Sponsored by the Institute of Psychiatry, Kings College London.

from the rarified altitude of grand theory and structural equation modeling.

Outpatient commitment laws came to exist for a number of reasons having little to do directly with the cultural worldviews or the “biases” of these laws’ principal proponents. There are also some reasons why many of these laws have *not* been implemented, which may have little to do with the ideologies of those who reject outpatient commitment and have tried to quash it. And while it is true that ideological arguments resembling the cultural biases that Douglas described have played some role in the adoption of, and continuing support for OCLs, it is not clear that any of these particular worldviews is more consistent with one side of the debate or the other; in fact, both sides have sometimes appealed to the same overarching cultural value principles.

It is well known that advocates for outpatient commitment succeeded strategically in passing OCLs in some states by tapping into the public’s (largely unfounded) fear of violence by persons with mental illness. D.J. Jaffe of TAC famously said at the 1999 NAMI conference, “Laws change for a single reason, in reaction to highly publicized incidences of violence. People care about public safety. I am not saying it is right. I am saying this is the reality.... So if you’re changing your laws in your state, you have to understand that.”<sup>21</sup>

The advocates also succeeded by appealing to a sort of *communitarianism*. After violence, the basic argument that E. Fuller Torrey has made for OCLs is that these laws are a humane imperative for the benefit of those afflicted with brain diseases, who are too sick to even know they need help; outpatient commitment is a way for the community to take collective responsibility, and to reach out and help its members in need.

What is less often acknowledged is that the advocates for OCLs co-opted the *individualist* and *egalitarian* arguments of the very civil libertarians who opposed outpatient commitment on moral and legal grounds. With respect to civil liberties, for example, D.J. Jaffe said, “It is the illness, not the treatment that restricts civil liberties. Medicines can free individuals ... to engage in a meaningful exercise of their civil liberties. [Outpatient commitment] cuts the need for incarceration, restraints, and involuntary inpatient commitment, allowing individuals to retain more of their civil liberties.” And to those who argued that the real problem is an unresponsive, hierarchical service system, the advocates said that OCLs actually leveled the playing field and improved access to care for those who otherwise would not receive it. Jaffe: “[Outpatient commitment] really involuntarily commits the mental health system to

provide care. When a patient doesn’t show up, they can no longer close the case...”<sup>22</sup>

I think one strong point for Kahan and colleagues’ argument about cultural bias is that the public’s media-hyped fear of violence by “the mentally ill” can trump any reasoned discussion of the evidence for whether OCLs in fact reduce the risk of community violence; indeed, the evidence—if considered at all, in public discourse—tends to be viewed through the prism of what people already think they know about the risk of violent behavior among people with psychiatric illnesses. And yet, what actually happened with OCLs on the legislative front transcended ideological skirmishes over violence risk and forced outpatient treatment; the reasons were pragmatic. At the same time, as the proponents of OCLs were deliberately using the publicity around violent incidents to promote statutes such as Kendra’s Law, the language of these laws was being redesigned to effectively exclude the most seriously violent individuals with mental disorder from outpatient commitment—that is to say, excluding those who would already meet the current “imminent dangerousness” prong in the criteria for involuntary hospitalization. The (mainly practical) reason was that in states requiring a finding of imminent dangerousness for outpatient commitment, the laws were rather unworkable and thus became irrelevant. As Appelbaum observed: “Clinicians and courts alike have a difficult time determining which patients are sufficiently impaired to meet dangerousness criteria for inpatient commitment and yet might be appropriate candidates for enforced outpatient care... Having declared a patient dangerous for purposes of commitment, many clinicians understandably shy away from recommending outpatient treatment, fearing that they will be held responsible for any harm that occurs to the patient or to other people.”<sup>23</sup>

It may help to remember that outpatient commitment did not originally concern violence risk or civil rights. Initially, it was much more about the problem of poor adherence to community-based treatment among deinstitutionalized hospital patients—a problem that was seen as contributing to an expensive and maladaptive pattern of hospital recidivism.<sup>24</sup> “Dangerousness” got involved indirectly because the legal criteria were initially the same for outpatient and inpatient commitment; community-based treatment was thus defined as a less-restrictive alternative for the same population, that is, for people who would otherwise be hospitalized.

More specifically, OLCs were adopted in the US beginning in the late 1970s as a way to address a practical problem that arose following the second wave of

<sup>21</sup> Jaffe (1999).

<sup>22</sup> Ibid.

<sup>23</sup> Appelbaum (2001).

