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Coercion: The Only Constant In Psychiatric Practice?

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> To allow every maniac liberty consistent with safety; to proportion the degree of coercion to the … extravagance of behavior; … that bland art of conciliation, or the tone of irresistible authority pronouncing an irreversible mandate … are laws of fundamental importance … to the … successful management of all lunatic institutions.
>
> Philippe Pinel (1806)

Introduction

In the Western world, since at least the 15th century, state-sanctioned force has been employed to control those who disturb others by their violent or existentially destabilizing behaviors such as threatening or inflicting self-harm. Coercing the mad into madhouses, separating and detaining them from the rest of society, and forcing them to comply with their keepers' wishes, occurred before physicians became involved in theorizing about the meaning or origins of madness, and it continues to distinguish psychiatric practice to this day. It is widely recognized that the mad used to be confined, beaten, tied, shocked or whirled into submission, but it seems less appreciated today by

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scholars, practitioners, and the general public that the physical control of "dangerous" mental patients remains a central function, and perhaps the only constant function, of public mental health systems.

In this chapter we discuss the hospital and community-based management and treatment, by public, state-supervised or state-controlled psychiatric and other mental health agencies, of those categorized as "mad" in America. We argue that the employment of coercion (that is, naked force or its threat, not requested or wanted) was the essential ingredient that enabled the formal emergence of professional psychiatry. American psychiatry originated in 19th century state asylums and, based on the state-granted legal authority that allowed psychiatrists (then know as alienists) to incarcerate people involuntarily, became a fundamental institution of social management of some of society's social deviants. This coercive policing power was typically used with considerable discretion and little or no independent review to confine the mad and other citizens who were destitute, abandoned, elderly, unsocialized, mentally retarded, or otherwise judged to be socially troublesome. This pattern of psychiatric practice continued virtually unchanged for over a century, until the beginning of some reforms following the Second World War.

Starting in the 1960s and extending for approximately two decades, the stated legal grounds for involuntary psychiatric hospitalization narrowed on paper in virtually every American state to include those who were deemed to be at immediate or imminent risk for harm to self or others as a result of a mental illness. The now formally mandated evaluation of dangerousness would, it was argued by reformers, restrict involuntary psychiatric interventions only to those individuals truly needing them. Legal psychiatric

scholar Paul Appelbaum (1994), however, confirmed in a wide ranging study that the reformed laws had almost none of their intended consequences, such that rates of involuntary detention increased (in some cases doubling and tripling) or remained unchanged, as did the characteristics of involuntarily detained individuals. The availability of psychiatric beds was the most important determinant of recourse to involuntary detention. Appelbaum insightfully proposed that the difference between laws on paper and laws in practice is best understood by recognizing that the application of laws is delegated to specific actors. He wrote:

> ... laws are not self-enforcing. Indeed, implementation of involuntary hospitalization is delegated to a variety of participants in the commitment process, all of whom have the potential to affect how the law is applied. When the results of a law narrowly applied will be contrary to the moral intuitions of these parties, they will act at the margins to modify the law in practice to achieve what seem to them to be more reasonable outcomes. (p. 142)

Appelbaum's observation illustrates well one of the obstacles to safeguarding individual liberty identified by Friedrich Hayek in *The Constitution of Liberty* (1960). In discussing what he called "the delegation of powers" by legislatures to administrative bodies, Hayek observed:

> The trouble with the widespread use of delegation in modern times is not that the power of making general rules is delegated, but that administrative authorities are, in effect, given power to wield coercion without rule, as no general rules can be formulated which will unambiguously guide the

> exercise of such power. What is often called "delegation of lawmaking power" is ... delegation of the authority to give any decision the force of law... (pp. 211-212).

To address this problem, Hayek suggested that administrative decisions should be subject to "independent judicial review." And it has come to pass in more modern times that involuntary psychiatric procedures may be submitted by almost any interested party to judicial review. However, according to the evidence in a few published studies from a few North American jurisdictions on this matter, close to 100% of such appeals are routinely rejected by the presumably independent judges (Dallaire et al., 2000; Kelly et al., 2002; Solomon et al., 2009). In sum, if those who operationalize the laws' guidelines operate with the paternalistic presumption that therapeutic considerations must take precedence over the civil and legal rights of individuals, even a slightly reformist law will be perceived as an obstacle or an annoyance and will be avoided, ignored, or transformed in practice. The courts, moreover, will overwhelmingly approve the practices of those to whom this application has been delegated.

Since the 1960s, the state supported professional mental health treatment system has morphed toward a more community-based system, with public and private clinics and outpatient centers integrated into general medical units or otherwise distributed widely across the mental health organizational landscape. Still, psychiatrists in the private and public mental health system retain the same authority to coerce and to incarcerate as they have always possessed. And, those coerced and incarcerated remain society's unwanted or undesirables, including those whose undesirability (in the form of non compliance to treatment, for example) has been spawned by the mental health system itself.

Following the intellectual tradition pioneered in psychiatry by Thomas Szasz (1963, 2007), we believe it essential to differentiate, on the one hand, state supported involuntary psychiatry based on coercion from, on the other hand, contractual or voluntary psychiatry, which mostly emerged starting with Sigmund Freud when he contracted his services to individual, fee-paying patients. In the second enterprise, the person seeking help and the psychiatrist or mental health practitioner offering it mutually agree to work together to address the intrapersonal or interpersonal difficulties identified by the help seeker. The relationship, which can be terminated by either person at any time, is based initially on mutual respect or neutrality, and usually involves persuasive discussion. Increasingly over the past half-century, such a relationship has included the encouragement to take or the prescription of licit psychoactive chemicals or other biotechnologies, with no coercion imposed by the practitioner (at least to the extent that the practitioner shares what he or she truly knows or does not know about these technologies).[i] This sort of practice occurs more frequently with the "worried well" and those who are more likely to be able to afford to pay for someone to work with them on their life difficulties. We believe that, to the extent that this contractual psychiatry or mental health practice is combined, confused, or conflated with *involuntary* psychiatry, observers of the mental health system are hampered from grasping the fundamental purposes and moral underpinnings of the overall mental health system, and consequently fail to understand how one might go about trying to improve it as a truly helping system.

