Rights, Responsibilities and Ideology in the Politics of Mental Health

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Abstract

In the field of mental health politics and policy, the rights revolution has produced a fundamental contradiction. Liberals, or left-leaning civil libertarians, are more ambivalent proponents of expanded mental health services than we might otherwise expect, for fear of constructing an administrative apparatus or service delivery system that could undermine consumer rights. Meanwhile, those on the mental health right, who worry that too many civil liberties mean disordered and dangerous individuals on the streets, are impatient with services restrictions, whether they originate with state budget-cutters or managed care companies. To test this hypothesis, we analyze public opinion data from the last two decades about mental health service provision.

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Liberals and conservatives can share blame for the lack of facilities for these people: liberals file suit against "warehousing institutions," and conservatives don’t want to pay for them. So bask in your ideologies, wingnuts, and ignore the consequences."

— "Beady Eye" commenting on Deborah Sontag’s article about the mental health system in Massachusetts, the New York Times, August 3rd, 2011

In the field of mental health politics and policy, the rights revolution has produced a fundamental contradiction. Liberals, or left-leaning civil libertarians, are more ambivalent proponents of expanded mental health services than we might otherwise expect, for fear of constructing an administrative apparatus or service delivery system that might undermine consumer rights. Meanwhile, those on the mental health right, who worry that too many civil liberties mean disordered and dangerous individuals on the streets, are impatient with services restrictions, whether they originate with state budget-cutters or managed care companies. Caregivers and parents may resist according too many rights to persons with a psychiatric diagnosis, but also demand extensive state provision.

In this political context, liberalism and conservatism promise relatively little in the way of illuminating the politics of service provision. Seemingly conservative demands to contain and control the disruption of psychological disorder are frequently and paradoxically conjoined with liberal demands that government assume responsibility for health care provision. At the same time, liberal civil rights advocacy offers little basis from which to challenge cuts in mental health services and programs.

We have derived this hypothesis regarding ideological contradictions in the field of mental health policy from readings of published positions by experts including psychiatrists, interest group representatives and other advocates. In this paper, we test its plausibility as a characterization of public opinion. We find some suggestion in the data we analyze that Americans are compassionate conservatives when it comes to mental health provision.

We proceed as follows. To begin, we detail the rationale for our hypotheses by sketching the background to contemporary controversies in mental health services provision. We focus our attention especially on the positions advocated by ideological opponents in this domain, and on the positions of these advocates on the question of coercing treatment. Next, we present analyses on two key questions: the first on how the American public thinks about coercing treatment, and the second on the relationship of thinking about restricting rights in the name of delivering treatment and thinking about the role of government in service provision generally. To conclude, we suggest that our analysis of public opinion provides plenty of reason to be skeptical of the idea that conservatives in the area of rights restrictions are necessarily also conservatives in the field of social welfare.

1Discussing “Teenager’s Path and a Killing Put Spotlight on Mental Care”
Conservatives and liberals in the mental health field

The two most prominent issues in the contemporary politics of mental health are first, mandated treatment and second, stigma. We reject the euphemistic language employed in many policy-based discussions of the first issue: coercion of various sorts is involved whenever psychiatric treatment is mandated, whether via explicit laws or other directive mechanisms. We thus will refer regularly in our discussion of mental health politics to forcing treatment in order to emphasize the clear political stakes in this issue. The second issue, stigma, deserves a political analysis of its own. Stigma is a major focus of the sociological analysis of mental health Pescosolido et al. (2010) and the subject of concerted efforts by advocacy groups like NAMI (the National Alliance on Mental Illness).

Part of our demonstration in this paper is that familiar expectations about ideological polarization are disrupted by the contemporary politics of mental health. Nevertheless, these two most prominent issues of forcing treatment and working against stigma nevertheless accord, at least at first glance, with predictable positions on the ideological spectrum. Proponents of treatment mandates are frequently affiliated with other conservative political positions; a clear example of such an advocate is Sally Satel, a psychiatrist and author (Sommers and Satel 2006; Satel 2000) who is a scholar at the American Enterprise Institute. By contrast, anti-stigma advocates like Patrick Corrigan, a researcher and activist (Corrigan, Roe and Tsang 2011), focus on personal empowerment, and invoke resonances between civil rights advocacy, overcoming stigma and improving the situation of persons with psychiatric diagnoses.

