What Motivates Public Support for Legally Mandated Mental Health Treatment?

Amy C. Watson, Patrick W. Corrigan, and Beth Angell

The use of legal coercion to compel individuals to participate in mental health treatment is expanding despite a lack of empirical support for many of its forms. Policies supporting mandated treatment are made by legislators and judges, often based on perceptions of public concern. Using data from the MacArthur Mental Health Module contained in the 1996 General Social Survey (N = 1,444), the authors examined the impact of political ideology, attributions about the cause of mental illness, and perceptions of dangerousness in determining public support for legally mandated mental health treatment. Perceived dangerousness and attributions about the cause of the mental disorder were significant predictors of support for legally mandated treatment. Conservative political ideology was related to attributing the vignette problem to bad character, indirectly affecting support for legal coercion.

KEY WORDS: attribution theory; coercion; mandated treatment; mental illness

The use of coercion to impose mental health treatment has been legally and morally debated for centuries. The discourse has moved from the use of involuntary hospitalization, to forced medication and the right to refuse treatment, to the current focus on the use of coercion in the community (Dennis & Monahan, 1996). Proponents of legally mandated mental health treatment argue that because of their illness, many individuals with mental disorders are unable to make rational decisions about treatment (Torrey & Zdanowicz, 2001). Research indicates that many people who are hospitalized lack decisional competence in at least one area related to treatment (Grisso & Appelbaum, 1995). Thus, legal leverage may be necessary for some to receive the benefits of treatment. Opponents question the therapeutic effectiveness of legally mandated treatment and rightfully argue that research supporting its use in many forms is lacking. They also argue that mandating treatment may discourage people from seeking voluntary services out of fear that they will be committed and held indefinitely (Allen & Smith, 2001).

Many ideological and empirical questions about mandated treatment remain (Draine, 1997), but its use is expanding (Halpern & Szmuckler, 1997). For example, in considering the reauthorization of the Substance Abuse and Mental Health Services Administration, the U.S. Senate included a proposed amendment requiring states to use outpatient commitment in response to homelessness among people with mental illness (Draine). This type of policy tends to be applied disproportionately to populations marginalized by race and poverty. Policies supporting mandated treatment are made by legislators and judges, often based on perceptions of public concern (Pescosolido, Monahan, Link, Stueve, & Kikuzawa, 1999). Thus, it is important to understand the process by which members of the public judge the appropriateness of legal means to coerce individuals into a range of mental health treatments.

Several recent studies have examined public views of legally mandated treatment and found that when respondents perceived that a hypothetical individual was dangerous, they were more likely to endorse forced treatment for that individual (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003; Pescosolido et al., 1999). These studies also suggested that perceived competence to make treatment decisions (Pescosolido et al., 1999), attributions about the cause of the condition, and affective reactions (Corrigan et al., 2003) play a significant role. Consistent with this earlier research, we
believe that both attributional processes and concerns about dangerousness motivate support for legal coercion, particularly when mandated treatment is viewed more as a method of social control than a means to deliver help. Building on earlier work, we examined the relative impact of attributions about the cause of mental illness and perceptions of dangerousness in determining public support for legally mandated treatment, and how political ideology shapes this process.

ATRIBUTIONAL MODEL OF PUBLIC SUPPORT
According to social psychologist Bernard Weiner (1995), when people encounter unusual circumstances (such as mental illness), they seek to identify causal processes as a way of making sense of the phenomenon. In doing so, they make attributions about cause and controllability. If the cause of an event is attributed to forces within an individual's control, that individual is judged personally responsible. For example, if mental illness is attributed to bad character (that is, people act depressed because they are lazy or immoral), the individual is judged responsible for the illness. If the cause is attributed to forces outside individual control, the individuals are not judged responsible. For example, people suffering from mental illnesses that are perceived by the public as being caused by a genetic abnormality or a traumatic brain injury would not be judged responsible. Thus, judgments of responsibility require human agency or choice.

To explain the link between thought and action, Schmidt and Weiner, 1988, posited that emotion (anger or sympathy) mediates cognition (attribution and judgment of responsibility) and action (helping or punishing behavior). If a member of the general public perceives that the cause of an individual's mental illness is controllable, that member of the public considers the person responsible for the condition, reacts angrily, and behaves in a punishing or neglectful manner toward the individual. Anger is generated by the belief that another person was able to behave differently or able to avoid a situation. It directs the individual to react in a punishing or self-protective manner (Weiner, 1995). Conversely, if the cause is perceived as not controllable, the person is judged not responsible, sympathy is experienced, and helping behavior is elicited. In our study we predicted that respondents who attribute responsibility for the illness to the individual (for example, as a result of bad character) would experience anger and be more likely to endorse legal coercion into mental health treatment. Although mental health treatment generally is intended to help, legal coercion into treatment involves stripping a person of some rights and liberties, and therefore, may be viewed as punishment.

