

FORCE IN MENTAL HEALTH SERVICES: INTERNATIONAL USER / SURVIVOR PERSPECTIVES

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EXPLANATION OF TERMS

Force. *A user / survivor movement term for compulsory interventions by mental health services that are allowed by the law.*

User (or consumer). *A person with experience of using mental health services who believes there should be a reduction in compulsory interventions.*

Survivor. *A person with experience of using mental health services who believes there should be an end to compulsory interventions.*

INTRODUCTION

In many countries of the world a heated and polarising debate periodically surfaces in mental health circles. This debate raises fundamental questions about human rights, duty of care, individual responsibility, the nature of mental illness and the purpose of mental health services. It has been particularly heated in the last 30 years since the rise of the user / survivor movement, and has created huge tensions between different stakeholder groups. This debate has also been responsible for a rift within the user / survivor movement in parts of the northern hemisphere. The issue at stake has even led a small number of survivors to consider the possibility of carrying out terrorist acts.

I'm of course referring to the issue of whether or not we can justify the legalised use of force by mental health services on some people diagnosed with a mental disorder who have not committed a crime.

The stakeholders who dominate this debate, such as mental health professionals, politicians and families tend to support and promote the legalised use of force. Their views are well known, well documented and well reflected in laws around the world that allow for compulsory intervention. But the views of users and survivors who want to see less or no force are relatively marginalised. As yet our views have not exerted any major influence on thinking, legislation or practice. This needs to change.

This paper is an attempt to bring the perspectives of users and survivors to the centre of the debate on force. It's possible that this paper doesn't pick up all the varieties of user and survivor views of force. I have done the best I can with a body of knowledge that is informal and not fully documented.

Part 1 explains how users and survivors experience force and what our positions are on it. Part 2 looks at the recovery values and practices in mental health service systems that could reduce or end the use of force.

PART 1: USER AND SURVIVOR PERSPECTIVES ON FORCE

Shared experiences of force

Millions of users and survivors throughout history and across cultures have in common the violating experience of force. Alexander Cruden in 1739 wrote the first known account of force on the grounds of madness in the English language. He said it was done to him 'in a most unjust and arbitrary manner'. John Percival in 1838 described his own, and others' experience of force as 'injudicious conduct pursued towards many unfortunate sufferers'. Elizabeth Packard in 1868 wrote about her 'hidden life' as a 'prisoner' inside an insane asylum. (Peterson 1982, Porter 1996)

The 20th century did not bring much more justice. In that century millions of people were confined and forcibly treated in psychiatric institutions for much of their lives. Over two hundred thousand people with various mental disorders were detained and killed by the Nazis in cooperation with mental health professionals. Later in the 20th century Soviet and Chinese psychiatrists forcibly detained and treated political dissidents. Mental health professionals and human rights activists in the west who objected this failed to see the same injustice being perpetrated against ordinary users and survivors in their own countries.

The saga goes on into the 21st century when we find that on this day millions of citizens in many countries have lost the freedom to decide where to live and whether or not to accept psychiatric treatments. At this moment users and survivors in countries as diverse as Japan, Mexico, Zambia, Germany, Australia and the United States are experiencing force and feel violated by it.

The user / survivor movement

History

There was no collective service user voice to speak out against force until the beginnings of the user / survivor movement in coastal America and northern Europe in the early 1970s. The early movement focused its attention on ending the use of force in psychiatry. As the movement grew in the 1980s, the

early activists were joined by users and consumers who saw some benefit in mental health services and wanted to reform them. Some of them voiced their belief that some forms of force can be beneficial in a few circumstances.

Influences on the user / survivor movement

The user survivor movement does not sit in a cultural vacuum. Over the last 30 years many ideologies, movements and intellectual trends have influenced the user / survivor movement's stand on force. It started as a liberation movement on the same historical wave that carried other movements of that era – women's liberation, gay liberation and civil rights – in which the oppressed claimed their right to self-determination. At this time anti-psychiatry gave users and survivors an intellectual critique of the foundations of psychiatry, particularly the bio-medical model. In North America the movement was no doubt influenced by the libertarian view that the state should not take responsibility for the lives of individuals. Consumerism has added fuel to the reformist end of the movement by validating their claim to rights as customers.

