

THE CONSUMER/RECOVERY MOVEMENT AND
INVOLUNTARY MENTAL HEALTH TREATMENT: AN EXAMINATION OF
STATE POLICIES REGARDING FORCED MEDICATION

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TABLE OF CONTENTS

	Page
ACKNOWLEDGEMENTS.....	i
ABSTRACT	iii
CHAPTER	
I. INTRODUCTION.....	1
II. LITERATURE REVIEW.....	2
Those in Favor of Involuntary Commitment.....	2
Those in Opposition of Involuntary Commitment.....	4
III. STUDY PURPOSE.....	12
IV. METHODS.....	13
V. ANALYSIS.....	17
Quantitative Analysis.....	17
Qualitative Analysis.....	23
VI. CONCLUSION.....	25
REFERENCES.....	26

ABSTRACT

This thesis examines state psychiatric civil commitment laws that dictate involuntary treatment and the use of forced medication for mental health treatment. It considers the ongoing and highly controversial debate between those in favor of involuntary treatment and those in opposition. My research emphasizes the latter by looking extensively at the consumer/recovery movement – a mental health empowerment movement largely consisting of people who have been treated against their will in the past. Through their fight for social justice, they urge states to make mental health policies that respect and well represent the rights and autonomy of people with mental health conditions. A content analysis of psychiatric civil commitment laws from ten states were analyzed using variables that capture the essence of consumer/recovery movement objectives. This analysis investigates to what extent the consumer/recovery movement has impacted state policy. For the state laws analyzed variability existed between and within states in the amount of consumer/recovery movement representation. Collectively however, consumer/recovery movement objectives were underrepresented within state policies that dictate the involuntary use of treatment and medication.

CHAPTER 1

Introduction

It is estimated that 57.7 million Americans over the age of eighteen have a mental disorder (Frankel, 2015). Statistics from the Center for Disease Control indicate that suicide is also a prominent issue that is likely linked to mental illness (Herper, 2016). While suicide accounts for approximately 40,000 deaths each year, 90% of those who commit suicide have a diagnosable mental illness (Frankel, 2015). The Government Accountability Office reported that there is an estimated 1.4 million people who receive federal assistance because they are disabled by a mood disorder (Whitaker, 2010). These astounding numbers reveal that the prevalence of mental illness is a national problem that requires a national solution.

Accompanying the status of mental health in the United States, is an extremely complex debate surrounding how we should treat those with severe mental illnesses. Should those exhibiting symptoms of mental illness be involuntarily committed to a psychiatric facility? If so, when is this necessary? During this commitment period, should there be forced treatment, and if so which types are appropriate? The present study is a pilot investigation using a content analysis of civil commitment laws to explore how policy makers are responding to this complex debate. It specifically focuses on forced treatment, specifically medication, during involuntary commitment. First, this thesis discusses two major views including those in favor of forced treatment and those in opposition. Second, it analyzes state civil commitment laws to investigate to what extent these two positions have reconciled.

CHAPTER II

Literature Review

Those in Favor of Involuntary Commitment

Dr. E. Fuller Torrey founded the Treatment Advocacy Center 15 years ago to remove barriers preventing those with serious psychiatric disorders from receiving care. He thinks one of the biggest barriers to people getting treatment is the legislation that allows for people to have the right to refuse treatment. Fuller pushes others to consider that a large proportion of people with mental illness are incompetent, unable to understand the nature of their illness, and therefore refuse treatment. Consequently, they should not have the option to refuse treatment if it would protect society.

Fuller advocates that tragedies caused by those with mental illness could be prevented if more people were involuntarily committed. While civil commitment procedures vary from state to state, most require that the person being considered for involuntary commitment is an imminent danger to themselves or others (Hanson & Miller, 2016). However, Fuller believes that there is a subset of people who should be committed, as a preventative measure, even if they are not a threat to themselves or others. Furthermore, the exhibition of psychotic symptoms should be sufficient for a civil commitment trial. Many people supporting this notion believe that society is failing this vulnerable population by making them wait until they are at crisis level to make them seek treatment.

