



Finding Common Ground for Diverging Policies for Persons with Severe Mental Illness

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Abstract

Two diametrically opposed positions predominate discourse for the care and treatment of persons with severe mental illness: anti-deinstitutionalization and anti-institutionalization. Both share the same goal of ensuring best quality of life for those with severe psychiatric disorders, but pathways to achieving this goal are very different and have resulted in much contention. Supporters of each position espouse a different belief system regarding people with psychiatric disorders and their presumed capabilities, placing varying emphasis on maximizing protection of the community versus protection of individual rights, and result in contrasting mental health policies and practice orientations. The authors delineate the history from which these positions evolved, consequent views, and policies and practices that emerged from these differing attitudes. The article culminates in a proposed practice approach that offers a more balanced approach to serving adults with mental illness –navigating risk management by preserving freedom and opportunities of risk while affording mutually satisfactory “risk control.”

Keywords Recovery · Coercion · Severe mental illness · Risk management

In the US and other countries such as the UK, Australia, and New Zealand, there are two prevailing policy positions being promoted for the care and treatment of persons with severe mental illness, specifically those diagnosed with schizophrenia spectrum disorders, major depression, and bipolar illnesses. While the two positions are dialectically in opposition to

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one another, their ultimate goal is the same: to ensure the best quality of life for people with severe psychiatric disorders. However, the pathways to reaching this goal are very different and, consequently, have resulted in much tension and contention, provoked by divergent approaches to navigating risk related to concerns about violence.

On one side of the argument is what we are calling anti-deinstitutionalization, and on the other side is anti-institutionalization. Although both share an historical foundation, each espouses a different belief system regarding persons with severe mental illness, their presumed capabilities, and varying emphasis on maximizing protection of the community versus protection of individual rights. What results from these opposing positions are very different mental health policies and practice orientations. The authors will delineate the history from which these positions evolved, consequent views regarding persons with psychiatric disorders, and the mental health policies and practice orientations that emerged from these differing attitudes. Following this discussion are suggestions for a practice approach that, when supported by appropriate policy, provides a more balanced approach to serving adults with severe mental illness.

Historical Background of Institutionalization to Deinstitutionalization

The story begins nearly 200 years ago with a rich sense of irony. In the nineteenth century in the US, the psychiatric hospital was established as a response to inhumane treatment of individuals with psychiatric disorders (Mechanic, 2008). Dorothea Dix advocated for building of state psychiatric institutions or asylums, places offering more compassionate care for people with mental illnesses than usual practices of almshouses, charitable housing shelters for the poor, and jails – including punishment for crimes not committed (Mechanic, 2008; Katz, 1996; [1]). Prior to this time the US was an agrarian society, and persons who were considered “insane” or “lunatics” were cared for by their families – in some cases quite brutally, shackled to bedposts or chairs and placed in sheds [2]. However, caring for people with mental illness was considered a private domestic problem and not one of public concern. With industrialization and urbanization, these individuals became more visible and were often left to their own devices for survival, which resulted in a need for a public response (Mechanic, 2008). Thus, psychiatric hospitals were viewed as more humane treatment and a means of social control for those who were “not of sound mind” and presented with out of control or unmanageable behavior [1].

While these institutions were built with good intentions, over time both the physical and functional infrastructures deteriorated to the point that they were seen as inhumane, abhorrent environments that were unfit for human habitation [3]. Immigration fueled population growth, and these sanctuaries became overcrowded, exacerbating behavioral dysregulation of the already neglected patients [1]. Consequently, care providers in these facilities frequently felt compelled to employ coercive and abusive means for crowd control. In the 1950s, psychopharmacological medications were introduced into state psychiatric institutions, engendering hope that people could be released [4, 5]. Thus, what came to be called deinstitutionalization was born from the unlikely coalescence of humanitarian/social justice advocates and fiscal conservatives. The latter saw community care as a cost-effective alternative to hospitalization, given that the monetary funds for rehabilitating the physical and organizational structures of psychiatric institutions were either unavailable or the common will to do so was not there.

