Liberty, Coercion, and Mental Health Treatment

Paul S. Appelbaum, MD
Dollard Professor of Psychiatry, Medicine, and Law
Columbia University/NY State Psychiatric Institute
History of MH Treatment in US Is Linked to Coercion

- From the inception of mental health treatment in this country, the majority of admissions were involuntary
- **1st hospitalization** 1751, **1st voluntary admission statute** 1881
- Involuntary admissions predominated into the 1970s
- Why?
Factors Underlying Coercive Approaches - 1

- Presumption that committed, mentally ill persons are incompetent
  - Written into statutes until mid-20th century
  - Burden on committed person to demonstrate that competence has been restored

- If incompetent, patients’ consent was considered irrelevant and interventions used regardless of their desires
Factors Underlying Coercive Approaches - 2

- Association between mental illness and violence
  - Common assumption in the popular mind— notwithstanding the empirical data
- Police power rationale preempts patients’ decisions, so again treatment can be undertaken regardless of patients’ desires
New Approach to Psychiatric Treatment (1960-1979)

- From a legal and moral perspective, the legitimate scope of the state’s power to intervene seen as limited to danger to self/others
- Movement for statutory change is explicitly aimed at reducing use of coercion
- By 1979, every state limits commitment criteria to danger to self/others
- By mid-1980s, most states adopt rules restricting involuntary treatment of committed patients
Aftermath of Reform: Coercion Still Exists

- Coercive approaches have not disappeared, and may not even have diminished
- But the locus of coercion has moved from the institution to the community
- And the form has changed from recognizable coercion to more subtle “leverage”
Concept of Leverage

- Leverage is the regulation of access to benefits that patients want (e.g., freedom, money, shelter, interpersonal support) based on patients’ adherence to treatment recommendations.

- Leveraged approaches can be formal or informal, legal or extralegal, overt or subtle.
What Accounts for the Persistence (Growth?) of Coercive Approaches?

- Effects of fear and stigma
- Especially prevalent after horrendous acts of violence by persons with mental illness
NAME is a RACE/ETHNICITY, MAN/WOMAN, who has completed EDUCATION. Up until a year ago, life was pretty okay for NAME. But then, things started to change. He/She thought that people around him/her were making disapproving comments, and talking behind his/her back. NAME was convinced that people were spying on him/her and that they could hear what s/he was thinking. NAME lost his/her drive to participate in his/her usual work and family activities and retreated to his/her home, eventually spending most of his/her day in his/her room. NAME became so preoccupied with what s/he was thinking that s/he skipped meals and stopped bathing regularly. At night, when everyone else was sleeping, s/he was walking back and forth in his/her room. NAME was hearing voices even though no one else was around. These voices told him/her what to do and what to think. S/he has been living this way for six months.
“How likely is it [John/Mary] would do something violent to other people?”

% very/somewhat likely

- Schizophrenia: 61
- Major depression: 34
- Drug dependence: 87
“Do you think that people like [John/Mary] should be forced by law... to get treatment at a clinic or from a doctor?” (% yes)

<table>
<thead>
<tr>
<th>Disorder</th>
<th>% Yes</th>
</tr>
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<tbody>
<tr>
<td>Schizophrenia</td>
<td>49</td>
</tr>
<tr>
<td>Depression</td>
<td>22</td>
</tr>
<tr>
<td>Drug</td>
<td>67</td>
</tr>
</tbody>
</table>
“Do you think that people like [John/Mary] should be forced by law... to get treatment... if he or she is dangerous to others?” (% yes)

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>% Yes Before</th>
<th>% Yes After</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>49</td>
<td>95</td>
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<tr>
<td>Depression</td>
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<td>94</td>
</tr>
<tr>
<td>Drug</td>
<td>67</td>
<td>96</td>
</tr>
</tbody>
</table>
Could Factors Other Than Fear/Stigma Also Be Operative?

- Coercion/leverage extraordinarily prevalent and diverse

- Might commonsense view that coercion is sometimes necessary be based in reality as well?
Nature of Mental Illness Plays a Role in Prevalence of Coercion

- Severe mental illnesses impair decision making in a subset of persons
  - Competence to consent to treatment may be limited
  - Unawareness of illness may lead to failure to get treatment
Unawareness of Illness Common Among Persons with Some Mental Illnesses

- Denial vs. anosognosia
- Typical finding: 57% of patients with schizophrenia had “moderate to severe unawareness of having a mental disorder” (Amador, et al., 1994)
Rates of Treatment of Severe Mental Illnesses

- National Comorbidity Survey reported 1-year treatment rate of 48.5% for all persons with severe mental illnesses
- Majority of persons not receiving treatment reported that they did not need it
Justification for Soft Paternalism

- Legitimate to intervene when people
  - Badly in need of treatment
  - Likely to suffer harm
  - Cannot recognize illness/need for treatment
Nature of Mental Illness Plays A Role in Prevalence of Coercion-2

- Some people with mental illnesses likely to be violent
- Risk is increased compared with general population
  - Attributable risk varies by country/base rate of violence
Violence in First 10 Weeks After Discharge – Pittsburgh

Community: 4.6%
Patients: 11.5%
Violence in First 10 Weeks by Substance Abuse Symptoms – Pittsburgh

% Violent

<table>
<thead>
<tr>
<th></th>
<th>Without Substance Abuse</th>
<th>With Substance Abuse</th>
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</thead>
<tbody>
<tr>
<td>Community (17.5)</td>
<td>3.3</td>
<td>11.1</td>
</tr>
<tr>
<td>Patients (31.5)</td>
<td>4.7</td>
<td>22.0</td>
</tr>
</tbody>
</table>
Justification for Hard Paternalism

- Society has right to protect citizens from danger
- Degree of competence may not be material
- Threshold lower if benefit provided
Coercive Approaches Reflect Belief That Paternalism is Justified

- Expectation of eliminating coercion appears to have been overly ambitious
- Hence, coercion has moved from institutions to the community along with patients
- New forms of leverage have been developed
Appropriate Use of Coercion Requires Caution

- Blanket endorsement unwarranted
  - Many people with mental illnesses can and should make decisions for themselves
- Blanket rejection also unwarranted
  - Nature of mental illnesses may justify coercive intervention
Challenges for Policy Makers

- Limit use of coercion by identifying circumstances that justify it
- Even within these contexts, encourage maximum possible exercise of autonomy