The Public's View of the Competence, Dangerousness, and Need for Legal Coercion of Persons With Mental Health Problems

Bernice A. Pescosolido, PhD, John Monahan, PhD, Bruce G. Link, PhD, Ann Stueve, PhD, and Saeko Kikuzawa, MS

ABSTRACT

Objectives. The authors examined Americans' opinions about financial and treatment competence of people with mental health problems, potential for harm to self or others, and the use of legal means to force treatment.

Methods. The 1996 General Social Survey provided interview data with a nationally representative sample (n = 1444). Respondents were given a vignette based on diagnostic criteria for schizophrenia, major depression, alcohol dependence, or drug dependence, or a "control" case.

Results. The specific nature of the problem was the most important factor shaping public reaction. Respondents viewed those with "troubles," alcohol dependence, or depression as able to make treatment decisions. Most reported that persons with alcohol or drug problems or schizophrenia cannot manage money and are likely to be violent toward others. Respondents indicated a willingness to coerce individuals into treatment. Respondent and other case characteristics rarely affected opinions.

Conclusions. Americans report greater concern with individuals who have drug or alcohol problems than with persons who have other mental health problems. Evaluations of dangerousness and coercion indicate a continuing need for public education. (*Am J Public Health.* 1999;89:1339–1345)

Modern public health laws dealing with mental disorders in the United States and in most other countries are premised on 3 core assumptions. The first assumption is that some (but not all) people with mental disorders are not competent to make autonomous decisions.[1] Laws have affirmed that people with mental disorders have the right to give or withhold consent for their treatment or to spend their assets as they wish. If their decision-making abilities are impaired, however, they may be declared legally incompetent. Some professionals claim that mental disorders almost invariably impair decision making sufficiently that people with such disorders should be considered legally incompetent.[2] Conversely, some patient advocates argue that all people with mental disorders are capable of making legally enforceable decisions about treatment and money.[3]

The second assumption animating modern public health law in this area is that mental disorders may place a person at increased risk of physically harming himself or herself or others.[4] In civil law, involuntary mental hospitalization is often predicated on clinical judgments as to whether the individual is "dangerous to self or others." In criminal law, involuntary treatment in a forensic hospital (e.g., for persons found "not guilty" by reason of insanity) turns on an assessment of undue violence risk.

The final core assumption in modern public mental health law is that coercion inherent in state intervention to redress incompetence or to reduce risk is justified.[5] Coercion plays a highly controversial role in the provision of mental health services. One set of empirical arguments revolves around the question of whether coercion "works," that is, whether any therapeutic outcomes produced by coerced treatment are offset by patients' becoming so alienated that they refuse to comply with treatments as soon as coercion is lifted. Recent studies have shown that more than a quarter of individuals using mental health services of one type or another report that they have been coerced into treatment either by legal means or by what they perceive as undue pressure from those around them.[6,7]

These 3 pivotal assumptions have been made by a small policy elite of legislators and judges on the basis of their perceptions of public concern. Yet, whether these perceptions are accurate remains in question. While there is some information available about how broadly the assumption regarding violence risk is shared by the general public,[8] there is no information available on how the general public views the competence of people with mental disorders to make various kinds of decisions and whether the use of legal means to coerce people into various forms of treatment is condoned. If public views regarding persons with mental illness motivate legal statutes and social practices involving those perceived as "disordered," then an examination of public opinion is critical to ongoing debates.[9]

In this article, we provide nationally representative data on the public's evaluation of the ability of persons with a wide range of mental health problems to meet daily challenges (i.e., money management and treatment decisions) and their likelihood of engaging in violence toward themselves or others. In addition, we discuss the public's willingness to use legal means to coerce individuals into a range of mental health treatments (e.g.,

Bernice A. Pescosolido and Saeko Kikuzawa are with the Department of Sociology, Indiana University, Bloomington. John Monahan is with the School of Law, University of Virginia, Charlottesville. Bruce G. Link and Ann Stueve are with the Joseph L. Mailman School of Public Health, Columbia University, New York.

Requests for reprints should be sent to Bernice A. Pescosolido, PhD, Department of Sociology, 744 Ballantine Hall, Indiana University, Bloomington, IN 47405 (e-mail: pescosol@indiana.edu).