Consequently, advocates promoting deinstitutionalization were pragmatically united but never ideologically or philosophically accordant.

Deinstitutionalization refers to a process whereby people who populated these psychiatric facilities were discharged to community alternatives; many who previously would have been admitted to psychiatric hospitals were diverted to other facilities and service programs, while those who required admission had extremely short hospital stays with quick return to the community [6]. The process of deinstitutionalization was, and continues to be, not just about reducing census counts and closing psychiatric hospitals, but also about the development of a comprehensive community-based system of care to provide for all the needs of people with severe psychiatric disorders who otherwise would have lived in hospital settings [7].

Consequences of Deinstitutionalization

To more fully understand the historical underpinnings of the opposing perspectives, it is important to explore the ramifications and consequences of deinstitutionalization. Initially the focus was on depopulating psychiatric hospitals. Patients who had families willing and able to care for them were the first to be released. Others were trans-institutionalized to nursing homes (Mechanic, 2008; [8]), where they encountered similar abusive conditions as in psychiatric hospitals. Some were released to highly structured residential housing, but these were few in number. Patients initially released, due to years of hospital confinement, were relatively compliant. Others, particularly those who in an earlier time would have been hospitalized long-term, overwhelmed general hospital emergency rooms and psychiatric inpatient units, where physical structures were ill-equipped and staff was ill-prepared to manage the needs and behaviors of these patients. The deinstitutionalized population began a cycle of short hospital stays and readmissions. Between these stays, affordable and appropriate housing was often unavailable. Student and vacation rooming houses were available in some areas, but increasing urban renewal contributed to the disappearance of low-cost rooming houses or hotels, resulting in homelessness for some former or would-be patients. Moreover former patients had nothing to do during the day since few day programs were available and employment was discouraged due to concerns about stress exacerbating their symptoms. With little to occupy their time, many wandered the streets often frightening people due to their strange appearance and bizarre behaviors. Limited or no planning occurred to meet basic needs of this population who previously relied on psychiatric hospitals for mental health treatment as well as for all basic social and functional needs required for survival in the community. The difficulty of former patients in navigating the fragmented and inadequate system of social services had been underestimated or disregarded, and limited cognitive abilities and social skills prevented many from accessing the paucity of services available [7–9].

A new generation of people with mental illness who were never confined to long-term institutionalization but spent the majority of their lives in the community were exposed to social and environmental ills, including illegal drug use and alcohol consumption. Although these substances may have served as self-medication to soothe their symptoms, their use compounds and exacerbates the psychosocial sequelae of mental illness. These individuals escaped institutional socialization to treatment and are less adherent with prescribed medication or choose to avoid treatment altogether. Thus, they are more likely to be homeless, display violent behavior within the public eye, and experience incarceration for illegal drug use, petty crimes, and vagrancy [7, 10]. It is unclear whether these phenomena have grown over time or

if the media began paying greater attention. These disturbing behaviors and situational conditions cause enormous consternation among mental health providers, administrators, family members, policy makers, and the general public who had concerns about the wisdom of deinstitutionalization from its very inception.

Over time, an entire system of community supports was developed to address the multiple challenges of community living, such that there is an established mental health system in most locations, at least to varying degrees [11, 12]. These services work for many, but there continues to be a small minority for whom program solutions remain allusive, and these tend to be the most visible: those who display offensive and sometimes violent behaviors in public view.

Views of Persons with Severe Mental Illnesses by Anti-Deinstitutionalizationists

The rare incidents that garner wide spread media attention perpetuate a particular image of people with severe mental illness and are emblematic of the views of anti-deinstitutionalizationists [13]. Many maintain outdated, stereotypical views of the dangerousness of this population. They believe that people with psychiatric disorders have disabling psychosis resulting in a lack of awareness regarding their illness and an inability to care for themselves, as evidenced by homelessness, incarceration, ill kept appearances, and bizarre behaviors including visibly talking to themselves, lack of coherent speech, and odd facial, body, and hand movements [14]. They believe cognitive challenges justify the curtailment of certain opportunities afforded other citizens, including voting, parenthood, and employment. Some providers share the negative views of this population held by the uninformed public and policy makers; they presume those with psychiatric diagnoses lack insight into their disorders resulting in non-adherence to prescribed medication, an inability to provide for their basic needs, and an incapacity for making rational decisions in their own best interest – all of which is used as evidence of a ubiquitous potential for explosive and uncontrollable violent behavior [14–17].

