Law and Disorders

Studies explore legally sensitive judgments in treating mental illness

By BRUCE BOWER

Mental health clinicians often make decisions that affect the personal freedom of people with mental disorders and, at times, the collective safety of everyone. Although state and federal laws set the ground rules for voluntary and forced admissions to psychiatric hospitals, clinicians wrestle with ambiguities that a judge's gavel cannot pound into submission.

Consider the following situations:

- A psychiatrist must size up whether a man diagnosed with schizophrenia, who is tormented by voices that only he can hear and suspicious of others' intentions, can discern the risks and benefits of a powerful antipsychotic medication well enough to reject the treatment if he so wishes.
- A psychologist who believes that a depressed woman needs immediate hospitalization to prevent her from committing suicide must either call her to discuss treatment options or threaten her with forcible admission to the hospital if she does not do it herself by the end of the day.
- Police take a man to a psychiatric emergency room after he has screamed at and threatened his wife for several hours from the sidewalk in front of their apartment. The man, identified as intoxicated by a breath analysis, tells physicians of his fury at his wife's many alleged infidelities. His medical records reveal a history of alcoholism. A psychiatrist and a psychiatric nurse must estimate whether the man poses enough of a physical threat to himself or others to be held in the hospital against his will.

Scientific research offers precious little guidance to harried (and hurried) clinicians faced with these situations. That's about to change, however. A landmark 8-year research project, scheduled to conclude in 1996, promises to make significant inroads into understanding the decision-making competence of people with mental disorders, the ways in which they get coerced into treatment, and their potential for violence.

Preliminary findings of this effort were presented in October at the American Academy of Psychiatry and the Law in Maui, Hawaii. The three-pronged investigation is coordinated by 12 researchers and will receive about $12 million from the MacArthur Foundation Research Network on Mental Health and Law, as well as smaller amounts from other sources.

"We're addressing what we see as the central issues in mental health law," asserts John Monahan, a psychologist at the University of Virginia in Charlottesville and director of the network. "Some of our main findings are at variance with what many clinicians have assumed and previous studies have suggested."

Initial results of the competence study, directed by psychiatrist Paul S. Appelbaum and psychologist Thomas Grisso, both at the University of Massachusetts Medical Center in Worcester, bear out this point. Some clinicians and policy makers argue that serious mental disorders routinely render people legally incompetent to make decisions about psychiatric treatment; conversely, patient advocates assert that these conditions usually leave unscathed the ability to reach sensible treatment decisions.

Neither camp can take comfort in the new findings, say Appelbaum and Grisso. Mental illness often coexists with competent decision making, but many hospitalized patients — up to one-half of those suffering from schizophrenia and one-quarter of those with major depression — show seriously impaired judgment, they assert.

Systematic screening of patients for signs of legal competence in decision making rarely takes place in psychiatric hospitals, Appelbaum says. He and Grisso are now testing a brief, standardized competence interview, based on their findings, that they hope clinicians will find useful.

The Massachusetts researchers' study of 498 people in three states included people hospitalized for schizophrenia or major depression, people hospitalized with physical symptoms related to heart disease, and healthy people living in nearby communities. Within 2 to 7 days after admission to the hospital, each patient underwent a 1 1/2-hour interview that explored the four legal linchpins of competence: the ability to state a choice, to understand relevant information, to appreciate the nature of one's own situation, and to reason with information. Nonpatients completed the same interviews.

Patients varied in their decision-making competence depending on which of the four measures, and how many of them, received consideration, says Appelbaum. About half of those hospitalized for schizophrenia performed well on all measures, with those suffering from the most severe psychiatric symptoms (such as disorganized thought and paranoia) scoring lowest. Most of the latter group demonstrated large gains in the ability to reason about their condition and available treatments when interviewed after spending 2 weeks in the hospital.

Three-quarters of depressed patients displayed competence on all measures. Those experiencing the most severe depression had about the same decision-making capacity as those with less serious depression, Appelbaum contends.

Patients with symptoms of heart disease achieved good overall scores in more than 9 out of 10 cases and exhibited a level of competence nearly equal to that of healthy persons.

Around half of the psychiatric patients initially contacted by the researchers suffered from severe mental symptoms that prevented them from completing interviews. Clinicians have no research-based guidelines on how to deal with such individuals, notes Howard Zonana, a psychiatrist at Yale University School of Medicine.

Zonana, who did not participate in the study, views the new competence interview as a means of providing mental health clinicians with some "common ground" when assessing a person's reasoning ability.

Appelbaum hopes that his technique for gauging competence catches on in branches of medicine outside of psychiatry. "In the real world, physician disclo-

sures to patients about treatment risks and benefits often either aren't made or aren't made properly," he argues.

A second line of research in the MacArthur Foundation project concerns another little-studied area — the role of coercion in getting mentally disordered people into psychiatric hospitals and the effect of patients' perceptions of coercion on treatment.