The political background of coercion and provision

For the most part, psychologically disordered citizens who have received a psychiatric diagnosis no longer live in mental hospitals. At previous points in American history, those mental health consumers who were most seriously ill were publicly invisible, hidden away on the back wards of the state institutions of legend. Now, many of the individuals who years ago would have resided in institutions instead live outside of them, sometimes on the streets of American cities.

This shift in residence has produced a substantial shift in the public imagination surrounding persons thought to suffer from mental illness. Previously regarded as doomed prisoners of snake pits and therefore as objects of sympathy and dread, psychologically disordered individuals now frequently provoke fear. Persons thought to suffer from psychological trouble are now widely perceived by Americans to be dangerous and violent. Such perceptions appear to have increased since the 1950s (Phelan et al. 2005).

John Monahan, Richard Bonnie and other legal academic analysts of psychiatric treatment compliance suggest that coercion might profitably be replaced by or extended into contractual mechanisms that provide leverages or inducements instead of overt legal force (Monahan 2008).

Satel is a resident scholar at the American Enterprise Institute. Corrigan is a professor and dean at the Illinois Institute of Technology and head of an NIMH supported research center National Consortium on Stigma and Empowerment (NCSE).
These new public perceptions of public opinion on mental health are a product of the phenomenon of deinstitutionalization. Deinstitutionalization is the appropriate context for understanding virtually all issues of contemporary American mental health policy. It is the right backdrop against which to consider the key questions for our paper: how American citizens, policy makers and voters alike, view the rights of persons with a psychiatric diagnosis and the responsibilities of government to provide mental health services.

Deinstitutionalization accelerated in the 1960s, but the consequences now associated with it are a product of the 1980s. Responding to both the community mental health orientation of the 1960s and the 1980s reaction against social services, public consideration of the situation of psychologically disordered individuals now engages a complex mix of political views. These include beliefs about the responsibilities of the federal government, the need to maintain public order, and the rights of persons with mental illness.

Deinstitutionalization began in a context of relative optimism about the prospects for medically treating mental illness. This optimism was fueled by the invention of new, apparently beneficial psychotropic medications. In the early 1950s, chlorpromazine, the first medication widely used to treat schizophrenia, was developed in France. Marketed as Thorazine, its use in the United States soared quickly after its introduction in 1954. Other promising new medications soon followed. The apparent efficacy of psychotropic medications raised hopes that mental illness could be treated outside of hospitals, installed the belief that psychological disorder reflected an illness, and reinforced growing optimism in the public’s mood toward mental illness (Rochefort 1997, 38-39; 46-52).

Changes in public provision

Some scholarship suggests that deinstitutionalization depended quite directly on the structure of public provision for persons with psychiatric disorders and diagnoses. The introduction of Medicare and especially Medicaid, and changes in the eligibility of persons with mental illness for SSI, SSDI housing and food stamps, may well have played a greater role in emptying out state institutions than either the introduction of meds or the critique of psychiatric power.

These alterations in the structure of public provision fundamentally changed circumstances faced by persons considered mentally ill. They provided states with an incentive to shift persons out of institutions and into programs where the federal government would pay for care and housing, in nursing homes, in expanded publicly supported housing, and through disability insurance (Rochefort 1997, 214-215, 221). Between 1955 and 1980 state hospital populations declined by more than 75 percent, but more than two-thirds of this decline occurred between 1965 and 1975, following the implementation of Medicaid (Gronfein 1985, 196). Deinstitutionalized persons depended heavily on federal social programs, which “provided the subsistence base necessary for relocating patients to the community (Mechanic and Rochefort 1990, 316).
When these programs were contracted in the 1980s, this subsistence base was fundamentally undermined, leaving persons with severe mental illness especially vulnerable to homelessness and other forms of material deprivation.

