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Stigma and coercion in the context of outpatient treatment for people with mental illnesses

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ABSTRACT

The policies and institutional practices developed to care for people with mental illnesses have critical relevance to the production of stigma as they can induce it, minimize it or even block it. This manuscript addresses two prominent and competing perspectives on the consequences for stigma of using coercion to insure compliance with outpatient mental health services. The Coercion to Beneficial Treatment perspective (Torrey, E. F., & Zdanowicz, M. (2001). Outpatient commitment: what, why, and for whom. *Psychiatric Services, 52*(3), 337–341) holds that the judicious use of coercion facilitates treatment engagement, aides in symptom reduction, and, in the long run, reduces stigma. The Coercion to Detrimental Stigma perspective (Pollack, D. A. (2004). *Moving from Coercion to Collaboration in Mental Health Sevices* DHHS (SMA) 04-3869. In Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration) claims that coercion increases stigmatization resulting in low self-esteem, a compromised quality of life, and increased symptoms. We examine these differing perspectives in a longitudinal study of 184 people with serious mental illness, 76 of whom were court ordered to outpatient treatment and 108 who were not. They were recruited from treatment facilities in the New York boroughs of the Bronx and Queens. We measure coercion in two ways: by assignment to mandated outpatient treatment and with a measure of self-reported coercion. The longitudinal analysis allows stringent tests of predictions derived from each perspective and finds evidence to support certain aspects of each. Consistent with the Coercion to Beneficial Treatment perspective, we found that improvements in symptoms lead to improvements in social functioning. Also consistent with this perspective, assignment to mandated outpatient treatment is associated with better functioning and, at a trend level, to improvements in quality of life. At the same time the Coercion to Detrimental Stigma perspective is supported by findings showing that self-reported coercion increases felt stigma (perceived devaluation–discrimination), erodes quality of life and through stigma leads to lower self-esteem. Future policy needs not only to find ways to insure that people who need treatment receive it, but to achieve such an outcome in a manner that minimizes circumstances that induce perceptions of coercion.

The policies and institutional practices we create to address social problems are critical for stigma – they can induce it or they can minimize or even block it. The history of treatment for mental illnesses is particularly interesting in this regard as it is checkered with a lush repertoire of policies and procedures that have varied greatly over time (Grob, 1994). This variation is evident at the macro

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