Results indicate that just-hospitalized patients cite the least coercion and the most readiness for treatment if they have participated in the hospital admissions process and feel that medical personnel listened to them and treated them with respect.

Virginia's Monahan and his coworkers interviewed 157 patients within a day after admission to either a hospital-based psychiatric unit or a rural state mental hospital. Patients had received any of a variety of diagnoses, including schizophrenia, major depression, and substance abuse.

Nearly 90 percent of those who faced only "negative" pressures to enter the hospital (defined as the use of threats or force) reported feeling coerced. In contrast, 10 percent of those who encountered only "positive" pressures to enter the hospital (defined as the use of persuasion or inducements) felt coerced — a comparable proportion to that of people who cited no pressures yet felt coerced.

One-third of patients exposed to both positive and negative pressures felt coerced into treatment.

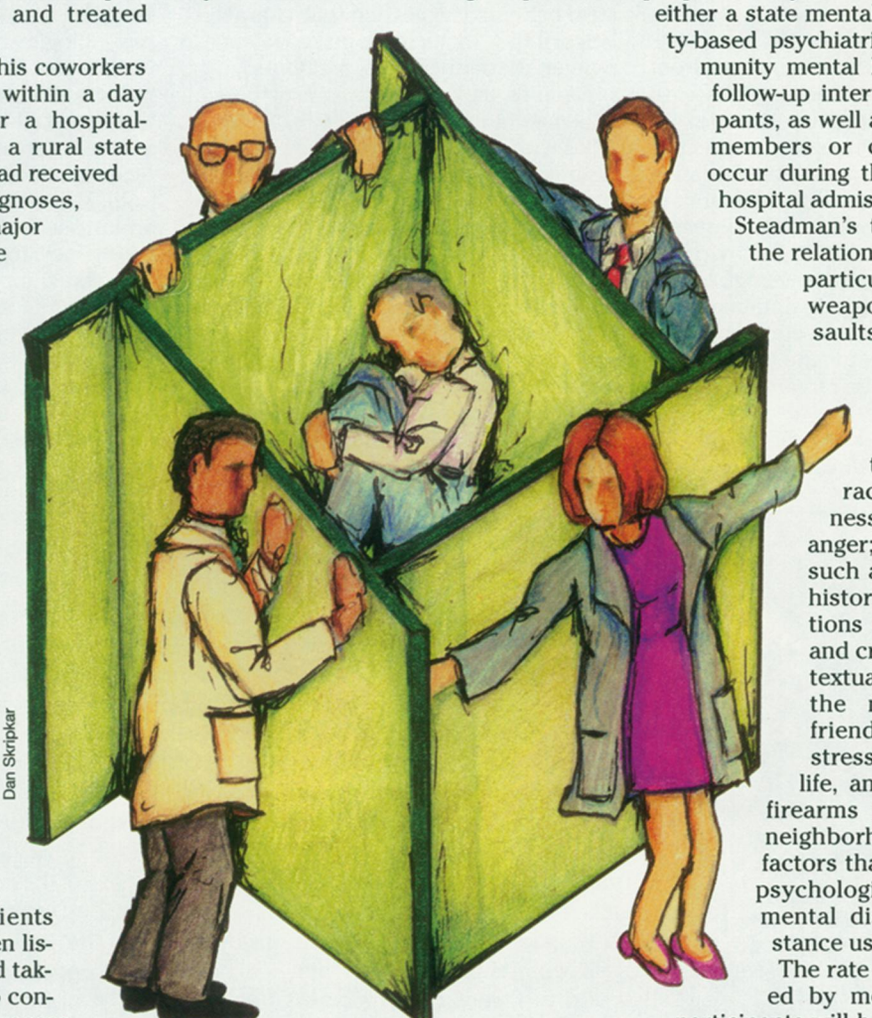
Only 2 percent of patients who felt that they had been listened to, treated fairly, and taken seriously by those who conducted the admissions process considered their hospital entry to have been forced; on the other hand, half of those who described being ignored, deceived, and treated dismissively during admissions felt coerced into treatment.

Patients' legal status as "voluntary" or "involuntary" often masks their perception of coercion, Monahan contends. About one-third of voluntary patients signed themselves into a hospital because they believed that otherwise they would be committed involuntarily. About the same number believed they did not suffer from a mental disorder.

One in five involuntary patients said it was his or her idea to come to the hospital for help and that he or she had initiated the admission. A majority of the involuntary patients reported that no one had offered them the opportunity of entering the hospital voluntarily, an option many said they would have accepted.

The researchers are now comparing patients' accounts of coercion to those of their family members and the hospital admissions staffs.

"If these findings hold up, they suggest that persuasion and other positive pressures are the strategies of choice to get people to accept treatment," Monahan says. "Clinicians should give patients concern and respect, consider what they have to say, and involve them in the admissions process."