Since the 1980s, the emergence of managed care has produced an additional structural incentive to keep persons out of institutions. The goal of managed care is to manage costs by eliminating inappropriate services and providing treatment in the least expensive form (Lefley 1996; Managed). Though the consequences of managed care for behavioral health policy still remain to be seen, it appears to be associated with a reduction in the average lengths of stays in psychiatric hospitals (Robinson 1996; Mechanic et. al. 1998). As state mental health authorities increasingly contract with managed care companies to administer Medicaid funding, managed care is a new source of pressures inconsistent with the reassertion of long-term, institutionally-based care for most persons with mental illness (Morrissey 1999).

Civil rights and liberties

The guarantee of civil rights and civil liberties for persons psychiatric patients is a legal/judicial product of the second half of the twentieth century. This production was rooted in an earlier and quite widely supported (here with wide support we mean to refer to public opinion) critique of psychiatric power.

While new medicines helped make deinstitutionalization imaginable, philosophical and political critiques of psychiatric power, especially as it was exercised in institutions, were being refined. Precursors to this critique began appearing soon after the nineteenth century movement to build state mental hospitals in the United States, but the critique was forcefully and famously enunciated in the 1960s by the libertarian Thomas Szasz (1961) and the radical R. D. Laing (1965). American anti-psychiatry critics also embraced the work of the sociologist Erving Goffman, whose seminal work Asylums appeared in 1961, and to a lesser extent, that of Michel Foucault. These challenges to psychiatric power were also reflected in a series of exposés of conditions inside mental hospitals. Joined with growing public interest in the problem of mental health following World War Two, these critiques helped reorient the guiding norm of care for persons with mental illness from hospitals to community-based care (Grob 1994). This reorientation culminated in the Community Mental Health Centers Act of 1963, which established federal support for a network of local mental health care facilities and represented a profound shift in national mental health policy (Rochefort 1998).

The critique of psychiatric power developed into a focus on the legal rights of institutionalized persons. The liberation politics of the 1960s inspired civil rights activists and lawyers to join in challenges to commitment law, leading to a series of court decisions preserving due process, extending the basic civil liberties of hospitalized individuals and reducing the authority of psychiatrists and state officials. In 1967, in Specht v. Patterson (386 U.S. 605, 608), the Supreme Court held that "involuntary commitment to a mental hospital, like involuntary confinement of an individual for
any reason, is a deprivation of liberty which the State cannot accomplish without due process of law.”

Political debates about forcing treatment

Deinstitutionalization thus reflected and drew on a constellation of forces and events, including changing attitudes towards mental illness, towards the exercise of psychiatric and legal authority, and the development of new forms of social welfare provision in the United States. Forced treatment in turn draws upon reactions to deinstitutionalization, upon interpretations of deinstitutionalizations causes and consequences. In particular, forced treatment is framed as an issue about whether the attribution of due process rights and civil liberties to psychologically disordered individuals has left them bereft, or whether the undermining of a structure of social service provision is to blame. Advocates of forced treatment sometimes adhere to both positions at the same time.

Coercion has been an issue in American mental health politics since large numbers of hospitals were constructed in the nineteenth century and people began to be involuntary placed in them. Since deinstitutionalization, a new form of involuntary treatment, coercion into outpatient treatment, has joined involuntary inpatient commitment as an issue. Specific procedures for involuntary commitment vary across jurisdictions, but usually involve some imminent threat of harm to oneself or to others. Requests for forced hospitalization are made primarily by law enforcement officials, friends, and relatives of the individual.

The experience of deinstitutionalization has given rise to multiple and frequently contradictory political orientations regarding the forced treatment of psychologically disordered individuals. When it comes to forced treatment, political ideology does not produce consistent and familiar patterns. According to a standard ideological framework, those who praise the liberalization and expanded programs of the 1960s oppose the curtailments of the 1980s, while critics of the 1960s welcome the conservatism of the 1980s. This framework does not describe the politics of forced treatment, where conservative demands to contain and control the disruption of psychological disorder are frequently joined with liberal demands that government assume responsibility for health care provision, while liberal civil rights advocacy offers no basis from which to challenge cuts in mental health services and programs.

