



Frontline Perspectives

Rethinking Involuntary Treatment For Psychosis

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In our society today there is a lot of controversy about when the mentally ill should be treated against their will. Some are opposed to ever using force or coercion. Others simply think we should lock up all the “crazies” and throw away the key. The reality is that the vast majority of the population (unfortunately including many people classified as mental health professionals or considered mental health activists) are completely uninformed about this issue. They believe myths or stereotypes and have no real knowledge of the subject.

As someone who has lived with a diagnosis of schizophrenia (the stereotypical psychotic illness) for 40 years, I would like to first clarify exactly what it means to be psychotic or in psychosis. Psychosis simply means that the person is experiencing hallucinations and delusions and acts in ways that make no sense to those around them because to the person in psychosis the hallucinations and delusions are reality. Being psychotic does not necessarily mean dangerous, and although a small number are a danger to self or others, the vast majority aren't any danger to anyone and are much more likely to be the victims of violent crimes than to commit them.

Hallucinations are sensory experiences that the person in psychosis has that those around him don't. The stereotypical example is hearing voices that no one else hears. This is an example of an auditory hallucination which is the most common kind of hallucination. It doesn't however have to be voices. It could be doors slamming, bells ringing, gunshots, or even music. An auditory hallucination can be any sound you can imagine hearing. To the person in psychosis an auditory hallucination is usually totally indistinguishable from reality. Hallucinations can affect any of the five senses and can be any sensory experience you can imagine for the sense affected.

Delusions are fixed false beliefs that the person in psychosis has. These can be anything imaginable. They could believe that the CIA or FBI is after them. That a family member is really an alien masquerading as the family member. That they are a great prophet, or the antichrist. That a computer chip has been implanted in their brain to monitor and control them. There is almost no limit to what a delusion can be and again to the person experiencing it the delusion is totally real and factually true no matter how bizarre or unbelievable it may be to those around him. You cannot argue someone out of a delusion or hallucination because to them that is reality.

Psychosis can have many causes and is part of many diagnoses. The most common psychotic illnesses are schizophrenia (always has psychosis), schizo-affective disorder (always has psychosis), bipolar 1 disorder (usually has psychosis), bipolar 2 disorder (usually does not have psychosis) and depression (usually does not have psychosis). It is very important to realize that psychosis is a symptom not a diagnosis.

Currently the criteria for when to treat a mentally ill person against their will is that they are deemed to be a danger to self or others. In my opinion this criterion is significantly flawed because it makes the psychiatrist doing the evaluation have to predict the future. Someone who presents themselves as being in psychosis may not appear to be a danger to self or others at this time but speaking from personal experience that can change on very very short notice. A change in the delusion or a different hallucination can totally change the person's patterns of action in moments. Remember to the person in psychosis the hallucinations and delusions are reality, and for example if he hears a voice that convinces him that someone is out to kill him, he may act in perceived self-defense and kill or harm that person. Hallucinations or delusions can also cause the person to take actions that are highly detrimental to themselves including causing their own death simply because they are not in touch with reality. In my opinion any person who is actively psychotic is a potential danger to self or others simply because they are actively psychotic.

How then should we go about determining when to treat a mentally ill person against their will? I would propose a very significant but minor change to the current procedure. Each state has slightly different rules, but all states operate along the same general lines in this process. First a person authorized by the state determines someone should be evaluated for possible treatment even if it is against their will. The person is then transported to a hospital (possibly by law enforcement or possibly by medical personnel) for evaluation by a psychiatrist. The psychiatrist interviews the person and looks at how the person acts, what they say, what the referring person had to say, and what is known of the past history of this person. Based on this interview the psychiatrist decides whether or not the person should be hospitalized. Currently the criterion for hospitalization is danger to self or others. This should become actively psychotic instead. If the psychiatrist thinks the person should be hospitalized, he will ask the person to admit themselves to the hospital. If the person refuses the psychiatrist will initiate a 72 hour hold and place them in the hospital anyway.

During this 72 hour hold the hospital will get a much better look at the patient than the psychiatrist got in the initial interview. If at any time during that 72 hour hold it is determined that the person is not actively psychotic, they should be released. At the end of the 72 hour hold if the person still appears to be actively psychotic (based on the opinion of a psychiatrist), he should be asked to admit himself voluntarily to the hospital. If he refuses the psychiatrist should initiate formal commitment proceedings. These formal commitment proceedings will be the same as currently used except that the criteria for commitment will be actively psychotic instead of danger to self or others. The patient will still be represented by a lawyer and two psychiatrists will have to provide their opinion of the patient's mental state to the judge before the judge rules on commitment. If the judge rules the patient is to be committed, he should authorize the use of forced medication if the patient will not take it voluntarily at the same time as he rules for commitment. This will avoid the currently necessary step of having a second hearing to get permission to forcibly medicate. Currently the judge in almost all cases authorizes forced medication at the second hearing because he cannot end the commitment unless the patient is medicated to bring him out of his psychosis. The formal commitment will end once the judge is notified that the patient is no longer actively psychotic.

By actively psychotic I mean that the patient cannot distinguish reality from hallucination and delusion. It is possible to have psychotic symptoms without being actively psychotic. For example, I still hear voices occasionally even though I am properly medicated. In fact, for many patients it is believed that we will still have some residual symptoms even though we are properly medicated. This is why it is so difficult to determine when someone is actively psychotic. Obviously, the decision needs to be made by someone who is highly knowledgeable about psychosis and psychotic symptoms. I think this means a psychiatrist. Because the decision is a subjective one (there is no medical test to determine if one is psychotic) mistakes will happen, after all psychiatrists are human too.

Some are going to be opposed to the above because the test is subjective. I would like to point out that before there were readily available breathalyzers and blood alcohol tests, police used to do something very similar to determine when someone was driving drunk. This was called a field sobriety test. The police officer would do things like have you walk a straight line or touch your nose with your finger while keeping your eyes closed. Just as it was important for police officers to try to stop drunken driving then, it is important for psychiatrists to protect the mentally ill and those around them. Just as not every drunken driver causes an accident, not every actively psychotic person will harm themselves or someone else. In both cases, however, the possibility of terrible outcomes is real and very present. In the case of the mentally ill this should be viewed as medically necessary treatment. It is in principle no different than someone who has been seriously injured or has become seriously ill and requires immediate treatment even though he is unable to give consent because he is unconscious or otherwise incapacitated and is incapable of giving consent for obviously lifesaving treatment. With our current state of medical knowledge, I believe that this is the best possible way to protect people who are actively psychotic from themselves and to protect the general public from them while still doing our best to protect their rights.

The above applies only to those experiencing psychosis. We obviously still need the current standard of danger to self or others for those not experiencing psychosis.

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