

My name is Lisa Cosgrove. I have a PhD in clinical psychology and am a full professor at the University of Massachusetts Boston and a Faculty Fellow at UMB's Applied Ethics Center. My research addresses ethical and medical-legal issues in psychiatric research and practice. I have co-authored and co-edited books, have published over 100 peer-reviewed papers and book chapters, and I teach courses on psychiatric diagnosis and psychopharmacology. I was a Research Fellow at the Edmond J. Safra Center for Ethics, Harvard University (2010-2015) and I served as a consultant to the United Nations Special Rapporteur on the Right to Health, child psychiatrist Dainius Puras. I am also a co-founder (with Julie Hannah, University of Essex) of the *Centre for Mental Health, Human Rights, and Social Justice*.

As a faculty member who teaches masters and doctoral level clinicians-in training, I want to emphasize the fact that involuntary commitment does not achieve the desired effect that proponents hope it will. Indeed, numerous studies have shown that involuntary outpatient commitment is not effective at meeting its proponents' goals of treatment compliance and reduced rates of hospitalization. For example, the Bellevue Study conducted in New York, which compared a group of individuals under involuntary outpatient commitment to a control group, found that court orders did not lead to lower rates of crime or hospitalization, or promote compliance with treatment. The results from empirical research are clear: involuntary outpatient commitment does not improve patient outcomes.

Indeed, a growing number of both health care professionals and people with lived experience argue that involuntary commitment undermines the therapeutic alliance, is not evidence-based, violates fundamental human rights, and disproportionately impacts BIPOC communities (Mustafa, 2018). Involuntary commitment poses clear threats to an individual's autonomy and agency, which can result in strained (or even loss of) familial relationships if family members are support such practices.

As Craigie et al. (2019), among others note, there is a diversity of opinions on the issue of legal capacity by clinicians as well as patients. What is agreed upon, however, is that voluntary treatment is more effective than involuntary treatment and that supported decision-making should supplant substitute decision-making (Bach & Kerzner, 2010; see also Cosgrove et al 2020).

In closing, we must end the non-evidence-based practice of involuntary commitment and adopt a philosophy of kindness, compassion, and empathic regard

for the well-being of all. In so doing we would be upholding one of the most important bioethical principles: “*Primum non nocere.*”

References

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