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clinic visits, medication, hospitalization). Finally, we examine whether and how these opinions are socially patterned by assessing how the characteristics of the study respondents, the characteristics of the persons in the case examples, and the nature of the mental health problems described influence the public's evaluation of competence, dangerousness, and coercion. We expected that respondents' attitudes would be affected by the nature of the problem (e.g., type, severity) on which they were asked to comment as well as by their economic, political, and social position in their communities. By documenting the nature and correlates of public concern, we have, we hope, filled an important gap in social and legal policy regarding persons with mental health problems.

Methods

Survey Design

The General Social Survey, conducted since 1972 by the National Opinion Research Center at the University of Chicago, is designed to monitor the attitudes, beliefs, and behavior of the American people on critical social issues. This face-to-face survey involves a nationwide, representative sample of adults living in noninstitutionalized settings and uses a cluster sampling design. In recent years, the survey has appended a set of topic modules of particular policy interest. In 1996, a team of researchers developed the MacArthur Mental Health Module, "Problems in Modern Living," to document the public's view of individuals with mental health problems. The module targeted the following issues: recognition and knowledge of mental health problems, stigma, appropriate treatments, and financial responsibility. Most relevant to the results presented here, the module included a series of questions about competence, dangerousness to oneself or others, and the use of legal means to force treatment.

Because survey researchers have argued that generic questions about "mental illness" are less likely to elicit discriminating public responses, the team developed a set of vignettes based on criteria for diagnosing schizophrenia, major depression, alcohol dependence, and drug dependence (specifically cocaine) from the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*[10–12] and a "troubled" or "distressed" person vignette as a control case (see the Link et al. article in this issue for details[13]). Because responses to any particular person described in the vignette might be influenced by sociodemographic profile, we used a technique developed by Rossi and Nock[14] that varied key characteristics (gender, race/ethnicity, educational level) of the person across vignettes by means of a computer algorithm. Respondents randomly received 1 vignette and were asked to answer the same set of questions.

Every 2 years, the survey fields 2 independent, representative national samples. The Mental Health Module appeared on the survey for only one of these samples. The sur-vey was pretested in the summer of 1995 and administered face to face in respondents' homes from February to May of 1996. The response rate for the sample who were administered the survey on which the mental health questions appeared was 76.1% (n = 1444). Nonresponses were primarily refusals or "break offs" (interviews terminated before completion, 19.8%). Our analyses revealed that the vignettes generated predictable patterns of response, suggesting that the measures have construct validity.

Dependent Variables

Respondents were asked to evaluate the competence of individuals in the vignettes via the following 2 questions: "In your opinion, how able is [NAME] to make his/her own decisions about the treatment he/she should receive—very able, somewhat able, not very able, or not able at all?" and "In your opinion, how able is [NAME] to make his/her own decisions about managing his/her own money—very able, somewhat able, not very able, or not able at all?" In regard to dangerousness, respondents were asked the following 2 questions: "In your opinion, how likely is it that [NAME] would do something violent toward other people—very likely, somewhat likely, not very likely, or not likely at all?" and "In your opinion, how likely is it that [NAME] would do something violent toward him/herself—very likely, somewhat likely, not very likely, or not likely at all?"

In terms of coercion, individuals were asked to respond to a battery of items with the following introduction: "Some cities and states have laws that force people with problems like [NAME] into treatment. Do you think that people like [NAME] should be forced by law to . . ." The options, to which respondents could answer yes, no, or don't know, were (1) get treatment at a clinic or from a doctor, (2) take a prescription medication to control his or her behavior, (3) be admitted to a hospital for treatment, (4) be admitted to a hospital for treatment if he or she is dangerous to himself or herself, and (5) be admitted to a hospital for treatment if he or she is dangerous to others. For the multivariate coercion analysis, we also created a simple Likert scale of the sum of yes responses over the 5 possible options. Although about 100 responses were missing for some questions, there was no systematic difference in the characteristics of respondents and nonrespondents.

