Letters from readers are welcome. They will be published at the editor's discretion as space permits and will be subject to editing. They should not exceed 500 words with no more than three authors and five references and should include the writer's e-mail address. Letters commenting on material published in *Psychiatric Services*, which will be sent to the authors for possible reply, should be sent to Howard H. Goldman, M.D., Ph.D., Editor, at psjournal@psych.org. Letters reporting the results of research should be submitted online for peer review (mc.manuscriptcentral.com/appi-ps).

The Role of Coercion in Public Mental Health Practice

To the Editor: In the July issue Moser and Bond (1) raise the important question of coercion in public mental health practice. Unfortunately, their article misses several important points.

First, the word "forensic" does not appear in the article. Most states are dealing with expanding populations of justice-involved consumers in inpatient and outpatient services. For example, at the hospital where I work, the forensic population has increased from 28% in 2003 to 65% currently. Assertive community treatment teams, the article's focus, are often used as a promising approach to complex, justice-involved patients (2). It would be helpful to know the percentage of consumers in the programs studied who had court involvement, because the criminal justice system is inherently coercive. Clinical teams wishing to avoid coercive interventions often are avoiding collaboration with the justice system, exacerbating the problem of criminalization.

Second, coercion is a continuous variable, is relative, and is an important, if unstated, aspect of every relationship. Usually, the choice is not between X or not X (where X is the undesired intervention) but rather between X and Y (where both X and Y are undesired interventions).

For example, the authors erroneously state that "[d]epot injections of antipsychotic medication, often used with resistant and nonadherent consumers, virtually eliminate choice for two to four weeks." Injections may in fact be required by providers or a court as a condition of outpatient treatment. The consumer can accept the injections or refuse them and remain hospitalized.

Furthermore, even assuming for argument's sake that injection removes choice, it removes only one choice—that of taking medication. The consumer retains many other options, such as where to live and what sort of food to eat. The consumer also has the option to refuse the injection, albeit with possible adverse consequences. This is no different from an employee's refusal to comply with an undesired directive, albeit on pain of losing his or her job.

In addition, many coercive interventions require assessment of decision-making capacity (such as the ability to manage funds effectively in assignment of a representative payee) or of dangerousness (in civil commitment). The authors ignore this issue.

Third, the authors found that the strongest predictors of a team's use of coercive interventions were the percentage of consumers with schizophrenia spectrum disorders and with active substance use. Both groups of disorders are associated with poor insight and denial of illness (3,4). Such individuals are prime candidates for involuntary interventions, and it is not surprising that these two factors predict use of coercive interventions.

Finally, the authors do not comment on outcomes of treatment provided with and without coercion for similar groups of patients. This is the most important area for future study: are coercive interventions useful in changing a person's life course? If they are, they will continue to be used, regardless of how uncomfortable the idea of coercion makes us. The authors are correct when they conclude that "excessive use of control should be cause for concern," but they leave us in the dark about the line between appropriate and excessive use of coercive interventions.

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In Reply: We thank Dr. Roskes for his thought-provoking letter. Coercion is a complex construct that has been poorly defined in the literature. Our pragmatic goal in this study was to define a heuristic set of simple, face-valid, objective indicators hypothesized to function as mechanisms for social control. These indicators do not measure coercion directly but, instead, assess opportunities for coercion. We intend them to complement, rather than replace, existing self-report measures of coercion.

By way of illustration, administrations of depot injections and daily monitoring of oral ingestion of medications provide opportunities for coercive practices, such as threatening to withhold money or using more subtle interpersonal pressures. Our statement that depot injections of antipsychotic medications "virtually eliminate choice" was imprecise; we were specifically referring to the dai-

ly choice many consumers face about whether to take their medications as prescribed. We, of course, also did not mean that all consumer choice was thereby eliminated.

In fact, as with all of the control practices we examined, opportunities for choice can be traced both upstream and downstream from the practice itself. Assuming control or exercising coercion in the present may indeed provide greater opportunities for more meaningful choice down the road. As Dr. Roskes suggests, outcome studies examining use of coercive practices in community mental health could shed light on this often contentious topic—clarifying the role of coercion in both short-term and long-term recovery.

As Dr. Roskes notes, our study did not address how the treatment of justice-involved consumers may influence the use of various control practices. Although it is clearly germane to the issue of coercion, we omitted any discussion of criminal justice involvement because of the low three-month prevalence rates of incarceration in our sample—on average, less than 5% of the caseloads. Also, when our study was conducted, there were no forensic assertive community treatment teams in Indiana.

We too were not surprised that a schizophrenia diagnosis and substance use were positively correlated with control, for the reasons Dr. Roskes describes. As explicitly stated in our article, use of agency control ideally should be determined on an individual basis. As a practical matter, the psychiatric field does not have adequate psychometric tools for identifying consumers who lack decisional capacity, so we wonder how realistic Dr. Roskes' observation is that "many coercive interventions require assessment of decision-making capacity." Moreover, many clinicians probably overestimate the prevalence of decisional incapacity in determining the need for intensive supervision, as suggested by a recent major medication study in which very few patients were excluded on this basis (1).

Lack of evidence-based guidelines prescribing when, how, and for how long restrictive practices should be used creates the potential for misuse. The assignment (and removal) of representative payeeship is an excellent example of a control that requires no formal assessment of financial decision-making capacity—instead it relies on a clinical opinion (2). Its use may be determined primarily by provider attitudes and agency policy, as our study sought to understand.

Lorna L. Moser, Ph.D.
Gary R. Bond, Ph.D.

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