Another form of dissidence stemmed from family advocacy organizations that view mental illness as a chemical imbalance in the brain that requires medical forms of treatment (Chamberlin, Rogers, & Sneed, 1989). The National Alliance on Mental

Illness, NAMI, is the nation's largest grassroots organization for mental health, and is also in favor of involuntary commitment. NAMI initially consisted of parents who had children diagnosed with schizophrenia, and now has hundreds of affiliates, state organizations, and volunteers to drive their efforts (NAMI,2016). While in favor of involuntary commitment, their main goals are to educate and support those affected by mental illness, and provide support for their loved ones.

Those in favor of involuntary commitment do so with justifiable intent. Herschel Hardin, a member of NAMI who has a son diagnosed with schizophrenia, argues that officials often hesitate to intervene to protect civil liberties, but this protection is actually more detrimental to them because they are not receiving treatment deemed necessary. In addition, it is believed that more involuntary commitment laws would lead to a decrease in the population of homeless and imprisoned persons with a diagnosis.

The prevalence of mentally ill on the streets and in prison have caused clinicians and family members to reevaluate mental health policies. They critique that current policies constrain the government's ability to detain the mentally ill and coerce treatment (Zaheer, 2001). According to NAMI, an estimated 46% of homeless individuals live with a severe mental illness that is often comorbid with substance abuse. Approximately 20% of state prisoners have been diagnosed, and about 70% of youth in juvenile justice systems have been reported to have early signs of mental health problems. Although these statistics are increasingly documented, less than half of individuals suffering from a mental illness actually receive adequate treatment (NAMI, 2016). In this context, there is a need for these issues to be magnified, as the lack of treatment for those who need it most continuously result in detrimental consequences.

Those in Opposition of Involuntary Commitment

Although these findings suggest a lack of treatment, on the contrary, many people are involuntarily committed to hospitals and psychiatric wards each year (Crockard, 2013). This usually happens when an individual experiences a psychotic break and the person's loved ones or a law enforcement official believes that they are a potential threat to themselves or to others (Lim, 2016). Therefore, they are removed from society to get treatment deemed necessary. Based on the state's civil commitment laws, they are then subjected to a series of court hearings to enforce the legality of the involuntary commitment process (Lim, 2016). In general, this includes a probable cause hearing in which medical certificates are necessary to prove the person to be severely mentally ill. Then, depending on the degree to which they assess the severity of the mental illness, forced medication hearings often follow (Crockard, 2013). These types of hearings take place when a physician files an application in a probate court to authorize the use of medication against someone's will. Many times, this process is viewed as appropriate and even necessary due to the idea that the individual at hand is highly incompetent. In other words, due to the mental illness one might be suffering from, the person is often viewed as being unable to make sound decisions, especially in regards to their course of treatment (Crockard, 2013).

A multitude of mental health empowerment movements have created a revolt against this type of psychiatric authority (Rissmiller & Rissmiller, 2006). While many physicians and mental health officials view involuntary commitment and coerced treatment as the best option for these individuals, people who have been treated against their will have been fighting for social justice for the past 150 years (McLean, 2009).

Mass numbers of people across the United States have come together and named themselves “consumers/survivors” (Everett, 1994). The consumer/survivor movement is a response to problems in the implementations of paternalistic services that dominated available treatment for those with mental illnesses (Bachrach, 1982). Over the years, this radical movement has remained true to a core belief; they feel their rights have been taken away from them, and that they are absolutely voiceless throughout their recovery process (Van Tosh, Ralph, & Campbell, 2000). They advocate for consumer empowerment, especially regarding the act of forced medication while they are committed (McLean, 2009). These individuals strive to be heard, as they deserve the right to have autonomy over their body and mind as much as possible. In rebuttal to coercive treatments, the consumer/survivor movement has organized themselves to provide alternative self-help, peer support, and education while advocating for reform within the mental health system (Van Tosh, Ralph, & Campbell, 2000).

Psychotropic drugs that were once considered a treatment of last resort, are now used more often than not (Wren et. al., 2003). In *Saving Normal*, former chair member of the Diagnostic Statistical Manual (DSM) Allen Frances (2013), discusses how we have become a society who views psychiatric medication as a panacea for mental health issues. Within a span of twenty-years, expenditures for antipsychotics have tripled. An average of 18 billion dollars are spent on antipsychotics and 11 billion dollars are spent on antidepressants annually (Frances, 2013).