Independent Variables

To examine the contingencies of the public's evaluations, we evaluated 4 sets of characteristics: characteristics of General Social Survey respondents, characteristics of the vignette person, characteristics of the vignette problem (e.g., type of mental health problem), and characteristics evaluated by respondents (e.g., individuals' assessment of problem severity). We used both previous research and preliminary analyses to select possible correlates and present a final, parsimonious model.[15]

Respondent characteristics included race, sex, age, religion, residence, education, self-reported political views, and whether or not the respondents had themselves thought, at some time, that they had experienced a "nervous breakdown." Sociodemographic characteristics of the vignette person included sex, race/ethnicity, and education.

Because the multivariate analysis was pooled across vignettes, the types of mental health problems were constructed as a 4-category dummy variable set (schizophrenia, major depression, alcohol dependence, drug dependence; the "troubled person" vignette was omitted). In analyses in which competence and dangerousness were the dependent variables, we included respondents' assessments of problem severity and a dummy variable indicating whether they evaluated the problem as a mental illness. When coercion was the dependent variable, respondents' evaluations of competence and dangerousness were added as independent variables.

Data Analysis

Cross-tabular analyses are used to present the distribution of respondents' opinions on competence, dangerousness, and coercion by type of mental health problem. Chi-square tests provided an indication of whether opinions across problems were statistically significant. Ordinary least squares regression was used for ordinal dependent variables (e.g., competence, coercion), and logit regression was used for variables that were categorical (e.g., yes–no responses on coercion options). Unstandardized coefficients and standard errors are presented. Because significance is affected by sample size, we used stringent alpha levels (.01, .001).

Results

Competence and Dangerousness

How do Americans assess the abilities of and threats posed by persons with mental health problems? Table 1 presents the distri-

TABLE 1—Distribution of Public Views of Competence and Dangerousness, by Type of Mental Health Problem: 1996 General Social Survey

Item	Mental Health Vignette				
	Alcohol Dependence, %	Major Depression, %	Schizophrenia, %	Drug Dependence, %	Troubled Person, %
Ability to make treatment decisions[a]					
Very able	13.6	20.4	4.5	8.6	60.8
Somewhat able	34.9	43.3	21.2	19.3	32.3
Not very able	37.9	27.0	48.6	36.6	6.8
Not able at all	13.6	9.3	25.7	35.5	0.0
Ability to make money management decisions[b]					
Very able	9.6	21.6	6.4	2.4	63.8
Somewhat able	30.7	48.6	23.4	5.6	30.9
Not very able	43.3	25.5	44.3	35.2	5.3
Not able at all	16.3	4.3	25.9	56.8	0.0
Likelihood of doing something violent to others[c]					
Very likely	17.5	9.2	12.8	42.0	4.3
Somewhat likely	53.4	24.1	48.1	45.3	12.5
Not very likely	23.9	49.3	30.8	10.1	45.9
Not likely at all	5.2	17.4	8.3	2.5	37.4
Likelihood of doing something violent to himself or herself[d]					
Very likely	30.2	27.2	32.0	52.3	6.3
Somewhat likely	51.9	47.7	54.5	39.9	19.6
Not very likely	17.2	20.2	10.5	5.3	42.7
Not likely at all	0.8	4.9	2.9	2.5	31.4

[a] $\chi^2 = 513.6$ (12 *df*, $P \leq .01$), n = 1402.
[b] $\chi^2 = 797.4$ (12 *df*, $P \leq .01$), n = 1386.
[c] $\chi^2 = 460.2$ (12 *df*, $P \leq .01$), n = 1332.
[d] $\chi^2 = 468.9$ (12 *df*, $P \leq .01$), n = 1360.

bution of responses to issues of competence and dangerousness. For each of the 4 items reported, the χ^2 test indicates that respondents discriminated among different mental health problems. Almost all respondents viewed the troubled person as able to manage treatment decisions (93.1% viewed the person as very or somewhat able to do so). Almost two thirds reported that those with major depression could manage such decisions, and nearly half reported that those with alcohol dependence could do so. Only about a quarter of respondents indicated that those with drug dependence problems or schizophrenia are very or somewhat able to manage treatment decisions (27.9% and 25.7%, respectively). More than one third of respondents (35.5%) reported that individuals with drug problems serious enough to meet diagnostic criteria for drug dependence are "not at all able" to make treatment decisions.