If controllability and responsibility attributions determine responses to people with mental illness, it is important to understand why people view mental illness as a controllable phenomenon for which the sufferer is responsible. We examined the possibility that a person's political ideology is influential. That is, some people, because of their personal ideological beliefs about how the world works, may be more likely to attribute individual responsibility for a problem than others. Several studies have examined the impact of political ideology on attributions and intentions to help and suggested that it may play a role in Weiner's attribution model (Skitka & Tetlock, 1992, 1993; Zucker & Weiner, 1993). These studies suggested that political conservatism is associated with the tendency to attribute personal responsibility for problems. Thus, we predicted that conservative individuals would be more likely to attribute mental illness to bad character and, therefore, more likely to endorse legally coercive treatment.

Whereas substantial support exists for attribution models of helping behavior, growing evidence also suggests that perceptions of dangerousness are central to the public's response to individuals with mental illness (Brockington, Hall, Levings, & Murphy, 1993; Cohen & Struening, 1962; Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999; Pescosolido et al., 1999; Taylor & Dear, 1981) and one of the criteria for mandating treatment. Indeed, these perceptions influence endorsement of legally mandated treatment (Corrigan et al., 2003; Pescosolido et al., 1999). Thus, we incorporated perceived dangerousness into our attribution model of support for legal coercion (see Figure 1) to determine the relative influence of attributions and dangerousness. We predicted that perceptions of dangerousness mediate the effect of causal attributions on support for legally mandated treatment.

METHOD
Data
The data for this study come from the 1996 General Social Survey (GSS), which was fielded by the
National Opinion Research Center at the University of Chicago. The GSS is a nationally representative probability sample of noninstitutionalized adults living in the contiguous United States. It is a survey of opinion, attitudes, and behaviors of the U.S. population. The longest running longitudinal survey of the population, it has existed since 1972. Currently, the survey operates with a biennial split sample design, which consists of two parallel subsamples of about 1,500 cases each. The subsamples receive an identical core survey and different topical modules. Earlier methodological work indicates that the subsample N of 1,500 is sufficient to provide a representative view of opinions held by Americans (Pescosolido, Martin, Link, Stueve, & Kikuzawa, 2000), making it likely that the results of this study are generalizable.

In 1996 the GSS included the topical MacArthur Mental Health Module, which addressed Americans’ knowledge, attitudes, and beliefs about mental illness by using a vignette experiment. Although several published analyses of the MacArthur Mental Health Module have used these measures to examine public views of mental illness, dangerousness, competence, and legally coerced treatment (Link et al., 1999; Martin, Pescosolido, & Tuch, 2000; Pescosolido et al., 1999; Pescosolido et al., 2000; Phelan, Link, Stueve, & Pescosolido, 2000), they did not examine the relative impact of attributions of cause and perceptions of dangerousness on support for legally mandated treatment. The module was administered to a randomly selected subsample of 1,444 respondents. Each respondent was presented with one of five vignettes, four of which depicted DSM-IV disorders and one that depicted subclinical problems (see Appendix for sample vignette wording). Included disorders were schizophrenia, major depression, alcohol dependence, and drug dependence. Sex, race, ethnicity, and education were varied at random in the vignettes. After being presented with the vignette, respondents were asked a series of questions pertaining to the vignette subject. A subset of those items was used for this study.

Sample

Slightly more than half of the respondents were male; 81% were white, 14% were black, and 5% were listed as other. Respondents’ ages ranged from 18 to 89 (M = 44.7) years; and years of education ranged from 0 to 20 (M = 13.3). Of the 1,266 respondents that reported total family income, 156 had annual household incomes of $75,000 or more. The average household income for the remaining 1,110 was $32,068. Means, standard deviations, and bivariate correlations for the model variables are listed in Table 1.

Measures

Political ideology was measured with one item in which respondents were asked how they thought of themselves in terms of being liberal or conservative. This single-item scale is correlated with more elaborate measures of political ideology and is adequate as a stand-alone measure (Farwell & Weiner, 2000; Skitka & Tetlock, 1993). Responses were based on a seven-point Likert scale ranging from 1 = extremely liberal to 7 = extremely conservative.

