On July 20, 2012, a gunman walked into a movie theater in Aurora, Colorado, and opened fire. Twelve people lost their lives that day, and 70 others were injured. For weeks after the tragedy, television, print, and social media were filled with images of the young shooter with his wide-eyed blank stare and tousled orange hair. Every videotaped court appearance and each tidbit of information about him was dissected as it emerged. Speculation abounded about the shooter’s motivation, his psychiatric history, how much his college supervisors knew about his mental state, and what could have been done to prevent the tragedy.

Barely five months later, a different gunman killed his mother, then walked into the Sandy Hook Elementary School in Newtown, Connecticut, and shot 26 people dead before taking his own life. The Sandy Hook tragedy triggered another cycle of media speculation and public outrage. Aurora and Sandy Hook were added to the list of tragic place names: Columbine, Virginia Tech, Fort Hood, Isla Vista, the Washington Navy Yard, Tucson. Tragedies like these have captivated both the media and the public with a mix of horror and fear. To the general public it seems obvious that anyone who could do such a thing must be mentally ill, and the question gets asked repeatedly: Why don’t we just commit people who are mentally ill so we don’t have these tragedies?

President Barack Obama announced an initiative in 2013 to strengthen gun control laws as a way to prevent future violence. In addition to restricting access to weapons, there were proposals to loosen privacy protections for psychiatric patients, to enhance the sharing of information between
mental health professionals and law enforcement, and to mandate the reporting of certain categories of psychiatric patients to the federal gun background-check database. To develop these recommendations, the president’s commission gathered input from hunting enthusiasts, gun control lobbyists, crime victims, and law enforcement professionals. Oddly, people with mental disorders were not included in these discussions. Many states followed the proposals of the federal government and enacted their own legislation. For example, the New York Secure Ammunition and Firearms Enforcement (SAFE) Act was passed, mandating that mental health clinicians report any potentially dangerous psychiatric patient to the government.

The route to preventing mass murders was split into two paths—gun control or mental health reform—each hailed as a way to prevent yet another of these rare but terrifying events. When it came to talk about improving mental health care, the conversation invariably included options that would make it easier to mandate that people with problems get help. Groups in favor of looser civil commitment standards called for legislation that would make it less difficult to force people to get mental health care by making it easier to commit people to hospitals and easier for courts to order outpatient treatment. Proponents of involuntary care overlooked the facts that some perpetrators were already in treatment at the time of their crime and that some never gave any signals that they might be dangerous. They also did not acknowledge that some of the perpetrators had never been offered voluntary care.

Psychiatrists and psychologists, as well as their professional organizations, attempted to balance the public’s concern with rationality and facts: the majority of people with psychiatric disorders never commit acts of violence; guns are more likely to be used to commit suicide than homicide; and people with psychiatric disorders are more often victims of crime than perpetrators. They also pointed out that substance abuse is a much greater risk factor for violence than is mental illness. Sadly, the facts did little to quell the public’s fear of people with mental illness.

Proposals to expand involuntary psychiatric care inevitably lead to public discussions about the difficulty of predicting violent behavior, the limited funding for mental health services, the lack of access to voluntary care, and infringement on civil rights. Further, involuntary treatment is not always about preventing acts of violence; sometimes it’s simply about
getting treatment for someone who is very ill, whose disordered behavior might lead him or her to homelessness, jail, or death, and about the tragedy of wasted potential. Sometimes, it’s simply about a family’s heartbreak when a loved one becomes terribly ill.

Psychiatric illnesses are common. Interviews conducted with members of more than 18,000 households revealed that one out of every five people suffer from a psychiatric disorder in any six-month period, and nearly half of Americans suffer from an episode of mental illness at some point in their lifetime. Informed discussion about all these issues is difficult because there are so few people who are violent solely due to mental illness, and there are no statistics that can help to predict who is at risk of becoming violent. The federal government website www.data.gov lists all the publicly available data that the government routinely collects. There are more than 91,000 data sets with information about countless topics. There is information about average annual rainfall and daily temperatures, the number of annual motor vehicle accidents, and occupational injuries and fatalities. There are 9 data sets related to the price of pork and 13 related to the price of beans. There is even a data set devoted to the stomach contents of Alaskan fish. But there is no federal database that tracks the number of patients who are committed against their will to psychiatric units each year. This makes it difficult to examine the issues we write about in this book. Given the loss of liberty, the personal distress, and the stigma involved, this lack of data is astounding.

What we do know is that the number of state hospital beds has been reduced over the years. In 1955 there were 558,922 state hospital beds in the United States; by 2010 there were only 43,318 beds—a reduction of more than 90 percent during a period when the nation’s population doubled. We also know that health insurers authorize admission only for the most dangerous of patients and for the shortest possible period of time, and that the typical length of a hospital stay—usually along the order of seven to ten days—is barely long enough to begin the process of stabilization for someone who is in a psychiatric crisis. We don’t know how this concentration of the “sickest of the sick” affects the safety and therapeutic atmosphere of inpatient units, a patient’s recovery, or a patient’s willingness to seek hospitalization voluntarily in the future.