While medication has been known to reduce symptoms of mental illness and relieve psychotic tendencies directly after hospitalization, they are often prescribed for long-term use (Falk, 2013). Furthermore, when considering the aversive risks associated

with long term use of psychotic medications, consumers feel they should be given the opportunity to self-determine the discontinuation of medications; especially if they are willing to comply with alternative treatment options (Gumber & Stein, 2013).

The Indian Journal of Psychological Medication (2015) acknowledges the transition between the early success of psychotropic medications, and the unsettling consequences that followed years later. When there was a substantial increase in the use of medications to treat mental illnesses such as depression and anxiety, symptoms of psychosis decreased substantially leaving mental health professionals feeling highly optimistic. However, decades later mental health professionals are realizing that despite the use of medications, there is still a significant number of people with mental illnesses that have been unable to resume their normal functioning (Jacob, 2015). This brings many to question the efficacy of medications in the long run. Studies in the early 1990's caused many to question how the psychiatric community viewed the necessity and benefits of antipsychotics (McLean, 2009).

According to information provided by the U.S Mental Health Consumers/Survivors Movement, economic forces may be driving this notion (Gumber & Stein, 2013). Managed care organizations and insurance companies prefer to cover time-limited interventions with clear measurable outcomes while disregarding the uniqueness of each individual's disorder (McLean, 2009). Often, this is done by utilizing a reductive biomedical model instead of providing continuous support and rehabilitation centers throughout recovery. While the expectation of a speedy recovery is logically paired with funding for treatment, it is also unrealistic when due to the complexity of

mental illness. Regardless of the diagnoses received, each case has unique differences that should therefore be treated with a similar kind of individuality.

As a result, the traditional approach relies heavily on a biomedical construct and uses medications as the primary means for treatment (McClintock et. al.,2011). By doing so, this imposes limits on mentally ill patients because they are not given the opportunity to utilize other forms of treatment in which they might further thrive. The underlying principle is that they are receiving a quick temporary fix that relieves symptoms, further implying that the medicine at work is purely curative. But what if the aversive side effects of these medications end up being worse for the person than the actual illness itself?

Journalist Robert Whitaker (2002) entertains this idea in his renowned book *Mad in America*. He argues that modern medication for the mentally ill are not as beneficial as many psychiatrists portray them to be. He specifically focuses on schizophrenia since it is considered a purely organic brain related disorder. His research supports the notion that long-term use of antipsychotics for schizophrenic patients might be causing more harm than good. He supports this with the fact that schizophrenics in the United States fare worse than schizophrenics in poverty-ridden countries that do not have access to medications, and are therefore forced to deal with the mental illness in other ways (Whitaker, 2002).

These cruel outcomes are exactly why the consumer/survivor movement despises a forced and generalized system of care (Rissmiller & Rissmiller, 2006). They want to put a halt to forced medication and promote the right to self-determination and choice over their own mind and body. They advocate for a comprehensive view of treatment that

will include medications only if one desires (McLean, 2009). With these possibilities at hand, one must consider what the mental health system can do to reconsider what is most constructive in regards to the treatment one will receive during involuntary commitment (Crockard, 2013). Mental health professionals must scrutinize what treatments would be most beneficial for each individual while viewing mental health treatment in a holistic light.

Although the actions of those in favor of involuntary treatment were made with good intent, consumers and survivors feel that patient rights have been lost in the process. They feel that through coerced treatment they have been abused by the psychiatric community, and want to maintain more power in their recovery process (Everett, 1994). Therefore, the goal of the consumer/survivor movement is to reform the existing mental health system to make it more responsive to consumers (Chamberlin, Rogers, & Sneed, 1989). Through their fight for social justice, they have established strategies to aid in accomplishing these goals.

For instance, the consumer/survivor movement feels very strongly about being referred to as a client or consumer rather than a patient, because it reduces the potential for a coercive and hierarchical relationship between the physician and person receiving care (Van Tosh, Ralph, & Campbell, 2000). Although slanderous references from the past such as brute and lunatic (Whitaker, 2010) have been retired, the consumer/survivor movement sees additional room for improvement. Using non-derogatory terms emphasizes equality and represents a person-centered approach to care. Whitaker (2010) emphasizes that a healthy doctor-client relationship is essential for the curative process.