Much of this confusion, we think, is dependent on the tactical use of language in psychiatry. Psychiatry has always used medical rhetoric to reinforce its medical image and minimize the visibility of its coercive authority. For example, the term "hospital

admission" used in physiological medicine when a medical patient requests to be hospitalized (through her doctor) to treat a medical problem, is used in psychiatric "medicine" to describe its opposite, the incarceration of a person in a psychiatric "hospital" who does not acknowledge having an illness nor is seeking admission. This linguistic sleight-of-hand is widespread, encompassing psychiatric participants, interventions, and facilities. For example, Assertive Community Treatment (ACT), a treatment program to be discussed later, was developed in Madison, Wisconsin, in an institution that began its life in 1860 as the *Mendota Asylum for the Insane*. In 1935, it was renamed *Mendota State Hospital*, and in 1974, it re-emerged as *Mendota Mental Health Institute*. These names suggest changing functions of the institution over 150 years, from a place of custodial asylum care to a venue for conducting scientific research and treatment as a mental health institute. In fact, the institution does today exactly what it has always done: manage involuntarily detained mad people. As explained in 2011 on the State of Wisconsin's website, "Mendota's Civil Program provides services to adults who are in need of psychiatric treatment. All admissions are involuntary" (Mendota Mental Health Institute, 2011).

We argue that the application of coercion has remained the fundamental tool that makes public psychiatry possible and distinguishes it from all other kinds of "mental health" services that other clinical practitioners provide to patients, their families, or society. We are not making the point that psychiatrists are more malevolent or less caring than other people. Rather, we make the simpler point that coercion applied with sufficient force and regularity works—if by working we mean obtaining people's behavioral compliance shortly after the application of coercion. We think that coercion

has always been an essential method for managing, in any social group, the complexities of human misbehavior. Throughout its history, psychiatry has specialized in managing complex human misbehaviors. In doing so, it has unfailingly chosen to employ coercion.

For example, getting caught by the police for speeding usually results in the immediate (or, in the age of electronic traffic surveillance, a delayed) penalty of a steep fine on the driver. For most folks this penalty "works," in that at least for a while after receiving the ticket, they may not violate speed limits or they keep a sharper eye out for the enforcers. They are quite likely to alter their driving behavior to avoid further coercion or punishment. But do drivers learn as a result that speeding is fundamentally wrong and dangerous and not in their best interest? We highly doubt it, if the continuing high rate of traffic citations is any indication (see for example Florida, 2010).

Yet, few people would seriously suggest that what the police do to enforce the speed limits (and other required driving behaviors, like carrying a driver's license, wearing seatbelts or having proper vision, demonstrating one's knowledge through drivers' education) is a therapeutic enterprise (but see ahead). Probably, no one would mistake this police activity for the treatment of a bodily or other condition called Automobile Speeding Disorder. People easily, unmistakably understand that the job of the police is to detect or hunt down and punish drivers who breech socially and legally expected behavior, who fail to conform with the traffic laws that manage potentially lethal activity (driving powerful vehicles), and then to place these individuals at least temporarily[ii] into the class of deviants known as "criminals." Society expects that punishment will alter the speeder's behavior and reduce accidents.

Psychiatry is the government certified profession for maintaining "normal" behavioral order among small groups of people, such as families or workplaces. Psychiatrists are expected to detect and to manage people who visibly violate interpersonal norms, codes, or rules without, for the most part, breaking any criminal laws. This detection activity superficially (and linguistically) resembles the diagnosis of medical conditions, and consists in placing such people more or less permanently into the category of deviants know as the "mad."[iii] Like all policing institutions (including schools, jails, the military), psychiatry is also granted legal authority to employ force to make recalcitrant individuals identified as mad conform to the prevailing norms of proper personal conduct.

Cultural historian Morse Peckham (1979) argued that the control of human behavior—ensuring that people conform to a society's rules in order to maintain smooth interaction among its members and stability of the social order—must always ultimately rely on force or its threat, if the *preferable* modes of social control, persuasion and seduction, fail to produce the desired conformity. Peckham's insight compels us to ask whether the psychiatric use of force is a therapeutic endeavor, and whether psychiatric coercion (as distinguished from other versions of publicly sanctioned coercion in society, as just described) is to be considered treatment rather than merely punishment.

In the remainder of this chapter, we begin by reviewing the 1961 report of the *Joint Commission on Mental Illness and Health* (JCMIH), created to assess how America had dealt with its mad citizens and to propose a national plan to "provide more humane care for the mentally ill" (p. xxix). The Commission underlined, in our view quite insightfully, the historical role of force and coercion in the psychiatric treatment of mad

Americans. Next, we describe the role of coercion in the creation of public American psychiatry, and we use contemporary literature to describe its various manifestations in community mental health treatment in the United States. We also attempt to estimate the prevalence of all coercive practices in current American psychiatry. We discuss how and why the employment of coercion, especially its "clinical effectiveness," has become a leading area for academic research. Finally we demonstrate that psychiatric detection (diagnosing) and the various psychiatric "clinical" interventions are not science-derived ameliorators of human travail, but rather, coercive social management activities deceptively marketed as therapies. What is left in the treatment landscape appears as nothing other than the various manifestations of coercion to control and manage mad behavior.

