

Community-Based Mental Health Services: Is Coercion Necessary?

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In community mental health, limitation of service recipient choice and freedom takes place through mechanisms ranging from subtle to blatant. The justification of coercion in these settings typically focuses on recipient deficits. We argue that this focus must shift to the service system itself, and that the most successful efforts to improve recipient engagement will be those that support respectful provider–recipient relationships and the delivery of services that help recipients achieve goals of their choosing.

KEYWORDS *aggressive outreach, assertive community treatment, case management, coercion, community mental health, outpatient commitment*

When dealing with vulnerable populations, policymakers and service providers alike are guided by two potentially competing principles: fiscal responsibility and the quest to provide quality care. In the best of all scenarios, these lodestars are in perfect alignment, offering clear direction to those entrusted with allocating social resources and those tasked with delivering services. Unfortunately, reality proves to be a much harsher mistress, as evidenced by the gut-wrenching choices made every day in human service organizations and in legislative offices throughout the land. If this weren't enough, these same providers and policymakers must also balance the demands of a conflicted public, particularly in those cases where those same vulnerable populations provoke both pity and fear.

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These challenges, although not new in the mental health arena, are now routinely enacted on a different stage. Even in that time where the institution was the primary locus of care for those with mental illness, psychiatric hospitals were asked to balance the responsibility to treat on one hand, and protect the public on the other. Rarely was this dilemma debated fully and freely. Indeed, the very threat posed by those kept behind locked doors and expansive gates was, on closer inspection, often more illusory than real.

Deinstitutionalization is one of the most misused terms in social policy texts and in public discourse. It is a single word used to describe a public policy that never existed, and presents as a sequential process a series of discrete events that led to a significant reduction in the rolls of state psychiatric hospitals beginning with the passage of Medicaid and Medicare in the mid-1960s (Mechanic & Rochefort, 1992). It would be gratifying to view the community mental health movement solely from an altruistic lens, but if one follows most public policy threads long enough, the trail usually begins and ends with money. When operating and maintaining large state institutions became a fiscal albatross, savvy state-level administrators were more than eager to explore alternatives. At the same juncture, a spate of legal decisions and a fertile cultural landscape sensitive to these judgments reaffirmed the individual rights of citizens challenged by mental illness.

This perfect storm of forces shifted the locus of care from the hospital to the community, and the concomitant cultural lag in the service landscape left many reeling. In the breach, new and restyled programs, like case management and assertive community treatment teams, were launched to provide care in the home and community. In theory, the impact of these interventions is enhanced when offered “in vivo,” and of equal importance, outreach reduces the odds that consumers will drift from care or, in common parlance, “slip through the cracks.” In time, these specialty programs emphasized the important role of consumer involvement and choice, and were subsequently championed by those who would come to embrace the concept of recovery as a principle goal for mental health programs (Anthony, 1993).

The ascendance of community-based mental health care was, at best, a bumpy ride marked by bitter debates centered on the wisdom of deemphasizing and discouraging inpatient care. Today, the debate is largely passé as the return to large-scale institutional care, due to prohibitive cost alone, is unforeseen by most. Yet, thorny questions yet remain—and most center on the primacy of individual liberty versus the use of legitimate leverage or outright social control as exerted in the courtroom and/or the clinic. Ironically, cries of unnecessary coercion now target the very services commonly hailed as evidence of a progressive ethos in mental health practice. Thus, the very programs that constitute the bedrock of contemporary community mental health now face the same litmus test once reserved for the more restrictive forms of care and practice that predominated in past decades. To wit—do aggressive or assertive forms of community treatment coerce unwilling

citizens in a treatment relationship they neither want nor need? Even more hotly contested are new methods to ensure treatment compliance, most notably the use of outpatient commitment. This article explores the issue of coercion and control in community mental health care with a focus on the necessity and justification for, and effectiveness of, programs and policies that wittingly or unwittingly bind citizens to the treatment enterprise.

WHAT CONSTITUTES COERCION IN MENTAL HEALTH SERVICES?

