Coercive Interventions in Mental Health

David Cohen, PhD, LCSW

HBSE II – Psychopathology

Feb. 10, 2010

1

Coercion

- To use force, threats, intimidation, pressure, or leverage of essential resources to get someone to do something
- the legal or physical ability to deprive another person of life, liberty, or property, or to threaten to do so

Coercion in mental health

- To impose a psychiatric diagnosis or intervention on a person against his or her will
  - this imposition is formally legitimized by the state
- To do the same, informally

2

Justification for coercion

- Coercion in mental health is justified by appeal to two principles:
  1. state's legitimate *parens patriae power* (to protect vulnerable people, as a parent would protect children)
  2. state's legitimate *police* power (to regulate behavior and enforce order)
- Coercion is a response to threat—real *or* perceived

3

Universal coercion of the "mad"

- Occurs in all societies
- Birth of psychiatry as a discipline tied to madhouses of 18th century Britain
- *Association of Medical Superintendents of American Institutions for the Insane* changed to American Psychiatric Association in 1844

4

Controversial and sensitive

- Coercion is the *distinguishing* feature of psychiatry as a medical discipline—no other medical discipline coerces its patients
- Civil commitment is most controversial psychiatric topic—widely opposing views
- Despite controversy, topic not often discussed squarely

5

Coercion in mental health is called

- **"Involuntary examination"**
- **"Involuntary treatment"**—forcible administration of psychotropic drugs or ECT (or other tx)
- **"Civil commitment"**—detention inside a psychiatric or other facility
- **"Outpatient commitment"**—coercion to receive tx in the community

6

Widespread, not decreasing

- Coercion is widely thought to be less frequent today than in the past—but it's the opposite
- Extrapolating from FL and CA data: about 50 per 10,000 adults/year get invol exam or hosp (> 1 million)
- Length of hospitalization has decreased but number has increased (e.g., 1.74 million hosps for psychoses in 2006; average stay: 7.7 days)[1]

1. www.cdc.gov/nchs/data/nhsr/nhsr005.pdf

7

Very little research on outcomes of involuntary hospitalization

- Review of 41 studies comparing voluntary vs. involuntary patients on different outcomes:
- > length of stay, risk of readmission and inv. readmission
- > suicide, dissatisfaction with treatment, felt treatment was unjustified
- < social functioning
- = psychopathology, treatment compliance

Kallert et al. (2009). Involuntary vs. voluntary hospital admission: A systematic review of outcome diversity. *Eur Arch Gen Psychiatry Clin Neurosci*, 258, 195-209.

8

Coercion and school of thought

- Most coercive interventions may be *informal* and not recorded officially
- Today, coercion most promoted by advocates of biological school of thought—**biological illness = non-responsibility**

9

Civil commitment

- For ~ 50 yrs, society has struggled with a way to make commitment look like it follows due process
- Due process: the fair, legal treatment of individuals accused of crimes or threatened with loss of liberty
- The struggle apparent around the issue of "civil commitment criteria"

10

History of civil commitment criteria

- New York – 1788 – 1st US commitment law
  - the "furiously insane" and those deemed a danger to the community may be apprehended by justices of the peace and kept in a secure, locked place
- Several U.S. states — early 1970s
  - there occurred many legal challenges to states' civil commitment criteria as unconstitutionally vague
  - as a result, newly defined criteria centered on *dangerousness*

11

"Dangerousness"

- **danger to self**: usually means threat of suicide
- **danger to others**: usually means threat of physical violence
- **gravely disabled**: usually means person at risk of serious physical harm due to their neglect of basic human needs
- courts have interpreted these phrases to mean "imminent" danger

12

Civil commitment criteria since the 1970s

- Many states patterned their commitment statutes according to "dangerousness standard"—a step viewed as a major rights-oriented reform
- The reform narrowed commitment criteria in theory, but all states experienced a large increase in number of civil commitments
- "Almost a revolution"—Appelbaum (1984): those charged with *applying* the law will bend it to their end