Psychiatric Coercion Before Deinstitutionalization

The *Joint Commission on Mental Illness and Health* (1961) was created under the auspices of the *Mental Health Study Act* of 1955, to review how mad people were previously managed. Its findings were expected to "make recommendations for combating mental illness in the United States" (p. v). Led by Jack R. Ewalt, chairman of the Department of Psychiatry at Harvard Medical School, the commissioners included 52 notable authorities and experts, 30 of whom were physicians. Non-medical experts on the Commission and its advisory committees included such luminaries as biologist Ernst Mayr, Columbia University English professor and cultural critic Lionel Trilling, famed Harvard psychologist Jerome S. Bruner, social psychologist M. Brewster Smith, vice president of the Commission, and University of Chicago philosopher Charles Morris.

The Commission members recognized that "[m]ental illness is different from physical illness," being "a disorder with psychological as well as physiological, emotional as well as organic, social as well as individual causes and effects" (p. xviii), that are "so closely intertwined that so far science has been unable to unravel the causes and establish their relative importance" (p. 86).

In contrast to its panchreston-like definition of mental illness, the Commission's historical review of treatments for the mad displayed no ambiguity whatsoever. It argued that the mad for centuries both in Europe and in America had been subjected to "a superstitious and retaliatory approach …. The instrument of this approach is punishment" (1961, p. 25). It recognized that this was attenuated by periodic efforts to employ less directly coercive approaches (i.e., moral treatment) but which were quickly abandoned and replaced by more forceful and outright coercive manipulation and management. One section of the Commission's report was entitled "Punishment As Treatment" (pp. 25-28). It quoted Benjamin Rush, a signer of the American Declaration of Independence and whose visage adorns the official emblem of the American Psychiatric Association: "Terror acts powerfully … and should be employed in the cure of madness" (p. 27).

The report argued that the religiously inspired notion that sinful behavior causes disease justified interventions by the medical and lay superintendents running America's madhouses in the 19th century. These interventions included "a wide assortment of shock techniques" (p. 28), such as bleeding to the point of fainting, near drowning, rapid spinning, forced vomiting, and applying an early form of electric shock to the body. The Commission members acknowledged that all of these techniques, forced on unwilling recipients, were based on "fallacious medical rationales" (p. 28), implying either that

some genuine medical rationales could today justify the employment of coercion on the mad, or else, as we shall see in other statements in the report, rejecting the use of any medical rationale for coercion and rejecting coercion *tout court*. In looking at some descriptions and justifications for coercion and torture proposed by leading alienists of 18th- and 19th-century America, for example, it is difficult to tell whether those who employed it did so because they thought coercion helped to "cure" or because it produced immediate behavior change, or both. Benjamin Rush's description of his new "tranquilizer" chair illustrates this point clearly.[iv]

Another section of the JCMIH report, "The Tranquilized Hospital," discussed contemporaneous treatments for the mad, namely, some chemical agents ("major tranquilizers") which the Commission believed had "revolutionized the management of psychotic patients in American mental hospitals" (p. 39). The authors described their effects as "tranquilizing patients who are hyperactive, unmanageable, excited, highly disturbed, or highly disturbing…" Their "most noticeable effect" was "to reduce the hospital ward noise level" (p. 39). They did not discuss whether the drugs were ever voluntarily requested or consumed by psychiatric patients or had known adverse effects.

The Commission's overall review of America's policy toward the mad from Colonial time to the mid 20th century concluded that the policy had been to confine the mad in institutions against their will and subject them to various physically and emotionally brutal treatments. The Commission went further, proposing that forced confinement in institutions without any other effective means of treatment had "shown beyond question that much of the aggressive, disturbed, suicidal and regressive behavior of the mentally ill … is very largely an artificial product of the way of life imposed on

them" (p. 47), and that "[t]o be rejected by one's family, removed by the police, and placed behind locked doors can only be interpreted, sanely, as punishment and imprisonment, rather than hospitalization" (p. 53). The Commission's point was unmistakable: America's approach to madness for the previous 200 years, whether carried out by a physician or by a policeman, relied on the use of coercion.

The Commission's ultimate advice to the Federal government, despite all the coercive history its members identified, was to fully embrace the medical psychiatric model and invest in a national mental health program that would move treatment from institutions to the community as rapidly as possible. This policy became known as the deinstitutionalization of the mentally ill. As M. Brewster Smith, the former vice-president of the Commission admitted some 40 years after the publication of the JCMIH report, "the rapid and ill-prepared deinstitutionalization … for which I take some responsibility as an officer of the Joint Commission … had unexamined consequences that are socially almost as irreversible as those of psychosurgery" (Smith, 2003, p. 215).

Psychiatry as a Coercive Enterprise

The first involuntary admission in America occurred in the City of Brotherly Love, Philadelphia, in 1752 (Anfang & Applebaum, 2006). Most historians concur, however, that mad doctoring fully emerged with the decision, several decades later, to construct specialized buildings to confine and manage mad people involuntarily. This fortuitous development allowed for "unparalleled scrutiny of lunatics under controlled conditions, particularly while interacting with keepers, [to form] the matrix for the practical (experimental) discipline of managing the mad" (Porter, 1987, pp. 174-75). Many of the keepers turned out to be medical men looking for stable employment.

According to Andrew Scull (1993), by the 1850s the early, fledgling economic enterprise had become resolutely medical, with mad folk "incarcerated in a specialized, bureaucratically organized, state-supported asylum system which isolated them both physically and symbolically from the larger society… [a]nd… now recognized [madness] as … a uniquely and essentially medical problem" (pp. 1-2). This state-sanctioned confinement gave free reign to mad-doctors to experiment on their charges, to claim that their controlling activities were medical treatments, and to assert and simultaneously confirm their authority over this new class of deviants. Psychiatrists could claim to be doing good medical treatment when actually they were constructing a "new apparatus for the social control of the mad" (p. 3).

