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Alison Barnes

Marquette University Law School, alison.barnes@marquette.edu

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COMPETENCY, COERCION, AND RISK OF VIOLENCE: LEGAL INTERSECTS WITH FUNDAMENTAL ISSUES OF MENTAL HEALTH

ALISON MCCHRYSTAL BARNES*

On October 15, 1998, Marquette University Law School convened a symposium for consideration of the findings of the MacArthur Foundation Research Network on Mental Health and the Law, which has members in numerous locations throughout the United States. The symposium was attended by an interdisciplinary audience that included psychologists, psychiatrists, lawyers, judges, social workers, and mental health advocates. Advocated by Wisconsin Chief Justice Shirley Abrahamson, who is a member of the Network and gave the keynote speech, the symposium seemed particularly appropriate to a jurisdiction where the legal rights of the mentally ill were articulated by the courts.¹

The format accommodated presentations on three research areas of the MacArthur Network: actual and perceived coercion in mental hospital admissions; the correlation between legal competency status and actual capacity to make treatment decisions; and the assessment of risk that a mental health patient will engage in violent behavior.²

Among the lawyers who responded were noted criminal defense attorney Stephen Glynn, University of Wisconsin professor of law and

* Associate Professor of Law, Marquette University Law School.

1. See *Lessard v. Schmidt*, 349 F. Supp. 1078, 1090 (E.D. Wis. 1972) (expounding new standards for civil commitment procedures and adopting the least restrictive alternative form of constraint to protect the individual or others).

2. See *MacArthur Research Network on Mental Health and the Law* (last modified Jan. 1998) <<http://ness.sys.virginia.edu/macarthur>>. Much of the basic material about the research project, presented here as the context for the symposium articles and these comments, is found on the Network's web site.

former Wisconsin Director of Corrections Walter Dickey, mental health advocate Diane Greenley, and Milwaukee County's district attorney for the past thirty years, E. Michael McCann. Psychiatrist Dr. Darold Treffert, perhaps best known for his 1974 monograph *Dying with Their Rights on*,³ and Villanova professor of psychology Dr. Kirk Heilbrun also spoke. Both prolific writers in the field, they expand on their responses to the MacArthur Network findings in this symposium edition. Perhaps the most moving of the presentations, however, was the presentation by Judge Maxine Aldridge White who spoke of her concern for people with mental illness both in the courts and in her personal experience.

I. THE MACARTHUR RESEARCH NETWORK ON MENTAL HEALTH AND THE LAW

The Network was created in 1988 by the Board of Directors of the John D. and Catherine T. MacArthur Foundation. Consisting of researchers throughout the country, the Network's purpose was to develop new knowledge regarding the assumptions on which the law rests and the effects the law produces on persons in the mental health system. It was intended that the research would allow legislatures, courts, and administrative agencies to choose more effective policies, and would allow mental health and legal professionals to respond with more productive strategies for dealing with persons with mental disorders. The Network pursued its research through December 1996, and in 1998 completed its analyses of the data.

II. THE RESEARCH

A. *The MacArthur Coercion Study*

The specter of coercion has always been strong in the drama of mental hospital admission. Patients are divided into two groups with significantly different rights: voluntary patients, who consent to their admission and therefore can, at least theoretically, withdraw consent and leave a facility; and involuntary patients, who are deemed to be unable to consent and must have another with authority to do so. A segment of voluntary patients are those who refused consent to admission until it was clear that only consent would avoid involuntary admission. Thus, the indication that an involuntary patient is unable to give consent

3. Dr. Darold A. Treffert, *Dying with Their Rights on*, 2 PRISM 49-52 (Feb. 1974).

sometimes consists of the adamant refusal to do so despite the fact that professionals and family members believe inpatient treatment is necessary. The involuntary patient cannot choose to be released, but must await the development of treatment within the procedural due process adopted by the hospital or imposed by state law.