Most respondents perceived those who were "troubled" to be competent to make money management decisions (more than 94% provided a response of very or somewhat able). In comparison with the area of treatment competence, a slightly larger percentage of respondents reported that those with depression (70.2%) or schizophrenia (29.8%) are competent to handle finances. There was almost a 10% drop, relative to ability to make treatment decisions, in the percentage of respondents who viewed those with alcohol dependence as very or somewhat able to manage money (40.3% and 48.5%, respectively). The biggest drop occurred for those meeting criteria for drug dependence. More than 90% of respondents believed that these individuals are not very able or not able at all to make money management decisions, as compared with just over 70% who indicated incompetence in the area of treatment decisions.

Americans continue to discriminate among different types of mental health problems regarding dangerousness. However, levels of concern are high. Almost 17% of the sample indicated that even the "troubled person" was either very or somewhat likely to do something violent toward others. That percentage rose to 33.3% for the depression vignette and to more than 60% for the schizophrenia vignette. A clear majority of respondents reported that individuals meeting criteria for alcohol problems (70.9%) or drug problems (87.3%) are very or somewhat likely to be violent toward others.

These percentages changed dramatically for the depression scenario when dangerousness to oneself was considered. Almost three quarters (74.9%) of the respondents indicated that an individual meeting criteria for major depression is either very or somewhat likely to do something violent toward himself or herself. Overall, levels of concern on this issue were quite high and showed at least some rise over the evaluation of violence toward others. More than one quarter (25.9%) of the respondents considered the "troubled person" to be very or somewhat likely to hurt himself or herself. The clear majority of respondents perceived that individuals with alcohol dependence (82.1%), schizophrenia (86.5%), and drug dependence (92.2%) are at risk for self-injury.

Coercion

To what extent is the public willing to use legal means to force individuals with a variety of mental health problems into a range of treatments? Table 2 presents the distribution of yes responses in regard to the use of the law to coerce individuals into seeing medical providers, using medications, and being hospitalized. There was clear discrimination by type of mental health problem described (for all of the χ^2 tests, $P <$ .01). When dangerousness to oneself or others was an issue (Table 2), respondents were almost uniformly in agreement with the

TABLE 2—Distribution of Public Views of the Need for Coercion Into Treatment, by Mental Health Problem: 1996 General Social Survey

	Mental Health Vignette						
	Alcohol Dependence, %	Major Depression, %	Schizophrenia, %	Drug Dependence, %	Troubled Person, %	χ^2	n
Visit clinic or doctor	39.3	21.6	49.1	67.3	6.7	254.7*	1347
Take prescription medication	24.5	24.3	42.1	36.8	9.7	84.54*	1342
Admit to hospital	40.7	24.3	44.5	65.8	10.1	204.66*	1341
Admit to hospital if dangerous to self	87.9	91.5	90.5	94.0	78.1	40.34*	1385
Admit to hospital if dangerous to others	93.4	94.4	94.8	95.5	82.8	42.28*	1393

*$P \leq .01$

need for coercion (e.g., even for the "troubled" person, 78.1% and 82.8% agreed with the use of legal means if he or she is viewed as dangerous to self and others, respectively). Respondents were slightly more likely to condone coercion if others, rather than the person himself or herself, are seen as in danger.

Responses with regard to alcohol and drug problems depended on the type of treatment suggested. In both cases, the percentage of respondents willing to force a person to take medication was noticeably lower regarding persons with substance abuse disorders (24.5% for alcohol abuse, 36.8% for drug abuse). About 40% of respondents were willing to use legal means for doctor or clinic visits and hospitalization for alcohol problems (39.3% and 40.7%, respectively). The most negative responses involved individuals with drug dependence problems. Two thirds of the respondents reported that coercion is justified to ensure that these individuals visit clinics or doctors (67.3%) or be hospitalized (65.8%). In findings not presented here, a clear hierarchy emerged in the Likert scale summing each respondent's positive answers. On average, of the possible 5 times, respondents were willing to use coercion 1.85 times for the troubled condition, 2.5 times for depression, 2.78 times for alcohol problems, 3.08 times for schizophrenia, and 3.5 times for drug problems.