The advocate E. Fuller Torrey exemplifies the former, seemingly contradictory position: in addition to being a strong proponent of forced treatment who blames the 1960s for the shortcomings of contemporary mental health services, he is a vocal critic of managed care and a proponent of centralized “single responsibility funding for mental health services (1997). Acknowledging the continuing reliance of many American mental health consumers on the network of federally-sponsored social services expanded in the 1960s and 1970s but contracted in the 1980s, advocates for consumers almost universally emphasize the need for enhanced funding, even when they are as reserved as Torrey is about the protection of individual liberties for persons with
psychological disorders.

Inadequate and inconsistent service provision, especially for those who are most seriously ill, is clearly a feature associated with the aftermath of deinstitutionalization in the 1980s and 1990s. Indeed, some of the most infamous incidents of violence by persons with mental illness, such as the murder of Kendra Webdale, who was pushed under a subway train by Andrew Goldstein, are accompanied by accounts of repeated requests for care, and repeated denials, prior to the incident. To elaborate upon the need for enhanced funding and treatment, advocates like Torrey and Sally Satel stress the violence risk posed by persons with mental illness. Again sounding a conservative note, they assert the rights of community and family members to respond to disordered behavior with mandatory hospitalization or other forms of treatment. Yet some of the strongest advocates for forced treatment combine their conservative emphasis on violence risks with liberal arguments about the necessity of enhancing funding for expanded care.

The prominence of this association between service expansion and coercion implies that opposition to coercion means opposition to enhanced services. In fact, consumer advocates and civil libertarians also favor expanded services, but they are forced to introduce a qualification as they do so: they favor only services that are compatible with the protection of civil liberties and consumer preferences. The appeals made by those on the left in mental health politics, such as the Bazelon Center for Mental Health Law, join civil libertarian advocacy with an endorsement of enhanced provision of mental health services. Outpatient commitment, Bazelon argues, “penalizes the individual for what is essentially a systems problem. Lack of appropriate and acceptable community mental health services is the issue.

Consumers prefer care in the community, and the civil liberties orientation that fueled criticisms of state hospitals accords with both basic protections of human rights and with funding for community-based, consumer-approved services (Sayce 2000). Nevertheless, in the contemporary political context, this left-leaning conjunction of community-based services and civil liberties protections is hampered by its lack of post-1980s credentials: it contains no reactionary “behave yourself appeal to individual responsibility, and it is up against demands for fiscal conservatism from states and managed care companies. Indeed, the legacy of civil liberties protections, ostensibly politically liberal, may provide a convenient rationalization for state officials eager to cut budgets; the focus on the right of mental health consumers not to be confined to state hospitals may justify disorganized, inconsistent provision of mental health services. Consumers reluctant to fortify an administrative apparatus that might be mobilized against their rights may lack the motivation to challenge these shortcomings. Indifference to vulnerable, politically less powerful populations may ironically be buttressed by claims to consider their rights.

In short, these political ambiguities and complexities topple conventional expectations about the ideological allegiances and priorities of those who would support or oppose coercion. When considering the situation of individuals with psychological disorders,
conservatives reacting against the excesses of the 1960s are also critics of the 1980s; they want to expand, not restrict, the welfare state. Meanwhile, the civil libertarian perspective emerging from the 1960s provides a convenient justification for the 1980s: or at least it limits the ability to challenge Reagan-era restrictions on mental health services. Right-inclined forced treatment advocates are impatient with services restrictions, whether they originate with state budget-cutters or managed care companies. Left-leaning civil libertarians are more ambivalent proponents of expanded mental health services than we might otherwise expect, for fear of constructing an administrative apparatus or service delivery system that might undermine consumer rights.