Linking popular mental health programs with value-laden terms like coercion is likely to raise eyebrows and evoke strident reactions. After all, these same programs were spearheaded by those who fought against the exclusion of those with mental illness. Undoubtedly, linking the term coercion with mental health practice conjures memories of a painful past, as well as the most upsetting features that still persist in the 21st century. Indeed, images of dank and unsavory aspects of custodial hospital care are still within reach. Long-term confinement, extensive use of seclusion and restraint, and at the extreme, psychosurgery, have been, or remain, aspects of mental health care that cause few to rejoice. Yet, coercive practices, or those aspects of care that restrict individual liberty, are often far more subtle and nuanced. Although less severe methods might come with fewer obvious personal costs, the long-term impact of such practices on recipients of service should not be assumed, and any restriction of personal rights should never be taken lightly.

Coercion is not limited to specific mental health service models. Although some interventions might be inherently coercive, coercion can occur in any service scenario, and might arise as much from the context in which the service interaction takes place as it does from the intervention itself. Our consideration of these issues begins with an examination of the ways in which coercion is defined.

Definitions of Coercion

Coercion has been defined as the opposite of autonomy (Hiday, Swartz, Swanson, & Wagner, 1997) or as the event occurring when one party (an agent) exercises control over another (a target) by constraining the target's freedom or control (Carroll, 1991). For research purposes, coercion has been defined as consisting of an objectively observable act committed by one person and experienced subjectively by another (Hoge et al., 1993). Although it has been suggested that there exists no definition that both addresses all situations and remains useful (Wertheimer, 1993) and prominent researchers in this area have seconded that stance (Lidz, 1998), others have argued for a broad and flexible definition of coercion, suggesting that coercion in mental health services occurs in "any use of authority to override

the choices of another” (O’Brien & Golding, 2003, p. 168). This constitutes both the working definition of coercion and the rationale for such definition for the purposes of this article.

Coercion in Practice

Although coercion is sometimes equated with involuntary legal status, both empirical and theoretical literature calls this equation into question (Bindman et al., 2005; Hoge et al., 1997; Hoge et al., 1998; Kjellin & Westrin, 1998; Lidz, Mulvey, Arnold, Bennett, & Kirsch, 1993; Rogers, 1993; Sjöström, 2006; Syse, 1999). It has been noted that the lines between legally voluntary and involuntary statuses are often blurred, and that coercion can occur in either case (Eriksson & Westrin, 1995; Hoge et al., 1997; Rogers, 1993). Related to this is the finding that significant proportions of both involuntarily and voluntarily admitted inpatients report feeling personally violated by at least some aspect of their treatment (Eriksson & Westrin, 1995; Kjellin et al., 2004). Indeed, the availability of legally coercive measures might change the nature of interactions between providers and recipients even when providers choose not to formally invoke these measures (Sjöström, 2006).

Similarly, although inpatient facilities provide the standard image of coercive psychiatric service settings, coercion runs through many outpatient services (Curtis & Diamond, 1997; Diamond, 1995, 1996; Gagne, 2005; Solomon, 1996). In fact, the shift to a primarily community-based system of care has been accompanied by the advent of complex new coercive service scenarios (Crilly, 2008; Dennis & Monahan, 1996; Monahan et al., 2005; Monahan, Swartz, & Bonnie, 2003). These include formal treatment models such as legally enforced involuntary outpatient treatment (Geller, 1991; Monahan et al., 2003; Steadman et al., 2001), mental health courts (Stefan & Winick, 2005), and Assertive Community Treatment, as well as other assertive outreach services (Dennis & Monahan, 1996; Diamond, 1996; Gagne, 2005; Gomory, 1999, 2002; Neale & Rosenheck, 2000; Watts & Priebe, 2002).

