3. Force and Coercion

ISSUE:

Perhaps the most controversial and divisive issue in the mental health community — including among family groups, providers, consumers/survivors, and citizen advocacy groups — is whether people diagnosed with mental illness should be treated, or even held in "custodial" care, against their will. On one side are those who would outlaw the use of force and coercion completely because forced treatment opens the door to abuse and dangerous interventions, creates distrust and avoidance of even voluntary treatment, violates basic civil and constitutional rights, and erodes self-determination, which is essential to recovery. Individuals on the other side of the issue run the gamut from those who believe that coercion is justified under extreme circumstances — when a person is demonstrably dangerous to himself/herself or others — to those who believe that commitment laws should be expanded to allow force based on a broad and subjective range of criteria.

BACKGROUND:

Some 30 years ago, when people who had psychiatric histories began to organize a movement for social justice, a primary organizing principle was opposition to the use of force and coercion and support for self-determination.

By the early 1980s, the movement began to mainstream, reaching out to the countless recipients of mental health services who had never heard of the "mental patient's" movement. Among this new constituency were people who felt that they may have benefited from treatment that had been forced on them. Therefore, they were hesitant to take a position that was categorically opposed to all use of force and coercion.

At the 1988 Alternatives Conference in Utah, for the first time there was a formal, public debate among consumers/survivors about forced treatment. Many believe that there is a schism in the movement traceable to the differences of opinion on the use of force and coercion.

There are a number of topics that naturally fall under a discussion of force and coercion. On some of these topics there appears to be consensus in the movement, on others disagreement. The topics include:

- **Involuntary commitment**
  There is common feeling in the movement that force and coercion are indicative of failed treatment, are generally harmful and counterproductive, and should be avoided. Within these parameters, there is some disagreement. Some believe that no one should ever be committed against their will, and that "involuntary treatment" is an oxymoron. Others believe that people may be held against their will under extreme circumstances to prevent them from doing harm to themselves or others, but only based on behavior demonstrating an immediate threat of such harm. Many of the latter group believe that such involuntary intervention must consist only of custodial care.

- **Involuntary outpatient commitment**
  The movement appears to be united in its opposition to outpatient commitment, which involves forcing people with psychiatric diagnoses who are living in the community to accept mandatory treatment, including forced drugging. This is ordered under threat of inpatient commitment if the individual does not comply. The court-ordered person is on a kind of probation conditional on certain behavior, like a criminal offender. The criteria used to determine when someone can be committed on an outpatient basis are often much less stringent, and far less objective, than the inpatient commitment criteria. This means that individuals are at risk of losing their rights often due only to the fact that they are diagnosed with a mental illness and refuse treatment that they believe is not helpful and perhaps even hurtful.

- **Expansion of forced treatment**
  The movement appears to be united in its opposition to a trend in the country to expand the ability to commit, or force treatment on, persons diagnosed with a mental illness. This trend includes outpatient commitment, but is not limited to it. It includes loosening commitment standards to include a broad and subjective range of criteria, extending the time that people may be held against their

will, reducing due-process rights during commitment procedures, and reducing the standards of proof for commitment. States around the country are initiating or considering legislation to do some or all of the above. Movement activists are alarmed and view this as a substantial threat to the rights they have fought for and won in the last 30 years.

- **Electroshock (ECT)**
  At Alternatives '89 in South Carolina, the consumer/survivor movement adopted a resolution calling for (1) a ban on forced shock treatment (ECT), (2) truly informed consent on ECT, and (3) the creation of a range of alternatives to ECT. This still appears to be the opinion of most of the consumer/survivor movement, since it can be embraced both by people who believe that ECT causes brain damage and those who believe ECT may be helpful. However, there are those in the movement who think ECT should be banned altogether.

- **Advance directives (to prevent force and coercion)**
  The movement is supportive of advance directives, which are a way to specify, in advance in writing, how people want to be treated if illness, including mental disability, makes them incapable, or deemed to be incapable, of making choices. There are two major forms of advance directives: a durable power of attorney for health care, also known as a proxy, which names a person (and a backup, if someone wishes) who is legally empowered to act as the person's agent for treatment decisions when they are deemed unable to make such decisions for themselves. There is also an instruction directive — "a living will" — which is a written document that states, in advance, what treatments someone would accept and what they would refuse at a point that they are deemed legally incapacitated to state their choices. Some people are concerned that advance directives can be misused as a way of decreasing a person's choice if they are entered into under coercive circumstances, if the wrong person is an agent for treatment decisions, or if the "living will" is difficult to change. Therefore, it is important to make sure that safeguards are in place so that this is an individual's free and informed choice.

- **Seclusion and restraint**

  There appears to be consensus in the movement that the practice of seclusion and restraint should be outlawed. This issue has been in the public eye in the last few months, due to a series in the Hartford Courant about people who had died or been injured while in restraints. The media spotlight led to the drafting of federal legislation to govern the practice. A question remains as to whether there should be voluntary restraint and seclusion, i.e., restraint and seclusion when requested.

The movement is united in its belief in the vital importance of rights protection and increasing these protections (including the right to refuse), as well as informed consent, confidentiality and privacy.

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FACILITATOR:

Sally Zinman is executive director of the California Network of Mental Health Clients, a statewide self-help and advocacy organization that she helped found in 1983. Active in the self-help movement for more than 25 years, she is the co-founder of the Coalition for Alternatives in Mental Health, also known as the Berkeley Drop-In Center, which provides a range of services for people with mental disabilities. Sally has served on many boards and advisory councils and has written extensively about consumer and survivor issues. She has received many awards and commendations for her work on behalf of mental health clients.