To protect rights, must one sacrifice public provision of mental health services, as Beady Eye suggested in the comment quoted in the epigraph at the start of this paper? Do conservatives intent on dismantling the welfare state deny suffering individuals needed services? Are advocates of forced treatment hypocrites who won’t pay for the services they think mentally ill individuals need? We can see evidence for all of these contradictions in the rhetoric of advocates and interested parties. What about ordinary citizens? We turn to our investigation of public opinion on these matters now.

**How the American public thinks about forcing treatment**

Our first order of business in testing our hypotheses is to examine the role of political attitudes in explaining support for legal mandates to demand that persons with various psychiatric diagnoses participate in treatment. To do so, we take advantage of the General Social Survey’s mental health modules, administered with slight variations in both 1996 and 2006.

The coercion questions ask about forcing a troubled person, described in the vignette at the core of the Mental Health Module, into various kinds of treatment. Each vignette described a person with symptoms consistent with drug use, schizophrenia, alcohol use, major depression or generic distress in 1996. In 2006, the vignettes described someone manifesting symptoms of depression, alcohol use, and schizophrenia. The problems faced by vignette characters, and the characteristics of the person described including race and ethnicity, gender, and education level, were randomly assigned. Following the vignettes, respondents were asked a number of questions about them, including the questions about forcing treatment of particular interest to us here. Specifically, respondents were asked to say whether they agreed that laws should mandate a visit to a clinician, medication, or hospitalization for a person as troubled as the one described in the vignette (Table 1).

From Table One, we see that consistently about a third of GSS respondents think it is advisable to use law to get persons like those described in each vignette into treatment. Some problems provoked a greater inclination to support coercion: when the vignette described a person with symptoms of schizophrenia, survey respondents were significantly more likely to agree with coercion (results not reported). Similarly, respondents in both 1996 and 2006 were overwhelmingly inclined to agree that involuntary hospi-
talization was called for when the vignette character posed a danger to him or her self or to others.

To assess overall support for coerced treatment, we produced an additive, continuous scale summing responses on the five coercion questions appearing in Table 1. On all of the questions about forcing treatment, black respondents were more likely than whites to endorse coercion; that greater propensity among blacks is reflected in the differences in the means on the scale reported in the last rows of the table.

The finding of higher levels of black support for coercion underscores the political stakes in forced treatment. We might expect black Americans to be less likely than whites to support involuntary psychiatric treatment; indeed, previous analysis utilizing the data we employ emphasizes blacks greater reluctance, compared to whites, to recommend that troubled persons consult a professional mental health practitioner (Schnittker et. al. 2000). However, like other researchers we found that the 200 or so black Americans who participated in the mental health module included in the 1996 and 2006 General Social Surveys, were consistently somewhat more likely than whites to support coercion.

We might expect blacks to oppose forced treatment because forced treatment may violate civil rights, and we expect black Americans to be especially alert to the rights of the vulnerable. Since forced treatment plausibly responds to fears of deviance and disorder, we would expect political conservatives to be more inclined to support it, but black Americans are less politically conservative than whites. We see this disruption of our expectations as a further invitation to examine the correlates of support for forced treatment in American public opinion, and to revisit our own assumptions about how political views might shape ideas about when people with psychological problems should be coerced into getting help.

**Antecedents of forced treatment support**

Supporting legally mandated treatment is a policy outcome that clearly demands a willingness to compromise the absolute right to autonomy of the persons pressed into treatment. Who might be especially willing to put personal autonomy second, or even to forego it? Most likely, those citizens who are especially sensitive to disorder or disruption in the civic community. We expect to find a greater willingness to tolerate civil liberties violations, and therefore more support for forced psychiatric treatment, among those who are most concerned about their fellow citizens violating the normative order, pushing themselves into inappropriate social domains or spaces, failing to obey rules or shared social values. We are referring here to a complex or rubric of politically relevant and consequential individual predispositions that, when discussed by contemporary public opinion analysts, engage the concepts of racial resentment, ethnocentrism and especially authoritarian predisposition. To the extent that these psychological orientations are also correlated with political orientations like partisan identification and ideology, we may also find that strong Republicans or political conservatives are more willing than other citizens to sacrifice individual liberties in the
name of social order.