Dan Skripkar

Unlike competence and coercion, the potential for violence in people with mental illnesses and the ability of clinicians to predict such violence have received a good deal of attention. Evidence generally suggests that mental disorders create no special risks for behaving violently and that mental health professionals usually err when forecasting which of their patients will commit violent acts in the near future.

However, those studies contain serious flaws, Monahan maintains. They have relied solely on arrest records to track violent acts, looked at only a few factors that might boost the likelihood of violence, and included poorly defined measures of clinicians' predictions.

The MacArthur network has just completed the first phase of what Monahan calls "the mother of all risk-assessment studies." Investigators directed by psychologist Henry J. Steadman of Policy Research Associates in Delmar, N.Y., conducted extensive interviews with 1,000 people shortly after their admission to either a state mental hospital, university-based psychiatric facility, or community mental health center. Five follow-up interviews with participants, as well as with their family members or close friends, will occur during the year after their hospital admission.

Steadman's team will examine the relationship of violence — particularly threats with weapons, physical assaults, and pushing or hitting that causes injury — to four areas of risk: dispositional factors such as age, race, sex, impulsiveness, and proneness to anger; historical factors such as family and work history, past hospitalizations for mental illness, and criminal record; contextual factors, including the number of close friends and relatives, stressful aspects of daily life, and the presence of firearms in the home and neighborhood; and clinical factors that focus on current psychological functioning, mental disorders, and substance use.

The rate of violence exhibited by mentally disordered participants will be compared to that of a random sample of 500 adults living in Pittsburgh.

Several lines of evidence suggest that the MacArthur risk-assessment study will find a modest elevation of violence in those diagnosed with mental disorders. Much of this work appears in *Violence and Mental Disorder* (University of Chicago Press, 1994), a book edited by Monahan and Steadman.

A reanalysis of data gathered in the early 1980s from more than 10,000 participants in a national survey of mental disorders indicates that mentally ill people commit two to three times as many violent acts during their lives as people

without a psychiatric disorder. Still, most of the mentally ill never assault others, asserts Jeffrey W. Swanson, an epidemiologist at Duke University Medical Center in Durham, N.C. And only 7 percent of those with a mental disorder that does not include substance abuse engage in violent behavior over the course of a year, he notes.

Mentally disordered individuals who abuse alcohol or illicit drugs become violent three to four times as often as those with a mental disorder alone, Swanson argues. Substance abuse by itself markedly raises the likelihood of violent behavior in the mentally ill and healthy alike, he adds.

Similar findings have emerged from studies of mental patients and random community samples in New York City and Israel, both directed by Bruce G. Link, an epidemiologist at Columbia University. Link has uncovered a trio of psychiatric symptoms closely linked to violent behavior in both countries: frequent feelings in the past year that one is being dominated by forces beyond one's control, that thoughts are being put into one's head, and that one has been targeted for harm by other people.

Almost two-thirds of both mental patients and community controls who cited these symptoms reported getting into at least one fight in the past 5 years, compared to 15 percent of those who did not. Still, the large majority of the former group had not engaged in violence in the prior month.

"These three psychotic symptoms, and drug and alcohol use even more so, make violence more likely, but they cannot predict an individual's behavior with certainty," Link contends.

Social influences also raise or lower the propensity for violence, the Columbia researcher says. For instance, a comparison of his two studies reveals comparable levels of violence in mentally healthy New Yorkers and Israeli psychiatric patients, suggesting that characteristics of the U.S. location make violence a readier alternative for its residents.

Families may also act as crucibles of violence. Mothers who care for an adult child with a serious mental illness face a slightly higher risk of being assaulted by that child, especially if there is no father present, asserts Sue E. Estroff, an anthropologist at the University of North Carolina at Chapel Hill. Estroff directed a 32-month study of violence in 169 patients given short-term treatment at any of four psychiatric hospitals.

Prevention of family violence may require more residential services for the mentally ill, such as structured group homes, as well as classes to teach mothers negotiating and self-defense skills, Estroff argues.

Monahan suspects that the MacArthur risk-assessment study will confirm these results and add to preliminary evidence that clinicians can often identify mentally disordered men who will soon become violent. Staff in a psychiatric emergency room identified nearly two-thirds of a group of male patients who, in the next 6 months, either assaulted others or threatened them with a weapon, according to a study published in the Feb. 24, 1993 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

The same clinicians identified only half of the female patients who later engaged in violence, reported Charles W. Lidz, a psychologist at the University of Pittsburgh, and his colleagues. This finding reflects an unfounded assumption by the hospital staff that the overall rate of violence in female patients would fall far below that of the men, the researchers hold. Mental health workers thought that about one in five women treated at the emergency room would act violently in the next 6 months, when in fact nearly half of them did (a slightly greater proportion than men).

"Our goal is to find a set of predictors that helps clinicians to improve their assessments of patients' risk for violence before releasing them to the community," Steadman says. □