Users and survivors have drawn on international human rights agreements, including the legally binding International Bill on Human Rights. The Bill states that no one shall be subjected to torture or cruel, inhuman or degrading treatment or punishment, and that everyone has the right to freedom of movement, to freedom of thought, and to freedom of opinion and expression. Force in psychiatry, they say, violates all these articles.

The general disability movement's social model of disability asserts it is society, not the impaired individual, that disables people. This resonates strongly with users and survivors. In recent years disability scholars and activists have added a post-modern analysis to their discourse. Reality and truth they say are uncertain, ambiguous, contextual and subjective. Disciplines such as psychiatry are based on the post-enlightenment platform of reason, science and grand theories. Post-modernism strips psychiatry of any monopoly on knowledge it may have once enjoyed. Also, in recent years some survivors have made important links with the anti-globalisation movement, out of their concern about huge multi-national drug companies and the spread of western psychiatry into low-income countries.

User and survivor positions on force

Users and survivors are not entirely in agreement on the issue of force. However, their views tend to be clustered towards the little or no force end of the spectrum.

Some survivors believe that all compulsory treatment is wrong and further that all compulsory detention is wrong, except for people who have committed a serious crime that would normally require detention.

Users tend to believe that compulsory detention can be justified under narrow conditions. However, many users believe there should be no compulsory treatment because it violates a even more fundamental right than the right to freedom of movement. Compulsory treatment sets out to control who you are, whereas compulsory detention merely controls where you are.

There appears to be universal user and survivor opposition to compulsory treatment in the community, and to the use of seclusion and physical restraints.

Everyone in the user / survivor movement would like to see at the very least a reduction in the use of force, according to the following principles:

Stricter criteria

The criteria for force, if any, should be serious and immediate or demonstrated danger to self or others. But most jurisdictions have much broader criteria than this, particularly laws that allow for compulsory treatment in the community. Most people would find it hard to imagine someone who meets the criteria of danger to self or others not needing to be in a protected environment. Because of this the criteria for force have been broadened in some jurisdictions to allow for compulsory treatment in the community.

Even when laws have relatively narrow criteria, practice suggests that the decision to compulsorily treat in the community involves a de facto broadening of these criteria. For example in a recent New Zealand survey (Dawson et al, 2002), psychiatrists and community mental health professionals were asked to rate the factors that influenced their decision-making concerning the use of community treatment orders. The most important factors were to ensure – contact with professionals, authority to treat the patient, rapid identification of relapse, compliance with medication, and so on. The factors in their decision making that most closely resembled the criteria in the Mental Health Act – to reduce the risk of self-harm and violence to others – came well down the list at nine and ten of twelve factors.

Emergency only

Force should only ever be an emergency intervention, only for as long as serious and immediate or demonstrated danger lasts. It should not be used to prevent future emergencies, enforce compliance or keep track of people. Much current mental health legislation, particularly those that allow compulsory treatment in the community can extend the use of force on individuals for months and years.

After the fact

Force should not be used for preventive detention or treatment for someone who is considered at risk of committing a crime but has not done so yet. This cannot happen in the criminal justice system and it is a double standard to allow it in the mental health system. Furthermore, psychiatrists acknowledge that they cannot predict violence with any certainty. User / survivor views are more divided on the compulsory detention of actively suicidal people. Some of the more libertarian people in the movement believe that the compulsory detention of suicidal people is never justified, but others see a role for brief compulsory detention for people who are in serious and immediate danger of killing themselves.

Maximum freedom and choice

Force should happen in the freest environment possible where people can experience safety without the threat of forced treatment, seclusion or restraints. Hospital settings do not offer this amount of freedom and choice. It's important that people subject to force should be offered genuine choices over the standard hospital and medication regime.

Last resort

Force should only be used after all other options have been made available, tried or considered.

Due process

Force should be regulated by a process where people are treated with respect and have access to legal and other forms of advocacy. Rights protections and advocacy processes in mental health legislation must be upheld – too often they are not.

Users and survivors on the assumptions underlying force

There are two core assumptions that provide justification for force in psychiatry (Carpenter, 2002). The first is the assumption that people with serious mental distress lose the competence take responsibility for their lives. The second is the assumption that mental health services are helpful to these people. Both these assumptions operate in a context where the bio-medical model is used to explain and treat mental health problems. The user / survivor movement has challenged these two assumptions and the bio-medical model because together they help to pave the way for the use of force by mental health services.