Table 1: Correlations for Model Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>M</th>
<th>SD</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Political ideology</td>
<td>4.2</td>
<td>1.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Bad character</td>
<td>2.1</td>
<td>1.0</td>
<td>.094**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Dangerousness</td>
<td>2.4</td>
<td>1.0</td>
<td>.003</td>
<td>.268**</td>
<td></td>
</tr>
<tr>
<td>4 Coercion Scale</td>
<td>2.8</td>
<td>1.5</td>
<td>-.036</td>
<td>.142**</td>
<td>.361**</td>
</tr>
</tbody>
</table>

**p < .01 (2-tailed).
This item was not asked in the Mental Health Module, but in the general section of the survey. Respondents were asked whether, in their opinion, the cause of the vignette subject’s problems was bad character. This item was used in this study as a proxy for Weiner's controllable cause attribution, based on the assumption that problems caused by bad character are considered within the individual's control. Responses were based on a four-point scale ranging from 1 = not at all likely to 4 = very likely. To determine perceived dangerousness, respondents were asked how likely the vignette subject was to hurt others. Responses were based on a four-point scale ranging from 1 = not at all likely to 4 = very likely. It should be noted, that although affective reaction is an important construct in Weiner's attribution model, the data used in this study did not allow us to test this component of the model.

Support for legal coercion was measured by five items that asked if the subject should be forced by law to get treatment at a clinic or from a doctor, take prescription medication to control his or her behavior, be admitted to a hospital for treatment, be admitted to a hospital if dangerous to himself or herself, or be admitted to a hospital if dangerous to others. All items were answered “yes” or “no.” The number of “yes” answers were summed to make up the score (α = .7620). Possible scores ranged from 0 to 5.

Analysis Strategy
Analysis was conducted in three stages to test the theoretical model (see Figure 2). Structural equation modeling was used because it examines both the size and direction of association among a set of variables (Hatcher, 1994). It allows for the specification and testing of complex path models that examine mediational relationships and the causal processes underlying the target phenomena (Kelloway, 1998), in this case, attitudes about mental illness and support for legally mandated treatment. We first tested a model (model 1) examining paths from political ideology to bad character, and bad character to support for mandated treatment. We then added dangerousness to the model (model 2) as an exogenous variable with a path to mandated treatment. Finally, we added a path from bad character to dangerousness (model 3) and examined dangerousness as a mediator of attributions of bad character (compare model 3 to model 1). All analyses were conducted using the SAS System's CALIS procedure. The maximum likelihood method of parameter estimation was used and analyses were performed on the variance—covariance matrix.

All variables are manifest, with one item (or in the case of legal coercion, one scale score) per construct. Because most of the variables are single-item indicators, no measurement model was computed. All path coefficients are standardized path coefficients. Measures of significance for individual parameters were calculated by SAS and reported as a t test. Given the large sample size, these values were interpreted using critical values for the z test. Values above 1.96 are significant at the p < .05 level and indicated in the figures and tables with an asterisk (*).

RESULTS

Variables
Political Ideology. The mean score was 4.23 (SD = 1.4), just slightly more conservative than moderate. Thirty-eight percent of the respondents thought of themselves as moderates. Twenty-four percent saw themselves somewhere on the liberal side of moderate, and 37% saw themselves on the conservative side.

![Figure 2: An Attribution Model of Public Support for Legally Mandated Treatment (N = 1,120)](image)
**Attribution of Bad Character.** Overall, 17% of the respondents indicated it was very likely, 28% somewhat likely, 32% not very likely, and 22% not at all likely that the vignette subject’s difficulties were due to bad character.

**Dangerousness.** Overall, 14% of respondents believed the vignette subject was not at all likely, 32% not very likely, 37% somewhat likely, and 17% very likely to do something violent toward other people.

**Legal Coercion Scale.** The number of “yes” answers to five items related to legal coercion to treatment were added together to make the legal coercion score. The mean score was 2.8 ($SD = 1.47$).

**Path Analysis**
A theoretical model provides a good fit to the data when it successfully accounts for relationships between a set of observed variables (Hatcher, 1994). Five goodness-of-fit indices are reported here. Chi square is a test of the null hypothesis. Unlike traditional hypothesis testing, a nonsignificant chi square implies that there is no significant discrepancy between the covariance matrix derived from the model and the observed covariance matrix. A nonsignificant chi square suggests that the model fits the data and can reproduce the observed covariance matrix.

