

**Report from the Force and Coercion Plank  
National Summit of Mental Health Consumers and Survivors  
Portland, Oregon  
August 27 and August 28, 1999**

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Panelists: David Oaks, Bob Bernstein  
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**Introduction:**

The group decided to consider the subject of force and coercion as it applied to several specific areas rather than as a broad issue.

Following the educational session, Sally Zinman began by giving background on the proposal for the expansion of forced treatment in California, which includes an array of areas, including loosening of commitment criteria, expansion of the number of days that someone could be held, a decrease in the standards of proof, and a reduction in the number of hearings. After some discussion, the question became not "Are there any circumstances under which forced treatment might be justified?" but whether the criteria for forced treatment should be expanded.

The group reached some degree of consensus on all the issues covered.

**I. EXPANSION OF FORCED TREATMENT, INCLUDING INVOLUNTARY OUTPATIENT COMMITMENT**

After some discussion, there was consensus that everyone opposed expanding forced treatment, including involuntary outpatient commitment. Outpatient commitment was defined as using a court order to force someone to undergo treatment not in a hospital but in his or her community, under threat of inpatient commitment if the individual did not comply with the court order.

Consensus was reached on the following:

- Outpatient commitment would not be necessary if there were appropriate community services available.
- Forced treatment drives people away from seeking voluntary treatment.
- Studies have shown that outpatient commitment has no positive value; what does make a difference is getting appropriate services.
- It is cheaper to put money into community services than to put it into the enforcement of outpatient commitment laws.
- People diagnosed with mental illnesses should have a voice in their own treatment.
- Choice is essential for recovery.
- Using violence as an argument for expanding forced treatment and outpatient commitment is wrong; every study shows that, absent drugs and alcohol, people with mental illness are no more violent than any other group of people.

**ACTION PLANS**

- Education

- Outreach to other groups
- Work to interest the media in this issue.
- Explore the possibility of a national Underground Railroad to move people out of states with outpatient commitment laws to places where supports, including housing and food, would be available.

## II. ELECTROSHOCK (ECT)

The group discussed two issues: whether forced electroshock should be allowed, and whether voluntary electroshock should be available. The group was in complete agreement that there should not be forced electroshock. The group was in complete agreement that shock treatment should be banned for people under 18 years of age. All but one individual felt that electroshock should not be available even on a voluntary basis. That person felt that, in the future, experts on both sides of an issue should be present in a group discussion such as the Summit plank sessions; in this case, the most knowledgeable person at the sessions was someone opposed to electroshock.

### ACTION PLANS

- Work to achieve a ban on electroshock for children and adolescents under 18.
- Work to achieve passage of an ECT reporting law, including information on outcomes.
- Work to develop an accurate and complete Informed Consent Form.
- Go after the Food and Drug Administration regarding having the electroshock machine investigated, and go after Congress about this issue. There should be a special emphasis on electroshock as it affects the geriatric population.

## III. ADVANCE DIRECTIVES

The session began with a general discussion in which people shared their knowledge, gained through their experience with advance directives in their own states.

### CONSENSUS

The consensus was that consumers/survivors should be working for the creation of a standardized national psychiatric advance directive.

### ACTION PLANS

- Work for uniform national laws governing advance directives so that consumers/survivors can write advance directives that will be recognized in other states besides their state of residence. This will protect people as they travel beyond their home state.
- Have protection and advocacy agencies monitor hospitals to make sure they are honoring advance directives.
- Work for education and training so that hospital staff understand what advance directives are and what they mean.

## IV. FORCED TREATMENT

The session began with a lengthy discussion of the issue, including suggestions that people should address forced treatment issues when they are able to do so, before they find themselves in a position to be involuntarily committed; that there should be no expansion of forced treatment; that forced treatment should be avoided as much as possible; that, if used, forced treatment should be done with respect for people's rights; and that all forced treatment should be stopped. At this time there was a call for a vision statement, which resulted in the following:

We have a vision: we will work toward a future where all the needs of a person with a psychiatric disability can be truly met in the community, gently, supportively, and holistically. There would be no more need, real or perceived, for forced treatment.

## V. RIGHTS PROTECTION AND CONFIDENTIALITY

This discussion focused on concerns by people about the privacy of their own records and their ability to access them when needed.

### CONSENSUS

- An individual has a right to access his or her own medical records at a reasonable cost and in a timely manner.
- An adult individual has an absolute right to control access to his or her records by others.
- Managed care companies should provide written, detailed information about what records will be shared and with whom.

## VI. SECLUSION AND RESTRAINT

The discussion began with two questions: "Should restraints be available as an option?" and "Are there alternatives?"

The facilitator's belief is that the only time seclusion or restraint should be employed is when an individual requests it. Another person felt that the movement should work toward a policy of zero involuntary restraint and seclusion, keeping in mind that it would take time to effect this change. Any exception would have to be justified as a medical emergency.

### CONSENSUS STATEMENT

Within a two-year period of the adoption of this plank, all institutions will establish a zero involuntary restraint and seclusion policy. This two-year period will allow institutions to change their culture, increase their staffing, enhance their supportive services or take whatever steps are necessary to create a safe and therapeutic environment. Under a zero restraint policy, all incidents of restraint and seclusion must be demonstrated as medical emergencies.

In the meantime, we support the new federal regulations on seclusion and restraint, including but not limited to the modifications recommended by the Bazelon Center. These are (in paraphrased form)\*:

- Seclusion or restraint should only be ordered by a physician, after a medical examination.
- Restraint of an adult should only be permitted for up to one hour, subject to renewal if the individual is still agitated
- Strict standards should be set for children, such as eliminating the use of seclusion and restraint for youngsters who are not posing an immediate physical threat, based on their age and weight and with prohibitions on certain types of restraints for children.
- The rules should not permit the use of seclusion and restraint simultaneously (especially for children under nine).
- Monitoring should mean requiring checks every 15 minutes and vital sign readings every two hours, with written documentation of such checks in medical records.
- Staff should be required to work actively with the individual to assist him in regaining control or to explain what he can do for the seclusion or restraint to end.

\* See [www.bazelon.org](http://www.bazelon.org) for specific information on the federal rules and the modifications suggested by Bazelon.