<sup>24</sup> Keilitz and Duizend (1986).

deinstitutionalization, in response to the acknowledged failure of the community mental health center movement to meet the needs of people with severe and persistent mental illness. That problem was termed the “revolving-door syndrome” with reference to a pattern of multiple readmissions to state psychiatric hospitals—a cycle that was not only costly, but deleterious to patients’ long-term chances of recovery.<sup>25</sup>

Based on the notion that some patients have an illness that impairs their ability to voluntarily comply with the continuing treatment they need—treatment which they would otherwise accept in their best interest—outpatient commitment was supposed to interrupt the revolving-door cycle through a court order to ensure the patient’s adherence with recommended outpatient treatment. The idea was that OCLs not only committed patients to treatment, but they also “committed the system” to provide it.<sup>26</sup>

As I have already suggested, arguments for OCLs have been made, at least implicitly, by appeals to communitarianism, individualism, and egalitarianism, not to mention hierarchical medical paternalism. Specifically, proponents say OCLs are about communities taking care of people in need; that OCLs can enhance individual autonomy in the long run; that OCLs enable people to participate equally in society, rather than being marginalized by mental illness; and that benevolent medical experts recommend OCLs.

But arguments *against* OCLs have appealed to some of the same values. Opponents say OCLs polarize mental health service recipients, their family members, and community stakeholders; that OCLs trample individual rights and autonomy; that OCLs treat people with mental illness differently and unfairly; and that OCLs undermine the patient’s trust in the doctor’s clinical and moral authority.

In my view, the key to understanding the conflict between the OCLs combatants is not that their cultural worldviews are so different, but that they are talking about different things. For one side, OCLs are primarily about coercion. For the other side, OCLs are about access to treatment and safety. And the main reason the advocates emphasize these different things is because they are following socially scripted arguments about OCLs—arguments which, in turn, serve an important social function as rhetorical indicators of membership in respective stakeholder groups, interest groups, constituencies, or actual organizations.

Of course, not everyone with a crystallized opinion on OCLs is a combatant following a “party line,” and there are truly principled, non-ideological arguments to be heard on both sides. Some legal scholars, who surely recognize the value of treatment and improving access to mental

health services, nevertheless oppose outpatient commitment as an unwarranted extension of state authority into people’s private lives. Such scholars think it is more important to protect the rights of competent individuals to refuse treatment—even if some people will exercise that right to make bad personal decisions—than to use the law to ensure that everyone who needs psychiatric intervention receives it whether they are competent or not, and whether they want it or not. These scholars also tend to think that protecting the public from potentially dangerous individuals is a matter for law enforcement, not the mental health system.<sup>27</sup> But on the other side are some legal scholars who argue, without any obvious ideological slant, that OCLs are legitimately about the state’s interest in preventing violence and taking care of people who are impaired.

These two opposing legal positions were heard *In the Matter of K.L.*,<sup>28</sup> a challenge to Kendra’s Law that was ultimately decided in the New York Court of Appeals. The plaintiff’s lawyers asserted that Kendra’s Law violates the Constitutional right to due process and equal protection, insofar as the statute permits treatment to be ordered “without a showing by clear and convincing evidence that the person to whom the order applies lacks the capacity to make a reasoned treatment decision.” The Court of Appeals rejected that argument and upheld Kendra’s Law. The court’s opinion held that the state has a compelling interest in taking preventive measures to make sure that patients who are at risk of becoming dangerous to themselves or others without treatment, in fact do receive treatment, so that they will not become dangerous. The court’s opinion read in part: “Kendra’s Law provides the means by which society does not have to sit idly by and watch the cycle of decompensation, dangerousness, and hospitalization continually repeat itself.” Aside from differing legal philosophies or opinions, did the clash of *cultural worldviews* play a significant role in the arguments, the consideration of research evidence for OCLs effectiveness<sup>29</sup> or the court’s decision? It is not obvious that it did.

There are other kinds of objections to OCLs having little to do with legal arguments. Some clinicians as well as mental health service recipients have asserted that outpatient commitment is inherently counter-therapeutic because it undermines trust; that it changes the culture of treatment to one of risk management at the expense of recovery. A statement against Kendra’s law from the Coalition to Stop Outpatient Commitment in New York put it this way:

<sup>27</sup> Dawson and Szmukler (2006).

<sup>28</sup> See *In the Matter of K.L.* (2004).

<sup>29</sup> Chief Judge Judith Kaye’s written opinion cited without elaboration the findings of the Duke outpatient commitment study (Swartz et al., 1999).

<sup>25</sup> Fernandez and Nygard (1990).

<sup>26</sup> Swanson et al. (1997).

“People recover when they have a choice among alternative treatments and services, when they are empowered to make their own decisions and take responsibility for their lives, and when they are offered hope. These conditions are impossible under outpatient commitment.”