13

"Gravely disabled"

- In 1990s, increased visibility of homelessness frequently explained in psychiatric terms
- some argued for broader "need for treatment" standard for persons who "needed" treatment but might not be imminently dangerous
- Some states revised "gravely disabled" criteria to include persons who cannot function independently or who are likely to deteriorate without treatment

14

Florida Mental Health Act

- Informally known as "Baker Act," 1971
- Website for Baker Act handbook, forms (English & Spanish), Habeas Corpus, FAQs, etc. http://www.dcf.state.fl.us/mentalhealth/laws/index.shtml
- Involuntary Outpatient Placement (IOP) passed in 2004
  - Also called IOT (treatment); IOC (commitment); mandated community treatment; leveraged treatment, and more…

15

Involuntary hospitalization criteria in *Florida Statutes 394.463*

(1) CRITERIA.—A person may be taken to a receiving facility for involuntary examination if there is reason to believe that the person has a mental illness and because of his or her mental illness:

(a)1. The person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; or

(a)2. The person is unable to determine for himself or herself whether an examination is necessary; and

16

Involuntary hospitalization criteria in *Florida Statutes 394.463*

(b)1. Without care or treatment, the person is likely *to* suffer from neglect or refuse to care for him/herself; such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; or

17

Involuntary hospitalization criteria in *Florida Statutes 394.463*

(b)2. There is a substantial likelihood that without care or treatment the person will cause serious bodily harm to himself or herself or others in the near future, as evidenced by recent behavior.

18

No duty to commit

"(1) CRITERIA.--A person **may** be taken to a receiving facility for involuntary examination …"

- The statute is **discretionary**, **not mandatory**.
- Courts have **not** recognized a duty to commit by psychiatrists, especially in an outpatient relationship (FL case of Paddock v. Chacko, 1988, is illustrative)

19

Professionals can refuse to treat

- **FL Statute 394.460**

  "Rights of professionals.--No professional referred to in this part shall be required to accept patients for treatment of mental, emotional, or behavioral disorders. Such participation shall be voluntary."
- *Professionals in ongoing relationships have more obligations toward their patients.*

20

Warning third parties

- **FL Statutes 456.029**
- Communications are privileged, but psychiatrist *may* disclose them if patient "has made an actual threat to physically harm an identifiable victim" and psychiatrist judges that client can commit the act and is likely to do so in the near future.
- "to the extent necessary to warn a potential victim" or "communicate the threat to a law enforcement agency"

21

Mandatory Reporting

- **FL Statutes 39.201**—child abuse, abandonment, or neglect
- **FL Statutes 415.1034**—abuse, neglect, or abandonment of vulnerable adults
- Law identifies various individuals who must report, including mental health professionals and social workers

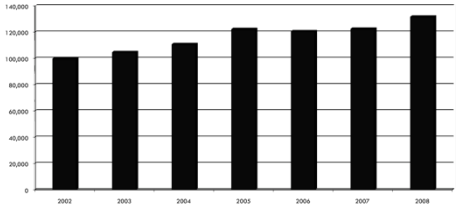
22

Baker Act statistics, 2008

- **~99,040** people had **131,621** involuntary exams
  - Exams have increased 31.1% between 2002-2008, while pop. growth was only 12.7%
  - range of 1-33 exams per person; ¾ have 1 exam
- Exam initiators
  - Law enforcement: 49%
  - Mental health professionals: 48%
  - Judges: 3%
- Average age of individuals being examined was 37 yrs; 17% of exams were for youth age 4 thru 17

23

Involuntary exams in FL, 2002-2008



2008: 131,621
2007: 122,454
2006: 120,506
2005: 122,206
2004: 110,697
2003: 104,600
2002: 99,772

