"Caring Coercion" can help insure some people with serious mental illness get the treatment they need. These two articles by Dr. Steven Sharfstein explore the issue.

Individual rights must be balanced with 'caring coercion'

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Until just 40 years ago, most people who were seriously mentally ill were coerced and confined. The combination of fear and compassion led Western society, through legal and medical means, to restrict the "insane."

Now the majority of people with mental illness reside in the community and receive treatment in the "least-restrictive settings."

One compelling reason, however, remains for involuntary hospitalization: fear of violence, especially from individuals who are behaving erratically or preoccupied with delusions and lacking a fundamental awareness of their mental illness and their need for treatment. Yet even this fundamental and historical justification for psychiatric coercion is controversial today, clashing with deeply held notions of individual liberty and autonomy.

In recent years the civil rights of mentally ill people have been in the forefront of discussion and debate, in terms of–depending on your point of view–their right to treatment when resources are dwindling or their right to refuse treatment. Society expects psychiatric physicians to exercise good clinical judgment in protecting psychotic patients from themselves or others. Since most inpatient care, including involuntary care, is short term, the issue of coercion has shifted, in part, from involuntary hospitalization to mandatory outpatient treatment.

Mandatory outpatient, or assisted, treatment is court-ordered outpatient care for certain individuals who have a severe mental disorder and do not comply with treatment. It is a preventative approach to trying to avoid not only inpatient care but also the much more deleterious outcome of homelessness and incarceration: the modern epidemic for severely and persistently mentally ill people in America.

As of today, 42 states and the District of Columbia have outpatient commitment statutes, although most of these states implement this authority in a haphazard and inconsistent manner. Assisted treatment has received media attention due to some well-publicized papers on violence in the community committed by mentally ill persons such as Russell Weston, who killed three U.S. Capitol police officers in 1998, and Andrew Goldstein, who pushed Kendra Webdale onto the subway tracks in New York.

The Goldstein case led to the passage of "Kendra's Law," establishing mandatory outpatient treatment in New York /(Psychiatric News,/ August 19). Recent data from the New York State Office of Mental Health on the first

five years of implementation of Kendra's Law indicated that of those participating (several thousand individuals), 77 percent fewer experienced hospitalizations.

In New York there is widespread acknowledgement that this law, despite the protests from some civil libertarians, has been an outstanding example of what I would term "caring coercion." A randomized, controlled study in North Carolina found that patients who received intensive routine outpatient services without a court order did not lead to reduced hospital admission rates. But when patients were given the same level of services (at least three outpatient visits a month, with a median of 7.5 visits a month) combined with assisted treatment of six months or more, hospital admissions were reduced by 57 percent and the length of stay by 20 days, compared with individuals without court-ordered treatment.

Despite the above findings, outpatient commitment, or assisted treatment, remains controversial, and currently there is no such law in Maryland, where I live and work. Another example of "caring coercion" is mental health courts. These courts use their judicial authority to impose treatment compliance as a condition of release from jail or bail or as an alternative to jail. Failure to comply results in the imposition of sanctions up to and including incarceration. The court-ordered treatment alternatives are another example of trying to deal with the number of people with severe mental illness caught up in the criminal justice system.

One of the great tragedies of modern psychiatry is the large number of incarcerated individuals who are mentally ill or drug addicted. This is the inevitable consequence of our reluctance to use caring, coercive approaches such as assisted treatment. A person suffering from paranoid schizophrenia with a history of multiple rehospitalizations for dangerousness and a reluctance to abide by outpatient treatment, including medications, is a perfect example of someone who would benefit from these approaches.

We must balance individual rights and freedom with policies aimed at caring coercion. Our responsibility to each other and our respect for personal rights lie at the center of our social and moral choices as Americans.

Psychiatric Review

The case for caring coercion

By

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Recently, half the patients on the dual-diagnosis unit at Sheppard Pratt were homeless. Even if staff could begin meaningful treatment in the three to four days their managed care companies allowed, it was clear that discharge would lead to readmission in the near future. It is becoming alarmingly apparent that as inpatient care wanes, vigorous outpatient treatment must take its place. But how will this work for those patients who do not take their medications or defy therapeutic efforts? They, too, stay a shorter time in the hospital. The revolving door of hospitalization for mental illness has already become a huge turnstile, disgorging mental patients onto the street or into jails. What is to be done?

One solution is that of involuntary outpatient treatment. Thus, a paranoid schizophrenic with a history of multiple rehospitalizations for dangerousness will be informed by authorities that he must comply with outpatient treatment and take his medication or he will be detained against his will. A welfare recipient with substance abuse will be told that he must submit to urine testing and therapy or face the cut off of his welfare benefits. And an attorney is warned that she must have treatment for alcoholism or suffer the loss of her license to practice law. These and other constraints on the freedoms of patients already comprise the elements of mandatory therapy in such states as Massachusetts and Washington. Yet society remains troubled by coercive treatment. Legislatures are loathe to impose such regulations on constituencies. Ironically, it is the patient advocacy groups such as NAMI who press for coercive treatments even more than victims of crimes such as pedophilia.