Coercive interventions that might be employed in a variety of treatment modalities include the use of food and shelter to engage homeless individuals (Lopez, 1996), strategic provider control of money and other benefits (Angell, Martinez, Mahoney, & Corrigan, 2007; Cogswell, 1996; Curtis & Diamond, 1997; Elbogen, Soriano, Van Dorn, Swartz, & Swanson, 2005; Gomory, 1999; Monahan et al., 2003; Susser & Roche, 1996), and child protective agency reporting to leverage participation in legally voluntary mental health services (Anderson et al., 1993; Nicholson, 2005a, 2005b). Coercion is inherent in the service-based housing system to which so many adults with psychiatric disabilities are relegated by virtue of a combination of low income, high housing costs, and discriminatory policy (Korman, Engster, & Milstein, 1996).

Coercive or potentially coercive interactions range from limit setting and persuasion (Susser & Roche, 1996) to manipulation or deception (Solomon, 1996) to threats of hospitalization or reporting to legal authorities (Angell, 2006). The social isolation many mental health service recipients face, as well as providers' position as the "expert" in the service relationship, can move providers' persuasion attempts into the realm of coercion (Angell, Mahoney, & Martinez, 2006). Although the term "coercive" is most often applied to interactions between providers and recipients, coercion can also be experienced in other relationships, such as those with family members (Solomon, 1996) and landlords (Robbins, Petril, Le Melle, & Monahan, 2006). Ultimately, coercion is implicit in all attempts to engage so-called "noncompliant" or "hard-to-reach" individuals with psychiatric disabilities (Lovell, 1996), and the reality of mental health service provision—high caseloads, service quotas, and frequent staff turnover—acts to make coercion more severe in practice than it is in theory (Cogswell, 1996).

Recipient Reports of Coercion

In keeping with the growing recognition that involuntary status and coerced states are not equivalent phenomena, recent inquiry into coercion has focused on consumer experience of coercion (Farabee, Shen, & Sanchez, 2002). Much of this body of literature reports on studies using self-report scales such as the MacArthur Perceived Coercion Scale, which is composed of items relating to the degree of influence, control, choice, and freedom experienced in a particular service interaction (Gardner et al., 1993).

As perspectives of mental health service recipients have often been discredited, there is risk that recipient reports will not be valued as a source of information on coercion, and will instead be considered an artifact of the respondents' psychiatric disability. Reports from people diagnosed with schizophrenia are probably most at risk of being discounted, given commonly held beliefs about the competence of people so diagnosed. Critiques of these beliefs (e.g., Chamberlin, 1998) support the value of recipient reports of coercion, as does the argument that coercion is inherently rooted in personal preferences, fears, and perceptions, and therefore best understood through the perspectives of those experiencing it (e.g., Carroll, 1991).

Also relevant are research findings comparing recipient reports of coercion to reports of other stakeholders. This line of inquiry considered recipient experiences of coercion during the psychiatric hospital admission process and compared these reports to those of clinicians and family members involved in the admission process (Hoge et al., 1997; Hoge et al., 1998; Hoge et al., 1993). Subsequently, all parties' reports were compared to a *most plausible factual account* (MPFA) constructed of triangulated reports and hospital records (Lidz, 1998; Lidz et al., 1997).

Several key points have emerged from this work. First, there are similarities among these three groups' perceptions of coercion overall, as well as the degree to which threats or force were used in the admission process, and the degree to which the recipient was involved in the admission decision-making process (Hoge et al., 1998). Second, recipients' experiences of coercion were more closely related to the MPFA than were the clinicians' or family members' accounts (Lidz et al., 1997). Additionally, discrepancy between recipient reports and the MPFA did not vary with overall or specific symptom severity. Furthermore, respondents diagnosed with schizophrenia offered reports of coercion that more closely matched the MPFA than did respondents with other diagnoses, although this relationship was rendered nonsignificant when duration of disability was considered (Lidz et al., 1997).

Based on this series of findings, the researchers conclude that variations in recipient reports of coercion are not a product of cognitive difficulties attributed to psychiatric disabilities, but are instead largely a function of coercive events: Those who report feeling coerced do so because they have been subject to coercive interactions (Lidz et al., 1997). Other attempts to compare recipient report of coercion to measures of actual events have yielded similar findings (Kjellin & Westrin, 1998; Poulsen & Engberg, 2001).