Loss of personal responsibility

In its purist form the bio-medical model of mental illness, more than psychosocial models, views people as victims of a pathology that weakens or destroys their free-will and personal responsibility. Service users are therefore unable to know what is best for them and need professional experts to act in their best interests. Their refusal to take treatment or use services is

viewed as a sign of their incompetence and illness rather than as a reasonable choice.

Helpfulness of mental health services

Compulsory interventions need to be viewed as helpful in order to justify them. However, the experience of users and survivors subject to force often doesn't support that view. They may experience compulsory interventions such as anti-psychotics, ECT, forced detention, seclusion and restraints as damaging to them. It's widely known that only around two-thirds of people will benefit from most psychiatric drugs. Even those who benefit from drugs may experience the adverse effects as outweighing the beneficial effects.

Users and survivors on the precipitants of force

Users and survivors have identified several conditions within the mental health system and wider society that can directly or indirectly encourage the use of force.

Institutional service philosophy

The ethos of institutionalised mental health services goes hand in hand with the use of force. These kinds of services are still common in community as well as institutional settings. They are characterised by paternalism over partnership, the dominance of the bio-medical model, the diminishing of individual service user responsibility, and the expectation of chronicity over recovery. There is also a tendency in these services to not take patients' rights or informed consent at all seriously.

Lack of advocacy

All service systems, especially those with the potential to hinder freedom need both systemic and individual advocacy to challenge the removal of rights. When advocacy is non-existent or weak, when no-one is wholeheartedly accepting and promoting the point of view of service users, force is bound to proliferate.

Service failures

Users and survivors are rightly critical of the day-to-day conditions in mental health services that encourage the use of force. Sometimes the decision to use force can be traced back to bad practice or service failures such as:

- the failure to support people so they can avoid crisis
- the lack of attention given to negotiating with service users about what to do in future crises
- the inability of professionals to get access to scarce acute beds unless service users are subject to compulsory assessment or treatment
- the lack of alternative treatment and residential options for people in crisis which means the professional has nothing to negotiate with the person in crisis apart from drugs and hospital.

Community paranoia

Community beliefs and expectations also precipitate the use of force. Community beliefs connecting mental illness and violence, put pressure on politicians, bureaucrats and psychiatrists to increase the use of force. In addition to this the wider community abdicates all responsibility to mental health services for keeping so-called dangerous people with mental illness off the streets. These pressures create a more risk averse culture in mental health services than is necessary or desirable. Professionals, in response, err on the side of using force, to ward off a media frenzy or a damning inquiry.

Users and survivors on the consequences of force

There is wide agreement among users and survivors that the use of force can have overwhelming negative consequences that outweigh any possible benefits. These consequences are a very high price to pay for any service system and society that gears itself to recovery.

No improvement in outcomes

Users and survivors often argue that force doesn't improve outcomes. For instance, there is no convincing research evidence to confirm the efficacy of forced treatment in the community. In a controlled study in New York City, those subjected to outpatient committal were compared with voluntary service users who were offered access to the same intensive services. Outpatient committal brought no additional improvement in 'compliance' with treatment, no differences in rates and length of hospitalisation and no difference in arrests or violent acts committed (Policy Research Associates, 1998). A North Carolina study (Swartz et al, 1999) showed some favourable outcomes for people on involuntary treatment orders in comparison to the voluntary control group. But even the North Carolina results have been assessed as not achieving 'outcomes that were superior to outcomes achieved in studies of assertive community treatment alone' (Ridgely et al 2001).

Dependency

Force can create passive compliance and dependency. Often people with ongoing mental health problems have never been as free of authoritarian processes as most other adults. When problems begin to occur, typically on the cusp of adulthood, the authoritarianism of the mental health system can replace that of parents and teachers. This places people in a state of extended adolescence – at risk of never experiencing full adult status and its expanded expectations of liberty. They may, with varying degrees of ambivalence, feel cared for and protected by force but it diminishes their belief in their power to take charge of their lives.