Practice Orientation for Anti-Deinstitutionalization Position

The negative views of individuals with mental illness did not disappear with the diminishing landscape of psychiatric hospitals, and the practice orientation that accompanies these beliefs still persists. Given that people with mental illness are perceived to have the potential for violence, mechanisms for social control are promoted as necessary. Providers dispute the capacity of people with psychiatric diagnoses to make rational decisions; thus professional expertise is privileged, justifying providers' authority to make decisions for the care and treatment of patients, rationalized by way of benevolence. In the maximum interest of service users, the paternalism of institutionalization continues beyond the walls of the asylum into community mental health settings [14, 17]. The medical model reigns supreme and provider-centric approaches direct professionals to decide what is best for service users to compensate for presumed cognitive deficits and irrational thinking. The scope of decision-making extends beyond service users' psychiatric treatment to their living arrangements, program choices, and how and with whom they spend their time [13]. Should the service users choose not to comply with these decisions, particularly with prescribed medications, then coercive mechanisms including commitments to the hospital, threats of hospitalizations, or the withholding of financial and other rewards such as housing are applied to avoid potential risks and protect

the safety of the service user and the larger community [18, 19]. Community safety and protection of the patient takes precedence over individual rights (Monahan, Swartz, & Bonnie, 2001). Moreover, if the provider does not take all precautionary measures, they may find themselves liable for the users' transgressions that cause harm to self or others [17]. For anti-deinstitutionalizationists, risk aversion is the better part of valor, given the anticipated likelihood of users' irrational behavior and poor judgment.

Rise of ex-Patient- Psychiatric Survivor Movement: The Anti-Institutionalization Movement

However, the continued paternalism of providers was met with an equal and opposite reaction. In the US in the 1970s there was an emergence of the ex-patient-psychiatric survivors' movement; like other minority and marginalized groups, people who were formerly hospitalized in psychiatric institutions wanted their civil rights respected and protected. Similar to other civil rights movements of the time, it was a rather militant movement against psychiatric institutionalization, forced drug treatment, and the paternalism of the mental health practice community. Ex-patients banded together to develop their own services and created alternative peer-provided services outside the traditional mental health system [20–22].

The leaders of this movement were comprised of those who had experienced abuses, were forced to take medications, and lost their freedom, dignity, and identities in behemoth institutions where they were treated with disrespect and subjected to restraints and seclusions, particularly when non-compliant with treatment orders [15]. Some were brought into hospitals in shackles, as the police were often afraid of them. The leaders of the movement saw themselves as victims of the mental health system that had caused irreparable harm. Many of the psychiatric ex-patient leaders felt dehumanized by the mental health system at the hands of providers who delivered prognoses of chronic, debilitating, and deteriorating conditions and predicted that patients would spend the rest of their lives in the back wards of institutions [15].

By the 1980s, there was a new breed of mental health leaders who came to be called mental health consumers. These consumers were less radical and more moderate, as they had not experienced the abuses of the psychiatric institutions. They saw benefits of voluntary mental health treatment. This differing view caused some controversy with the old guard who saw themselves as radical reformists, adamant about destroying the traditional mental health system and its use of involuntary treatment. However, the newer leaders considered themselves consumers of services and wanted to reform the mental health system, promoting choices about what services they wanted from an established menu of available options. Eventually these advocacy efforts came to be referred to as the consumer movement, and consumers became somewhat more accepted by the mental health establishment. State departments of mental health and the National Institute of Mental Health began funding peer-run mental health services and added offices of Consumer Affairs directed by mental health consumers [21, 23]. At the same time, writings by consumers began to appear in scholarly journals about their recoveries from mental illness, whereas earlier they were only available in newsletters such as *Madness Network News* published by self-help radical advocacy groups [20]. Also there was emerging scientific research by the World Health Organization and other researchers demonstrating that disorders like schizophrenia were not long-term deteriorating diseases; but people did recover from these illnesses and integrated into their respective communities (for example see [24–29]).