Problems With the Justification of Coercion

Coercion tends to be justified by claims about recipient competence and the negative consequences that would result from treatment (or lack thereof) according to recipient wishes; these consequences are often framed in terms of recipient dangerousness to either self or others. This reasoning can be observed across the spectrum of coercive service scenarios—from carefully constructed arguments for formal coercive policy to provider rationale for applying informal pressure to specific recipients—and is employed to both justify the use of coercion and to contend that the scope of its application will be limited (see Szmukler & Appelbaum, 2008, for a discussion of various justifications offered for coercive practice).

The latter contention suggests that coercion should be applied in a relatively predictable manner, consistent across service systems and varied settings. However, multisite studies of coercive practices and consumer reports of coercion have found considerable variation by site (Angell et al., 2006; Monahan et al., 2005; Moser & Bond, 2009; Swartz, Swanson, Steadman, Robbins, & Monahan, 2009). Such differences have largely been attributed to a range of factors unrelated to recipient competence and dangerousness, including local policy, community and agency resources, agency culture, provider background, and variations in recipients' needs (Angell et al., 2006; Moser & Bond, 2009; Swartz et al., 2009). Research examining the relationship between coercion and disability-related variables or dangerousness further

calls into question any assertion that coercive interventions are applied in the same manner that they are justified.

RELATIONSHIP BETWEEN COERCION AND DISABILITY-RELATED VARIABLES

The issue of competency is central to the justification of coercive treatment (Breeze, 1998; Kaltiala-Heino, 1996; Kaltiala-Heino & Valimaki, 1999; Lutzen, 1998; O'Brien & Golding, 2003; Olsen, 2003; Pescosolido, Monahan, Link, Stueve, & Kikuzawa, 1999; Syse, 1999); psychiatric disabilities are assumed to reduce competence, and coercion is assumed to be a just response (O'Brien & Golding, 2003; Pescosolido et al., 1999; Playle & Keeley, 1998; Terkelsen, 1993). Implicit in this justification is a relationship between the degree of psychiatric disability and the need for coercion: If lack of competence is assumed to be related to psychiatric disability and is cause for coercion, then those experiencing more significant disability-related effects would be expected to receive more coercive services.

This relationship is largely unsupported by studies examining the relationship between reports of coercion and clinical variables such as symptom levels, Global Assessment of Functioning (GAF) scores and psychiatric hospitalization variables, including number of past hospitalizations, history of involuntary hospitalizations, and hospitalization length. Many studies considering level of symptoms have found no relationship between scores on symptom measures and coercion reports (Hiday et al., 1997; Iversen, Hoyer, Sexton, & Gronli, 2002; Poulsen, 1999; Swartz, Wagner, Swanson, Hiday, & Burns, 2002; Taborda, Baptista, Gomes, Nogueira, & Chaves, 2004). There have been contrary findings, suggesting that higher scores on symptom measures might be associated with higher incidence of a range of coercive provider interactions (Angell et al., 2007; Neale & Rosenheck, 2000) or reported coercion (Bindman et al., 2005). However, in some cases these findings have not remained significant when researchers accounted for personal and situational variables (e.g., age, ethnicity, and involuntary status; Bindman et al., 2005), whereas in other cases they have only been true for certain subgroups of recipients interviewed (e.g., those with representative payees; Angell et al., 2007).

The relationship between GAF score and reported coercion has been tested less frequently, but the studies that do exist are not generally supportive of a direct, positive relationship between coercion level and level of psychiatric disability. Although some evidence of such a relationship has been found (Swartz et al., 2002), other studies have suggested that there is no relationship between reported coercion and GAF score (Angell et al., 2007; Iversen et al., 2002), and one study found a negative relationship: Recipients with higher GAF scores at hospital discharge were in fact more

likely to report coercion during the admission process (Nicholson, Ekenstam, & Norwood, 1996). GAF scores have also been found to be unrelated to provider reports of employment of coercive interventions (Neale & Rosenheck, 2000).

