Coercion in Psychiatric Care: What Have We Learned from Research?

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The use of coercion to assure that people with a mental illness receive treatment has been the focus one of the longest running controversies among mental health professionals. Until quite recently, however, this debate has been almost entirely based on abstract principles. Empirical research concerning coercion was quite limited. Recently, however, research in this field has blossomed. The development of a validated measure of perceived coercion has spawned a variety of new studies. A five-nation study in Scandinavia has begun the difficult task of assessing the impact of different legal systems and systems of care on perceived coercion. Two new studies have used random assignment designs to study the impact of outpatient commitment. This article reviews these and other studies and describes what they do, and do not, tell us about coercion in mental health treatment.

Should members of the mental health profession coerce patients into treatment when they need it? Does coerced treatment work as well as treatment with which the patient is overtly cooperating? What sorts of pressures are put on patients to cooperate with treatment? What is it that makes patients feel coerced? These and related questions have been debated in the mental health system for years; yet, until very recently, there has been little systematic research on coercion in mental health care.

The last decade has seen an explosion in research about coercion in psychiatric care. By the mid-1980s, there had never been a large scale study specifically focused on coercion in psychiatric care. By the late 1990s, two major studies had been completed—one of which has engendered a variety of related studies, some of which are major studies in their own right. Yet despite the publication of some of this work in the major psychiatric journals, few people have a comprehensive picture of what is known about these issues. This commentary will describe both what we now know and where re-

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search in this field must go in the next decade if it is to stay relevant to our changing mental health system.

The Ethics of Coercion

Ordinarily this sort of discussion would begin with a definition of the term "coercion." Certainly one should not talk about an issue without making clear what one is discussing. Years of debate in philosophy and political science have not, however, yielded a general agreement on this subject.[1] In what is clearly the most thoughtful recent philosophic work on the subject of coercion in mental health settings, Wertheimer[1] has suggested that it is not possible to describe behaviors as coercive separate from the judgment that they are wrong or inappropriate. Many researchers in the field, however, routinely use the word coercion to describe legally involuntary treatment, the use or seclusion or restraints, or other such specific behaviors. Because research related to coercion has used so many definitions or implicit definitions, it is better not to restrict this discussion of the findings by a rigid definition, but to remember instead that the construct refers to quite different things in different research studies.

The reason there is concern about these issues at all is clearly that we in the mental health profession find something problematic about using "coercive pressures" to get patients to accept treatment given "in their own best interests." As the recent report from the Group for the Advancement of Psychiatry says: "there seems to be a kind of embarrassment about situations in which the patient did not enter treatment entirely on his or her own initiative."[2] Perhaps there should not be such hesitation,[3] but there appears to be considerable discomfort with coercion, and the discomfort does not seem to disappear easily. The demand for research in this area is driven largely by our normative conflicts concerning coercive behavior by mental health professionals. However often it is repeated that this is being done "for their own good" or that it must be done to promote public safety, coerced treatment will always be at least somewhat suspect in a free society. One reason for doing research on this subject is the hope of finding a definitive answer to the question of whether mental health professionals should be using coercive methods to provide treatment to individuals who need it.

There are two approaches that ethicists use in deciding whether it is ethical to do something.[4] First, one can take a deontological approach; that is, one can analyze the *rights and duties* involved in a particular situation or behavior. Thus, one could reason that in our political system, all are entitled to make decisions about their own lives as long as they do nothing to interfere with others' similar rights[5, 6]; thus, involuntary commitment and other forms of coercion should not be permitted. However, it is certainly not so simple. The opponents of such a position can easily argue that individuals with mental illness have diminished competence to make decisions for themselves and that such rights apply only to mentally competent individuals. Moreover, the dangerousness criterion involves precisely the need to show substantial evidence of being likely to do harm to someone—but

we are all familiar with these debates and their lack of resolution.

In an effort to resolve these disputes, we often turn to a different mode of ethical reasoning, assessing the *consequences* of the acts. It has been endlessly debated whether the consequences of involuntary commitment are good or bad, but empirical research on the question has been seriously limited by basic methodological problems such as failing to control for differences between coerced and noncoerced patients and assuming that anyone who was legally involuntarily committed must also have been coerced, while anyone who was legally voluntarily admitted was not coerced.