The Recovery Movement

In the 1990s, mental health advocates began writing about a new notion of recovery [30]. Whereas the medical model of recovery referred to a cure from an acute non-chronic disease, the new notion promoted learning to live with the disabling effects of a chronic disease in spite of the persistence of symptoms [31]. This conceptualization of recovery grew out of the consequences of deinstitutionalization which made apparent that people with severe psychiatric disorders wanted more than merely symptom relief, but a meaningful and productive life. While this meaning of recovery was not new to the fields of chronic somatic illness or physical disability, it was revolutionary when applied to psychiatric diagnoses. According to the frequently cited definition by William Anthony [30]

Recovery is described as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness. (p. 15)

The idea was that recovery was more than overcoming illness, but also rising above stigmatizing identities that psychiatric patients incorporated into their being, "the iatrogenic effects of treatment setting," the lack of "opportunities for self-determination," and the lost hopes and dreams about future possibilities (p. 15). This process of recovery is long and arduous, rather than a smooth linear trajectory, but is within the control of the individual and does not necessarily require formal psychiatric intervention. Often the loss of self-esteem and functional roles as well as the stigma and discriminatory societal practices encountered as a result of being labeled mentally ill are far more debilitating and difficult to overcome than the illness itself.

This new conceptualization of recovery is not unique to the US, but is pervasive in most western societies that have undergone deinstitutionalization. However, the idea of recovery is not new; its origins can be found in the writings of John Perceval [32], a son of the Prime Minister of England, who described his recovery from psychosis in the early 1830s despite the "lunatic" physicians who treated him.

In early 2000 in the US, this idea of recovery came to have profound effects on the public mental health service delivery system when the President's New Freedom Report was issued and called for the transformation of the mental health system to that of a recovery-oriented system of care [33]. This was about a transformation, not a reform, which requires major shifts in thinking, beliefs, attitudes, and practices on the part not only of mental health providers, but also service users who are well socialized into the authoritarian behavior of providers and have internalized stigma and low expectations. It is the mission of the U.S. federal government and all states to realize a recovery-oriented system of care.

Views of Persons with Severe Mental Illness from a Recovery Orientation or Anti-Institutionalization Perspective

In contrast to anti-deinstitutionalizationists, those with a recovery perspective see individuals who experience mental illness as autonomous, whole persons not defined by their illness. Rather than positioning people with mental illness as objects of treatment, they are recognized

for their full humanity and appreciated for their capacity to make their own decisions about their lives and psychiatric treatment. They are regarded as having inherent strengths and abilities to live meaningful lives of their own choosing without interference from the mental health system or undue force. People with mental illness are seen as having the same rights, responsibilities, and opportunities as any citizen – including the right to take risks and make mistakes without paternal oversight and surveillance from mental health providers, regardless of whether others agree with their choices ([34–36];). As Pat Deegan, a psychologist and a mental health consumer advocate stated, “people have the dignity of risk and the right to failure” [37]. Most of all they are recognized as people first, not their illness: they are not “schizophrenics,” just as someone with cancer is not “a cancer.”

Practice Orientation from a Recovery Orientation or Anti-Institutionalization Perspective

Anti-institutionalizationists advocate that the locus of care for people with mental illness should be in their home communities, not hospital settings. Care should be person-centered and empower service users to exercise self-determination. Providers recognize service users’ expertise about what has and has not worked, most notably about medications and which side effects are manageable or unacceptable. Providers listen to service users without unilaterally prescribing treatment. They provide validation, believe in service users’ capabilities, and respect their right to make their own decisions regardless of whether providers agree with those decision or not. Further, recovery-oriented providers recognize that service users who have lived experience of mental illness have something unique to offer their peers that cannot be obtained from traditional mental health providers; thus they support hiring service users in advanced stages of recovery to provide peer-delivered services [21].