Trauma

The processes and technologies involved in the use of force can be more traumatising than the experience of the mental health problem itself. Being restrained, held down and injected, put in seclusion, locked in wards, told where to live and told what drug to take, can understandably create intense

anger and humiliation, and even aggravate past memories of abuse. Service users sometimes look back with horror on their experiences of compulsory interventions – particularly seclusion, restraints, anti-psychotics and ECT. To be compulsorily subjected to an intervention that is experienced as more damaging than beneficial, is a double violation.

Loss of trust

Force can undermine people's trust in mental health services. In an American study of over 300 service users, 55% of those service users who had been involuntarily hospitalised responded that their fear of force caused them to avoid mental health services (Campbell et al, 1989). In addition to this, the potential to use force or the threat to use it, undermines the voluntary basis of mental health services for those who are not formally subjected to force. In a British survey of 500 service users, 44% of informal patients did not regard their status as genuinely voluntary (Rogers et al, 1993).

Fewer resources for voluntary service users

There is a risk that the more force is used the more services will be funded and provided specifically for compulsory service users, making access to services difficult for voluntary service users. This could result in an added increase in the use of force to ensure that a person gets a service.

Stigma and discrimination

Compulsory service users are more stigmatised than voluntary ones. People subject to force cannot always vote, hold public office, or enter other countries. The existence of force also gives the message to the wider community that mad people are either helpless victims or deranged perpetrators, and are unable to take responsibility for themselves. This confirms the public image of mad people and helps to fuel discrimination.

PART 2: OPPORTUNITIES TO REDUCE OR END FORCE

It's clear that users and survivors are demanding less or no force. This should compel legislators, bureaucrats and providers to consider how to reduce or end the use of force in mental health services. The ultimate way to do this is through the long and labyrinthine process of legislative reform. However, in the meantime there are many opportunities for the people who design, fund, monitor and run mental health services to discourage the use of force.

A culture of recovery in mental health services

Users and survivors in a number of countries are defining and promoting a recovery approach in mental health services. This is starting to influence mental health policy and service delivery. A recovery approach, as defined by

users and survivors, does not sit easily with force. The core value underlying the recovery approach is autonomy or self-determination. Therefore, any service response that restricts autonomy or self-determination does not come from a culture of recovery.

Personal resourcefulness

The recovery approach is based on the belief that users and survivors are by and large, able to take responsibility for their own lives. This differs from the belief in traditional mental health services and in mental health legislation – that users and survivors are victims of a condition that can deprive them of personal responsibility. The belief in personal resourcefulness fosters hope, motivation and gives service users the permission to take charge of their lives.

Equality and partnership in mental health services

A recovery oriented service actively protects service users rights, including their right to autonomy and self-determination. In such a service the views and preferences of service users are of paramount importance, unlike traditional services where other people are assumed to know better. Equality and partnerships need to be reflected in all aspects of service delivery. The interactions between individual service users and the people who serve them should be based on mutual respect for the knowledge and expertise both parties bring to the relationship. Users and survivors should drive policy, funding and management. They also need opportunities to join the mental health workforce to help break down the hierarchical division between ‘us’ and ‘them’ in traditional services.

Diversity of models and treatment choices

Most users and survivors believe that the bio-medical model is of limited or no use to their recovery. The bio-medical model offers very negative and reductionist explanations for the intense and powerful experience of madness. The only treatment people can reliably access in many mental health services is drugs. Yet there is a huge unmet user and survivor demand for peer support services, psychotherapy and alternative treatments. Recovery oriented services are much more eclectic and accepting of the various models and therapies users and survivors find helpful. This translates into services that offer a much wider range of therapies and supports in the recognition that they are providing to a diverse range of people from different cultures, communities and lifestyles.

Promotion of citizen rights and social inclusion

Recovery oriented mental health service systems assume a much more major role than traditional services in supporting people to establish a good life for themselves, outside the mental health system, and on their own terms. These service systems recognise that if people with mental health problems had a more valued place in society their risk of being subjected to force would reduce. One approach to reducing force is to increase their social status. People who enjoy their days, are valued by their families and communities and have decent housing, work and income will be less vulnerable to relapse.

And if they do relapse they will be in a stronger position to get the support and advocacy they need to avoid force.