Contingencies of Public Opinion on Competence, Dangerousness, and Coercion

Are there segments of the American population that respond differently to mental health issues? Table 3, which reports the results of multivariate analyses, suggests that in terms of competence and dangerousness, very few characteristics of either respondents or the vignette person mattered. For competence, only age significantly affected evaluations of either treatment or money management. Older respondents reported less faith in the ability of individuals with mental health problems to competently handle their important affairs. Finally, respondents with higher levels of education were less likely to report that those with mental health problems are dangerous to themselves or others and less likely to be willing to use coercion in general.

What appeared to be important were respondents' overall reactions to their assigned vignettes. As in the earlier bivariate analyses, for both competence and dangerousness, respondents reported less ability among all of the subjects whose cases met *DSM-IV* diagnostic criteria than for the one whose case did not (i.e., the "troubled person"). The only exception was in the case of depression with regard to the risk of violence toward others. Both an evaluation of greater severity and recognition of the vignette conditions as representing mental illness decreased evaluations of competence and increased perceptions of dangerousness.

The pattern of coefficients for the actual mental health problems described suggests a response hierarchy in which depression was associated with the least negative evaluation of competence and dangerousness. On the other end of the hierarchy, respondents reacted most consistently and negatively to those with drug problems. They were seen as the least competent, particularly in regard to financial issues. Furthermore, the effects of drug dependence on evaluations of dangerousness both to oneself and to others were the largest.

While respondents were less optimistic about the competence of individuals with schizophrenia, there was almost an equal impact on evaluations of dangerousness to oneself for schizophrenia and alcohol. However, respondents expressed a higher level of concern regarding the dangerousness of individuals with drug problems than of those with schizophrenia.

The last set of columns in Table 3 presents the analysis of the effects of characteristics of the respondent, the vignette person, and the case on the overall coercion scale. This scale has a higher value when the public is more willing to use coercion to move individuals into treatment. Overall, those with higher levels of education were significantly less likely to do so.

Respondents who received the drug vignette were significantly more likely to endorse coercion than those who reacted to the troubled person vignette. However, respondents were not more likely to report an endorsement of forced legal action for individuals with alcohol problems, depression, or schizophrenia (Table 3). More important to the respondents' reaction was their evaluation of how competent and dangerous to others the vignette person appeared. When respondents perceived less competence and greater potential danger to others, they were more likely to endorse coercion options.

Table 4, which presents analyses of respondents' willingness to use particular types of coercion, suggests 4 extensions of the findings in Table 3. First, respondents' willingness to use legal means to force a person into treatment tended to show the same effects for no religious affiliation and high educational status. This was not the case for respondents with no religious affiliation reporting on legal means for ensuring that individuals visited a doctor or clinic. However, the influence of sociodemographic characteristics disappeared once the coercion question referred to hospital care for those persons described as dangerous to themselves or others.

Second, there was a consistent impact of competence and dangerousness on using coercion for any treatment option. Respon-

TABLE 3—Ordinary Least Squares Regression of Characteristics Affecting Public Evaluations of Competence, Dangerousness, and Need for Coercion (Overall Scale) With Regard to Persons With Mental Problems: 1996 General Social Survey (n = 1283)