The instrumentation in the GSS allows us some purchase on the question of whether the same folks who want to crack down on violations of the social order are also those who demand that psychologically troubled individuals to talk to a doctor, take some medication, or check into a hospital. We have tried to be exhaustive and inclusive, entertaining this hypothesis even when our representation of our key concepts is less than ideal. The analyses generating the results presented in Table 2 include controls for vignette type: in 1996, GSS participants were randomly assigned to one of five conditions representing symptoms of psychiatric trouble; in 2006, participants were exposed to a more limited set of vignettes that also included a physical illness. In most estimations, vignette type is a significant predictor of support for coercion, with coercion most likely to be supported when the vignette character exhibits symptoms consistent with a diagnosis of schizophrenia.

As we scrutinize the contribution of political predispositions to forced treatment support, we find very little at best, really nothing at all, in either 1996 nor 2006 to support the hypothesis that any element of a complex of underlying punitive, directive or authoritarian predisposition inclines the ordinary American represented by the GSS samples to compels citizens to support forcing treatment. The results of our exploration of this possibility are contained in Table 2. There we show OLS regression coefficients representing the power of the relationship between racial conservatism, authoritarian preferences and (the probable opposite) libertarian inclination, as well as partisan and ideological orientations.

In no case, in neither year, do we see more than an extremely modest glimmer of a significant relationship between how far, and whether by law, GSS respondents think the character in the vignette they heard should be pushed into treatment. Racial conservatives are no more likely than anyone else in the survey to support coercion, whether their reservations about blacks are assessed with a well-known racial resentment item or (admittedly controversially) via a question about whether government should help black people. Those who think that suicide is always wrong, even when someone is faced with an incurable disease, are not moved more than their more libertarian fellows to recommend coercing someone suffering mental illness into treatment. Nor are we more likely to find coercion proponents among those who generally support corporal control or punishment, whether represented as capital punishment, as the belief that law enforcement officials must sometimes hit citizens, or the idea that children should be spanked.

The only glimmer of a relationship in this table is the row noting that black people are systematically more likely to support coercion. Some previous scholars find that blacks are more authoritarian, inclined more than others to advise corporal punishment for children, and paradoxically willing to tolerate some civil liberties violations. We note the consistency of the pattern across years; we will remark later on its general robustness across specifications. When we consider forced treatment support as a predictor of broader policy choice, we will appreciate the importance of not only con-
trolling for race but also explicitly modeling the inclination of black people to support using legal coercion in order to get sufferers of psychiatric and substance use problems into treatment.

Are we disappointed? At first glance, as political as ideas about forcing compliance with psychiatric treatment seem to be, the issue of whether to require by law that persons with a diagnosis receive treatment seems in fact to be a domain quite remote from the obvious political suspects. By our lights, the topic of how to provide for persons with diagnoses, and how much force to use to make sure they benefit from what is provided, engages too many basic questions of politics to give up so easily.

Political correlates of forcing treatment

We suspect that some of the particular characteristics of the administration of the mental health modules in the 1996 and 2006 GSS help account for the lack of patterns that we see. Most of the instrumentation we used to indicate respondents’ underlying orientations was probably, we think, in the context of the survey, far too antecedent to be mobilized and marshalled when respondents addressed the quite specific (and still, we believe, quite political) question of mandating treatment.

Indeed, when we dig into the actual passages in the mental health modules where the vignette is directly engaged, where questions are based on it, and identify in that more immediate context questions posed to respondents about the vignette characters and also containing political content, we see strong evidence of a clear link between thinking about politics, the role of government, and thinking about using coercion.

Torrey is wrong in two significant ways at least. First, Table 3 establishes that organic causal attributions do not predict endorsement of coercion (nor does bad character). Second, folks who support coercion are more likely to think those who support community self-help than psychiatric expertise. Coercion support appears more solidly related to a mandate to engage in peer-driven treatment models than medically or professionally driven treatment modalities. Given the justificatory language invoking organic and biological models that accompanies arguments like Torrey’s for forced treatment, it is perhaps paradoxical to think of the possibility of a mandate to engage communally. But that paradox seems supported in these data.

