

be difficult, at best, for members of a disadvantaged group. If nearly all members of the receiving community are accepting, nonjudgmental and compassionate, healing even with barriers of difference may be possible. But many real communities are less than ideal.

The point is that, in clarifying the concept of community, it becomes clear that not all communities are good ones in which to assign the seriously mentally ill. This point is an obvious one, but it bears repeating when so much is at stake: the already vulnerable should be subjected to as little structural violence as possible—by which I mean systematic racism, gross economic inequalities, and inadequate quality health care for the unemployed and working poor.

But communities cannot just be bifurcated into good and bad ones. Eileen John and I argued that there are different kinds of community, including communities of home (John and Potter 2002). These are ones where home is “not necessarily a location but instead is a mutually nourishing group where each member can, in significant ways, be himself or herself among others” (2002, 268). If either voluntary or involuntary outpatient commitment can accomplish this sense of community, it would be a great achievement.

One such community can be found in southern California. The Village is an Integrated Service Agency for the homeless mentally ill that serves as a “sanctuary from the rejecting community around us,” says Mark Ragins, a psychiatrist there (Ragins 2007). The Village’s values hold that patients, called “members,” are the ones to drive their program; members are viewed as active agents in their own recovery. The focus is on the whole person, including his talents and capabilities, and not just his illness. Perhaps most striking is that this Integrated Service Agency fosters close emotional relationships between members and staff and aims to minimize the barriers and boundaries that come with professional services. The reasoning is this:

People will accept help more readily if they are treated as equal and active partners in finding solutions to their needs. This is in contrast to being treated as passive recipients by people who

are characterized (by themselves or others) as their superiors or experts. It is easier to accept help when we feel that we bring something to the relationship rather than just take from it (www.village-isa.org/index.htm).

It is hard to imagine that we can find anything close to egalitarian relationships when patients are mandated to participate. It may well be that we have to mandate them anyway, sometimes, but when we do, we should take great caution in ascertaining that the worst of social vices are not present in those communities of command. ■

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Revisiting Hume’s Law

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Zanni and Stavis (2007) claim that empirical evidence demonstrates that outpatient psychiatric commitment has an economic and clinical utilitarian basis, and from that position they assert that *parens patriae* is ethically strengthened.

Indeed, their objective is to use empirical findings to “guide and justify ethical public policy consistent with the ethical and efficient use of the government’s welfare authority” (2007, 31). We maintain that the science may support *parens*

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patriae as a rational course of action once the ethical decision is made regarding commitment. More specifically, *parens patriae* neither stands nor falls on clinical science: the empirical evidence may serve an instrumental role, as opposed to becoming constitutive to the ethical argument. Their error is common and reveals the power of an incipient scientism and the conflation of moral and epistemological discourses (Tauber 1999).

We do not contest the legitimacy of *parens patriae*. Indeed, the issue is not the judicial or ethical standing of *parens patriae*, but rather its proper application. By looking at *parens patriae* exclusively through the lens of utility, however defined, Zanni and Stavis (2007) ignore the moral question that always confronts the court: at what cost to personal liberty is commitment made? Contrary to the authors' assertion that "libertarian paternalism is . . . the bedrock principle of American public welfare" (2007, 37), the judiciary has reiterated endlessly the careful balance of *parens patriae* responsibility with personal freedom (Winick 1997). On what basis would utility trump opposition to the position taken by these authors?

The argument for or against the application of *parens patriae* is made in moral debate. A strong case may be made that *parens patriae* is justified, morally, on the basis of providing the severely ill with a more robust personhood, namely, the ability to enjoy autonomy in its full exercise as a rational human being (Tauber 2003; Tauber 2005). That argument is refuted with the Stasz credo against imposing normative standards, which are hardly objective and certainly fraught with uncertainty (a controversy not further considered herein). Instead, we wish to discuss the violation of Hume's Law, i.e., an "ought" cannot be derived from an "is," which in this case is conflating scientific evidence with moral argument. There may be clinical and economic justification for the application of *parens patriae*, but that is not the ethical issue at stake: The moral dilemma is the balance of *parens patriae* against protection of individual autonomy. Their empirical data purportedly demonstrates commitment's utility, not its ethical justification. Opting not to deal with the moral question, the authors instead turn to clinical evidence as a basis for justifying the broader use of *parens patriae*. Obviously, policy follows utility, and who would argue against good scientific evidence as powerful support for judicial judgment? But the moral question is whether, and under what conditions *parens patriae* should be imposed once its usefulness is established. Even if the clinical claims are correct, (which is not clear, as discussed later in text), we remain bewildered on how the connection to widened use is made ethically.