Consumer/Survivors also urge psychiatric authorities to consider their requests for how medications should be incorporated throughout their treatment. In opposition to state institutions forcing high doses of drugs, consumers want the right to refuse medication (Rissmiller & Rissmiller, 2006). Individuals are almost always reserved this right, unless it is overruled due to the physician's discretion of an unsafe situation. The instance in which a physician can consider a situation unsafe, is referred to as a psychiatric emergency (Lim, 2016). The criterion for a psychiatric emergency differs by state and is included within civil commitment laws (Lim, 2016).

In the occasion that there is a psychiatric emergency and individuals are summoned to take medications against their will, consumers believe they should have the right to decide which medications they take, how much they should take (with careful consideration from a physician), and when to take them because every individual is affected differently (Gumber & Stein, 2013). It is usually only from self-report that physicians can be aware of any aversive side effects from the medications being consumed (Wren et. al., 2003). Through these self-reports, physicians need to respect the discomfort one is feeling due to a certain medication and alter dosages or prescriptions as need be.

With this, consumer/survivors would like detailed information to be given regarding the medication (Rissmiller & Rissmiller, 2006). Information commonly included in civil commitment laws include: the type of medication, the dosage, potential benefits and consequences, the expected course of treatment, and dangerous side effects (Crockard, 2013). Due to previous friction with psychiatry and pharmacological

treatment, consumers advocate for the disclosure of detailed information regarding medication (Rismiller & Rismiller, 2006).

Taking any medication comes with the possibility of negative side effects, however antipsychotics are common for having aversive and sometimes irreversible side effects (Wren et. al., 2003). It is said that these drugs successfully normalize brain chemistry, but they also have the capacity to hinder brain function resulting in abnormal behaviors (Whitaker, 2010). Behaviors affected often include lack of emotion, cognitive impairment, and shrinking of the frontal lobe (Wren et. al., 2003). Rosenberg et. al. (2003) executed research that examined the side effect of sexual dysfunction from long-term use of psychiatric medications. The research revealed that 62.5% and 38.5% of males and females respectively, felt that their psychiatric medication was causing them to have sexual dysfunction (Rosenberg et. al.,2003). Furthermore, permanent side effects such as tardive dyskinesia, a severe impairment of dopamine transmission that results in symptoms like those of Parkinson's disease, are common with long-term use of these medications (Whitaker, 2002). Since the use of psychotropic medications to treat mental health conditions always come with the risk of detrimental side effects, the individual being forced to take them should at least be informed of risks involved when taking the recommended and sometimes forced medication.

Along with forced medication, electroconvulsive therapy (ECT) a practice that originated in the early 1900s, is still utilized in a less severe form today (McClintock et. al., 2011). Negative attitudes about ECT came with the start of the practice when the shocks would temporarily paralyze patients and then cause them to wildly thrash and break bones (Whitaker, 2002). Today ECT is considered less excruciating (Reisner,

2003), and is said to be the most effective treatment for medically resistant major depressive disorder (McClintock et. al., 2011). Although the modern practice of ECT is less intense, it remains highly controversial. There appears to be a consensus developing in the field of psychiatry that ECT is effective, but it still has negative side effects (Reisner, 2003). Treatment with ECT tends to be long-term, because although it is known to be effective in ending a current episode of depression, it does not prevent future ones (McClintock et. al., 2011). It also causes transitory memory problems in which an individual has trouble remembering historical and personal information for up to three years after treatment (Reisner, 2003). Consumers have voiced that ECT should not be used long-term because there is insufficient evidence that benefits outweigh risks during treatment (Rissmiller & Rissmiller, 2006). One consumer even referred to ECT as psychiatry abusing the vulnerable in the name of science (Reisner, 2003).

To address both the etiology and symptoms of mental illness, consumer/survivors request that safer and more holistic alternative treatment options be available instead of or in conjunction with medication (Chamberlin, Rogers, & Sneed, 1989; Barnett-Rose, 2014). They want to embrace the notion that they have the capacity to heal in ways other than mind altering drugs which merely suppress symptoms.