It would appear obvious that police authority granted to psychiatry to imprison mad individuals for psychiatric treatment in specialized facilities (whether called insane asylums, mental hospitals, or mental health institutes) is the key to its professional importance. Yet we think that the impact of this unique police authority on mental health practice overall has not been adequately studied. Police authority makes truly voluntary psychiatric treatment in the current public mental health field a near-impossibility.[v] All the relevant "stakeholders" (the mad, their friends and families, the treating psychiatrists, and society at large) are on notice that involuntary commitment may be deployed on any diagnosed mad person who refuses to follow prescribed psychiatric treatment. We believe that this knowledge shapes the behavior of all parties to psychiatric encounters as surely as the knowledge that one's parent has used and may use physical punishment shapes the behavior of a child. Furthermore, not knowing when punishment will be employed makes compliance by the less powerful party much more likely. So, voluntary medical

treatment, in the sense entertained by most people when they consult their physician for a physical health problem, is much less likely to occur in public psychiatric practice.

Those fortunate enough to afford medical care or purchase health insurance go to their personal physician by choice, whether for an annual health checkup or over a concern about some possible ailment. Regardless of the doctor's recommendation, they can choose to follow it entirely, partly, or reject it altogether. That's so, because the power imbalance between a medical patient and the doctor is only marginally in favor of the doctor. It is based on the doctor's hopefully more informed opinion about the problem, resulting from specialized education, training, and experience—the very reasons a patient would seek a physician's advice in the first place. But once informed about his medical condition and having received advice or even exhortation from the physician, the patient retains full control over his course of action from that moment onward. This is true even if the health problem diagnosed by the doctor, if left untreated, could shortly kill the person. Our physicians cannot force us to take medications, such as statins, for our coronary heart disease, or involuntarily inject insulin into our bodies to control our runaway diabetes.

In contrast, if the diagnosed mad person resists "emergency" psychiatric treatment (where the person is deemed to be at risk for harm to self or others), she knows very well that she can be involuntarily hospitalized in a locked facility and be subjected to stupefying psychotropic drugs and other "therapies" (from talk to electroshock treatment) against her active protests and physical resistance. This common knowledge, we think, colors and shapes many (all) engagements between mental health patients and mental health professionals. No true voluntary treatment can ever occur when a (because no)

mad person can freely walk away from the recommended treatment if there is a serious disagreement between the psychiatric professional and that patient. It is true that the patient's behavior must be judged to place the patient or others at risk of harm in order to involuntarily commit and treat, but only if this behavior is *believed to result from a mental illness* (e.g., daredevil Evel Knievel's death-defying motorized leaps never earned him the unwanted attention of psychiatrists). Since this judgment of "mental illness" is a "clinical decision" (a statutorily authorized *personal* judgment of the professional based on still-unvalidated diagnostic criteria, see Kirk, Gomory, & Cohen, 2013), this is not a very difficult standard to meet. The legislated protocols found in any state's involuntary hospitalization laws or statutes reveal the intimate intertwining of psychiatric practice with legal power, making the two virtually indistinguishable.[vi]

Psychiatric Coercion in Contemporary America

Madness Counts

When the JCMIH published its report in 1961, 527,500 people resided as inmates in state and county mental hospitals in the United States (Scull, 1976, p. 176). Including the latter, fewer than one million people were diagnosed mental patients using psychiatric services in any sorts of public mental health facilities (Grob, 1994, p. 248). Fifty years later, the National Institute of Mental Health (2011) declares that "[m]ental disorders are common in the United States …. An estimated 26.2 percent of Americans ages 18 and older …suffer from a diagnosable mental disorder in a given year … this figure translates to 57.7 million people." The NIMH further specifies that about 6% (3.5 million people) of those individuals are diagnosable with a "major mental illness."

This amazing epidemiological uptick in psychiatric diagnoses has occurred despite, or in tandem with, the increase in the number of mental health professionals, treatment centers and funds devoted to preventing or treating mental illness. In 2010 in the United States, there were approximately 40,000 psychiatrists, 174,000 psychologists, and 255,000 clinical social workers (U.S. Bureau of Labor Statistics, 2010). The federal government has increased its funding for NIMH (2011) from $0.3 billion in 1986 to $1.5 billion in 2010 (most of it spent on research about treatments for the "seriously mentally ill"), making that agency the seventh highest funded of the 27 Institutes and Centers that comprise the National Institutes of Health (NIH). In 2005, year of the latest comprehensive national figures available for mental health service expenditures, the total national private and public expenditures for mental health services were approximately $113 billion—about 60% of it coming from tax revenues (Garfield, 2011).

The Numbers of Mad Coerced

In Hospitals. The threat of involuntary hospitalization and the use of coercion is no idle one. Given how the American tradition and political system conceive of the loss of liberty and the protection of individuals from the encroachment of the state on their natural spheres of sovereignty, one might expect such loss under any state-sanctioned circumstances to be meticulously documented, as it is in connection with criminal arrests and incarcerations. Nonetheless, there currently exist no comprehensive national data regarding involuntary hospitalization or even unduplicated counts of the number of individuals hospitalized psychiatrically in a given year. Thus one must rely on extrapolations from state and local data for any such estimates. Based on the data released by the two large states of California and Florida, we conservatively estimated

that approximately 1.37 million American adults are the subjects of involuntary hospitalization each year (Gomory, Wong, Cohen & Lacasse, 2011). This number makes up about 62% of those hospitalized for any psychiatric reason. However, it does not include the unknown (but almost certainly quite large) proportion of those deemed to be "voluntarily" hospitalized but who know that they might or will be forcibly hospitalized if they do not submit (Sorgaard, 2007).

In Prisons. Another group of involuntarily confined mad people in America are those currently confined in jails. The data here are again not based on actual national counts, since no such data exist, and since distinguishing "mental illness" from "normal" behaviors and distress within oppressive jails and penitentiaries may be a conceptually impossible task. Thus, counts must be estimated from studies conducted on subsamples of this population. Recent research suggests that the average prevalence of "serious mental illness" among the approximately 2.1 million people incarcerated in jails, prisons, and penitentiaries is 14.5% for men and 31% for women (Steadman, Osher, Robbins, et al., 2009). These percentages convert to roughly 330,000 mad people confined in our penal institutions as a result of having been found guilty of criminal offenses.