Perhaps more important, mandated treatment is not a classically conservative position, if conservatism means skepticism about the possibility that government could be part of the solution or an endorsement of private or market mechanisms. Supporters of forcing the vignette character to get treatment are more likely to say that government should pay for that treatment than they are to say that an insurance company or the vignette character’s family should pay.

With these results in hand, we are ready to turn more broadly to a consideration of the relationship between endorsement of forcing treatment, and views about mental health service provision, health care more generally and social welfare spending. Our aim is to construct the best political model we can with our limited data.
Support and Opposition to Government Provision

We turn next to investigating the role of views about a legal coercion and government responsibility in explaining support or opposition to government provision in the area of mental health, compared to health care more broadly and social welfare policy in general. In this investigation, we again make use of the Mental Health Modules in both 1996 and 2006 GSS, as well as GSS instrumentation outside of the module. This mixture means that we are in some cases modeling support or opposition to broad policy positions as a function of narrower choices spurred by consideration of the particular case of the vignette character presented to respondents in the Mental Health Module.

To make this sort of model psychologically plausible, we must assume that vignette-based choices regarding intervention and ideas about government responsibility represent at least to some degree broader underlying considerations about these issues, and that we are testing for the relationship of these broader considerations to respondents’ opinions on the role of government in these three issue domains. For various reasons, including our reliance on responses to questions about specific cases to predict broader policy views, we believe that appropriate interpretations of the regression results presented in Tables 6-10 emphasize the illumination of relationships among closely related constructs rather than causal claims.

We constructed each of the dependent variables in these analyses by building modest scales out of GSS items. For evaluating opinion on mental health policy, we relied on SPMENTL and GOVMENTL to construct a variable combining responses to distinct policy questions, one about spending and one about government’s role, posed separately to two half-samples in both GSS years. Unfortunately this means that our measurement of a key dependent variable of interest relies on very thin instrumentation, a limitation we must accept given the shortage of survey-based inquiries into this subject matter.

Our measurements of health policy choices and ideas about government responsibility to address income inequality are based in better instrumentation; for these dependent variables, we produced modest additive scales out of GSS items HLTHCARE and HELPSICK in the first instance and EQWLTH and HELPPOOR in the second. The association between the three variables we constructed is shown in Table 4. The Mental Health variable and the Health Care and Economic Inequality scales are all coded 0-1, with 1 representing strong opposition to a role for government in general.

Our key question of interest addresses the relationship between a conservative stance on protecting civil rights, or, in other words, a willingness to tolerate sacrifices in personal autonomy and liberty in the name of accepting health care treatment, and conservative political ideology more generally. Overall, we find no evidence in the analyses presented in the tables (nor in our other explorations of GSS data not presented here) to support an interpretation that coercion in mental health service delivery is either primarily a function of a generally punitive orientation, or an indication of re-
sistance to a role for government provision generally. That is, conservative orientation in the domain of coercion does not imply unwillingness to support a role for government provision; if anything, we find in our data a paradoxical suggestion that it might in fact imply the opposite. The same citizens who endorse using the force of law to push their suffering or diagnosable fellows into treatment are also willing to support a role for government, and spending by governments, to provide for the existence of treatment services.

The variables of primary interest to us appear in the first two rows of Tables 2uyxv. These tables detail comparable analyses conducted across two administrations of the GSS, ten years apart. The first two tables in this set address the correlates of support for mental health service provision through government; the next two, government’s role in health services generally, and finally, a comparison of these opinions to thinking about social welfare generally, represented by attitudes on government intervention to address economic inequality. In the first row of each table, we see the relationship between attitudes about forcing treatment and government provision. The second row reports on the relationship between ideas about service provision, social welfare and the idea that government should pay for the care of the person described in the vignette in the Mental Health Modules.