	Competence		Dangerousness		Coercion Scale, b (SE)
	Treatment Decisions, b (SE)	Money Management, b (SE)	To Self, b (SE)	To Others, b (SE)	
Characteristic of respondent					
Non-White	–0.07 (0.09)	–0.20 (0.08)	0.09 (0.08)	0.23* (0.08)	0.20 (0.10)
Female	0.10 (0.07)	0.01 (0.06)	–0.02 (0.06)	–0.09 (0.06)	–0.04 (0.08)
Age	–0.01** (0.002)	–0.01* (0.002)	–0.003 (0.002)	–0.003 (0.002)	0.002 (0.002)
Religion					
None	0.11 (0.12)	0.25 (0.11)	–0.03 (0.10)	–0.10 (0.11)	–0.31 (0.13)
Other	–0.04 (0.14)	0.06 (0.13)	–0.11 (0.13)	0.11 (0.13)	–0.09 (0.15)
Liberal Protestant	–0.10 (0.11)	–0.03 (0.10)	0.12 (0.10)	–0.03 (0.10)	0.15 (0.12)
Conservative Protestant	–0.01 (0.10)	–0.04 (0.09)	0.09 (0.09)	–0.04 (0.10)	–0.005 (0.11)
Other Protestant	0.13 (0.10)	0.14 (0.09)	0.06 (0.09)	0.06 (0.09)	0.08 (0.11)
Residence					
Suburban	–0.13 (0.08)	–0.07 (0.08)	0.14 (0.07)	0.07 (0.08)	–0.05 (0.09)
Rural	–0.10 (0.13)	–0.21 (0.12)	0.05 (0.11)	0.13 (0.12)	–0.13 (0.14)
Education	0.005 (0.01)	0.002 (0.01)	–0.05** (0.01)	–0.06** (0.01)	–0.04* (0.01)
Political views (liberal)	–0.004 (0.03)	–0.01 (0.02)	0.02 (0.02)	–0.003 (0.02)	0.03 (0.03)
Nervous breakdown	0.13 (0.08)	0.06 (0.07)	0.10 (0.07)	–0.01 (0.07)	0.07 (0.08)
Characteristic of vignette person					
Female	–0.06 (0.07)	–0.04 (0.06)	–0.01 (0.06)	–0.37** (0.06)	–0.002 (0.07)
Black	0.05 (0.08)	0.01 (0.07)	0.01 (0.07)	–0.06 (0.08)	0.04 (0.09)
Hispanic	–0.05 (0.08)	–0.11 (0.07)	0.11 (0.07)	–0.02 (0.08)	–0.03 (0.09)
Less than high school education	–0.07 (0.08)	–0.10 (0.07)	0.08 (0.07)	–0.10 (0.08)	–0.06 (0.09)
College education	0.02 (0.08)	0.14 (0.07)	–0.17 (0.07)	–0.17 (0.08)	–0.06 (0.09)
Characteristic of case					
Alcohol	–1.00** (0.15)	–1.25** (0.13)	1.03** (0.13)	1.08** (0.13)	0.12 (0.16)
Depression	–0.65** (0.14)	–0.51** (0.12)	0.83** (0.12)	0.16 (0.12)	0.05 (0.15)
Schizophrenia	–1.56** (0.15)	–1.49** (0.13)	0.97** (0.13)	0.71** (0.14)	0.30 (0.17)
Drugs	–1.64** (0.15)	–2.33* (0.14)	1.40** (0.13)	1.64** (0.14)	0.62** (0.18)
Severity	–0.24** (0.06)	–0.28** (0.05)	0.29** (0.05)	0.19** (0.06)	0.15 (0.07)
Mental illness	–0.24* (0.08)	–0.26** (0.07)	0.37** (0.07)	0.31** (0.07)	0.21 (0.08)
Competence					–0.17** (0.03)
Dangerousness					0.16** (0.03)
α	5.31	5.52	2.16	2.71	2.32
F[a] (R^2)	25.54 (0.33)	48.42 (0.48)	27.27 (0.34)	26.94 (0.34)	14.28 (0.23)

[a]$P \leq .001$ for all F tests.
*$P \leq .01$; **$P \leq .001$.
Note. All dependent variables are dummy variables except age (years), political views (coded from low to high), severity (coded from low to high), competence (coded from 1 to 4, not able to very able), and dangerousness (coded from 1 to 4, not likely to very likely).

dents' perceptions of less competence and greater dangerousness increased the probability of their answering yes to most types of coercion, with the exception of forcing medication (Table 4).

Third, there was an impact of severity and the sense that the case described a mental illness only rarely when particular options were offered. Respondents who agreed that the case represented a mental illness were significantly more likely to endorse only legal means for ensuring that individuals visited a doctor or clinic. Those who rated a case as more serious or who were older were more likely to be willing only to force persons to take medications.

Fourth, respondents did not appear to differentiate among mental health problems regarding forcing medications against a person's will, as indicated by the lack of statistical significance for vignette type (Table 4). Respondents did not appear to endorse coercion into any treatment for those meeting criteria for depression. However, respondents evaluating the alcohol, schizophrenia, and drug scenarios were significantly more likely to agree to use coercion for doctor or clinic visits.