Similar results have been found by those studying the relationship between coercion reports and hospitalization variables, often used as a proxy for extent of psychiatric disability. Most studies have not found a significant relationship between hospitalizations and reported coercion (Hiday et al., 1997; Iversen et al., 2002; Swartz et al., 2002). Others have found some evidence suggesting that hospitalization variables and coercion reports or coercive interactions are positively related (Bindman et al., 2005; McKenna, Simpson, & Coverdale, 2006; Neale & Rosenheck, 2000), whereas another found a negative relationship: Respondents with histories of fewer psychiatric admissions reported more coercion in the service episode studied (Nicholson et al., 1996). In some studies that did find evidence of a relationship between hospitalizations and coercion, the relationship was either not examined in light of other factors (Nicholson et al., 1996), or lost its significance when factors such as age, ethnicity, and involuntary legal status were considered (Bindman et al., 2005; McKenna et al., 2006).

Another personal variable that is often argued to be related to degree of disability is the belief that one has a mental illness, and that mental health services and medication are helpful in addressing that illness. Generally referred to as insight, this variable has fairly consistently been associated with both reported coercion (e.g., Bindman et al., 2005; McKenna et al., 2006; Rogers, 1993; Swartz et al., 2002) and with receipt of formally coercive services (e.g., Angell et al., 2007). Although there have been a few exceptions (Lucksted & Coursey, 1995), coercion is more commonly experienced by recipients who do not self-identify as having a mental illness or who do not believe that services are necessary or helpful.

The finding of an inverse relationship between these two constructs is hardly surprising. Whereas proponents of coercive intervention argue that treatment refusal is inevitably a result of incompetence, critics counter that this assumption relies on a circular argument (see, e.g., Chamberlin, 1998; O'Brien & Golding, 2003; Slobogin, 1996) and that nonparticipation in the formal mental health system is a legitimate choice (Anthony, 1993; Chamberlin, 1998; Davis, 2007; Playle & Keeley, 1998; see also McCabe, Quayle, Beirne, & Duane, 2000, for a related perspective). These same critiques can and have been applied to the construct of insight. Indeed, as it is conceptualized here, insight virtually precludes coercion: Providers are unlikely to find themselves in the position of pursuing treatment engagement through pressure or threats when working with recipients who believe services to be necessary and helpful.

Given that, it might be preferable to reframe the construct as recipient-provider agreement, with agreement generally referring to the two parties'

beliefs about the recipient's situation and the provider's services. This conceptualization points to the importance of the provider's beliefs—be they individual or organizational—in the interaction at hand, and highlights the role that staff and organizational perspectives play in determining the degree of coercion in service delivery.

RELATIONSHIP BETWEEN COERCION AND VIOLENCE

Perceived dangerousness is also used to justify coercive mental health practices. People are more likely to approve of coercive treatment if they believe the individual in question might be dangerous (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003; Pescosolido et al., 1999; Slovic & Monahan, 1995; Watson, Corrigan, & Angell, 2005; for a related study see Corrigan, Watson, Warpinski, & Gracia, 2004), as can be observed anecdotally in most debates on inpatient or outpatient commitment criteria. Indeed, efforts to promote or expand involuntary treatment are often founded in the equation of psychiatric disability with dangerousness, and the suggestion that involuntary services will reduce or eliminate future violence on the part of people with psychiatric disabilities.

This suggests that recipients with histories of violence are more likely to be subject to coercive interventions than those who do not have such histories. Although there is little evidence regarding this relationship, much of the evidence that is available does not bear out this expectation. In a study of reported coercion in outpatient services among recipients recently discharged from inpatient commitment, no relationship was found between reported coercion and general violence or involvement in physical fights (Swartz et al., 2002; see also Swanson, Borum, Swartz, & Hiday, 1999). Similarly, provider reports of coercive interventions have been found to be unrelated to recipient self-reports of violence and threats (Neale & Rosenheck, 2000).