A few mental health policy scholars have argued that outpatient commitment builds perverse incentives into the service delivery system; that it diverts resources away from the voluntary treatment sector to the involuntary sector, disadvantaging those who actually want treatment, and thus motivating clinicians to seek the court order as a sort of new entitlement to treatment—to use it as a “queue-jumping” ticket in a fiscally constrained system.

Still others raise practical objections to OCLs simply because the legal criteria can be difficult to operationalize. Outpatient commitment recipients are supposed to have impaired capacity to adhere to treatment, but what is capacity anyway? We speak as if it were a thing one either has or doesn’t have; perhaps that is an artifact of the need to make binary decisions about intervention and treatment. Clinicians trying to implement outpatient commitment for a particular person may enter a foggy zone between a clearly informed, clearly competent and reasoned refusal of treatment and a clearly incapacitated, pathologically irrational decision to refuse or resist treatment.<sup>30</sup> Legal and clinical definitions notwithstanding, there is not such a bright line to distinguish capacities in many cases. And if capacity in a discrete moment is often difficult to ascertain, how much more uncertain is the business of predicting impaired decision-making *over time*, linked to a related forecast of noncompliance, linked to still another forecast that noncompliance will lead to relapse, and then to dangerousness?<sup>31</sup> (One doesn’t have to be a civil libertarian ideologue to see how difficult this might be.)

None of these is to deny that overarching cultural worldviews have played some role in the OCLs debate. Notwithstanding the legal evolution of OCLs, the social structure and history of the Treatment Advocacy Center, or the fact that OCLs—*qua* social cause—fulfill a social function as TAC’s *raison d’être*, it still appears that Torrey is a medical paternalist of sorts. And it seems likely that his culturally shaped views about doctors and patients have, to some degree, motivated his actions with respect to OCLs’ advocacy. After all, Torrey has made very public his view that psychiatrists are benevolent medical authorities who should be in charge of making treatment decisions for mentally ill individuals because they know better than the patient. From this perspective, if a person with a psychiatric illness needs treatment but won’t accept it, it is the

clinicians’ job—and part of good clinical care—to use (pretty much) whatever means are necessary and available to treat the person anyway.

The word paternalism is an apt one here, because this is not unlike what a parent does, in the course of being a good parent, if a sick child needs medical attention but does not want to go to the doctor or take the nasty medicine. If you are the parent, you make it happen anyway—the assumption being that the child lacks full capacity and thus should not have the right to decide what is in his or her own best interest.

On the other side of the spectrum from medical paternalism, civil rights advocates would protest that persons placed under OCLs are neither children nor legally incompetent. (If they were, legal guardianship would obviate the need for OCLs.) People who champion this view, such as the lawyers at the Bazelon Center, probably do “see the world” somewhat differently than Torrey does.

Somewhere in between the vocal extremes of strong medical paternalism (where there be hierarchs and communitarians) and strong civil libertarianism (where there be individualists and egalitarians) is a large group of stakeholders, not to mention the general public, with diverse cultural worldviews and ambivalent, if inchoate, positions on OCLs. I suspect most of them would take a pragmatic stance and disagree marginally, and non-ideologically, about three things: (1) *the evidence* (how strong is the evidence for the benefits vs. drawbacks of outpatient commitment in practice, and what outcomes are most important); (2) *the target population* (what is the size and nature of the appropriate population to be subjected to outpatient commitment—what are the right criteria for defining that population); and (3) *the reach* of outpatient commitment (how long should it last, what range of services must accompany it, and what are the safeguards.)

Many family members and clinicians, and even many consumers are in this middle group. It is probably fair to say that a large portion of the family constituency in the US now accept outpatient commitment as (at least) a tolerable way to compensate, either for the failure of service systems to meet the needs of their mentally ill relatives, or the inability of these persons to remain in treatment voluntarily—or both. The National Alliance for the Mentally Ill (which does not represent all families, of course) has taken positions on outpatient commitment that have evolved, in recent years, toward stronger but still ambivalent and qualified support for coercion. NAMI once opposed outpatient commitment, but in 1995 offered qualified endorsement: “NAMI recognizes that [outpatient commitment] is a serious infringement on the personal autonomy of individuals with severe brain disorders and therefore takes the position that it should be considered only under extreme circumstances when other interventions are not

<sup>30</sup> Appelbaum and Redlich (2006).