Problems with the Anti-Institutionalization or the Recovery Movement

However, it is just as important to critically examine the views of anti-institutionalizationists. One of the contentions with this perspective is that there is no unanimously agreed upon definition of recovery, but rather three. The first definition refers to remission from an acute illness or the medical view of cure; the second refers to illness management or controlling one’s symptoms while continually monitoring the illness by both the patient and their medical professionals [38]. The third definition describes one’s own personal recovery process referring to building a positive identity apart from one’s illness and living a full and balanced life – perhaps in spite of continued symptoms [38]. This last definition is the one embraced by proponents of the recovery movement.

Many providers and family members do not see the process of recovery as being applicable to everyone diagnosed with a severe mental illness [39, 40]. They feel that certain mental health service users are not ready for recovery, particularly those in inpatient settings or those in the community who do not adhere to treatment recommendations. They do not feel all service users are capable of making valid and rationale choices, and they worry about adverse consequences and increased risk when service users engage in a recovery process. They believe that policies need to be put in place to protect against the potential risk of harm. This position, however, is antithetical to the philosophy of recovery that privileges trial and error rooted in self-determination [17, 41].

Policymakers are unable to legislate a personal process of recovery, but they can set forth a framework for the mental health service delivery system [42]. However, the implementation process is difficult and incomplete. Research demonstrates that there are often systems and structural priorities that include the need to use medical and diagnostic language, requirements for treatment plans, funding and program standards that preclude a person-centered approach to name a few – all of which conflict with a recovery orientation [43]. Furthermore, even seasoned staff require re-training and education to adjust their attitudes and practice approaches.

Some anti-institutionalizationists take the definition of personal recovery to its extreme position of consumerism, whereby the service user is always right and all choices about treatment and life in general are made by the service user with no input from professionals [44]. Positioning mental health service users as the expert to such an extreme may counter-balance the long-standing tradition of providers holding all the power, but it also excludes the wisdom and experience of providers, causing contention and a potential dismissal of the recovery movement [45]. For example, families and providers' voice concerns when mental health service users make choices they feel will result in harm to self or others. Family members are upset when the choices their relatives make do not seem to move them toward a more purposeful and functional life, such that their relative sits around the house smoking cigarettes all day rather than going to a mental health program.

Resurgence of the Anti-Deinstitutionalization Movement

In reaction to extreme views of anti-institutionalizationists, there is a growing backlash of anti-deinstitutionalizationists working in opposition by promoting policy efforts to expand mechanisms for mandated community treatment as well as a very recent call for a resurgence of asylums [14, 46]. The two most popular names for what used to be called outpatient commitment are Assisted Outpatient Treatment (AOT) in the US and Community Treatment Orders (CTO) in England. AOT and CTO are processes whereby civil courts mandate individuals with mental illness to mental health treatment in community settings [47].

Research on the effectiveness of AOT is limited, and proponents of AOT point to publications suggesting AOT may reduce criminal justice involvement, homelessness, hospitalization, further violence, and overall service costs (for example: [47–53]). Many of the research articles cited in the most recent Cochrane review [54] are often invoked as evidence of the efficacy of AOT even though the authors point out methodological weaknesses in many and ultimately conclude there is no evidence to support legislation or implementation of AOT. We argue that legislation and policies have developed not in response to evidence of the efficacy of mandated community treatment but rather in response to public concerns about safety as well as a paternal argument employing an ethical justification about protecting the health and safety of people with mental illness.

State laws regarding AOT are being promoted by those concerned that people with mental illness are potentially dangerous to themselves and others. These efforts have been fueled by media coverage of rare violent incidents committed by persons with mental illness. For example, in January 1999 when Andrew Goldstein, a person diagnosed with schizophrenia who had a long history of psychiatric hospitalizations, pushed Kendra Webdale in front of an oncoming subway train in New York City, legislation was instigated [55]. Another incident prompting legislation occurred in California in January 2001 where Laura Wilcox, a 19-year-

old college student working at a community mental health facility, was shot to death by a 41-year-old man who refused psychiatric treatment [56]. Often emerging in response to pressure put on law makers to enact measures to protect the public, 45 states and the District of Columbia [57] have passed such legislation, frequently named for the victims of these violent acts who provoked the laws' passage, such as Kendra's Law and Laura's Law. Ironically, it is not clear if Andrew Goldstein would have been a targeted candidate for AOT had it been an option, as he had voluntarily been seeking treatment on numerous occasions [55].