Instead of solely receiving inpatient treatment that regularly involves medication, consumers/survivors would like to feel supported during their outpatient recovery as well (Barnett-Rose, 2014). The formulation of a discharge plan upon release of inpatient care, reflects an augmentation of support for the individual. These additional resources optimize opportunities for growth and improvement towards independence (Chamberlin, Rogers, & Sneed, 1989). This act of support implies that recovery is possible.

CHAPTER III

Study Purpose

The consumer survivor movement as well as other advocacy groups such as Mental Health America are urging states to make mental health policies with the intent that the rights and autonomy of people with mental health conditions are being respected and well represented (Gumber & Stein, 2013). With such a controversial debate that seems to hold validity on each side, how do policy makers respond? Have the two positions been able to reconcile, and if so to what extent? This study more specifically focuses on the extent to which consumer/survivor movement objectives are represented within state policy.

My study aims to fill in gaps in the literature by analyzing how current state policies view involuntary commitment processes of those with mental illness. The study will analyze civil commitment laws from ten different states, and primarily focus on laws regarding the use of forced medication during inpatient treatment.

CHAPTER IV

Methods

The following nine states were chosen using random sampling: Arizona, California, Kansas, New Mexico, Louisiana, Mississippi, Washington, New Hampshire, and Colorado. Texas was purposely picked for relevancy. A content analysis was done on each state's mental health civil commitment laws that dictate how state psychiatric facilities implement policies regarding forced treatment and medication. The documents were public and obtained from state legislature websites. Policies within the documents apply to state psychiatric facilities that reside within that state.

A mixed method approach was used in which I used both quantitative and qualitative analyses. Using the identified consumer/recovery movement objectives previously discussed, I sought to create variables that best captured those concepts. Ten variables were extensively analyzed throughout the documents. The variables are defined as:

- 1) Reference of person – How individual being treated for mental illness is being referred to. If they were referred to as the client or consumer, that was coded as 1 for being representative of the consumer movement. If their reference of the person was unrepresentative of the consumer movement that was coded as 0.
- 2) Right to refuse medication – Seeks to see if document explicitly states that the individual has the right to refuse medication. If the document states that the person has the right to refuse medication that was coded as 1. If the document did not state this right, it was coded as 0.

- 3) Psychiatric Emergency – Circumstance in which the right to refuse medication is taken away from individual. This variable aimed to analyze what different states considered a psychiatric emergency, including:
- a. Individual is at an imminent risk of causing harm to self
 - b. Individual poses an imminent risk of causing harm to others
 - c. Grave disability – individual lacks the ability to provide basic needs for oneself including but limited to: food, shelter, steady employment, clothes.
 - d. Incompetency – individual lacks the ability to make rational decisions about treatment options due to their mental illness.
 - e. Other – components of the definition that were unique to that state, and did not fall into the categories of a-d.

For the psychiatric emergency variable, states were coded as 1 if their psychiatric emergency was exclusively for those who fell into the categories of a-c. If the definition included an incompetency factor or another component other than a-c, the state was coded as 0 for being unrepresentative of consumer objectives.

- 4) Electroconvulsive Therapy (ECT) – does document state that ECT can be forced under the conditions that there is a psychiatric emergency. If the state did not allow for ECT, that was coded as 1. If ECT was allowed in the presence of a psychiatric emergency, it was coded as 0.
- 5) Medication Details – how much information about psychiatric medication is the individual required to have before medications are administered. This variable was calculated on a point scale in which each of the seven aspects regarding medication information was compiled. If 0 to 3 components were mentioned

within the document, the state received a score of “0” for this variable. Contrarily, if 4 to 7 components were mentioned within the document, then the state received a “1” for that variable.

- a. Name and dosage of medication
 - b. Benefits of taking the medication
 - c. Consequences of not taking the medication
 - d. Potential and common side effects of the medication
 - e. Long-term and potentially permanent side effects of the medication such as tardive dyskinesia
 - f. Description of the course of expected treatment including but not limited to:
 - i. Long-term goal/outcome
 - ii. Lab work required for medication
 - g. Discontinuation of medication – Is the discontinuation of medication stated as a possibility in the future
- 6) Right to Alternative Treatment – Treatments other than psychotropic medications that could be used instead of and/or in collaboration with psychotropic medications. If the state offered alternative treatments, that coded as 1. If the state was unrepresentative of the consumer movement and did not offer alternative treatments, it coded as 0.
- 7) Discharge plan – additional resources put in place by the facility who involuntarily committed the individual, that aim to aid in their success once they are done with inpatient treatment. If the state document mentioned having a

discharge plan for the individual, that coded as 1. If discharge plans were not present within the document, that coded as 0.