PREVALENCE OF COERCION IN MENTAL HEALTH PRACTICE

Bonnie and Monahan (2005) argued that the term coercion is certain to engender strong emotion, and as a result, this truncates what might be a useful discussion about the nature of the relationship between professionals and recipients of care. In recent years, other words have entered the lexicon, such as leverage and pressure, to describe aspects of mental health practice where professionals directly intervene to influence the behavior of consumers (Angell et al., 2007; Appelbaum & Redlich, 2006; Monahan, 2008; Robbins et al., 2006; Szmukler, 2008; Szmukler & Appelbaum, 2008). Definitional disputes aside, leverage, pressure, or outright coercion appears to be a routine aspect of care (Bonnie & Monahan, 2005; Davidson & Campbell, 2007; Szmukler & Appelbaum, 2008).

Coercive practice can be viewed along a continuum from the use of interpersonal persuasion to more drastic measures such as involuntary commitment (both inpatient and outpatient), and the use of seclusion and restraint (Link, Castille, & Struber, 2008; Szmukler & Appelbaum, 2008). Concerns are also raised when treatment participation is required to gain access to necessities of life, such as money and housing—strategies that are not uncommon (Angell et al., 2007; Appelbaum & Redlich, 2006; Bonnie & Monahan, 2005; Monahan, 2008; Robbins et al., 2006). In practice, recipients are often subject to multiple forms of coercive measures simultaneously, and Bonnie and Monahan (2005) estimated that about half of those involved in public-sector mental health services have experienced some type of leverage in their lives. Thankfully, several studies of standard community-based services, such as ACT and case management report that, when used, professionals tend to use less coercive measures such as persuasion and education (Angell et al., 2006; Appelbaum & Le Melle, 2008; Stanhope, Marcus, & Solomon, 2009).

A common feature of community-based treatment that has come under increased scrutiny is the use of outreach services. As noted earlier, outreach services are identified as vital to enhancing treatment compliance, and as a useful way to detect early signs of relapse. In addition, services offered in the home and community provide a platform to aid recipients seeking to learn and practice the skills needed for independent living. What happens, however, when a recipient expresses little desire to continue the relationship? When does aggressive outreach become simple harassment? To this end, Stovall (2001) asked, “Is treatment that won’t go away ethical?” (p. 140). Furthermore, Williamson (2002) argued that when there are no legal obligations for individuals to continue in treatment, “the involvement of assertive outreach in their lives represents a blatant disregard of their rights to privacy and autonomy” (p. 544).

This discussion serves to remind that attention to this relevant issue cannot simply be guided by a consideration of those facets of mental health practice that cause most to pause, but that coercion can be rooted so deeply in our systems of care such that even those most vigilant can overlook it. The wide range of studies and reports cited throughout this article provides evidence that this issue has become more salient in the general mental health community. Not surprisingly, these efforts have attempted to measure the actual occurrence of discrete behaviors, and events that might fall under the umbrella of coercion. More difficult to capture is the interpretation of these events by relevant stakeholders, in particular, what meaning recipients of care ascribe to the behaviors, attitudes, and actions of professionals (Olofsson & Norberg, 2001). Stanhope et al. (2009) felt strongly that coercion “is determined largely by how consumers interpret provider behavior” (p. 184). Taking this one step further, Zolnierek (2007) suggested, “Professionals may not recognize or acknowledge how their seemingly innocuous

behavior may be experienced as for by psychiatric patients, and this lack of awareness may have significant ramifications for the individuals who experience mental illness” (p. 104).

THE EFFECTIVENESS OF COERCION

However framed, coercive practices are motivated by a range of factors, from a genuine desire to help to outright social control. Failure to participate in and comply with treatment can have serious individual costs. Some argue that given the advancement in treatment methods, including new medications, it is more important than ever to encourage treatment compliance because the potential benefits are substantial (Lehner et al., 2007). The paternalistic argument is easy to grasp. If only recipients would follow through with the recommendations that are offered, their life would be vastly improved. Nonetheless, the question remains: Is coercion necessary to get desired results?