All states have existing involuntary commitment laws that allow for psychiatric inpatient confinement for people who have mental illness and are clinically assessed to be imminently dangerous to themselves and others or, in some states, gravely disabled and unable to care for themselves [58]. AOT laws, presented as ethical solutions to minimize risk of dangerousness, expand social control mechanisms of the state and deny civil rights to community-dwelling individuals who otherwise do not meet the restricted dangerousness criteria for involuntary psychiatric hospitalization. This expansion of social control is based on a paternalistic presumption that legally mandated external surrogate decision makers protect the safety of the individual and the community [59]. AOT is usually applied to people with mental illness who have histories of non-adherence to prescribed medications on the assumption that non-adherence contributed to past hospitalizations, homelessness, incarceration, and acts or threats of violence. AOT is designed to take corrective action caused by deinstitutionalization by placing a larger group of persons with mental illness under community control and surveillance who do not meet conventionally confined standards of hospitalization and who have committed no crimes [59].

For the same reasons given for AOT, bioethicist Dominic Sisti and his colleagues [46] published a recent article in the *Journal of American Medical Association* calling for the return to asylums or long-term care institutions. These authors' position is based on the same moral argument of the past that institutionalization would be more humane than cycling between homelessness, prison, emergency rooms and acute hospitalizations. These sanctuaries would purportedly provide refuge and care for those with severe psychiatric disorders who are unable to live independently or to provide for their own basic needs and are a potential danger to themselves and others. Thus, they are trying to expand the current, relatively narrow criteria not only for admission but for continued institutional confinement.

Problems with the Anti-Deinstitutionalization Position

A problem with the anti-deinstitutionalization position is the lack of effectiveness of legally mandated community treatment. Most systematic reviews of randomized and non-randomized studies have not determined any clinical advantage for these legal mandates [50, 54, 60–62]. Furthermore, there are practical and practice issues that jeopardize the implementation of these mandatory treatment orders. The enforceability of the mandatory adherence to prescribed medication and for other stipulated conditions, such as living arrangements, program attendance, and abstinence from illicit drugs, is questionable. Some providers find having the leverage to coerce mental health service users into complying with mandatory stipulations useful; others do not want to attend court hearings or be enforcers, as they feel it violates their therapeutic relationship with mental health service users. Furthermore, police frequently do not want to transport non-compliant service users, as they find that these individuals do not always meet the standards for admission to inpatient hospitals and, even if they do, they are usually returned to the community very quickly. With the lack of police transport to inpatient

hospitalization, there is no means of enforcement for these legal orders. This has led providers and others to say that these mechanisms have no teeth [63, 64]. From the research that has been conducted, among the minority for whom these orders successfully force them to comply with medication while under the order, it is primarily due to a false belief that if not compliant, they will be returned to the hospital. Research has found that clinicians intentionally do not correct this misconception, for then the mandate would not work as intended [64].

Similarly, long-term hospitalization has not been shown to be effective in reducing subsequent hospitalizations or improving medication adherence upon return to the community. Research has shown that patients quickly return to hospitals, as these institutions do not prepare patients for the enhancement of these outcomes upon community entrance [5, 65]. For example, Assertive Community Treatment or ACT was started in Mendota State Hospital in the 1970s to prepare patients for discharge [66, 67]. The developers realized that patients, particularly those with schizophrenia, have cognitive deficits, concrete thinking styles, and limited ability to generalize knowledge from one environmental setting to another; therefore, they transferred the training program from the hospital into the community in order to teach patients the skills they needed in the setting in which they would be used [66]. Furthermore, a patient once stabilized cannot legally remain institutionalized should they be able to reside in the community with reasonable accommodations according to Donaldson and Olmstead Supreme court cases.