Practical ways for services to reduce or end force

Creating a recovery culture in mental health services that reduces or ends the use of force won't happen overnight. But there are some practical changes the people who design, fund and provide services could put into place quickly.

Anti-discrimination projects

In several countries campaigns are working to reduce discrimination against people with mental health problems. However, many of these projects base their messages on the bio-medical model which supports the assumptions that users and survivors are incompetent victims in need of medical treatment. This does not do a lot to calm community paranoia and pressure to subject users and survivors to force. A growing number of anti-discrimination projects are basing their messages on human rights, social inclusion, the competence of people with ongoing mental health problems, and the validity of the madness experience. These projects should have more success in reducing community pressure to use force.

Crisis prevention

Mental health services still tend to be crisis-oriented. They need to put much more resource into the kinds of service responses that help to prevent crises. Many service systems still need to be reconfigured, away from beds and meds, with much more emphasis on access to peer support, psychotherapy, alternative treatments, education, work, housing and income.

Advance directives

All service users need to be actively involved in their recovery planning and be encouraged to communicate in writing what kinds of interventions they would like or not like to have if they have another crisis. They can also designate another person to make decisions on their behalf. Although some jurisdictions do not require advance directives to be honoured for people subject to compulsory interventions, an enlightened professional would do everything reasonable in their power to meet the service user's preferences.

More and better crisis options

The standard service response to crisis is hospitalisation and drugs. Yet most service users hate hospital and some don't want drugs. Services need to develop more crisis options such as home based crisis services or user run crisis houses where people rather than drugs are used to calm and restore people. Providing more choices for people would give more room for negotiation between professionals and people in crisis, and reduce the likelihood of resorting to force.

Advocacy

Advocacy is the promotion and protection of the rights and inclusion of people whose liberty or equal participation is put under threat by others. It needs to be equally developed at both the individual and systemic levels. Advocacy should reduce the use of force by helping to create service systems that are more open, transparent and rights focused. Many countries do not have a tradition of strong systemic user / survivor advocacy to counter community pressure to increase the system's powers to compulsorily treat and detain people. User / survivor advocacy needs strengthening everywhere.

Mediation

When negotiations fail between service users, professionals and others who want them to have treatment, mediation could offer a mutually agreeable solution without resorting to the use of force.

De-escalation

All mental health workers need the skills and insight to identify the warning signs of impending aggression and to prevent it before the need for any form of coercion arises. They also need to know how to create a service environment that provides safety, equality and respect for all service users. Traditional de-escalation approaches often haven't considered how the coercive service context could contribute to service user aggression and violence.

CONCLUSION

Users and survivors have developed a credible and compelling case against the use of force, based on our lived experience. But in most countries our views on this issue don't always get a good hearing from legislators, policy makers, mental health professionals, lawyers, human rights activists or the media. At the international level users and survivors have been disappointed at the endorsement for force that has come out of the United Nations and the World Health Organization. We are also disappointed that the World Federation for Mental Health, a leading advocacy organisation with these international agencies, has supported their positions on force.

For instance, it's not much more than a decade since the World Federation helped to develop the United Nations 'Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care'. These principles give approval for member states to limit of the right of people diagnosed with mental disorders to refuse treatment and hospitalisation. Four years ago at the World Federation's Santiago congress general assembly, the members of the World Federation passed a resolution tabled by users and survivors – to end compulsory treatment in the community. As far as I'm

aware this resolution has not been reflected in any subsequent World Federation policy or advocacy activity.

I strongly urge the World Federation board to reconsider its position on force and to use its considerable influence to call for, at the very least, an end to seclusion, an end to restraints and an end to compulsory treatment in the community.

Many of you in the audience today, who allow force in psychiatry to continue unchallenged, are enlightened people with a commitment to human rights. In general you detest acts of degrading treatment, the persecution of people with minority beliefs, and the confinement of innocent people. But for some reason the high value you place on freedom does not always extend to people diagnosed with a mental disorder. You are bureaucrats, service providers, health promoters, volunteers and family members. You all have your own perspectives on force and that is your right. But it's time you acknowledged users and survivors as the primary stakeholders on this issue. In recent decades users and survivors have found their voices after centuries of virtual silence. You simply cannot engage in a fair and full debate on force with us, unless our voices lead the way.

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