On the larger question of protection of society as a whole, the results are mixed at best. Davidson and Campbell (2007) argued that there is scant evidence that coercion reduces risks to public safety. In terms of outpatient commitment, Swartz and Swanson (2008) reported that when used, there is some evidence that treatment compliance can be enhanced, and the number of hospitalizations and homelessness can be reduced, but they cautioned those who assume that particularly violent behavior will be curbed. These researchers also noted that the standards for outpatient commitment vary widely (and also results by site), that certain recipients tend to benefit more than others, and having adequate time to work with individuals (more than 6 months) is vital to success.

The larger concern surrounding all coercive practice, and one that is widely discussed, is the damage caused to the therapeutic alliance (Angell et al., 2007; Stanhope et al., 2009; Swartz & Swanson, 2008). Furthermore, when initial efforts to forge such an alliance fail, professionals might rely on more coercive and damaging strategies to prompt treatment adherence (Angell et al., 2006; Davidson & Campbell, 2007). There are other problems as well. Practitioners also lament the dual role that arises when outpatient treatment orders are used, express concerns over the additional paperwork that follows, and the looming threat of legal liability in this arrangement (Elbogen, Swanson, & Swartz, 2003; Swartz & Swanson, 2008).

For the recipients of care, even the benefits that accrue might come with a cost. In particular the experience might produce a sense of devaluation and result in greater social stigma (Link et al., 2008). Swanson et al. (2008) suggested that “as a routine practice, these interventions can be counter-therapeutic and may contribute to stigma, trauma, and the criminalization of the mentally ill” (p. 256). In the final analysis the process might become

so distasteful to consumers that they flee from services (Davidson & Campbell, 2007; Elbogen et al., 2003; Stanhope et al., 2009).

The irony that looms in modern community mental health treatment is that as the locus of care has shifted away from an institutional base, and as more attention has been devoted to consumer rights and social inclusion, new forms of coercive practice—such as the use of outpatient commitment—have emerged. Lewis (2009) argued that “such developments sit uneasily alongside social policy drivers to address human rights through tackling stigma and promoting social inclusion for those using mental health services” (p. 211).

In reality, mechanisms remain in place to remove from society those who pose a threat to themselves or others, so the recent rise of outpatient commitment and other forms of leverage that now dot community mental health appears to be a step backward. Szmukler (2008) argued that the recent use of tools like outpatient treatment commitment has little to do with changes in the number of those facing mental illnesses or the seriousness of their disorder, but rather a reflection of an increasingly risk-averse society.

Certainly, all efforts should be extended to improve the quality of life among those facing serious mental illness, and public safety should be addressed, but coercive solutions fail to address the multiple facets of treatment compliance, save acknowledgment that there are times when mental health services are ineffective. Underscoring the foregoing concerns, Lehner and associates (2007) contended:

Our stance, a position that is well supported by research, is that treatment adherence is a reflection of factors related to the client, clinician, and the client–clinician relationship as well as larger systems in which the client and clinician operate. We consider any problems of adherence as a serious failure in the development of a practical treatment plan. . . . Our perspective emphasizes the importance of providing treatment where the goals, procedures, and outcomes are important and acceptable to clients. (pp. 248–249)

BACK TO BASICS: AN ALTERNATIVE TO COERCION

After studying the perceptions of recipients about the care they received, Stanhope and associates (2009) felt their work provided “empirical support for one of the central tenants of the recovery movement—that there is no role for coercion in mental health services, either short or long-term” (p. 187). We agree. Interestingly, it appears that one key factor that mitigates the perception of coercion on the part of recipients is the strength of the relationships they have with professional helpers (Appelbaum & Le Melle, 2008; Olofsson & Norberg, 2001; Stanhope et al., 2009). It is unsurprising that recipients value staff who listen, demonstrate that they care for the other as a person, not as