Discussion

Analyses from the 1996 General Social Survey suggest that Americans hold a relatively complex view of issues of competence, dangerousness, and coercion. They clearly differentiate on these issues by the severity they attribute to the scenarios, and they embrace traditional legal notions of "danger to self or others" in making assessments. However, the negative attitude associated with mental illness continues. After control for the nature of the problem and evaluation of case severity, respondents reported less competence and increased expectations of violence if they labeled the vignette person as having a mental illness. The equivocal findings on depression may suggest that the public has more compassion for those with depression, has greater personal experience with depression (given its prevalence), or continues not to recognize depression as a mental health problem despite widespread educational efforts. Finally, the extremely negative reactions to those with alcohol and drug dependence problems reflect Americans' widely reported fear of substance dependence.[16]

How accurate are Americans' perceptions regarding the competence and dangerousness of persons with mental illness? Com-

TABLE 4—Logistic Regression of Characteristics Affecting Public Willingness to Use Coercion in the Case of Persons With Mental Problems, by Type: 1996 General Social Survey

	Doctor or Clinic, b (SE)	Prescription Medication, b (SE)	Admit to Hospital, b (SE)	Hospitalization If Dangerous to Self, b (SE)	Hospitalization If Dangerous to Others, b (SE)
Characteristic of respondent					
Non-White	0.53* (0.18)	0.38 (0.19)	0.44 (0.18)	–0.01 (0.26)	–0.23 (0.29)
Female	0.05 (0.14)	–0.06 (0.14)	–0.08 (0.14)	–0.001 (0.19)	–0.25 (0.23)
Age	0.003 (0.004)	0.02** (0.004)	0.005 (0.004)	–0.01 (0.01)	–0.01 (0.01)
Religion					
None	–0.26 (0.24)	–0.92* (0.29)	–0.82* (0.25)	0.09 (0.31)	–0.03 (0.35)
Other	–0.30 (0.29)	0.02 (0.29)	–0.20 (0.28)	–0.35 (0.35)	–0.19 (0.43)
Liberal Protestant	0.45 (0.22)	–0.004 (0.23)	0.25 (0.22)	0.05 (0.28)	0.32 (0.35)
Conservative Protestant	–0.14 (0.21)	–0.07 (0.21)	–0.07 (0.20)	0.28 (0.28)	0.23 (0.32)
Other Protestant	0.12 (0.21)	0.01 (0.21)	–0.27 (0.20)	0.35 (0.28)	0.74 (0.35)
Residence					
Suburban	–0.33 (0.17)	–0.31 (0.17)	0.03 (0.17)	0.05 (0.22)	0.01 (0.27)
Rural	–0.13 (0.27)	–0.12 (0.27)	0.07 (0.27)	–0.27 (0.34)	–0.56 (0.38)
Education	–0.08** (0.03)	–0.08* (0.03)	–0.08** (0.03)	–0.05 (0.03)	–0.003 (0.04)
Political views (liberal)	0.05 (0.05)	0.06 (0.05)	0.02 (0.05)	0.07 (0.07)	0.12 (0.08)
Nervous breakdown	0.03 (0.15)	0.03 (0.15)	0.13 (0.15)	0.29 (0.20)	0.20 (0.24)
Characteristic of vignette person					
Female	–0.003 (0.14)	–0.24 (0.14)	–0.15 (0.14)	0.20 (0.18)	0.30 (0.22)
Black	0.13 (0.17)	0.13 (0.17)	0.09 (0.16)	0.01 (0.22)	0.02 (0.26)
Hispanic	0.09 (0.17)	0.11 (0.17)	0.01 (0.16)	0.15 (0.22)	0.17 (0.26)
Less than high school education	0.03 (0.17)	–0.08 (0.17)	–0.06 (0.16)	0.07 (0.22)	–0.06 (0.25)
College education	0.03 (0.17)	–0.13 (0.17)	–0.18 (0.17)	0.06 (0.22)	0.33 (0.27)
Characteristic of case					
Alcohol	1.27** (0.37)	–0.06 (0.36)	0.75 (0.34)	–0.30 (0.37)	–0.25 (0.45)
Depression	0.60 (0.36)	0.28 (0.33)	0.30 (0.32)	0.19 (0.33)	0.14 (0.39)
Schizophrenia	1.45** (0.37)	0.69 (0.35)	0.73 (0.34)	–0.41 (0.38)	–0.22 (0.45)
Drugs	2.19** (0.39)	0.36 (0.38)	1.49** (0.36)	–0.07 (0.44)	–0.35 (0.51)
Severity	0.20 (0.14)	0.48* (0.15)	0.23 (0.14)	0.08 (0.15)	0.22 (0.17)
Mental illness	0.44* (0.16)	0.24 (0.16)	0.12 (0.16)	0.25 (0.21)	0.39 (0.25)
Competence	–0.18** (0.05)	–0.14 (0.06)	–0.29** (0.05)	–0.37** (0.08)	–0.25* (0.10)
Dangerousness	0.23** (0.06)	0.20* (0.06)	0.20** (0.06)	0.24*(0.08)	0.27* (0.10)
α	–2.28	–2.98	–1.18	2.63	1.26
χ^{2hra}	333.83	187.65	293.88	84.83	71.46
n	1259	1258	1254	1257	1257