For the quantitative analysis, each variable was made dichotomous, and was coded as either “0” for policies that do not represent consumer/survivor objectives, or “1” being policies that represent the movement. I also created an index that provides a summary of dichotomous measures (1-7 above). A score ranging from a minimum of 0 points to a maximum of 7 was compiled for each state. Higher scores were more representative of consumer/survivor objectives than lower scores.

Although doing a quantitative analysis made my research more concise and well organized, it also oversimplified the analysis. Therefore, a qualitative analysis was additionally done for each state’s civil commitment laws. For the qualitative analysis, I examined the detailed language within the policies to provide a deeper understanding of how consumer rights are, or are not, represented in state policy.

CHAPTER V

Analysis

Quantitative Analysis

Table 1 (below) provides a summary of the quantitative data for each state analyzed.

Table 1. The Representation of the Recovery Perspective in State Policies										
VARIABLES	STATES									
	NH	CA	AZ	CO	KS	TX	MS	LA	NM	WA
Uses client versus patient	X								X	
Right to refuse medication	X	X	X	X	X	X	X	X		X
Has narrow psychiatric emergency	X	X	X	X					X	
Does not use Electroconvulsive Therapy	X						X			
Requires disclosure of details about medication	X	X	X		X	X				
Alternative treatments are offered		X	X	X		X				
Mentions discharge plan	X	X	X	X	X		X	X		
Score	6	5	5	4	3	3	3	2	2	1

Table 1 displays how states scored for each variable analyzed. The presence of an “X” denotes that the measure was present within the state’s civil commitment law.

Figure 1 (below) provides a summary for the summation of dichotomous measures for each state.

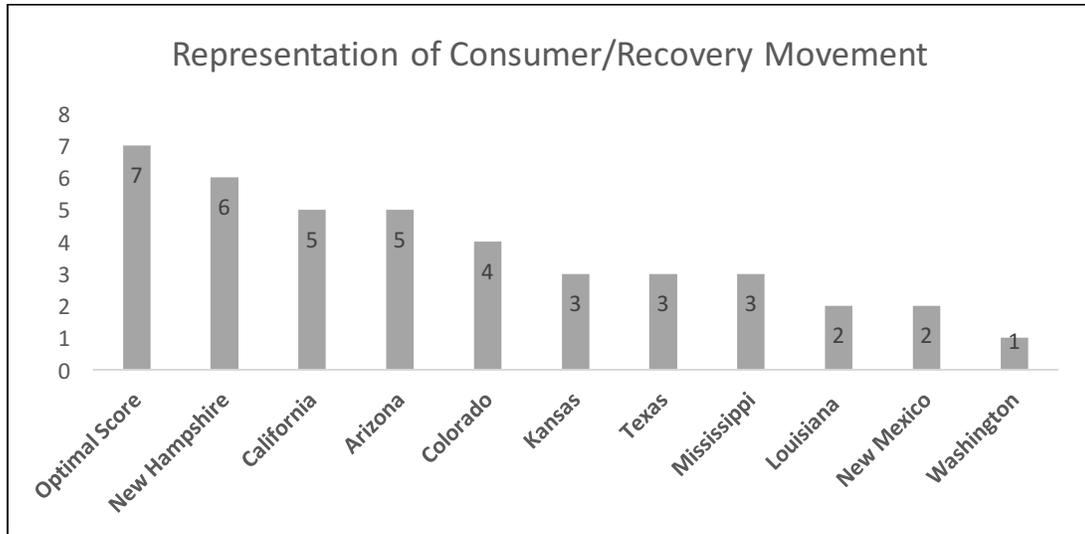


Figure 1 illustrates that the optimal score a state could have received based on the measures analyzed was a 7. Figure 1 shows the states in order from most to least representative of consumer/survivor objectives, with New Hampshire being the most representative and the state of Washington being the least.