24

Initiators of Baker Act exams, 2007

INITIATOR OF EXAM	%
PHYSICIANS	78%
SOCIAL WORKER	7%
LMHC	5%
PSYCHOLOGIST	2%
PSYCHIATRIC NURSE	2%
UNKNOWN	6%

25

More Baker Act statistics, 2008

- Involuntary exam criteria:
  - Harm : **65%**
  - Neglect : 12%
  - Harm and neglect: 19%
  - Not indicated: 4%
- Type of harm for exams initiated for "harm":
  - Harm to self only: **51%**
  - Harm to both self and others: 19%
  - Harm to others only: 6%
  - Not indicated: 13%

26

Race & ethnicity among Baker Act examinees, 2007

RACE/ETHNICITY	% OF EXAMS	% OF FL POP (U.S. Census 2008)
WHITE	73	80
BLACK	21	16
ASIAN	0.5	2
OTHER/MIXED	6	1.5
HISPANIC orig.	9	21

27

Involuntary outpatient commitment

- A court order requiring an individual to comply with an outpatient treatment plan
- Aims to reduce hospital readmissions, involvement with the criminal justice system, and improve treatment adherence
- Requires looser commitment criteria
- Consequences of noncompliance with court order are not always clear

28

Involuntary outpatient commitment

- May also entail other forms of leverage
  - Making the person's access to funds or subsidized housing contingent on treatment compliance
  - lenient criminal sentence/probation on condition of treatment adherence
- IOC is fueled by presumed dangerousness of mentally ill; seen as mechanism to protect the public
  - In reality, most persons diagnosed mentally ill are not violent. Schizophrenia diagnosis associated with violence only with substance abuse comorbidity (Fazel et al. 2009)

29

Outpatient commitment—Pros

- Refusal or non-compliance is rooted in mental illness, which abridges ind'l's autonomy—so "small" limitations of that autonomy increase freedom
- Better than life behind locked door, or psychotic life
- Increases the effectiveness of treatment, cost-effective, decreases involvement with criminal justice system and inpatient hospitalization

Geller. (2006). The evolution of outpatient commitment in the USA: From conundrum to quagmire. *International J Law &Psychiatry*, *29*, 234-248.

30

Outpatient commitment—Cons

- Another coercive social control mechanism will widen the net of involuntary patients and increase stigma
- Treatments of dubious value are forced on marginal persons because services are unavailable
- May be more intrusive than inpatient commitment because intrudes on person's room and board
- No serious evidence that it "works"—reductions in inpatient use may be *administrative* mechanism

Geller (2006) 31

Involuntary Outpatient Placement (IOP) FL Statute 394.4655

- ✓ Person is unlikely to survive safely in the community without supervision, based on a clinical determination
- ✓ History of lack of compliance with treatment
- ✓ Within last 36 months has: At least twice been involuntarily admitted to a facility or Engaged in ≥ 1 acts of serious violent behavior or bodily harm toward self or others
- ✓ Unlikely to voluntarily participate in the recommended treatment plan or is unable to determine for him/herself whether placement is necessary
- ✓ Person needs IOP in order to prevent a relapse or deterioration
- ✓ All available, less restrictive alternatives that would offer an opportunity for improvement of his/her condition have been judged to be inappropriate or unavailable 32

IOP statistics in Florida

- 2005 was first year IOP was implemented in FL, hailed as "the first important step in halting the relentless revolving door of repeated arrests, and homelessness for thousands of people in Florida with untreated mental illnesses…"
- 2005—mid 2007
  - Only 71 placements in 3 years, despite ~43,000 people having had 2 or more 72-hour holds (and therefore "eligible" according to IOP statute)
  - Service descriptions + goals + approval by mtl health prof within 72 hours may limit applicability

Petrila & Christy. (2008). Florida's outpatient commitment law: A lesson in failed reform? *Psychiatric Services, 59*, 21-23. 33