The normed fit index (NFI) (Bentler & Bonett, 1980) ranges from 0 to 1. It indicates the percentage of improvement in goodness-of-fit over the baseline independence (null) model. The nonnormed fit index (NNFI) is similar in logic, but takes degrees of freedom into consideration. This index may result in numbers greater than 1. The comparative fit index (CFI) (Bentler, 1990) is based on the noncentral chi-square distribution. Values range between 0 and 1. Values on the NFI, NNFI, CFI of .90 or greater suggest an acceptable fit between the model and data. The root mean square error of approximation (RMSEA) estimate (Steiger, 1990) is based on the analysis of residuals, with smaller values indicating a better fit with the data. Values below .05 are considered a very good fit.

Fit measures for model 1 (see Table 2) suggest adequate fit to the data, and the direct paths from political ideology to bad character and bad character to mandated treatment are significant. However, the model explains only 2% of the variance in support for legally mandated treatment. In model 2, dangerousness to others was added as an exogenous variable. The direct path from bad character to coercion remained significant but decreased in strength. The direct path from dangerousness to mandated treatment was significant with a standardized beta coefficient of .34. Although the variance explained increased to 12%, none of the fit measures approached adequacy. In model 3 (see Table 2 and Figure 2), we added a path from bad character to dangerousness. All paths in the model were significant at the $p < .05$ level, and all fit measures indicated a good model fit with the data. This model explained 14% of the variance in support for legally mandated treatment.

Results from these path models suggest that the perception of dangerousness to others partially mediates the relationship between attributions of bad character and support for legally mandated treatment. When dangerousness was added to the model, the strength of the path from bad character to mandated treatment was reduced from .15 to .08. The path from bad character to danger was significant, with a standardized beta weight of .27, indicating that bad character is partially mediated by perceptions of dangerousness.

### Table 2: Path Models for Variables Supporting Legal Coercion for Treatment of People with Mental Illness

<table>
<thead>
<tr>
<th>Variables:</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dependent/Independent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bad character</td>
<td>.08*</td>
<td>.08*</td>
<td>.08*</td>
</tr>
<tr>
<td>Political ideology</td>
<td>.08*</td>
<td>.08*</td>
<td>.08*</td>
</tr>
<tr>
<td>Danger to others</td>
<td>.15*</td>
<td>.08*</td>
<td>.08*</td>
</tr>
<tr>
<td>Bad character</td>
<td>.27*</td>
<td>.34*</td>
<td>.34*</td>
</tr>
<tr>
<td>Coercion</td>
<td>.02</td>
<td>.12</td>
<td>.15</td>
</tr>
</tbody>
</table>

| $\chi^2$ (df) | 2.51 (1) | 88.28 (2) | 3.49 (2) |
| $p$ value for $\chi^2$ | .11 | .00 | .18 |
| NFI            | .93     | .66     | .90     |
| NNFI           | .86     | .02     | .98     |
| CFI            | .95     | .66     | 1.00    |
| RMSEA          | .04     | .20     | .03     |

Notes: NFI = normed fit index; NNFI = nonnormed fit index; CFI = comparative fit index; RMSEA = root mean square error of approximation.

*p < .05.
Additional analyses were completed that controlled demographics, familiarity with mental illness, perceptions of condition seriousness, and likelihood that the subject was experiencing a mental illness (Watson, 2001). Demographics and familiarity did not significantly change the relationships in the models. Clearly, perceived dangerousness was the strongest predictor of support for legally coercive treatment for the vignette subject, whereas, attribution of bad character had a weaker but still significant direct association with support for legal coercion and an indirect effect through dangerousness. Thus, people seem more willing to legally coerce people that they feel are dangerous and to blame for their problems.

Post hoc analysis was also performed to examine the effect of mental illness condition (Watson, 2001). Respondents were most likely to attribute drug dependence to bad character, followed by alcohol dependence, major depression, minor troubles, and schizophrenia. Respondents also perceived the subjects of the drug and alcohol dependence vignettes as most dangerous and were most likely to endorse legal coercion for the subjects of the drug dependence and schizophrenia vignettes. Although mental illness condition had significant direct and indirect effects on support for legally mandated treatment, including it in the model did not significantly alter any of the relationships reported above.

**DISCUSSION**

When considering whether individuals should be subjected to legally mandated treatment, respondents relied heavily on their perceptions of dangerousness. This is not surprising given that much of the public is at least vaguely aware of the danger to self or others criteria for involuntary commitment (Link et al., 1999). It also makes sense that people would behave in a self-protective manner. In addition, this study demonstrated that people were more likely to support legally coercive measures for individuals who were believed responsible for their problems. This effect is partially mediated by perceptions of dangerousness, perhaps being strongest when dangerousness is less of an immediate issue.