<sup>31</sup> These “forecasts” roughly correspond to some of the criteria for court-ordered treatment under Kendra’s Law.

available or appropriate.”<sup>32</sup> In 1998, then Executive Director Laurie Flynn affirmed outpatient commitment in much less equivocal terms, choosing a provocative moment immediately after two US Capitol police officers were shot to death by Russell Weston, a man diagnosed with schizophrenia who reportedly was not receiving treatment at the time.<sup>33</sup> NAMI now endorses a continuum of (more or less) coercive interventions, as appropriate depending on persons’ ability to recognize their need for treatment and to safely manage their own illness through voluntary adherence with treatment. Outpatient commitment falls in the middle between Assertive Community Treatment and inpatient civil commitment on this scale, described by NAMI as “required participation in treatment as a condition for living in the community for *those who do not respond to outreach and resist treatment* [emphasis added].”<sup>34</sup>

I think the telling difference between these early and later NAMI statements speaks of a key tension in the view of noncompliance which underlies the rationale for outpatient commitment: On the one hand, treatment noncompliance is viewed as a symptom of the state’s failure to provide appropriate, effective, acceptable, and accessible services; on the other hand, it is construed as individual resistance—a problematic behavior of the person with severe mental illness, and a feature of their disease. So in the former reference outpatient commitment is deemed appropriate when “other interventions are not available or appropriate,” whereas in the latter statement, outpatient commitment is for “those who do not respond...and resist.”

Many clinicians, service providers and systems are also in the middle. From the point of view of many who are serving clients with severe and persistent mental illness, outpatient commitment appears to offer at least a promising—if unproven—strategy to reduce high-cost recidivism, manage risk, and enhance the effectiveness of therapies that depend on continuity and sustained adherence.

Still, there is little consensus so far among clinicians about the long-term value and appropriate role of outpatient commitment. Some professionals side more with consumer advocates in the view that coercive treatment is probably counterproductive. Some urge caution against an overemphasis on legal mandates in violence risk management, at the expense of resources for services: Psychiatrist Paul Mullen wrote: “The most effective response to the risks of dangerous behavior in the mentally ill is not to return to policies of greater control and containment but to

improve the care, support and treatment delivered to patients in the community.”<sup>35</sup>

According to this perspective, arguments about the state’s authority to treat vs. the mental health client’s interest in liberty merely obscures the larger ethical issue of what kind of services society ought to provide, and the possibility that, if adequate and accessible community care were widely available—and designed realistically for persons with psychiatric disabilities—then coercive interventions per se would simply be unnecessary. (Of course, this view may beg the question, where is the line between coercion and assertive outreach?)

In the middle group, I would also count myself as a researcher. I think, this is one of those issues where research can actually help us decide. Can it work? Does it work? In what ways, for what sorts of people? And what are the drawbacks of OCLs? Of course, even in scientific research there are value judgments involved, and individual biases that may cloud those judgments. Academics and researchers, being human actors, are not always in the best position to see, let alone to acknowledge, their own biases.

In deliberating over whether OCLs work and how they should be implemented, perhaps, one of the most important long-term outcomes to consider is quality of life<sup>36</sup>—as defined in terms that are most meaningful to the people most affected, i.e., the recipients of outpatient commitment orders themselves. Somewhat ironically, the “objective” evidence on this matter must involve inherently subjective judgments, and therefore may inevitably incorporate the bias of cultural cognition insofar as it helps shape individual judgments. Perhaps the question, then, is not whether we can avoid or remediate all bias about OCLs, but whether we should privilege particular stakeholders’ points of view at particular junctures in time. Intriguing questions lie in the paradox: What if “the evidence shows” that overriding some individuals’ present wishes and subjective judgments about their own needs is a reasonably effective way to promote their long-term quality of life—a fact that may only be appreciated in the future subjective views of these very individuals, made possible by the present curtailment of their liberty? If such were the case, which would be the evidence-based position proceeding from individualism vs. communitarianism—OCLs or no OCLs? Which would be the position from hierarchy vs. egalitarianism—OCLs or no OCLs? And finally, how do our own social positions—and the cultural worldviews that arise from them—guide us, and sometimes hinder us, as we strive to interpret such evidence and work out its implications for action in public policy?

<sup>32</sup> NAMI (1995).

<sup>33</sup> See NAMI Press Release, May 14, 1998.

<sup>34</sup> See NAMI Press Release (1998).

<sup>35</sup> Mullen (1997).

<sup>36</sup> Swanson, Swartz, Elbogen, Wagner, and Burns (2003).

In the end, to understand a topic as important and complex as the controversy over OCLs, we need a variety of types of evidence, produced by a range of methodological approaches. Large-scale community surveys and multivariable analysis of public attitudes, of the sort that Kahan and colleagues have reported, make an informative contribution to solving the puzzle. But they only go so far. We could also use an ethnographic accounting, of the sort Mary Douglas taught, to situate the story of OCLs in the particular context of social actors and groups and the social matrices of their thought and behavior.

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