In the Community. New developments in the application of force and coercion on the mad have emerged from the community where the mad mostly live and are treated today. Not surprisingly, here too no national prevalence data exist, but again, by reviewing some recent studies on community-specific psychiatric coercion, one might make educated guesses. One study conducted in five American cities found that 44% to 59% of the sampled individuals reported having been subjected to at least one of four

coercive measures (the researchers call them "tools," p. 38) while in outpatient community treatment (Swartz, Swanson, Kim et al., 2006).

In Toto. Using the above evidence our tentative guess is that at least 50% of the mad in the above three settings are the regular recipients of at least one form of psychiatric coercion. We can put numbers to this percentage by using the latest Federal government data on "patient care episodes" (the odd name the government uses for the count of the total number of persons under psychiatric care[vii] in any one year in the United States). We find that there were 9.5 million patient care episodes in 2002 (Manderscheid, & Berry, 2006, p. 209), translating to at least 3 to 4 millions of our mad citizens subjected to coercion in the name of mental health in any single year.

"Tools" of Community Psychiatric Coercion

Community based mechanisms of coercion are deployed by the judicial and the public welfare systems, the two major institutions outside the mental health system where the mad are managed or located (Monahan, 2008). The judicial system employs several coercive civil mechanisms on non-criminal mad persons to keep them out of hospitals and force them into community treatment (by far the less costly option) (Swartz, Swanson, Kim et al., 2006). The best known of these is court ordered outpatient commitment, and it usually comes in three forms: first, conditional release from involuntary hospitalization if the person is willing to submit to mandated community treatment; second, as a substitute for involuntary hospitalization for those meeting commitment criteria; and third, as a form of preventive detention for those who are not legally committable but are considered to be "at risk."

Mad individuals who are adjudicated of a minor or non-violent crime might be further subjected to mental health courts, such as so-called "drug courts." These courts use judges' recently expanded extralegal role to force some mad criminals into psychiatric treatment by "play[ing] a hands-on, therapeutically oriented, and directive role at the center of the treatment process" (Monahan, Bonnie, Appelbaum et al., 2001, p. 1200). The research indicates that such courts appear to have at best a moderate effect in reducing criminal recidivism among those who complete their programs (a high drop out rate is common). However, because the participants are often selected by judges "based on personal knowledge of an individual's history" as those "most likely to succeed," even this outcome is not generalizable (Sarteschi, Vaughn, & Kim, 2011, p. 14).

The social welfare system uses two prominent coercive measures to gain behavioral compliance. One is by controlling funds that the mad may be entitled to. This is done by appointing payees who will control the patient's access to public disability benefits, predicated on the patient's level of cooperation with psychiatric treatment. The second measure is by providing access to subsidized housing only to those who comply with treatment, an effective mechanism of subjugation because most of the public mental health patients cannot afford to pay fair market rents from their monthly disability checks. These powerful pressure tactics are today ordinarily called "leverage" by academics (Monahan, Redlich, Swanson et al. 2005). John Monahan, the dean of psychiatric coercion scholars, goes as far as to argue "that framing the legal debate on mandatory community treatment primarily in terms of coercion has become counter productive … [and it is] unhelpful and [a] misleading assumption that all types of leverage necessarily amount to coercion" (2008, p. 284). Monahan seems to forget that

"mandatory community treatment" means, if it means anything at all, treatment not voluntarily sought but forced on the patient, a deliberate interference in an area within which the patient could act. The scientific work of some eminent scholars of coercion might be summed up in one phrase: Coercion by any other name is *not* coercion.

The New Case for Psychiatric Coercion

Other eminent psychiatric scholars, however, have recently come out unabashedly in defense of psychiatric coercion, which they insist *is* plain coercion, period. Jeffrey Geller (2012), professor of psychiatry and director of public sector psychiatry at the University of Massachusetts Medical School, asserts that "the psychiatrist's *option* to employ coercion is an integral component of functioning in this recovery oriented paradigm..." (p. 493, italics added). Geller is candid about the level of coercion in outpatient treatment:

> Coercive interventions, with little or no review by anyone other than a physician or a treatment team or administrator, are rampant in entitlement programs; they include leveraged housing (for example, "If you want to live in this residence, you have to take your medication as prescribed and go to a day program"); representative payeeships; "bargained" psychopharmacologic regimens (for example, "You take your antipsychotic and you can have a benzodiazepine"); waiver of civic responsibility (for example, jury duty); treatment "contracts" through Individual Service Plans; and threats of emergency detention (for example, civil commitment). (p. 494)

Geller proposes that regardless of psychiatric status, individuals routinely get coerced in the community, which he finds equivalent to "prevention and treatment":

> A person who repeatedly gets stopped for speeding loses his or her license and must attend classes to get it back (treatment). ... Someone who disrupts a public event is removed from the venue (treatment, behavior modification). If you park illegally, the car is towed and you get fined...(treatment and prevention). (p. 495).

After medicalizing drivers' education, Geller feels he must now demedicalize forced treatment by medical doctors: "If a person behaves in a way that is dangerous to others, and the danger can be mitigated by psychiatric treatment, the person gets treatment. ... It is coercion in the same way that others in the community are subjected to coercion. It is not coercion because of "psychiatric status": it is an intervention to address behavior. Just as we all experience" (p. 495).

But Geller is clearly mistaken here. Society does not enact special laws to coerce speeding drivers on the basis that they suffer from a mental illness that is responsible for their speeding. But society coerces dangerous people into psychiatric treatment *only* on the basis of special laws that require a diagnostic evaluation by a psychiatrist. Actually, Geller is on to something, but not what he intended. Geller repeats that coercion occurs everywhere in society, not just in psychiatry, because he wants to make psychiatric coercion palatable. But as he makes this argument, he is forced to recognize that *no existing psychiatric treatment can compete with coercion*: "the notion that we can eliminate all coercive interventions by using our current array of psychopharmacologic

agents, psychotherapies, and rehabilitation interventions is without precedent" (p. 494). Undoubtedly, Geller is resting psychiatry on a foundation of coercion.