just as a client, and offer tangible and practical support in everyday life (Appelbaum & Le Melle, 2008; Stanhope et al., 2009; Williamson, 2002). In contrast to other models of mental health care that emphasize detachment and objectivity, Zolnierek (2007) noted that the “ethic of care proposes the opposite: personal engagement and responsiveness” (p. 105). In the presence of this type of relationship, what might be deemed as unnecessary pressure in one situation, might now be seen as a genuine desire to help. Engagement is not easy, particularly with a client group that has experienced many helpers, and has undoubtedly had negative experiences. Accordingly, it is difficult to decide how persistent to be in outreach efforts, as outreach can be useful to forge a relationship with a recalcitrant consumer (Angell, 2006). In these situations a clinician or team should establish guidelines to assist them (i.e., how many contacts will be made) and should always explore if the problem rests with a particular client–professional match. In general, recipients should retain the right to fire the staff assigned to them.

In the final analysis, adherence problems are a reflection of recipient indifference or outright rejection of the existing plan of action. In the face of such rejection, professionals might fall back on coercion as the only possible course, particularly when they lack a set of procedures or rubrics (as in how persistent to be in outreach) to guide them (Stanhope et al., 2009). It is for this reason that Bonnie and Monahan (2005) argued that attention must be paid to the process of negotiation between parties, as a working contract, freely entered into, is the linchpin for an equitable and successful alliance. At the core, respect for individual autonomy is a deeply held cultural value and also an important guidepost for medical practice. Therefore, any intervention that limits choice and freedom must be considered with extreme care (Classen, Fakhoury, Ford, & Priebe, 2007). Bonnie and Monahan (2005) offered several key questions that should be asked in the course of clinical work. First, does the intervention expand or restrict choice? Second, as a result of the solution offered, will the person be better or worse off? Finally, is the proposal best viewed as an offer or a threat? These simple questions focus attention squarely on the benefit offered to the recipient, and by emphasizing the processes of negotiation, interventions predicated simply on paternalism are viewed as out of bounds. Naturally, forced choices and deception in the negotiation process are coercive, and given the power imbalance that is endemic to these relationships, commitment to ethical practice becomes paramount.

Another potential strategy that can reduce unnecessary coercion is the use of psychiatric advance directives (PADs). This tool allows recipients to provide parameters for their care and express treatment preferences should they suffer setbacks that restrict their capacity to make prudent choices. Swanson et al. (2008) argued that the process of developing the PAD can strengthen the alliance between recipients and professionals, and motivates

recipients to get involved in the treatment process. The conversation might also help uncover helpful clues on how to help in times of crisis, and avoid the need to use more restrictive measures. When less extreme measures are taken in these situations, the insidious damage that follows acute crisis can be softened.

Preserving choice and autonomy in the process of care has important long-term ramifications for the process of recovery. Even in those cases where it appears that gains have been made due to mandated care, these reflect changes in behavior and status at one point in time. Additionally, gains are often defined by professionals or researchers, and by necessity might be limited to outcomes that are easily observed and quantified. Although positive changes in the life of a consumer should never be minimized, it is still important to consider the impact on less tangible aspects of life, such as self-confidence and self-esteem. In the end, it is rarely desirable to relinquish control to others. It is, in part, these concerns that lead some to conclude that the long-term impact of coercive practice is further devaluation and stigma (Link et al., 2008).

To avoid coercion in community mental health requires that a number of important contextual factors are addressed. At the top of this list is an adequate number of trained staff who have the requisite skills and attitudes needed to abet recovery, reasonable caseloads, and the time needed to forge strong relationships with recipients of care. Some might argue that the lack of these key elements for success, in particular the tragic imbalance of demand and resources, is precisely why steps like outpatient commitment become necessary. Nonetheless, developing appropriate treatment standards and values should never become a slave to the pragmatics dictated by an unacceptable condition. When coercion is used in helping—regardless if it is putting people in restraints, or mandating them to attend services—it should be viewed first as a treatment failure. Justifications for coercion tend to direct attention to the deficits of the individual, and away from the consideration of other supports that could have tipped the balance in a more just fashion. Principles should always be preserved as ideal standards and efforts should always be expended toward reaching the highest possible goal. To shoot for anything less than the elimination of coercion from community mental health is unacceptable.

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