Given the lack of clear clinical benefits from either AOT or long-term hospitalization, it is extremely difficult to justify the curtailment of liberty, loss of autonomy, and further stigmatization of individuals with severe mental illness. Proponents of mandatory outpatient treatment make the case that this is the least restrictive alternative to hospital confinement. These coercive intervention strategies rely on either structured confinement or continual surveillance to produce behavior change, and once these mechanisms are removed, patients likely resort to non-complying behaviors, as there is no change in internal motivation of patients. Engaging individuals in their own treatment decisions has a greater likelihood of long-term change in behaviors while AOT bodes future overcrowding of hospitals and foreshadows the abuses of the past or a lifetime of community monitoring and threat of hospitalization.

Finding Common Ground

Both anti-deinstitutionalizationists and anti-institutionalizationists ultimately want the same outcome: the best quality of life for persons with severe mental illness. However, both recognize that for this population, the risk of harm to self and violence towards others may hamper the achievement of this goal [59]. Given their differing perspectives, they have varying ways of managing these risks. The anti-deinstitutionalizationists believe deinstitutionalization has taken away their mechanisms of controlling this population and that returning to increased hospital confinement and coercive monitoring in the community will effectively manage safety risks by enhancing adherence to prescribed medication. In contrast, anti-institutionalizationists do not want people with mental illness to lose their hard won autonomy and self-determination regarding personal freedoms or to see a return to total paternalism. The anti-institutionalizationists assert that if hospitalization becomes absolutely necessary, it should be done with input from the service user, aided by psychiatric advanced directives, which the service user created when competent. They advocate that people with mental illness be afforded the same opportunities, like all other citizens, to be exposed to possible dangers or

harm. Failures and risks, they believe, can be managed independently. Thus, there is a dialectical struggle between opposing positions with regard to managing risk for this population – risk control versus risk opportunity. We employ the phrase risk control rather than the commonly accepted term, risk management, because we see managing risk with this population as minimizing adverse outcomes from occurring, but not simultaneously considering maximizing their engagement in risk opportunities. Unfortunately, risk management today is more about controlling harm than treatment and care [68].

Although these two positions are about broad-based policies, the locus of care between the provider and the service user is where both of these policies are enacted and implemented. Consequently, the focus on finding a synthesis needs to be based in mental health clinical practice, the interaction and relationship between the provider and the service user, with a concomitant policy that supports the practice. The relatively recent promotion and application of person centered care in the mental health practice arena, along with the use of shared decision-making processes, has the potential to create common ground for these contrasting positions. Person-centered care is about a true partnership between the provider and the mental health service user, where each party has their own expertise, each is respected for their knowledge, and each is involved in deciding on a course of treatment based on unbiased information regarding one's choices [43]. This collaborative approach is consistent with the policy emphasis on evidenced based practice whereby the best available evidence is used to make collaborative decisions. AOT and long-term hospitalization do not meet evidence-based practice criteria.

Shared decision-making is about the interactional and communication process between the two parties so that both are fully informed about treatment and services [69]. The service user becomes knowledgeable about the illness and the treatment options, while the clinician becomes aware of and honors the values, preferences, and concerns of the service user. Moderate proponents of the recovery movement accept shared decision-making as fulfilling the tenets of recovery, particularly its consistency with the definition of recovery as illness self-management, whereas those who take a more extreme consumerism position do not [17, 70]. When service users do not trust the system or the clinicians who represent it based on prior negative experience, they take an extreme position that equates self-determination and risk opportunity with making all medical decisions entirely independently, which does not even occur in somatic medicine. Providers have clinical experience and expertise that can be of benefit, and they, also, need to manage risk to avoid repercussions of possible harmful clinical decisions. The concern arises when providers are not cognizant of the paternalism that can pervade their interactional exchanges with users. Clinicians often do not recognize the personal components of users' medical choices, such as medication side effects that result in living with obesity, involuntary facial movements, susceptibility to diabetes and other illnesses, and lower sex drive, to name a few [71]. Hence, making paternalistic decisions without taking these personal issues into account may well result in non-adherence. Due to the potential risk of dangerousness, mental health providers have always desired higher rates of adherence from those whose capacities can be compromised than those with somatic illnesses; however, rates of adherence in mental health are not very different from most other illnesses, including those with somatic illnesses and associated life threatening consequences of non-adherence [72].