Another eminent psychiatric scholar and activist, Allen Frances (2012), best-known as the Chair of the DSM-IV Task Force but, over the past few years, transformed into an energetic denouncer of (some) psychiatric imperialism in the new DSM-5, goes even further than Geller in his acknowledgement of the nature of coercion in psychiatry, and in doing so, also probably unintentionally, deals a fatal blow to the claim that coercion has *anything* to do with medical treatment.

In a reply to an article by psychologist Jeffrey Schaler (2012) stating the Szaszian case that mental illness is a myth, Frances writes: "I agree completely with Schaler and Szasz that mental disorders are not diseases and that treating them as such can sometimes have noxious legal consequences." He singles out "schizophrenia": "... mental disorders are constructs, nothing more but also nothing less. Schizophrenia is certainly not a disease; but equally it is not a myth. As a construct, schizophrenia is useful for purposes of communication and helpful in prediction and decisionmaking—even if ... the term has only descriptive, and not explanatory, power" (p. 1).

Having robbed psychiatry of medical pretensions ("mental disorders are not diseases"), Frances must therefore squarely come to terms with the nature of psychiatric coercion: "I have evaluated [patients who 'desperately needed to be protected from hurting themselves or others'] many hundreds of times. While it is never comfortable to coerce someone into treatment, it is sometimes the only safe and responsible thing to do, and occasionally it is life saving. ... Coercive psychiatry, however unpleasant, must be available as a necessary last resort when nothing else will do" (p. 2). We applaud

Frances' plain statement of the case *for* psychiatric coercion, even if we think it is a weak case. Let us return to Peckham's previously summarized position that the functioning of a relatively smooth society requires force when the intermediary social control functions of persuasion and seduction fail. In this regard, the imposition of force or violence is always a policing action, one normally entrusted to soldiers and policemen. Medicine was never envisioned as violent policing, and of course is not marketed that way, and psychiatry is certainly not marketed that way either. Therefore, when psychiatrists or mental health professionals coerce, they are essentially state paid police mercenaries posing as doctors or therapists.

The relentless use of coercion to control the mad in America for four centuries has continually been marketed, not as the use of force to manage a disobedient and troubling group, but as the application of better and more progressive treatments to aid a group suffering from a serious medical infirmity. The presumed treatments are presented as having been developed through advanced scientific techniques and building on previous work to create increasingly more effective interventions. Over the last couple of decades, many of these interventions have been anointed as "evidence-based practices" (EBPs). We think such claims were bogus in the 18th century and we believe they are bogus in the 21st century. To illustrate how reputable researchers and mental health professionals can come to such judgments, we now examine some of the purportedly scientific bases for the acceptance and dissemination of ACT, one of the most popular of mental health EBPs, but one of the least critically examined community psychiatric interventions, and a coercively employed intervention designed to change the behavior of mad people.

Coercion as Assertive Community Treatment

ACT was one of those mental health programs developed during the late 1960s and early 1970s to respond to the federal mandate for shifting the locus of care and control of psychiatric patients from isolated institutions into the community (Stein & Test, 1985). It was considered to be an immediate success (Marx, Test, and Stein, 1973) and received the Gold Achievement Award in 1974 from the American Psychiatric Association. It closely fit the prevailing psychiatric disease model and its concomitant reliance on psychiatric drugs: "Congruent with our conceptual model, we tell our patients that indeed we believe they are ill, otherwise we would not be prescribing medication for them" (Stein & Diamond, 1985, p. 272).

ACT has four essential characteristics, which may be summarized as follows: 1) a three to five-person team approach, involving at least one case manager and psychiatrist per patient; 2) the use of "assertive outreach," with the team reaching out and taking both biological and psychological service to the patient; 3) highly individualized treatment; and 4) ongoing rather than time limited services (Test, 1992, pp. 154-156). Phillips and colleagues (2001) claimed that ACT was to be deemed an EBP because it had shown superiority over alternate treatments:

> Research has shown that assertive community treatment is … more satisfactory to consumers and their families. Reviews of the research consistently conclude that compared with other treatments under controlled conditions, such as brokered case management or clinical case management, assertive community treatment results in a greater reduction in *psychiatric hospitalization and a higher level of housing stability*. (p. 771, emphasis added)

What is noteworthy about the quote above is that keeping people out of a hospital or in a community residence is used as the marker of treatment success, rather than usual measures of efficacy, such as direct symptom reduction, reduced disability, better functioning, or improvements in behavior, self- or other-rated. Nonetheless, ACT aspired to do more. In 1992, one of its originators, Mary Ann Test, now Emeritus Professor of Social Work at the University of Wisconsin, indicated that they always "target[ed] goals for the model … going far beyond the reduction of time in hospitals. Additionally, improvements in patients' psychosocial functioning and quality of life are sought" (Test, 1992, 164). But over time, the ACT model simply failed to demonstrate these sorts of outcomes. In fact, Philips, Burns, Edgar, et al. (2001) admit that "[t]he effects of assertive community treatment on quality of life, symptoms, and social functioning are similar to those produced by these other treatments" (p. 771). In other words, ACT does not reduce the mad behavior or improve the functioning of the severely mentally ill any more than any other approach. What then was the basis for its purported success?

The one consistent claim reported in the extensive ACT research effort is that of reduced hospitalization and inpatient treatment costs. Lest one thinks that reducing hospitalization rates was accomplished by reducing patients' symptomatic behaviors and therefore the perceived need for hospitalization, the facts appear otherwise: in many published studies, ACT methods reduced hospital stays by enforcing a fairly strict *administrative* rule not to admit or readmit any ACT patients for hospitalization regardless of psychiatric symptoms, but to carry out all treatment in the community. The comparison group of troubled patients at the same time could be freely readmitted.