Originally conceived as an analysis of the therapeutic or detrimental outcomes of the use of coercion, the Coercion Study had to begin with a more fundamental question: What is the experience of coercion and when do mental health patients feel their treatment decisions are coerced? Two successive studies followed, the first utilizing 157 randomly-chosen adult patients in a rural Virginia state hospital and a Pennsylvania community hospital, and the second with 433 patients in the same places. The studies gathered and compared the perceptions of patients, family members, admitting clinicians and a "most plausible factual account" devised by researchers. Perceptions were gathered at the time of admission and about one month later.

A third study, concurrent with the two described above, developed and tested measures of perceived coercion for use in an assessment tool. The 1,136 participating patients from hospitals in Massachusetts, Pennsylvania, and Missouri were assessed in the hospital and five times during the year after their release on a large number of variables. The purpose of this study was to determine whether factors such as compliance with outpatient treatment regimens or incidence of re-hospitalization correlated with the perception of coercion or non-coercion.

The findings, in brief, indicate that a patient's voluntary/involuntary legal status does not strongly correlate with a patient's perception of coercion or with treatment that would generally be considered coercive. This is true despite the finding that patients' accounts of the events surrounding their admission are very often as complete and plausible as those told by family members or hospital staff.

In part, the gap between legal status and perception of coercion may be accounted for by the fact that about half of the patients who initially resisted admission changed their minds about the need after the fact. Two other factors of great interest were developed: so-called positive pressures such as persuasion and inducements were not perceived as coercion, while threats and force might be; and the patient's evaluation of the actions of others to bring about admission and treatment were strongly and positively related with the patient's beliefs that the others really cared about the patient's well-being, acted and spoke in good faith, and let the patient tell his own story. The study reports that such characteristics of procedural justice were very important to a patient's

perception of non-coercion, though generally patients reported less due process took place in admission than did family members or hospital staff.

Responder Diane Greenley, who for more than twenty years has been involved in legal advocacy for persons with mental disabilities, cited a recent Wisconsin study of 170 mental health services consumers who were queried about their views of the most important components of the mental health system. To her surprise, she reported that the aspect identified as most important was the consumer's knowledge of his or her rights, and to be free of discrimination. Regarding treatment, consumers rated as most important being treated with respect, and having choices about providers, drugs, and treatments. These justice oriented concerns even ranked above improvement in the consumers' conditions. Thus, consumers confirm that treatment is a participatory experience—a view that managed care organizations for all types of health care should consider carefully.

Attorney Greenley cited profound changes in progress in the mental health system orientation and values due to established policies favoring de-institutionalization, opportunities to rehabilitate mental health patients with drugs and therapy in the community, and the increasingly available goal of recovery and productive community living. The new paradigm necessarily rests on individual responsibility to recognize symptoms and take prescribed medications. The law also provides individuals the opportunity to direct their own care in the event of future loss of capacity by executing advance directives.

Given these requirements for successful recovery, Attorney Greenley asserts that coercion—involuntariness—is incompatible with recovery for all. Further, specific populations may be particularly burdened by coercion, including those who have suffered in families and communities that reward with power those who engage in abuse and violence. For these individuals, largely women and (former) children, violence may be considered toxic. Additionally, where their mental health is bound up in coercive lifestyle and community, trust, power, and control are key issues. Failure of the mental health services provider summons up that dysfunctional and degrading model of hard lives.

In more than thirty years as a mental health clinician and administrator of inpatient facilities, Dr. Treffert brings to his critique of the research the views of an informed and enlightened clinician. Recognizing the value of the raw information in the study reports, he calls for implementation that balances the autonomy interests of the patient with society's and the profession's need to treat those whose apparent pain and

dysfunction could be alleviated by chemical and counseling therapy.