Diversion to jails

- Jails have become a principal place to house/ divert people with mental disorders
- Approx. 14.5% of men and 31% of women in sample of prisoners in Maryland and New York jails diagnosable with depressive or schizophrenic disorders.[1]
- > 50% of prisoners have a lifetime diagnosable condition, especially substance-related

1. Steadman et al. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric Services, 60*, 761-765.

34

Issue #1: Predicting dangerousness

- Series of studies since 1970s have shown clinicians are more likely to be wrong than right in predicting future violent acts
  - No empirical evidence that we can accurately predict "dangerousness"
- Further, no evidence that involuntary placement (and any interventions provided during placement) prevent violent acts (to self or others)

35

Issue #1: Predicting dangerousness

- Predicted dangerousness has not historically been sufficient cause for detainment of American citizens
  - IOC laws based on what an individual *might* do rather than what an individual *has* done
- Persons having highly contagious diseases and those diagnosed with mental illness are the only people who can be forcibly restrained and treated

36

Suicide debate: Ivanoff's view

- Suicide is not just a personal decision because it has social repercussions
  - Families/friends of patient, police, other professionals demand and expect that we manage disruptive behavior
- Our professional, ethical duty is to safeguard the lives of others

37

Suicide debate: Gomory's view

- No evidence that suicide is preventable or predictable
  - If there is no effective suicide prevention, then no coercive treatments can be useful (or ethically justifiable)
- Existentialist/Humanistic perspective:

"The decision of whether a life under a certain set of circumstances is worth continuing is clearly a tragic human question, answerable only by the person living that life."

38

Issue #2: Positive vs. Negative Liberty

- **Positive liberty**: advocated by many professionals and family advocacy groups
  - assume that individuals would comply with treatment if their mental capacity were not diminished due to mental illness
- Equates noncompliance with incapacity to make decisions/ lack of insight
  - Ignores that people may have *reasons* for refusing treatment

39

Issue #2: Positive vs. Negative Liberty

- **Negative liberty**: advocated by civil libertarians, legal scholars, and many ex-patient groups
  - an individual has a right to be left alone and to be free from interference by others ; includes right to refuse unwanted or unsolicited treatment
- Recognizes that our interventions are not universally helpful, and are often harmful
- Acceptance of negative liberty requires us to become more tolerant of disruptive behavior

40

Issue #3: Incompetence

- The issue of incompetence arises only when the individual refuses treatment
- Are individuals who accept treatment ever found incompetent?
- Clients complain that treatment refusal + disagreement with clinicians equate "incompetence" and "lack of insight"
- Few practitioners have a sense of how to evaluate competence

41

SW and self-determination

- NASW ethical principle: "right of client to self-determination"
  - Related to value: respecting the dignity and worth of every person
- Self-determination (broad): right of individuals to have full power over their lives
- Self-determination (specific): right to be free from all involuntary treatment; right to be involved in health/treatment decisions

42

SW and self-determination

- Some SW critics argue, "the very notion of self-determination within a system that includes forced treatment and loss of basic rights and freedoms is untenable"
- Get clear on your perspective regarding involuntary interventions, self-determination
  - How can you foster self-determination with your clients in daily practice?
  - Can we do without involuntary interventions in mental health system? Should we?

43

Recommendations

- Changes to mental health service delivery
  - "Recovery-oriented"
  - Voluntary
  - More peer-run, consumer-delivered services
  - Address social problems like poverty & unemployment
- Encourage workers to reflect on their use of involuntary measures—who says workers must participate?
- Reframe involuntary interventions as part of the criminal justice—not mental health—system

44

Recommendations

- Psychiatric Advance Directives (PADs)
  - Indicate treatment preferences while "competent" to be implemented when deemed "incompetent"
  - Likely that refusal of treatment in PAD could be overridden by clinician citing "dangerousness"
- Helping-professionals assume responsibility for informing clients of PADs
  - SWers should inform/educate clients about PAD
  - Assist clients in completing PAD (like at discharge)
  - Make a plan for communicating/distributing PAD to other professionals in times of crisis

45