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Involuntary vs. Voluntary Care: The Mental Health Debate

Margaret DeParde

Maggie DeParde

Professor Karin Orr

Criminal Justice/Mental Health 3430-A

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Involuntary psychiatric treatment is currently a debate within the mental health system in the United States. Dr. Dinah Miller and Dr. Annette Hanson in, *Committed: The Battle Over Involuntary Psychiatric Care,* explore both sides of the debate, should patients be involuntarily committed or should their civil rights be enough to prevent this? In the following paragraphs, I will present both sides of the argument given by Dr. Miller and Dr. Hanson, along with an overview of *Committed* and my own thoughts on the debate.

Committed contains many stories from various patients about their experiences being involuntary committed and being voluntarily committed. The authors also interview many different professionals in the field of mental health, including police officers and psychiatrists. There are many statistics about the various ways of treatment and what is affective and what is not, but one thing the authors make clear is that these statistics are almost non-existent: "… there is no research: we don't know if committing people to the hospital prevents suicide and homicide or drives people away from getting care in the future, perhaps leaving them even more vulnerable" (112). In the beginning chapters, Dr. Miller states many times how there are just too many interpretations and definitions for words that often determine if a patient is involuntarily committed, such as the words violence and dangerous. In the later chapters of the book, Dr. Hanson focuses on mental health in relation to gun violence, mass shootings, and suicide. While

the book was informational with various ways to treat mentally ill people without using involuntary treatment, the authors were very biased. They started off the book with commenting on how they will be providing information about involuntary care, but then continue to mostly focus on voluntary care and the various other ways to treat a person without committing them against their will. The book concludes with the authors reasons as to why involuntary treatment is wrong.

When a person is having a psychotic episode and does not know right from wrong or that they are acting differently than normal, should they be involuntary committed into psychiatric care? That is one of the debates etched out in *Committed.* The mental health system in the United States is a broken system and needs to see change. In terms of involuntary commitment, some of those changes need to take place in the facilities housing the mentally ill, "we need much better oversight: unannounced inspection of the wards at any given time, review of all the involuntary treatment, and review of all the seclusion room use… most seclusion room use could be avoided" (24). Currently, involuntary treatment is seen as a "battleground." Dr. Miller sees a battleground and determines that, "with one more swing of the pendulum, we risk becoming a society that focuses our resources toward forced care at the expense of denying services to those who *want* what psychiatrists have to offer. It's a mess" (19). Miller wants to focus on those who *want* to be committed, not those who are being forced. According to Miller, the mental health system needs to focus their resources on alternative solutions to involuntary treatment that helps those who want to be helped: "… if we had a really good mental health system, characterized by early identification and strategies to keep people engaged, more use of ACT (assertive community treatment) teams, more supported housing, and all the critical elements needed to

achieve therapeutic gains and recovery, we would have far less of a need for involuntary treatment" (28). But if involuntary treatment is necessary it, "should be a method of 'last resort'" (26). That being said, if forcing treatment is required, the results may lead to a decrease number of psychiatric patients who end up jails or prisons. As said earlier, the disclaimer is that there is not enough statistics to accurately say if any of these treatments have long-term effects on patients. While involuntary commitment is an issue about violating civil rights, it is also a societal issue. Society oftens wants those who are "different" to get of the streets and into treatment in order to make the streets "safe" again. Yet society does not take action to find a solution to this, "...forced care is held up as a way to prevent homelessness, violence, and incarceration, and on the other hand, society does not want to voluntarily hospitalized and treat homeless people" (103). If there is to be any change to the mental health system and involuntary commitment, then society needs to be committed to helping those in need.

For the case of voluntary treatment, Dr. Miller and Dr. Hanson hears the stories of many patients who were committed. One patient, who volunteered without realizing she could say no states, "the staff was abusive, demeaning, and dismissive. I felt in fear for my life" (3). The common theme voiced by patients committed involuntarily is that they felt violated. This promoted the start of the authors research into alternative methods beside involuntary care. One such voluntary alternative method is Mental Health Court. These courts are an alternative to incarceration and involve, "... both sides come together as a team to fix a problem, usually a social problem involving a particular issue, and the goal is treatment rather than punishment… the goal is to solve the problem of people with serious mental illnesses who are caught up in the criminal justice system" (203). Other alternatives to involuntary care are, "educational groups,

occupational therapy, and perhaps individual and group psychotherapy," for those who are willing to seek treatment (162). A surprising completely voluntary treatment option is electroconvulsive therapy. Today, ECT procedures are done with, "...the patient come willingly, without shackles, threats, or intimidation" (166). ECTs are almost never the first treatment method and is only given to those with severe mental illness and if, "...medications either don't work or are not safe to use" (167).