Test and psychiatrist Leonard Stein, the other major player in the creation and popularization of ACT, provided an early clue to the importance of administrative control over hospitalization and discharge: "[ACT] results in less time spent in the hospital. This finding is certainly not surprising since experimental patients were usually not admitted to hospital initially and there were subsequent concentrated efforts to keep them out" (1978, p. 354). ACT articles acknowledge that reduced hospitalization in ACT is the result of administrative control, not clinical treatment. Scott and Dixon (1995), examining the impact of case management and ACT programs, observed that "the effectiveness of ACT models in reducing hospitalization may be a function of their capacity to control hospital admissions, length of stay, and discharge" (p. 659). Several studies have noted that the length of hospital stay "returned to pre-intervention levels when ACT team … control of discharge was blocked by hospital authorities" (Craig & Pathare, 1997, pp. 111-112). Finally Minghella, Gauntlett and Ford (2002), discussing the failure of some Assertive Outreach teams in England to reduce hospitalization, write that "[w]hile the teams partly adhered to the ACT model, there were major areas of deviation. The teams had little influence over admissions and discharge" (p. 27).

In short, if one does not allow particular people to be hospitalized, they will not be. "Clinical" interventions are irrelevant in this case. Rigorously keeping people, regardless of their behavior, away from hospitals by active administrative control, could be employed by any intervention, and show the distinguishing results that ACT showed. A crucial point to be made here is that the same psychiatric administrative activity may force people into hospitals for treatment, may prevent them from entering hospitals and force them into the community for treatment. The coercive element is that no approach

considers whether any of the patients being forced in want out, or vice versa. Client choice is not an option. Yet, responding to a communication accusing ACT of being coercive, Test and Stein (2001) formally responded that "[t]he assertive community treatment approach never was, and is not now, based on coercion" (p. 1396). These authors nonetheless know intimately that ACT activities can include all the acknowledged coercive measures earlier listed by Geller (2012) in his description of "treatment in the community." Of course, this is not to say that non-coercive inducements are not used, as even bribery may be appropriate ACT treatment: "it might be necessary to pay a socially withdrawn patient for going to the movies in addition to buying his ticket" (Test & Stein, 1976, p. 78).

In any case, a large body of literature today addresses the "therapeutic" value of community-based coercion of psychiatric patients, an ongoing discussion which can be tied directly to the existence of ACT. A 1996 edited book legitimated the study and use of such coercion with the title specifically identifying ACT and its coercive approach: *Coercion and Aggressive Community Treatment: A New Frontier in Mental Health Law* (Dennis & Monahan, 1996). More recently, conventional psychiatric coercion research is well summarized in a major book published in 2011, also co-edited by John Monahan, *Coercive Treatment in Psychiatry: Clinical, Legal and Ethical Aspects*. Though some psychiatric experts still occasionally ask, "Is Assertive Community Treatment Coercive?" (Appelbaum & LeMelle, 2007), ACT experts acknowledge that "assertive engagement" or "assertive outreach" is a core element of ACT. These two concepts are included in the most popular scale for evaluating ACT program replications' fidelity to the original Madison model, the *Dartmouth Assertive Community Treatment Scale* (DACTS).

Assertive engagement is measured in DACTS primarily by counting the frequency of formal coercive legal mechanisms (i.e., mandated outpatient treatment or appointed financial payees). Its developers state plainly that "the criterion for assertive engagement was operationalized in such a way that it emphasized use of legal mechanisms" (Teague, Bond, & Drake, 1998, p. 229). A report prepared in 2000 for the Federal Health Care and Financing Administration and the Substance Abuse and Mental Health Services Administration devotes a section to ACT coercion. The report notes that "[w]ithin the context of ACT programs, coercion can include a range of behaviors including, friendly persuasion, interpersonal pressure, control of resources and the use of force. … Research generally suggests that coercion may be harmful to the consumer" (LewinGroup, 2000, p. 43). It is noteworthy that "friendly persuasion" is included as an example of "coercion" in a federal government report on psychiatric treatment. Is this a simple error, or part of a strategic effort to dilute the meaning of coercion? Is the inclusion of an obviously non-coercive interpersonal activity (indeed, perhaps the essential ingredient of *voluntary* talk therapy) in the preceding list of coercive activities an effort to mask externally imposed force as treatment? Similar strategic inclusions regularly occur in psychiatry. The most common examples besides those noted earlier include the efforts to authenticate "mental illnesses" as physical diseases by lumping together problems called depression and schizophrenia within lists of common neurological disorders or "brain-based disorders" that have identifiable neurological signs, such as Parkinson's Disease or Alzheimer's Disease, though neither depression or schizophrenia have any such signs.

ACT is merely a recent manifestation, adapted to the exigencies of life beyond hospital walls, of the longstanding coercive strain that has characterized psychiatric

interventions with mad persons to this day and that surreptitiously subsumes the cloak of scientific activity and scientific progress.

Conclusion

Psychiatric practitioners used to pretend that when men and women of science motivated by the desire to heal forced mad persons to submit to their ministrations, this was not coercion but medical treatment. Today such a pretense no longer seems necessary. A thriving body of research, supported among others by the NIMH and the MacArthur Foundation (Dennis & Monahan, 1996, p. 15), fully explores the therapeutic value of coercion. The deprivation of autonomy and freedom is increasingly being redefined as a therapeutic tool rather than an obvious human rights violation.

When we searched the Medline database until 2007 for indexed articles about psychiatric coercion (using coercion*,* outpatient commitment*,* and civil commitment as independent key words) we identified 796 articles. Only 22 articles were published before 1970, in contrast to 665 articles between 1991 and 2007 (39 articles a year). The first noticeable spike in publications occurred in 1971, just around the time community treatment became a focus of research. In the abstracts, we note only a handful of voices dissenting from the general view that coercion, though "controversial," is ultimately just another therapeutic mechanism deserving examination.