Historically, most of the seriously mentally ill in Western society have been confined to institutions against their will. Fear of violence-to self or others-especially from delusional individuals or those behaving erratically has traditionally justified the concept of involuntary hospitalization. But in recent decades, the civil rights of those very mentally ill have triumphed. These victories have led to grave deficiencies in treatment as patients are released from the hospital prematurely. Paralleling this phenomenon is the very essence of hospitalization, an event which has changed dramatically with managed care. Patients are now admitted not simply because they are ill, but because they are dangerous. The criteria for retention within the hospital is continued risk, but nothing more. Thus after a few days of what is called "crisis stabilization," the patient's insurance is halted and he is put out or, in severe cases, transferred to a state hospital. There, too, stays are shortened. Fashioning itself like the private counterpart, the public sector has eliminated any semblance of refuge. Once functioning as a community haven for the ill, state hospitals are barren real estate with boarded up units, empty recreation halls, and vending machines instead of kitchens.

The psychopharmacologic treatment of severe mental illness has had a paradoxically contributing effect to abrupt hospital stays. Rather than augmenting care, drug treatment has counterintuitively undercut it by effecting acute symptomatic relief at the price of long term treatment. Patients are rapidly medicated, then released as if the core illness was abolished. The truth is otherwise. Core illness takes great time to effect and requires the full range of individual and social therapies. But few hospitals have full-time art or occupational therapists on their staffs any more. Psychosocial therapies are seen as luxuries, not necessities. Leaves of absence to test improvement are no longer allowed.

Discharge without adequate treatment has created a vast new set of problems. In the last four decades, hundreds of thousands of patients have been deinstitutionalized. Some have managed well with supporting housing, rehabilitation, and community outpatient settings. But for others, the return to the community is a phantom concept. Many have gone from the hospital to the street, and from the street to jail. As long ago as 1939, Penrose demonstrated a negative correlation between the portion of people in a given nation placed in mental hospitals and the portion held in jail. In 1999 the Department of Justice reported that as much as 16 percent of the population of state jails and prisons suffer from several mental illnesses. This translates to more than 250,000 individuals. Housing 3,500 and 2,800 mentally ill inmates respectively, the Los Angeles County jail and New York Riker's Island jail are currently the two largest psychiatric inpatient treatment facilities in the country. This warehousing of the mentally ill in jails and prisons harkens back to the deplorable conditions in the nineteenth century which prompted Dorothea Dix and the Quakers, who founded Sheppard Pratt in Baltimore, to develop asylum care.

We have, then, expanding populations of partially treated severely ill patients flowing into our communities. In 1995, Torrey and Kaplan estimated that 250,000 individuals were living in the community who just a few decades before would have been patients in state psychiatric hospitals. Yet we know full well that an episode of mental illness may last many months, if not years. What, then, is the recourse for patients who need help to remain functional?

As of today, 40 states and the District of Columbia have outpatient commitment statutes, although most of these states implement this authority in a haphazard and inconsistent manner. Generally, some form of tragedy has spawned the creation of an outpatient law; for instance, the case of Andrew Goldstein who pushed Kendra Webdale onto the subway tracks in New York ultimately led to the passage of "Kendra's Law" establishing mandatory outpatient treatment in New York. But this is a drastic case. Are less extreme cases eligible for coercive treatment?

I believe we have little choice in the matter if we are to meaningfully treat the mental patients in our country. Doing something to someone else for "their own good" is fraught with ethical and moral dangers. To insure a democracy, there must be checks and balances, rights to hearings, advocates, and judges. I call for a "caring coercion." I believe rather than abandon our mentally ill, we can thoughtfully attempt to treat them outside the hospital. Day and partial care facilities can be constructed. The hospital milieu-once a haven of healing-will need to be resurrected in spaces once bordered by locked doors and shatter-proof windows. And novelty and innovation will be requisite; simple legislation is not enough.

In November of this year, President Clinton signed a bill that authorized funding of up to 100 mental health courts for nonviolent offenders who are mentally ill. Building on models from Broward County, Florida and King County, Washington, this initiative would have special judges hear cases involving persons with mental illness who committed nonviolent crimes. These judges would decide whether the offender should be placed in outpatient or inpatient treatment programs to be monitored closely. Simultaneously, grants also will be awarded to local governments to set up the training of law enforcement officials and judiciary personnel to identify and address the unique needs of mentally ill offenders. These alternatives, though far superior to simple incarceration, still await meaningful implementation. Most community mental health centers are not equipped to handle mentally ill offenders. There must exist all those techniques and modalities which would be available within a hospital. This is hardly a casual undertaking. The coercion must be a caring one insofar as there is present a panoply of services-a full hospital without walls. If we can erect such institutions, we can begin to erase the shame of our untreated mentally ill.