We could not determine from the data used in this study whether respondents interpreted legal coercion primarily as helping an individual receive necessary treatment, as a method of social control aimed at correcting unacceptable behavior and protecting the public, or some combination of the two. We also did not test the direct effect of public perceptions and judgments on policy decisions related to the use of legal mandates to treatment. However, recent attention to issues of mandated treatment among policymakers appears to be in part a response to public fear and the lobbying of groups such as NAMI and the Treatment Advocacy Center, who are working to change legislation to relax criteria to involuntarily commit people with mental illness to inpatient or outpatient treatment.

Four other limitations of this study should be noted. First, the cross-sectional nature of the data does not allow us to confirm the direction of the paths, only that significant relationships exist. Second, our model explained only 14% of the variance in support for legal coercion. Having manifest rather than latent variables, we could not run a measurement model; thus, it is difficult to be sure how much of this low amount of variance explained might be due to measurement error. Clearly, other factors must be identified and examined. Finally, although our model was based on Weiner's attribution-affect-action model, we were not able to test the affective component. Future studies should test the full model and examine affective reaction as a moderator of attributions on support for mandated treatment.

Despite its limitations, this study provides new insight into the motivation behind policies that define under what conditions individuals with mental illness can and should be legally mandated to participate in treatment. This understanding provides direction for education and advocacy programs that seek to affect policy decision makers. Policies related to legally mandated treatment should balance the goals of clinical outcomes, client autonomy, and public safety and be informed by accurate information and research evidence. These policies should not be knee-jerk reactions based on erroneous stereotypes such as the belief that mental illness is caused by bad character or exaggerated perceptions of dangerousness. Education campaigns should target these myths about mental illness. In clinical training programs students and professionals should be encouraged to address the extent to which such stereotypes about mental illness inadvertently influence their own decision-making process. Our findings also highlight the need for future research into the decision-making process at the policy and individual clinical level.
The results of our analysis also may have implications for the distribution of resources to different types of mental health services. Research indicates that programs that serve people who are viewed as responsible for their problems are likely to be allocated fewer resources (Skitka & Tetlock, 1992, 1993; Zucker & Weiner, 1993). This would suggest that legislators who view people with psychiatric disabilities as responsible for their illness would likely divert funds from mental health programs. However, attributions of responsibility may evoke anger and, as our research indicates, the desire to apply legally coercive measures in the interest of social control. Thus, legally coercive and socially segregated programs may be allocated substantially more resources than integrative and consumer-oriented community services (Corrigan & Watson, 2003). Both policymakers and members of the mental health community must question whether this is a wise direction in which to move.

REFERENCES


Amy C. Watson, PhD, is director of research, Center for Psychiatric Rehabilitation and the ENH Research Institute, Northwestern University, 1033 University Place, Suite 450, Evanston, IL 60201; e-mail: awatson@gmail.com.

Patrick W. Corrigan, PsyD, is professor of psychiatry.
APPENDIX: SAMPLE VIGNETTES

Vignette A: Alcohol Dependence. NAME is a RACE/ETHNICITY, MAN/WOMAN, who has completed EDUCATION. During the last month, NAME has started to drink more than his/her usual amount of alcohol. In fact, s/he has notices that s/he needs to drink twice as much as s/he used to—to get the same effect. Several times, s/he has tried to cut down, or stop drinking, but s/he can’t. Each time s/he has tried to cut down, s/he became very agitated, sweaty, and s/he couldn’t sleep, so s/he took another drink. His/her family has complained that s/he is often hung over, has become unreliable, making plans one day, and canceling them the next.

Vignette C: Schizophrenia. NAME is a RACE/ETHNICITY, MAN/WOMAN, who has completed EDUCATION. Up until a year ago, life was pretty okay for NAME. But then, things started to change. S/he thought that people around him/her were making disapproving comments, and talking behind his/her back. NAME was convinced that people were spying on him/her and that they could hear what s/he was thinking. NAME lost his/her drive to participate in his/her usual work and family activities and retreated to his/her home, eventually spending most of his/her day in his/her room. NAME became so preoccupied with what s/he was thinking that s/he skipped meals and stopped bathing regularly. At night, when everyone else was sleeping, s/he was walking back and forth in his/her room. NAME was hearing voices even though no one else was around. These voices told him/her what to do and what to think. S/he has been living this way for six months.
Copyright of Social Work Research is the property of National Association of Social Workers and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.