Note. All dependent variables are dummy variables except age (years), political views (coded from low to high), severity (coded from low to high), competence (coded from 1 to 4, not able to very able), and dangerousness (coded from 1 to 4, not likely to very likely).
[a]$P \leq .001$ for all χ^2 tests.
*$P \leq .01$; **$P \leq .001$.

paring our findings on public perceptions with existing data on the actual behavior of individuals with mental health problems offers an interesting contrast. Grisso and Appelbaum's[17] recent landmark study evaluated the competence of individuals with schizophrenia and major depression to make treatment decisions. Here we found that respondents correctly differentiated between these 2 disorders in terms of the relative degree to which they reported that decision making for treatment is impaired, with schizophrenia being associated with greater impairment. Grisso and Appelbaum found that just over half (52%) of persons with schizophrenia and less than one quarter of those with major depression were "impaired" on at least 1 of the standards for competent decision making.

In terms of the risk of violence to others associated with mental disorders, the general public is also accurate about the relative risk posed by people in different diagnostic groups. Steadman et al.[18] recently reported that persons discharged from acute psychiatric facilities who had a co-occurring diagnosis of alcohol or drug dependence posed a much greater risk of violence to others than those discharged without such a profile. The Steadman et al. study reported relatively few individuals (17.9%) with a major mental illness but no co-occurring disorder as being involved in violent behaviors toward others. With regard to the effects of drug and alcohol dependence on violence, they found that the rates of violence were 31.1% among individuals with a major mental disorder and co-occurring diagnosis of substance dependence and 43% among those with some other mental disorder diagnosis (e.g., a personality or adjustment disorder) and a co-occurring substance dependence diagnosis.

Finally, 3 issues stand out with regard to coercion. First, the public appears to be as ambivalent as policymakers about the use of legal force to ensure that individuals receive mental health treatment. Coercion is more readily endorsed by Americans for those with schizophrenia than for those with major depression. Second, the public is much more likely to endorse coerced treatment for persons with drug dependence problems than for those with any other diagnostic profile. More than two thirds of the respondents in this study endorsed forced visits to clinics or hospitalization. Third, any ambivalence of Americans is resolved when the profile includes an element of danger to self or others. Such a description produces nearly unanimous endorsement of legal means to force hospitalization. Indeed, in the absence of any diagnosis at all, more than three quarters of Americans favor coerced hospitalization if the

"troubled" person is dangerous to himself or herself or to others.

These findings suggest a certain knowledge and complexity on the part of the American public and a congruence with what motivates public health laws. However, the General Social Survey results also continue to reflect an underlying negative attitude toward persons with mental health problems, an exaggeration of the impairments or "threat" associated with these disorders, and a startling negativity toward individuals with substance dependence problems. Furthermore, these opinions do not appear to reside within any particular sociodemographic group; rather, they indicate a widespread reaction to mental health problems. Future research and outreach and policy efforts should consider the challenges posed by the public's response to mental illness and substance dependence problems. □

Contributors

B. A. Pescosolido and B. G. Link conceptualized the larger study, designed the special Mental Health module in the 1996 General Social Survey, and took major responsibility for the analytic plan and writing of the paper. J. Monahan and A. Stueve worked on the design of the module and provided guidance for the analyses; J. Monahan assisted in the writing of the first draft, and both revised the paper. S. Kikuzawa, with B. A. Pescosolido, was responsible for most of the analysis and interpretation; S. Kikuzawa also revised the paper. All authors have approved the final version of the paper.

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