Even if a patient goes voluntarily into care or involuntarily, there are issues that still follow. The top two are that there are often not enough beds for patients and that insurers are often the ones to hold back treatment: "As a society… we have become victim to the demands of insurers, who often require justification for every day… of hospitalization, and hospitals in turn encourage, reward, and publicize their ever-shrinking lengths of stay" (162). Psychiatrists often want patients to remain in the hospital to make certain they are really well enough to go home even though they do not know how long it will take, "...there are no studies on how long someone should be free of symptoms to allow for a safe discharge" (120). This is an issue for insurance companies who will often stop paying for treatment because of the time spent in the hospital. Since deinstitutionalization, the number of beds offered in treatment facilities have decreased while patients have increased. From state to state the reason for this varies, from cost of housing these patients to not enough funding or laws prohibiting the number of beds. Because of this, patients often end up back on the streets where they encounter the police again, who often time, are the ones who initially brought the patient to the Emergency Department for treatment. These Emergency Departments are the portals to nearly all inpatient commitments and is, "a place to contain someone and make a decision about the need for admission" (97).

If there is to be any change to the mental health system, then there needs to be an adequate place for people with a mental illness to go where they will receive the right treatment for them and where they feel safe. There have been steps towards this already, such as the example of Johns Hopkins Hospital. In the psychiatry inpatient services of the hospital, patients meet will a team of doctors and psychiatrists regularly to discuss what is working and not working and what could be done better. The psychiatrist in chief at the hospital makes it a point to always try to find a commonality between him and the patient to connect with them (125). This is one example of a program that is in step in the right direction. Other action that can be done is the implementation of CIT programs in police departments nationwide. There has been an increase in the number of CIT programs across the country, but there could be more. Dr. Miller and Dr. Hanson concluded that, "while CIT programs reduced the money spent on criminal prosecutions and incarceration, the amount of money spent on mental health services increased- making the programs cost-neutral" (89). CIT will reduce the number of criminal prosecutions and will help make mental health programs more efficient.

I started reading *Committed* with the opinion that when a mentally ill person is in need of treatment, but are not in sound mind, then they should be involuntarily committed. After reading this book, my opinion has slightly changed. I still believe that involuntary commitment is necessary in desperate times, but I now also believe that there needs to be more options to treat the mentally ill that is catered to their specific needs. There needs to be treatment programs that help house patients while also providing group and individual therapy and programs to get them back on their feet. But in order for any of this to happen, society needs to realise that the mental health system is in need of repair. We need to fix the system to reach anytype of solution.

Despite *Committed* feeling one-sided at times, it is an insightful book about the various involuntary and voluntary psychiatric care programs among the states. Every state has different laws and regulations for treating the mental ill and Dr. Miller and Dr. Hanson provide evidence of this from various states. They also try to find a correlation between mental illness and guns, mass shootings, and suicide. While guns and mass shootings were hard to link together, suicide was not. When it comes to statistics about suicide and mental illness, it is hard to do research on it, but there is, "evidence that mental health services can reduce suicide death" (245). It is during this chapter of *Committed* that the authors agree with the use of involuntary treatment saying that, "we justify involuntary care because suicidal thoughts are often part of a treatable psychiatric illness" (246).

While I did not agree with some of the arguments written in this book, I did learn more about the reason for and against both involuntary and voluntary care. I also learned the factors derailing any progress from being made to help fix the issues. While I expected the book to discuss what involuntary treatment entails it did not, and the authors were justified for not discussing it. This is because there is simply not enough information about involuntary treatment. There is not enough research to determine if it is beneficial or harmful and how long a patient truly needs to stay in the hospital before they are better. *Committed* is a book that helped expand my opinion on this controversial topic of involuntary vs. voluntary psychiatric care. It is a book I would recommend to others if they wish to learn more on the various other treatment methods to help the mentally ill.

Work Cited

Miller, Dinah, and Annette Hanson. *Committed: The Battle Over Involuntary Psychiatric Care*. John Hopkins University Press, 2016.