Anti-deinstitutionalizationists have concerns about the capacity of those with mental illness to make decisions, particularly regarding medical care but also regarding psychosocial choices [71]. However, evidence from a large medication trial found that 96% of psychiatric patients presented with comprehensive information were competent to make an informed decision

about their participation. Furthermore, it has been determined that those who do not grasp information initially can be educated [71, 73]. For the very few people with compromised decisional capacity, there are legal guardianship mechanisms in place for appointing proxy decision-makers, or advanced directives that can identify a proxy when a person becomes incapacitated. Ironically, outpatient commitment laws do not require a clinical assessment of competency.

Shared-decision-making does not preclude involuntary inpatient commitment for those whose decisional capacity with regard to medical care is lacking. Proponents of both policy positions recognize a place for involuntary hospitalization. The difference is the manner in which it is executed. Research has found that acceptability of involuntary hospital admission is related to procedural justice, which is a comparable process to shared decision-making – the perceived fairness about resolving a dispute or conflict is dependent on degree of meaningful participation in the decision. Patients who felt heard with their concerns validated during the admission process had less negative feelings about the involuntary admission and felt the process was fair [74, 75]. Furthermore, there is no evidence for supporting the effectiveness of either formal or informal coercive strategies in community mental health care [48]. Theories of reactance support the resistance found in service users when they feel coerced to do something to which they are opposed; they then resist, and coercive measures are likely to rupture therapeutic relationships and undermine the engagement in treatment. Thus, coercive policies defeat their intended purpose.

Research related to shared decision-making with persons with severe psychiatric disorder has found support for enhanced treatment adherence. For example, a positive clinician alliance and good communication with the patient are associated with more favorable patient adherence [76], and increased engagement in decision-making enhances treatment satisfaction [77, 78]. Satisfaction with treatment results in improved adherence [79], but coercive interventions produce treatment dissatisfaction [80].

In Conclusion

Managing risk for persons with severe mental illness means controlling risk while affording risk opportunities. This population does have a slightly elevated risk of violence as compared to the general population; however, violent incidents are still extremely rare events, and estimates are that only 4% of US violence can be attributed to those with a mental illness [81]. Furthermore, over half of the targets of violence by this population are family members, not strangers or the general public [82–84]. Those with mental illness have a greater likelihood of self-harm and being victimized than perpetrating violence against others [85]. We need a more balanced approach between risk control and risk opportunity and a better understanding of risk from a mental health service users' perspective. In almost two hundred years of a failed policy of institutionalizing people with mental illness, one would think that the collective clinical wisdom and scientific evidence would result in a more effective policy solution than recycling past failures. As sociologist Joseph Morrissey [86] recently wrote

...legislating outpatient commitment without reinvesting in the restoration and growth of intensive and high-quality community services is nothing more than a cruel hoax....Meaningful changes in community mental health outcomes will require

attention to the intensity and quality of care as well as to its patient centeredness and recovery orientation. (p. 1)

The recovery movement led to important lessons about the benefits of voluntary, participatory treatment. Policy should not be based on rare events. Key elements of common ground between anti-deinstitutionalization and anti-institutionalization include policies that balance risk control and risk opportunity by investing in voluntary, participatory services that maximize autonomy and self-determination while supporting clinical practices that emphasize partnership and shared decision-making. Policies should not enable treatments that feel like punishment. It is time to think morally and scientifically on the path to supporting the best quality of life for people with mental illness, their loved ones, and their communities.

Compliance with Ethical Standards

No research was conducted for this manuscript – therefore no IRB was sought and no informed consents obtained.

Conflict of Interest Phyllis Solomon and Ryan Petros have no potential conflicts of interests.

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