To make their case morally, Zanni and Stavis (2007) would have to demonstrate that commitment restores patients more successfully to an autonomous state, where their liberty is more suitably exercised. That would diminish the distance between the opposing arguments, albeit hardly solve the problem. But do such studies showing the positive impact of outpatient civil commitment (OPC) on quality of life (e.g., Hiday et al. 2002), or even reduced death

rates (Segal and Burgess 2006) serve the moral argument? They might strengthen the use of OPC as a tool in the moral agenda of *parens patriae*, (i.e., committed patients did better clinically than those not committed), yet only by inference might we conclude from Hiday et al. (2002) that these committed persons are more autonomous *in toto* than those committed to hospitals or not committed at all, and the Segal and Burgess (2006) study only supports potential autonomy, notwithstanding that saving life and reducing victimization are moral virtues in their own right. The question about comparative states of "autonomy" might have an empirical answer, but how autonomy is construed in the various clinical scenarios has not been addressed, and for good reason: autonomy is a moral state, not readily defined empirically. Appropriately, Zanni and Stavis make no attempt to deal with this matter.

Related to Zanni and Stavis's (2007) use of science for their own purposes, it is disingenuous to dismiss anti-civil commitment as "ideologically driven," because the opposition does not utilize empirically based arguments. First, Zanni and Stavis are hardly innocent of ideology, but more to the point, we find it extraordinary that a discussion about moral philosophy would claim that science justifies an ethical principle. What in science makes a moral principle? Do notions of distributive justice, personal freedom, theological ethics, and even the authors' *a priori* commitments rest on science? Surely judgments may be framed and supported by scientific evidence, but ultimately ethics rest on what is perceived as right or just. In this schema, science is instrumental, a tool for helping to reach rational decisions. Those decisions are grounded in moral principles, which are applied to policy-making and adjudication. For example, a policeman having a gun that shoots well has nothing to do with the moral decision of whether to use it. It is only an instrument to be used in a moral setting: He shoots to defend himself if absolutely required; otherwise not. On our view, the clinical evidence is the gun: if one decides to shoot (OPC), let us hope it works well.

Finally, let us consider the argument if the clinical data showed no difference between controls and the outpatient committed. Then by the authors' logic, *parens patriae* would be weakened, even rejected. But that conclusion also would be unjustified, because *parens patriae* could be maintained on the moral basis of benevolence or protection of dignity, or some other principle of social justice. Accordingly, the clinical evidence would be rendered secondary, or at least subordinated to those other principles.

In short, the implicit scientism of this paper conflates a moral position about the ethical basis of *parens patriae* and the support derived from an empirical study. The authors have committed the same error as those advocating cost effectiveness arguments that might provide an empirical basis for the abandonment of *parens patriae*, making the avoidance of involuntary inpatient hospitalization the primary objective of mental health care rather than patient need for protection (Segal and Riley 2003). At best Zanni and Stavis (2007) might justify involuntary OPC as a better clinical and

economic outcome than the alternatives, but that does not make it morally justified from the vantage of protecting individual autonomy. The argument might be made on other ethical grounds, e.g., utilitarianism, but again the moral debate must be pitched against personal freedoms, and the clinical data again fails to alter the ethical argument.

Beyond these concerns, the empirical evidence of this study does not necessarily support the clinical conclusions made by Zanni and Stavis (2007). The most significant clinical problems derive from partial and ill-considered use of clinical data: nonequivalent groups and failure to apply multivariate controls. The most interesting findings relate to the reduced use of restraint and seclusion, yet, the strength of these data lie in the observation that while the OPC group experienced a decline in the use of restraint and seclusion, no similar decline was observed in the control group leading the authors to note that "... the findings cannot be attributed to decreases in overall utilization of... seclusion and restraint" (Zanni and Stavis 2007, 31). This observation is problematic as the new and less seriously ill controls were less likely to have had a previous hospitalization and an opportunity to be secluded or restrained in either period. One might suspect that, in a multivariate analysis controlling for the amount of time patients were at risk of seclusion or restraint (i.e., in hospital), the attribution of the decline in seclusion or restraint to the use of OPC would disappear. While not altering our judgment about differentiating the moral argument from the clinical science, we

would be interested as a clinical matter in a better-controlled analysis. ■

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Psychiatric Outpatient Commitment: One Tool Along a Continuum

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Zanni and Stavis (2007) offer important support in their article for the practice of outpatient civil commitment (OPC). Ultimately, outpatient commitment should be viewed as one tool for the treatment of persons with mental illness along a continuum that includes psychiatric advance directives as well as loosening the harm principle used to justify involuntary civil commitment (both inpatient and outpatient). Such a continuum is respectful of patient autonomy whenever possible and, when patients lack autonomy or their autonomy is severely impaired, seeks to restore their autonomy. A brief analysis of the tools in this continuum will provide ethical support for outpatient commitment as envisioned by Zanni and Stavis against charges that the practice is unjustifiably paternalistic.

The issue of anosognosia or lack of insight into one's disease is central to the ethical defense of outpatient commitment offered by the authors. As they argue,

... many criticize outpatient commitment as a flawed intervention that violates patient rights and argue that aggressive case management and outreach interventions would decrease patient noncompliance and lessen or even eliminate the need for commitment. This logic, however, fails to take into account the condition of anosognosia (lack of insight to the disease itself) that is often concurrent with psychotic disordered thinking and behaviors, delusions and hallucinations (Zanni and Stavis 2007, 31).

The argument then is that, while some may object that outpatient commitment violates patient rights, as it does

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