New Research

Efforts to assess the consequences of coercion in the last two years have involved, for the most part, two major studies, which will be discussed here in some detail: the MacArthur Foundation Network on Law and Mental Health study on coercion[7] and the Duke University and New York studies on outpatient commitment.[8, 9]

The members of the MacArthur Network began with the goal of assessing the consequences of coercion surrounding inpatient admission decisions. However, their main research has actually focused primarily on developing a measure of perceived coercion in these decisions and describing the correlates of patients' perceptions of coercion (what Monahan *et al.*[7] have described as "coercion as a dependent variable"). Although this is a less dramatic problem than the consequences of coercion (coercion as an independent variable), it is also a more easily managed research task, and the MacArthur group as well as other researchers who have used their scale have made significant headway.

The scale that the MacArthur group produced[10] contains five items that focus on control, decision making, choice, freedom, and initiation of treatment. It has been shown to be a single dimension,[10, 11] stable across time,[11, 12] and to work well with substantially different types of hospitals,[10, 13] and in a culture other than the United States (Sweden).[14] The importance of having a validated scale should not be underestimated. It helps to assure that research projects done in different settings are focused on the same thing.

The MacArthur study also involved in-depth interviews with recently admitted patients who had completed the perceived coercion scale. In a detailed analysis of transcripts of these interviews, Bennett *et al.*[15] presented evidence that the perception of coercion was inextricably linked to other aspects of the process. Specifically, she found that subjects' feelings about (1) being included in the decision making, (2) the nature of the other person's intentions in facilitating the admission, (3) the absence of deceit, and (4) receiving respect were very closely linked to subjects' judgments about whether or not they had been coerced.[15] These qualitative findings were later confirmed by papers showing that these issues, variously called "procedural justice" or "process exclusion," were more closely connected to patients' perception of coercion than threats, physical force, or even legal status.[13, 16, 17]

One study of particular importance that is making good use of the MacArthur scale is a five-country Nordic study in which similar data on coercion at admission are being gathered in Sweden, Norway, Denmark, Finland, and Iceland.[18, 19] This study, however, is going far beyond simply assessing perceptions of coercion. Using a mixture of interviews and reviews of clinical and state data sources, it will determine the epidemiology of coercive behaviors in all five countries and assess how the prevalence of coercion is related to the different legal structures of the different countries. They are also looking at the validity of public records as a means of assessing the frequency of such behaviors.

Consequences

Although the research on what determines patients' perceptions of coercion (coercion as a dependent variable) is important because it will help mental health professionals to reorder the way they deliver care, and epidemiology is important to the assessment of the extent of the use of coercion, the policy question of most importance is what the consequences of coercion are (coercion as an independent variable). Unlike the study of coercion as a dependent variable, about which much is now known, the research on the consequences of coercion has not yet reached fruition.

Two recent studies will demonstrate the reason for this deficit. In a small study, Kaltiala-Heino *et al.* [20] report that there is no difference in the size of changes in either Brief Psychiatric Rating Scale (BPRS) or Global Assessment Scale (GAS) scores between an initial hospital interview and one done six months after discharge between those reporting coercion at admission and those who did not. Nicholson *et al.*[11] report that, on one of several measures of clinical status, subjects with higher perceived coercion scores improve slightly more during their inpatient treatment than those with lower perceived coercion scores, although the difference is very small. Although these findings suggest that coercion may be less destructive than some theorists have suggested, they are far from conclusive.

One problem is simply a matter of design. People who have to be coerced into treatment are unlikely to be the same as people who undertake treatment voluntarily. This is more than a matter of personality. It also involves their values, living situations, social support networks, and possibly many other unknown factors. Even when controlling for demographic and diagnostic differences as many studies do, it seems likely that substantial differences between the groups will remain and that the differences will affect how quickly subjects respond to treatment.

Until fairly recently, it was thought that researchers were simply "out of luck" in trying to study the problem of coercion—because patients could not be randomized to either a coerced or noncoerced condition, one had to accept studies of the sort that have just been described. Perhaps one could gather larger samples and control better for variables related to outcome, but in general, there were limitations on the certainty of the conclusions

that could be drawn about coercion as an independent variable because of design problems.