For the issue of referring to the person as a client or consumer rather than a patient, New Mexico and New Hampshire did this, but Texas, Kansas, California, Arizona, Louisiana, and Mississippi did not.

Nine out of 10 states had the right to refuse medication, with New Mexico being the only state that did not explicitly state that.

The right for individuals to refuse medication, is only initial, and is taken away if a psychiatric emergency is present. States differed in their definition of 'psychiatric emergency', but the following components were a possibility: 1) individual is an imminent harm to themselves, 2) individual is an imminent harm to others, 3) individual

is gravely disabled because of their mental illness, 4) individual is considered incompetent because of their mental illness, and therefore cannot make rational decisions regarding their treatment. A 5th component “other”, was included in the analysis to compensate for components of the definition that did not fall into the first 4 categories.

States were coded as “1” if the state’s definition of psychiatric emergency was narrow and only included the individual being an imminent harm to themselves, being a harm to others, and/or being gravely disabled. States were coded as “0” if their definition of psychiatric emergency was broad and entailed more than being a harm to themselves, being a harm to others, or being gravely disabled, but instead included being incompetent or other reasons.

Table 2 (below) provides a summary for how each state received a score for their definition psychiatric emergency.

Table 2. State Definition of Psychiatric Emergency										
Psychiatric Emergency Components	STATES									
	NH	CA	AZ	CO	KS	TX	MS*	LA	N M	WA
Harm to Self	X	X	X	X	X	X		X	X	X
Harm to Others	X	X	X	X	X	X		X	X	X
Grave Disability		X	X	X				X		X
Incompetent					X	X		X		X
Other					X	X				
Score	1	1	1	1	0	0	—	0	1	0

*Unable to find explicit definition of psychiatric emergency within the state policy

For the state’s definition of psychiatric emergency, New Hampshire, California, Arizona, Colorado, and New Mexico were narrow. Kansas, Texas, Louisiana, and

Washington had broad definitions of psychiatric emergency. Consumers view broad definitions of psychiatric emergency as problematic because the decision process becomes more subjective causing more people to undergo forced treatment and medication. For the state of Mississippi, I was unable to find the line item components that formulate their definition of psychiatric emergency.

For the issue of electroconvulsive therapy (ECT), Texas, New Mexico, California, Arizona, Colorado, Washington, Kansas, and Louisiana allowed for it in the presence of a psychiatric emergency. New Hampshire and Mississippi did not allow it.

Once a psychiatric emergency is identified, and physicians have decided that the involuntary use of medications is in the best interest of the person being treated, consumers prefer that details regarding medication and course of treatment be disclosed (Rissmiller & Rissmiller, 2006). The amount of detail involved in this disclosure varied between states. As referred to in the methods, this variable was scored on a scale between 0 and 7, where 0 is the least amount of information required to be disclosed and 7 is the most. Each specific detail about the medication was worth 1 point. The summation of these points determined whether the state would be coded as “0” or “1” for the medication details variable. If the total amount of details was between 0 and 3, the state was coded as “0” and if the total number of details was between 4 and 7, the state was coded as “1”.

Table 3 (below) provides a summary for how each state received their code of either “0” or “1” for detail disclosed about medications.

Table 3. Details Required to be Disclosed about Medication										
Medication Details	STATES									
	NH	CA	AZ	CO	KS	TX	MS*	LA*	NM	WA
Name and Dosage	X	X	X	X	X	X			X	
Benefits of Taking		X	X	X	X	X			X	X
Consequences of not taking	X		X	X		X				
Potential/Common Side Effects	X	X	X	X	X	X				
Long-term Permanent Side Effects		X	X	X		X				
Course of Treatment	X		X	X		X				
Discontinuation of Medication			X	X	X	X				
Total Points	4	4	7	7	4	7	0	0	2	1
Score	1	1	1	1	1	1	0	0	1	1

*state policy did not mention the physician being required to disclose information about medications

Table 3 displays which details regarding medication was required to be disclosed for each state. The presence of an “X” denotes that the state’s civil commitment law required the detail to be disclosed to the individual being treated.