When it comes to discussions of forcing people to get psychiatric help, one thing is clear: the topic is touchy. Many people who have experience
with mental illness—and many who don’t—have strong opinions, and
the topic quickly becomes a battleground populated by patients, families,
mental health professionals, lawyers, advocates, and politicians. When
we began collecting stories and data for this book, we quickly found that
involuntary psychiatric care was a more sensitive topic than one might
think. Some people were eager to take part, while others wanted nothing
to do with the creation of this book. Simply put, not everyone was open
to the concept of dialogue.

Many patients discuss their experiences with hospital commitment,
sometimes in very public forums. Long after discharge, many remain very
angry about being forced to get care and are haunted by their hospital-
izations. They describe these experiences as degrading, frightening, and
disrespectful. But some proponents of involuntary treatment dismiss
patients’ objections, deeming the treatment to have been necessary for
the patients’ own good when circumstances were dire and there seemed
to be no other reasonable option.

What we also have heard is that there are people who won’t get help
because they are afraid they will be locked up, be stigmatized, lose their
civil rights, or suffer other negative consequences. In a quick, unscientific
online survey, we learned that 77 percent of our respondents who had
previously been committed would not want to be committed again, even
if they were imminently dangerous to themselves or others. Although our
survey was not scientifically validated, we report the number because there
simply are no other data.

We found this response to involuntary treatment perplexing. Shouldn’t
people who are ill, dangerous, or suffering from tormenting depression,
delusions, or hallucinations be grateful that they were rescued from their
misery and returned to a state of sanity? Shouldn’t they be glad that no
one was hurt or killed? Some are, but gratitude certainly doesn’t seem to
be the sentiment expressed by the majority of those who speak up. It is this
divide that captured our attention and compelled us to write this book.

While psychiatrists practice at the center of this political and ethical
maelstrom, the greatest impact of the changing social policy in the United
States is obviously felt by patients, and we’ll start with their voices. Some
patients were grossly mistreated, while others were treated kindly but still
felt anguish at their loss of freedom and control. As just one example of
the stories that follow, a woman wrote to us about her experiences:
In 1998, I sought treatment at my Employee Assistance Program for depression. Over time it grew worse and I became suicidal. My therapist asked if I would be willing to go into inpatient treatment and I agreed. But she also started the involuntary commitment process so that when I arrived at the hospital, I was handcuffed and placed in leg irons. All my belongings were taken and I waited in a locked room for hours until the sheriff came to transport me. I was led through the waiting area in handcuffs and chains and put in the back of a police car where I got to listen to the deputies describe their hate for the “crazies” during the 45-minute ride to a different hospital. Upon arrival there I was strip searched and placed in isolation.

I was terrified throughout this whole process. I didn’t understand why I was being treated as a criminal when I agreed I needed help and I wanted help. I am also a survivor of sexual assault and being strip searched was horrible. I felt as though I had no value. I thought, wow, this is what everyone who has a psychiatric problem has to go through.

Would anyone be surprised if this woman hesitated to seek treatment the next time she felt suicidal?

There are no studies that prove that involuntary treatment prevents suicide, much less that such harsh treatment would be beneficial to anyone. Given the new push for loosening the restrictions on involuntary commitment, stories like this are particularly difficult to hear.

The converging forces of fear-based legislation and financially driven health care systems have taken American mental health care to a dangerous point. People in need of inpatient psychiatric care experience unacceptable delays even when they seek care voluntarily, and they face competition for beds from patients who have been civilly committed. Psychiatric units are increasingly filled with more potentially dangerous and unpredictable patients.

When it comes to psychiatric treatment, and involuntary treatment in particular, the battleground is busy. The discussions are animated and often painful. On one side of the field, there are groups who oppose involuntary psychiatric treatments under any condition; in fact, some groups oppose psychiatric treatments for everyone, voluntary or not. They portray psychiatrists as money-hungry powermongers who push toxic medications on people to further the interests of the pharmaceutical companies, and
they may see medication as the cause of symptoms rather than as a means to recovery. Why would anyone want what psychiatrists have to offer? Listening to these voices, it is hard to imagine that there are many people who benefit from psychiatric treatments and that there are many psychiatrists who find their work to be immensely rewarding. Activists often don’t acknowledge that psychiatric symptoms really can render people dangerous or unable to negotiate their lives, and they see decisions to live on the streets or to cycle in and out of institutions as a “choice” without acknowledging that severe mental illness might alter the decision-making process. They also don’t acknowledge that the civil rights of an individual may be at odds with the heartbreak of a caring family and that the concerns of loved ones cannot simply be ignored.

On the other side of the battleground are groups that push for the increased use of involuntary treatments. They are quick to point out that people with psychiatric illnesses often don’t recognize that they are ill. From their perspective, this makes any concern about civil rights moot. In these discussions, treatment is often synonymous with medications, but they omit the downsides of psychiatric medications. Medications may cause some (but not all) people to feel sedated and slow, make them fat, destroy their sex lives, and increase their risk of getting heart disease and diabetes—problems that have the potential to decrease both the quality and the quantity of life. And the proponents of involuntary treatment don’t acknowledge that patients, even after their symptoms have abated, are sometimes unhappy that treatment was inflicted on them. These patients are viewed as having no insight, are deemed the sickest of the sick, and treatment is forced for their own good, based on a doctor-knows-best mentality.