As a lawyer who lived and studied medical law in the United Kingdom in 1990-91, I am reminded by Darold Treffert's remarks concerning the mental health system there. Enacted in 1959, the mental health system was completely "medicalized," i.e., providing no legal process to intervene between the observation of need for mental illness treatment by a medical professional and the delivery of treatment. Institutionalization was the preferred response of the mental health system; guardianship and community-based care were largely a statutory theory since institutionalized patients were considered to be without any practical need for a substitute decision-maker. Rather, the decisions of hospital professional staff were the technically correct response to patient needs and institutional routine dictated all other details of living. Once identified as a mental health patient, the individual's choices were without weight.⁴ The MacArthur findings clearly undercut such a view, which in the United Kingdom has been the subject of criticism and investigation throughout the 1990s.⁵

B. The MacArthur Treatment Competence Study⁶

Since the 1960s, law has required patient consent before treatment can proceed. Arguably, there are few areas where new treatments can be as effective as in the treatment of severe mental illness, which might

4. See generally Alison Barnes, *Beyond Guardianship Reform: Toward Principled Decision Making in Long Term Care*, 41 EMORY L.J. 633 (1992).

5. For the initial white paper in the mental health system debate, see THE LAW COMMISSION, CONSULTATION PAPER NO. 119, in *MENTALLY INCAPACITATED ADULTS AND DECISION-MAKING: AN OVERVIEW* (1991).

6. Due to time constraints, the symposium emphasized the Treatment Competency study, giving its companion Adjudicative Competency study only passing mention. The Adjudicative Competency study follows the model of the other Network projects, building on three phases. First, the researchers defined legal competence in the context of the social purposes to be served by an adjudication of incompetency, particularly in the criminal context. The researchers next sought to develop an instrument to test for capabilities deemed essential to adjudicative competence and, last, made a survey of the incidence of decision-making impairments in a prison population generally. The instrument was tested in a small study in Florida and Virginia, identifying prisoners in the general population as distinct from those in mental health care.

The findings in brief: While no diagnosis equates with adjudicative incompetence, schizophrenia is once again most likely to impair decision-making. As with other decision-making capabilities, patients are likely to improve with treatment and may be able to return to participate in adjudication.

The study also indicates that about ten percent of criminal defendants are perceived by their attorneys as having potentially impaired incompetence, but are not usually referred for formal mental health evaluation.

restore to a patient his own thoughts, personality, and willful actions. Yet, the doctrine of informed consent is quite muddled in mental health care because no studies have clarified the extent to which persons with mental illness are capable of giving consent. If a person's capacity of consent is doubtful, but an individual is not considered to meet the standards of legal incompetency for appointment of a substitute decision maker, a patient may be barred from treatment for lack of someone to consent.

The Competence study was established to provide information about the actual decision making capabilities of mental hospital patients. Interestingly, an initial stage sought to identify those aspects of decision making that are legally significant. The four identified (in likely order of difficulty) "were the abilities to state a choice, to understand relevant information, to appreciate the nature of one's own situation, and to reason with information."⁷

The decision making abilities of 498 patients in three cities were assessed, including recently admitted mental patients with either schizophrenia or serious depression; medical patients, with heart disease with angina; and non-patients living in the community.

The findings in brief: mental hospital patients, especially those with a diagnosis of schizophrenia, were less capable of making decisions than the medical patients, who were about as capable as the community/control group. Yet, even persons with schizophrenia had some decision-making capabilities. Indeed, half did well on all measures of decision-making capacity combined. About three-fourths of patients with severe depression did well on all measures. Clearly, diagnosis does not identify persons who cannot make decisions for themselves.

The final phase of this project was the development and testing of the MacArthur Treatment Competence Assessment Tool (MacCAT-T). Corresponding to the abilities needed to make treatment decisions, described above, the MacCAT-T measures:

Understanding of treatment related information, focusing on categories of information that must be disclosed as required by the law of informed consent;

Appreciation of the significance of the information for the patient's situation, focusing on the nature of the disorder and the possibility that treatment will be beneficial;

7. *The MacArthur Treatment Competency Study, Executive Summary* (last modified Sept. 1998) <<http://ness.sys.virginia.edu/macarthur/treatment98.html>>.

