

Negotiated coercion: Thoughts about Involuntary Treatment in Mental Health.

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Abstract:

This article, written by a service user/mental health advocate and an academic/ practitioner, explores the concept of 'negotiated coercion' as a way to frame involuntary treatment that acknowledges its coercive essence, yet advances suggestions to maximize negotiation with consumers.

Keywords: coercion | involuntary mental health | mental health | social work | social welfare | ethics | mental health hospitalization | involuntary commitment

Article:

This paper illustrates a conversation that the authors have on an ongoing basis. The first author, John, is a consumer advocate and himself a 'survivor' of involuntary crisis hospitalizations, and due to intervening medical issues left just two papers short of a Yale law degree. The second author, Melissa, is an academic and mental health advocate who often writes in the area of mental illness and involuntary treatment. The two met about six years ago and have collaborated on policy work, academic presentations, and writing projects. They decided to commit some of their discussions about involuntary treatment to paper in hopes that it will stimulate others to continually revisit this ethically complex, easily abused mental health practice. While there are no easy answers in this area, the authors do offer some practical ideas for mitigating the coercive aspects of involuntary mental health treatment.

The involuntary commitment process is theoretically reserved for individuals who present a threat either to themselves or others. In practice, this definition calls for the exercise of considerable discretionary judgment manifested through an arguably flawed due process model, such that individuals subject to commitment may range from the genuinely psychotic to those whose eccentricities have made them nuisances, with a considerable gray area in between. It should be noted that evidence in such procedures is not subject to cross-examination by the affected individuals or even open for inspection, and that publicly provided representation, at least in the United States, is quite minimal at best, often involving only a five-minute interview with the appointed attorney. This cursory decision-making process may give rise to exaggeration

or outright deception on the part of concerned parties. Can society do no better by such a vulnerable population than leaving them feeling victimized? Any assertion that such feelings reflect ingratitude and continued poor judgment, aside from being patronizing, may reflect the medical establishment's unwillingness to submit their own behaviors to reality testing. After all, in the clear light of retrospect, would many current doctors or practitioners find the development of the frontal lobotomy worthy of the Nobel Prize, for all that it might have rendered subject individuals more manageable and convenient to treat?

The point to be made here is that those individuals suffering from conditions requiring medication for stabilization, and in a position to make comparisons from experience, have reported that commitment is more appropriate than jail, the increasing dumping ground for those labeled mentally ill centuries plus after Dorothea Dix's groundbreaking work (an early American advocate for the humane treatment for mental illness) sought to bring an end to that barbaric practice. However, society should have an obligation to raise this negligible bar.

Having taken note of these murky and questionable procedural waters, even speaking as a mental health consumer advocate, John would not deny that some individuals vitally need hospitalization and that broadly considered he was in need of some kind of treatment the times he was hospitalized. However, even putting aside the increasing prevalence of jail horror stories, John and many other consumer activists would deny that there is any logical connection between the genuine need for treatment and the form of treatment currently provided by the traditional coercive mental hospital model. To put it plainly, these hospitals have often protected abuse to the point of torture and, as is increasingly being acknowledged and revealed, daily degradation and humiliation can be a common occurrence. Even death, though being slowly chipped away at with increased regulation of seclusion and restraint, has not been uncommon. To respond to a terrifying illness by further traumatizing the patient defies logic and points to a dark side in society's need to control deviant behavior. The extent to which such traumatic situations actually lead to a post-traumatic response which can then greatly exacerbate future crisis is a matter requiring further study. John himself reports that for years the slightest noise could awaken him screaming and has no doubt that fear of further gross mistreatment exacerbates any medical crisis.

In short, society can do better. Recognizing the coercive aspects of involuntary mental health is an essential first step in mitigating this coercion as much as possible. In other words, terms that 'water-down' the coercion inherent in being placed, against your will, in a facility not only is 'crazy-making' but insults the intelligence of the service-user. The authors like the term 'negotiated coercion' as it recognizes that coercion is part of the process but allows the patient to retain as much dignity as possible. Of course, terms mean little without some follow-up practice so it is important to shore up the current practices with real supports for patient autonomy.

While consumers in crisis may be in need of stabilizing treatment, they should still retain all other rights to the greatest extent possible. Too often, societal stigma has broadly stereotyped all

individuals requiring commitment subject to the actual or equivalent of a criminal response, practically ensuring a feeling of degradation in the absence of any appropriate findings. Even many professionals misunderstand the term ‘incompetent’, which in the United States is actually a legal description for someone who has been adjudicated unable to make their own decisions; most definitely NOT someone who may be in a psychiatric emergency who, at that point, needs proxy decision making. Individuals in crisis involuntary situations should still be able to make decisions about what medications they most prefer to be treated with, and where and by whom they choose to be treated, including access to consults as needed. In other words, while the treatment itself is not a choice the treatment process should offer as much choice as possible.

Given that the medical model so frequently demeans and dehumanizes patients of all stripes, care should be available directly to provide peer support to people with mental illness, such as would likely occur and has proven beneficial for cancer patients. The pattern of treating the mental patient as, at best, a short-term guest at their own treatment team meetings must be broken. Too often, staff are allowed to remain uninterested and unavailable behind the nurses’ station with only the most necessary forays into minimal relations with patients, most notably in situations requiring restraint. Such a reality is hardly conducive to gaining consumer confidence and trust. If suicide counseling, rape counseling, or therapy is needed, care should be available to provide it, rather than forcing all patients indiscriminately into structured conversations about drug abuse or crafts such as making Christmas ornaments. Recognizing the individual behind the diagnosis is the essential first step for any genuine personcentered plan. This emphasis on the person in partnership with treatment providers may well increase the adherence or ‘compliance’ that is often an issue for this sometimes ‘treatment-reluctant’ population.

In short, the us/them polarity, so frequently behind the caregivers’ and mental patients’ relationship, must be broken. John once witnessed a hospital social worker in a teaching institution respond to a consumer statement that all people go through emotional cycles by saying ‘not like you all’, as if the bipolar individual is a separate species. Many would recognize this attitude as both unprofessional and factually wrong. On one side, justice, and on the other, good treatment practice, demands more. The B that follows from adjudicated treatment, in potentially further traumatizing individuals and inappropriately limiting their autonomy, simply does not logically follow from the A of requiring crisis intervention in the first place.