Unsurprisingly, respondents who think government should be primarily responsible for the vignette character’s care are also strong advocates of a role for government role in, and spending government dollars for, mental health service provision, consistent across both GSS years. The association is moderately robust across alternative specifications, as represented by the three alternative specifications of the model of opposition to government’s role detailed in columns 1, 2 and 3 in each table. It is also consistent across alternative social welfare domains: those who think government should pay for the health care of the vignette character, also support government’s role in all three issue domains.

The relationship of forcing mental health treatment to ideas about other roles and responsibilities of government is our key question in this paper; the first row of Tables 2uyx zero in on this question. We observe a consistent and powerful negative relationship between the effect of advocating forced treatment and opposing government’s responsibility or spending in the domain of mental health care. That is, the same GSS respondents who want to get the vignette character into treatment are also supporters of government’s role in mental health care generally.

This result, which looks like a powerful association in 1996, is not repeated in 2006; still, we observe that the non-significant coefficients in our 2006 specifications nevertheless point in the same direction as 1996, that is, the relationship between forcing treatment and opposing government’s role in mental health remains negative, though weakly and somewhat shakily, ten years later. We can safely conclude from these results that, at least in the domain of mental health service provision, one seeming correlate of political conservatism, coercion into treatment, does not imply another, that is opposition to government’s role in social services.
We note the complexity in these results of the relationship between race and coercion. Black Americans are strong representatives of a kind of compassionate conservatism: they tend both to advocate forced treatment and to insist that government take responsibility for, and spend tax dollars on, mental health care.

**Conclusion**

Laws mandating involuntary mental health treatment engage questions about the legitimate use of force to constrain citizens mobility and liberty, a fact that provides an unequivocal theoretical rationale for including political views in a model to explain public opinion about these laws.

The prominence in arguments about coerced treatment of references to civil rights suggested the possibility that among the mass public, support or opposition to forced treatment might be explained in part by a similar complex of political attitudes as those that help explain public opinion on issues related to race, social welfare and government authority more generally. Are people who support the use of force by authority figures more likely to support forced treatment? Are those who object to a role for government in healthcare less willing to limit the civil liberties of psychologically troubled persons?

The issue of forced mental health treatment illuminates the complexity of American political ideology in the wake of the rights revolution of the 1960s. Forced treatment seems both to be at the center of the constellation of forces swirling through American politics since the 1960s, and to depart from conventional expectations about them. It engages questions of civil liberties, civil rights, and the role of the federal government to provide for all of its citizens, but in seemingly contradictory ways.

The politics of forced treatment is not a politics where liberals are distinguished from conservatives, but one where something closer to compassionate conservatism and reluctant libertarianism might obtain. Forced treatment appears to be an area of American politics where many citizens are willing to use the power of the state to shape private choices, in the name of both individual and civic health and well-being. A question worthy of further exploration, we think, is the degree to which forced treatment advocates resemble compassionate conservatives in other areas: how similar are those who endorse using laws to force people to get professional help for psychological problems to those who want to use government to encourage responsible fatherhood, to discourage single motherhood, to introduce faith-based programs in schools and communities?

Citizens are, on average, quite willing to violate civil liberties and to recommend coercion into treatment of persons displaying symptoms consistent with psychiatric diagnoses. But this seemingly punitive orientation is not accompanied by resistance to government provision. We find some suggestion that support for coercion into treatment predicts support for spending on and governmental involvement in mental services, and an unequivocal dearth of evidence to support any suspicion that advocates of forced treatment also want to cut government services.
This finding suggests a complexity in American public opinion that belies a simplistic association between a belief that the rights revolution has gone too far and an insistence that government is outsized. In the domain of mental health politics and policy, a willingness to restrict rights does not imply a concern to downsize government.

Our paper also presents results that lend skepticism to some particular ideas and claims by conservative advocates in the domain of mental health policy. Americans are quite inclined to agree with these advocates that coercing troubled folks into treatment is frequently necessary. But the citizens represented in the General Social Surveys - the evidence we rely on for our interpretations here - are decidedly less amenable to the some of the other ideas represented in mental health conservatives’ world view.

References