Reasoning in the process of deciding upon treatment, focusing on the ability to compare alternatives in light of their consequences, including the ability to draw inferences about the impact of the alternative on the patient's everyday life; and
Communication of a decision about treatment.⁸

Paralleling the requirements of informed consent, the test requires that patients be provided with (1) diagnosis; (2) the three most important features of the disorder, such as symptoms, critical biological effects; (3) the course of the disorder; (4) a recommended treatment; (5) three features of the recommended treatment; and (6) alternative treatments.⁹

While no particular summary rating necessarily signifies legal incompetence to make treatment decisions, the authors indicate that scores in the average or better range indicate the patient is likely to be capable of making most treatment decisions.

Professor Dickey and Attorney Glynn each reflected in their own ways on the elusiveness of the decision-making process, and the failure of the law to reflect the complexity of determining competency for particular purposes.

The paradigm of "normal" capacity versus total incapacity persists. State by state statutory reform of the guardianship system in the United States has resulted in only a tiny increase in the number of limited guardianships, intended to leave to wards all the decision-making powers they are capable of effecting.¹⁰ The question to be pursued is: What limited powers should be left by the legal system to partially incapacitated persons? The answer must take into account the diagnosis and prognosis, as well as the person's autonomy rights, since the court cannot and should not return weekly or monthly to reallocate rights between guardian and ward.

8. THOMAS GRISSE & PAUL S. APPELBAUM, MACARTHUR COMPETENCE ASSESSMENT TOOL—TREATMENT 1 (1995) [hereinafter "MacCAT-T"]. The MacCAT-T is available from Professional Resource Press, P.O. Box 15560, Sarasota, FL 15560.

9. See MacCAT-T, *supra* note 8, at 2.

10. See generally PAT M. KEITH & ROBBYN R. WACKER, OLDER WARDS AND THEIR GUARDIANS (1994); HERBERT KRITZER & HELEN MARKS DICKS, ADULT GUARDIANSHIPS IN WISCONSIN: AN EMPIRICAL ASSESSMENT, A REPORT FOR THE CENTER FOR PUBLIC REPRESENTATION AND THE ELDER LAW CENTER COALITION OF WISCONSIN AGING GROUPS (1992); Herbert M. Kritzer et al., *Adult Guardianships in Wisconsin: How is the System Working?* 76 MARQ. L. REV. 549 (1993).

C. MacArthur Violence Risk Assessment Study

The risk that a patient will engage in violence generates recurring concerns for mental health professionals and the justice system. Yet, it has been asserted that for many years the predictions of psychiatrists and psychologists were less reliable than mere chance.¹¹ The MacArthur Research Network on Mental Health and the Law identified problems that “severely limit the ability of existing studies to provide information about risk assessment useful to either clinicians or to policy makers,” including:

- 1) The range of predictor variables studied has been very narrow, often no more than chart diagnosis or simple demographic information.
- 2) The measures of the criterion variable—violence in the community—have been very weak, typically arrest or rehospitalization for a new violent crime.
- 3) The patient samples analyzed have been highly restricted, usually to males with a prior history of violence.¹²

The MacArthur Violence Risk Assessment Study identified a more complex and comprehensive set of variables, “in four ‘domains’: (1) disposition or personal factors; (2) historical or developmental factors; (3) situational factors; and (4) clinical factors.”¹³

The project included a total of about 1,000 patients in three mental hospital sites in Pennsylvania, Massachusetts, and Missouri. The patients’ demographics reflected those of the inpatient populations overall, including both sexes, with and without a history of violence, of voluntary or involuntary status, regardless of mental illness diagnosis, and of a mix of races and ethnicities. In order to provide data from a comparable population living in the community, researchers studied non-hospitalized persons of comparable age (18-40) in one of the communities. Corresponding information was gathered, including self-report of violence, reports of a “collateral” family member or friend, arrest records, and any mental hospital records. In a year, inpatients were interviewed five times, or about once every ten weeks. Non-patients were

11. See JOHN MONAHAN, *THE PREDICTION OF VIOLENT BEHAVIOR* (1981) (cited in Kirk Heilbrun & Gretchen Witte, *The MacArthur Risk Assessment Study: Implications for Practice, Research, and Policy*, 82 MARQ. L. REV. ____ (1999).