This is why the Duke University and New York studies of outpatient commitment are considered so important among those interested in the consequences of coercion. Although outpatient commitment is only one type of coercive legal pressure, and not the most coercive, these two studies have managed to obtain the authority to randomize patients who are eligible to be outpatient committed.

The goal of the Duke University study was to determine the impact of this allegedly coercive legal procedure on treatment outcome, adherence, and other dependent measures of considerable import. Using a design involving random assignment to either outpatient commitment or usual treatment, the study has the potential to rigorously assess the impact of one type of coercive pressure on many of the important outcome variables. A similar, if somewhat smaller study is ongoing in New York City under the direction of Dr. Henry Steadman. Although the results of this study are not yet reported, they will go a long way toward understanding the impact of this form of legal pressure on outcomes.

Unfortunately, the above-mentioned studies also have difficulties. For example, at a recent conference on coercion, the Duke University group described some of the difficulties of maintaining their randomized groups. The North Carolina law allows a commitment for only three months before it must be renewed. The Duke researchers, of course, believe that they need to follow their cases for a longer period than three months to get a reasonable assessment of the impact of outpatient commitment on outcome. However, the researchers have found many clinicians very resistant to renewing the commitment, because the patient "doesn't need it." Thus, the pool of patients who are supposed to be getting the intervention is much smaller than it should be, which weakens the power of the study and undercuts the basic randomized design. The New York study has had different problems but also has had practical difficulties maintaining the comparability of the index and control group. Thus, although these studies potentially will allow us the first real assessment of the impact of coercion on important outcome variables, both studies may face significant obstacles in interpreting their data.

What We Do Not Know

These studies have barely scratched the surface of what we need to know. One limitation is the narrow focus of the MacArthur Foundation research and the research of those who have used their scale. As Kaltiala-Keino[19] has noted, much coercion is built into the structure of care—including, for example, the limits on the choices that patients are given about treatment and arbitrary restrictions that have little clinical justification. Another substantial limitation of this work is that it has focused almost exclusively on admission decisions. This focus does not necessarily yield information about coercion after admission to the hospital or coercion in the community care setting.

Hopefully, these limitations will soon be remedied.

Despite the generally high quality of the recent consequentialist research, it has tended to be framed fairly narrowly, focusing almost exclusively on clinical issues. Several other domains need to be considered as well. First are other issues concerning individuals with mental illness: how does coercion affect their self-image, sense of efficacy, and relationships with others? How does it affect their on-going relationships with the mental health professionals who work with them? Do any such effects persist beyond the immediate period surrounding the commitment? How does coercion affect subsequent adherence to treatment? Does it matter who is involved in the coercion? How does coercion affect the lives of those close to the patient? Does it matter if they are involved or not?

Even if all of the above questions are answered, it is arguable that the real question has not been adequately tested. When one ask whether coercion "works," one is really asking, "Is it advisable for society to have a policy in which an individual can be forced to receive mental health treatment?" (and then, of course, under what circumstances, what types of treatment, for how long, etc).

To answer this question, one cannot simply compare patients receiving some sort of coercive treatment either with those who receive no treatment at all or with those receiving voluntary treatment. Instead, one must compare the outcomes of all patients in different systems: a system that uses the minimum possible coercive pressures consistent with the legal responsibilities of the professionals and another that uses the maximum coercive pressures consistent with our legal system. Why can the policy question not be answered effectively otherwise? Because policies often affect others for whom the policy is not intended. Increasing the availability of coercion may lead otherwise voluntary patients to shun the mental health system altogether for fear of stigma or of being committed themselves. Conversely, this policy (of increased coercion) may lead people to come for treatment earlier so as not to be committed. Perhaps a system that makes coercion easier would draw limited resources away from voluntary patients, and whatever improvement it creates in the coerced patients might lead to deterioration in the voluntarily treated patients.

There is no shortage of difficult work for coercion researchers. In the meantime, however, mental health professionals must make their best assessments of the available data. So far, there is no clear evidence that the use of coercive treatment significantly reduces the social or personal burdens of mental illness. However, there is equally no evidence that coercive treatment is less effective than treatment undertaken voluntarily.

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