For the issue regarding details required to be given about medication, Mississippi, Louisiana, New Mexico, and Washington were required to give the least amount of information. New Hampshire, California, Arizona, Colorado, Kansas, and Texas were required to give the most details about medication.

For the issue regarding the right to alternative treatment options, 4 out 10 states (New Hampshire, Louisiana, Mississippi, and New Mexico) did not mention alternative treatments that could be used instead of or in collaboration with medication. Alternative

treatments were mentioned in Texas, Kansas, California, Arizona, Colorado, and Washington.

A discharge plan for the individual once their involuntary inpatient treatment had concluded, was mentioned and required in 8 of the 10 states (Kansas, California, Arizona, Colorado, Washington, New Hampshire, Louisiana, and Mississippi). The only two states that did not mention or require a discharge plan were New Mexico and Texas.

Qualitative Analysis

An example of language used that supports the recovery movement is New Mexico referring to the individual as “client”. Examples of how the individual was referred to in terms that are least supportive of the recovery movement include, Mississippi referring to the individual as “persons with mental retardation”, and Colorado as “person with mental illness”.

All the states were representative of recovery movement objectives when giving people the right to refuse medication except for New Mexico. New Mexico’s law was vague and stated that they had the “right to be free from unnecessary or excessive medications”.

For the measure regarding the state’s definition of a psychiatric emergency, an example of language that was most representative of recovery movement objectives is New Mexico stating that a “person receiving care should not be considered incompetent to make decisions during treatment”. Conversely, language that was least representative is Texas including “*emotional harm* to others because of threats, attempts, or other acts the patient makes or commits.” This entails that in the state of Texas one can be subjected to forced treatment in the presence of emotional harm to others. In addition, Kansas’ definition included an additional component which stated that the likelihood of “substantial property damage to another’s property” was considered a psychiatric emergency.

For electroconvulsive therapy (ECT), language in New Hampshire’s state law was most representative of recovery objectives, and explicitly stated that “involuntary treatment is for medication only...psychosurgery, ECT, or experimental treatment of any

kind were not considered for emergency treatment.” On the other hand, the state of Kansas does not require an imminent psychiatric emergency to be present for forced ECT. Instead, if someone had a court- appointed guardian assigned to them in the past, written consent from the person’s legal guardian was enough. This can be controversial because if a psychiatric emergency is not present in the given moment, should ECT be an acceptable form of forced treatment?

In regards to the details required to be disclosed about medications, Louisiana’s law was least representative of recovery objectives because it did not state that physicians were required to notify the individual of details regarding medications. The state of Washington’s law was also considered least representative by only requiring physicians to disclose that “...medication is a necessity and an effective part of treatment.” Texas was the most representative for this measure, requiring that all details that were analyzed be disclosed to the individual.

For the measure regarding alternative treatments, Kansas and Arizona were most representative by mentioning and highly encouraging them. Texas was least representative of recovery objectives, because the state law only mentioned alternative treatments in the context that the physician must tell the individual why the alternative treatment was being rejected.

For the discharge plan measure, Kansas was most representative of recovery objectives by wanting to implement the most social support, and stated that “no patient shall be discharged from a state psychiatric hospital without the hospital receiving and considering recommendations from the participating mental health center serving the area where the patient intends to reside”.

CHAPTER VI

Conclusion

The extent to which consumer/survivor movement objectives were represented within state civil commitment laws varied extensively both between and within states. Overall however, among these select states, there were more states that were unrepresentative (score of less than four) than representative (score of four or higher) of the preferences that consumers have voiced regarding their psychiatric treatment.

Analyzing a small sample size was a weakness for my study. This study could serve as an initial preliminary investigation whereas future research could analyze all 50 states. That would provide a clearer representation of how policy makers within the entirety of the United States are responding to the pressures of mental health reform from consumers. Other directions for future research could include considering the rate of involuntary commitment per state. Another area in need of exploration, is how these laws apply to pregnant woman, minorities, and the elderly population.

While the present study has significant limitations, there are no published empirical studies that examine the extent to which the consumer movement has influenced state policy. Thus, this research is a necessary first step in the effort to document progress made by the movement and the additional work that needs to be done. This will aid in ensuring that mental health consumers have a voice in the policies designed for their treatment.

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