It is apparent that coercion is increasingly seen in psychiatry and in other mental health professions and the legal profession as an acceptable form of psychiatric treatment needing no critical scrutiny by psychiatric professionals and academics beyond meeting the technical criterion of effectiveness. "Psychiatric scientific authority" has transformed coercion into a routine intervention, leaving the average psychiatric researcher to focus

on the technical details of the issue (i.e., how well does coercion "work" to produce this or that outcome?) and to lose sight of larger moral issues regarding human freedom, dignity, and autonomy (Cherry, 2010); of the perspectives of those subject to coercion (Oaks, 2011; Olofsson & Jacobson, 2001); and even the narrower issues of whether coercion should ever be used as a "tool" of helping professionals, free of the safeguards that surround its uses outside of the mental health system.

We believe that the two roles of psychiatry, that of policing and detaining (involuntary psychiatry) and therapeutic helping (voluntary psychiatry) of the mad, are irreconcilable. In order for one to work the other cannot. The first requires a coercive social technology (ultimately, incarceration) in order to enforce compliance if social seduction (i.e., friendly persuasive rhetoric or incentives) fails. Having psychiatric coercion at the ready eliminates or at least greatly constrains choice of their treatment for those mad who are under the purview of this psychiatric approach. As we have repeatedly suggested, one should not define the police who are in charge of managing criminal behavior as therapists, even if sometimes they act to deescalate the anger and potential violent behavior of those they must control. We think this is obvious. Thinking that psychiatrists with very similar policing or punitive authority over the mad (as policeman and jailers have over everyone else) can be therapists consistently watching over the interest of their wards suggests the magical symbolic power of labels like "doctor" and "mental illness" to transform how their activities are perceived. Force is force, regardless of how we label it. The intention of the one who wields force may be benevolent, but force hurts equally whether we call it punishment or "punishment therapy." Perhaps, if

we indeed call it and manage it as “punishment therapy” — thus refusing to acknowledge that it is actually *punishment* — it might hurt even more.

We believe that a voluntary psychiatry and an involuntary psychiatry cannot both be the same enterprise, evaluated by the same criteria, scientific or otherwise. The very small number of dissenting voices concerning the legitimacy of psychiatric coercion doesn’t indicate the rightness of the approach, only the numbing of our moral and critical faculties. The historical role of punishment of those people society calls mentally ill remains imbedded in the medical model because of the ways in which control and coercion easily slip into the benevolent rubric of treatment for the relatively powerless and vulnerable, and because of the ways that, outside hospital walls, control and coercion have been chopped up into bits, each of which is echoed by various professionals and institutions in society, and each of which seems like a relatively small price to pay to ensure proper “medical” treatment of widespread distress and misbehavior.

Coercion is the only intervention in the management of the mad to have endured since the birth of the discipline of psychiatry, over 200 hundred years ago. We suggest that coercion and the threat of coercion persist in psychiatry because coercion is all there ultimately is.

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[i] This is of course an enormous problem, well documented by David Healy (2012) and others, who argue that most of the information relevant to making judicious decisions about using this or that drug with this or that patient is actually, and actively, hidden from the view of the medical practitioner by the pharmaceutical industry and its willing or helpless allies. There is also the important issue that psychoactive drugs (such as opium) that might prove to be of significant benefit to some people and less harmful at comparative doses and durations than many tranquilizing drugs currently prescribed (such as lithium), are illegal and therefore practically unavailable for relief of distress. In these circumstances, the physician's presumably learned confidence in the efficacy or safety of a treatment, and the physician's and patient's confidence that all appropriate drug treatments have been fairly tested to ascertain benefits to the *consumer*, are illusory.

[ii] Once the individual pays his fine or serves his time he regains his full rights as a normal member of society.

[iii] We prefer the category label word "mad" over the more contemporary versions of it such as "mentally ill" or other terms such as Schizophrenic, Bipolar or Borderline because we believe that these represent an explanation of mad behavior dependent on the entirely unproven claim that it is, or is a sign of, brain disease. The word "mad" on the other hand traditionally has served as a general category for collecting all disturbing and disturbed behavior not categorized criminal and had no particular etiological commitments attached. We note however that unlike the label of criminal the label of mad or any of its alternative versions, once ascribed, cannot be eradicated.

[iv] Dr. Rush described the chair in a letter to his son:

> I have contrived a chair and introduced it to our [Pennsylvania] Hospital to assist in curing madness. It binds and confines every part of the body. By keeping the trunk erect, it lessens the impetus of blood toward the brain. By preventing the muscles from acting, it reduces the force and frequency of the pulse, and by the position of the head and feet favors the easy application of cold water or ice to the former and warm water to the latter. … It acts as a sedative to the tongue and temper as well as to the blood vessels. In 24, 12, six, and in some cases in four hours, the most refractory patients have been composed. I have called it a Tranquilizer. (cited in Scull, 1993, p. 73, footnote no. 104)

[v] Think of the payment of income taxes. Because the Internal Revenue Service is able to enforce the tax code through criminal and civil sanctions, it would be naïve to conclude that people pay taxes "voluntarily."

[vi] As argued by Dallaire et al. (2000), in civil commitment the psychiatric system and the legal system reveal their "common logic: *treatment-control.* Our analysis of the treatment role and of the control role, when manifested in civil commitment, has not been able to separate them, either conceptually or in practice" (p. 144). These authors rest their

conclusion partly upon the fuzziness of concepts central to the control role (dangerousness) and treatment role (mental illness).

[vii] The counting of patient care episodes tracked by the federal government since 1955 is a duplicate count, since a person may be admitted to more than one type of service or can receive the same service more than once in any one year. The number of individuals who receive multiple service episodes is unknown, so we are unable to have a total unduplicated count of the number of persons under care in any one year.