12. *The MacArthur Violence Risk Assessment Study* (last modified Sept. 1998) <http://ness.sys.virginia.edu/macarthur/violence.html>.

13. *Id.*

interviewed once.

Interestingly, the studies found no significant differences in the risk of violence between the inpatient and non-patient populations, absent factors of drug and/or alcohol abuse. The presence of substance abuse created an increased likelihood of violence in both populations. Discharged mental patients are, however, more likely to engage in substance abuse, according to the study.¹⁴ Thus, a higher proportion of former patients were likely to engage in violence, most often at home and directed at family members and friends.¹⁵

A principal finding asserted by the Network researchers is that mental illness does not correlate strongly with violent behavior. Regardless of diagnosis, persons discharged from mental hospitalization are no more likely to engage in violent behavior than demographically similar persons in the community, absent substance abuse. This finding posed perhaps the most debated assertion by the researchers, being apparently counterintuitive and contradicting experience with regard to some patients.

District Attorney E. Michael McCann cited thirty years of case law, during which many psychiatrists and psychologists have testified for the courts regarding the risk of an individual's future violence. He noted that in prominent cases in the 1980s the American Psychological Association filed amicus briefs asserting that it was not possible to predict future violence. One court's explicit response: Asking the court to proceed with the case without such a prediction is like asking the court to un-invent the wheel.

III. THE SYMPOSIUM

The participants in the symposium were called together to advance our thinking on aspects of fundamental issues: How to reconcile the optimum treatment opportunity (delivered by a medical system unimpeded by legal process) with minimal detriment to patient rights and freedoms (protected by strong legal principles and procedural due process). The pendulum has swung between treatment and legal protection from time to time, for one group of mentally impaired persons or another, under the various laws governing substitute decision making and treatment. For example, the strong procedural due process protection

14. See MONAHAN, *supra* note 11, at 13.

15. See generally Henry J. Steadman et al., *Violence by People Discharged from Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods*, 55 ARCH. GEN. PSYCHIATRY 393 (May 1998).

of traditional guardianship law, reserved mostly for persons of property until the 19th century, was supplanted in a number of states by conservatorship statutes intended to provide for management of the property of elderly persons without the proof of impairment associated with other mental disabilities.

A significant drawback to implementation of the recommendations discussed in the symposium is the lack of judicial resources. Judge White and District Attorney McCann cited instances of urban courts hearing as many as fifty cases daily, with limited time and budgets for psychological assessments.

The findings are a mandate for more effective substance abuse treatment. It also highlights the need for mental health services, which are being squeezed by HMO cost-efficiency and in any case are typically offered with lower limits on coverage and higher copayments. Initial reports on the implementation of federal legislation mandating parity between physical and mental health benefits find that the initiative has failed to produce more generous mental health coverage.¹⁶

Perhaps most significant is the lure of new knowledge, far more detailed and reliable than previously available, that leads to new ways to address the needs of mentally ill persons in their interactions with mental health services and the courts. The path forward from the studies must include finding new ways for the courts to act in determining competency and dangerousness, and new orders for treatments that help rather than simply restrain the ill in their suffering. Science has provided many new options. The courts must now draw from the experts' recommendations on the best ways to promote safety and healing for the individual and society.

16. See The Mental Health Parity Act, Pub. L. No. 104-204, 110 Stat. 2944 (1996); see also *Only Four Companies Claim Exemption from Mental Health Parity Requirements*, HEALTH. L. REP. (BNA) No. 46, at 1850-51 (discussing the restructuring of benefits to avoid the intent of the law).