We join the battle with this book and advocate for the judicious and limited use of involuntary and humane psychiatric care, as a last resort, after every attempt has been made to thoughtfully engage patients in accessible, kind, and comprehensive services on a voluntary basis. That sounds like common sense, right? But oddly enough, in a world where mental illness has come to be equated with mass murder and escalating suicide rates, there is no place for common sense, and American society risks falling prey to a “round ’em up” mentality. When you get down to it, engaging reluctant people to get help can be costly and a lot of work. Why bother putting in all that effort to convince unwilling people to
get care if you can simply force them? We have gone to great lengths to present a balanced view of involuntary treatment and all that goes with it, but we are not unbiased. Forced care comes at a cost, and it should be avoided except when it is the only way to get treatment for a person who is dangerous or tormented.

Federal and state legislation is often colored by fear. It is driven by legislators who want to say they are doing something to prevent mass murders. The National Rifle Association wants to be absolutely certain you understand: it’s not guns that kill people, it’s crazy people. Policy is now guided by emotion and reaction. It is no longer about creating realistic ways of keeping people safe and healthy in a nation that is hesitant to use its financial resources to help those who can benefit from services. At its heart, involuntary psychiatric care is a conflict among the desire of a family to care for a loved one, the need of a society to feel safe from real or perceived danger, an individual’s civil liberties, and the imperative of psychiatry to respect patient autonomy while abiding by professional ethics.

These issues are complex and nuanced, and they can also be tedious. As in any political debate, each side cites the research that furthers its cause, and few people want to read a book of research studies. While we do present the research, we illustrate the issues by telling the stories of people who are involved with many facets of involuntary psychiatric care. Stories leave impressions in our mind and bring facts to life. This is the first time anyone has put the conflicting stakeholders together in the same book.

We’d like to take a moment to clarify some of the terms used throughout this book. At times we use the terms “civil commitment” and “involuntary hospitalization” interchangeably to refer to treatment in a hospital that is mandated by a legal process, against a patient’s wishes. They are not always the same. Patients can be involuntarily hospitalized, then decide to become voluntary patients, or they may be released at a hearing. “Civil commitment” indicates that the hospitalization continues after a hearing on the issue. When it is necessary to make the distinction, we do.

The term “civil” indicates that these patients have committed no crime; their treatment is mandated to protect them or to protect members of society from the possibility that the patients’ mental illness will lead them to do harm. Because the commitment is legally ordered, these patients do not have the right to leave the hospital, and they may consider their
Before We Get Started

treatment to be forced. Each state differs in terms of how long a civil commitment can last without another hearing, and commitment often ends when the treating psychiatrist decides that the patient is well enough to be released. In other areas of medicine, patients can be treated against their will only when they have been deemed incompetent to make decisions for themselves because they cannot understand the treatment options. Psychiatry is the only field where someone may understand what is being offered and still be denied the right to refuse treatment.

We have tried to limit the use of the term “force” (versus “involuntary”) to instances where a patient is physically restrained, but this is a nuance of language that has different meanings to different people. To people being ordered to swallow medication, it may well feel like force if they know that the consequence of refusing will entail being held down and injected. We also discuss outpatient civil commitment, where patients are ordered by a judge to go to treatment and to take medications outside the confines of a hospital.

We are psychiatrists, but we approached this book as an endeavor in journalism. We hope, however, that our expertise and experience have added a layer of understanding that a lay journalist does not have. As psychiatrists, we were able to gain access to settings that typically do not allow visitors. And we are good at getting people to tell their stories; after all, that’s part of a psychiatrist’s job.

To produce this book, we divided the labor. Dinah Miller conducted the interviews and visited the settings. She is part of the story, and the first-person voice is hers, unless indicated otherwise. Annette Hanson wrote about the historical and legal perspectives of involuntary treatment and summarized the research. She also has a personal story in the chapter on the use of restraint and seclusion.

We looked for stories that illustrated the different aspects of involuntary treatment. When we discuss patients and their families, we do not use their real names. Identifying facts are simply omitted; other details have not been changed unless we specifically indicate that they were—for example, in the chapter on guns and mental illness, the location has been changed and details have been altered. In a few instances, we also use pseudonyms for the doctors. Some of the examples were obtained from published accounts. In these instances, we have not changed the names of
the people or the facts of the cases. Any place in the book where it is not clearly stated that a name has been changed, that is the person’s real name. When we discuss incidents of mass shootings, we refer to these events by location rather than by the name of the gunmen because we don’t want to contribute to their notoriety.

Because we are interested in giving everyone a fair opportunity to express their beliefs, those who are quoted at length were given the option to read their statements and correct any inaccuracies. It is our hope to avoid misinterpretation and sensationalism and to present all viewpoints in a respectful manner. All opinions and suggestions in this book represent a consensus of the professional judgment of both authors.