



National Coalition for Mental Health Recovery

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Position Statement on Alternatives to Force/Coercion in Mental Health Treatment

Policy Lessons from *Facing Mental Illness: MINDS ON THE EDGE*

NCMHR is united by these values:

Recovery:

We believe it is possible for everyone.

Self Determination:

We need to be in control of our own lives.

Holistic Choices:

We need meaningful choices, including a range of recovery-oriented services.

Voice:

We must be centrally involved in any dialogues and decisions affecting us.

Personhood:

We will campaign to eliminate stigma and discrimination.

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There are at least two perspectives on the issue of forced treatment. Some believe that it can be lifesaving – and that position was given a disproportionate percentage of attention in “Minds on the Edge.” However, others believe that forced intervention is, by definition, traumatizing and counterproductive. This perspective is often overlooked in the media, and was not given adequate time for discussion and consideration in “Minds on the Edge.”

The National Coalition of Mental Health Consumer/Survivor Organizations (NCMHCSO) believes that the public needs to be informed that forced treatment is intrinsically traumatic because it is isolating and disempowering, whereas choice and self-determination facilitate recovery.

We should work to eliminate force and coercion, and develop instead the compassionate, consumer- and family-driven system called for in the 2003 report of the President’s New Freedom Commission on Mental Health.ⁱ

- Research clearly shows that forcing patients to take medication is not supported by clinical evidence.ⁱⁱ
- Coercive interventions are routinely traumatizing to the individuals they purport to help and make people fearful of seeking treatment.ⁱⁱⁱ
- Involuntary interventions are a poor substitute for building recovery-focused, culturally attuned, community-based mental health and social support services.

There is an alternative to force and coercion: the fostering of trusting and stable relationships while emphasizing choice in treatment plans.

- A growing evidence base validates the efficacy of “peer-directed services” – services directed by individuals who themselves have psychiatric diagnoses.^{iv}
- Peer support workers can often help persons whom traditional services cannot reach; they can also train non-consumers on how to reach those experiencing extreme emotional distress or “psychosis.”
- Person-centered crisis plans (also known as psychiatric advance directives) can also avoid force. Such plans are written documents in which individuals express their treatment preferences in the event that they experience an emotional crisis. An individual can also identify someone to act as a health care agent who can make sure his or her wishes are respected.

The goal of treatment should be recovery of a full role in society, not mere maintenance of “symptom-free” behavior.

- In 2003, the President’s New Freedom Commission on Mental Health, charged with reviewing the public mental health system in the United States, reported “that the current system is unintentionally focused on managing the disabilities associated with mental illness rather than promoting recovery, ability to withstand stresses and life challenges.”^v

Policy Recommendation:

Congress should appropriate funding for peer-run crisis alternatives in every state in the Nation.

- Peer-run crisis respite centers are the most recovery-oriented, cost-effective alternatives to psychiatric hospitalization.
- These voluntary centers provide hope, trust, person-centered treatment, and interpersonal connection from the outset.
- Unlike involuntary hospitalization, which disconnects and disempowers the individual, these centers start people with psychiatric disabilities on their road to recovery at one-third to one-fifth of the cost.
- There are many different types of peer-run alternatives to psychiatric hospitalization. Successful peer-run respites are currently operating in New Hampshire, Maine, New York, West Virginia, Ohio, and Georgia, and more are being created in New Mexico, Vermont, Nebraska, Massachusetts and Arizona.

To learn more about mental health peer-operated crisis alternatives, and to view a directory of crisis alternatives currently in operation and learn about the growing evidence base to support these programs, please visit <http://www.power2u.org/peer-run-crisis-alternatives.html>

NCMHCSO welcomes the opportunity to have a balanced public dialogue on the issue of force and coercion in mental health treatment. The more the public becomes aware that alternatives to force and coercion work, the more the public will support policy changes leading to a recovery-oriented system.

ⁱ President’s New Freedom Commission on Mental Health. July 22, 2003.

<http://www.mentalhealthcommission.gov/press/july03press.htm> (Accessed September 30, 2009).

ⁱⁱ Campbell and Schraiber, *In Pursuit of Wellness: The Well-Being Project*, 1989. National Association of State Mental Health Program Directors (NASMHPD) position statement on seclusion and restraint,

http://www.nasmhpd.org/general_files/position_statement/S&R%20position%20statement.Forensic%20Div.%20prop.%20approved%20by%20NASMHPD.07.07.final.pdf

(Accessed September 29, 2009).

ⁱⁱⁱ Greenfield, TK, Stoneking, BC, Humphreys, K, Sundby, E, and Bond, J. A Randomized Trial of a Mental Health Consumer-Managed Alternative to Civil Commitment for Acute Psychiatric Crisis. *American Journal of Community Psychology* 42 (1/2):135-144.

^{iv} Press Release, President’s New Freedom Commission on Mental Health, op. cit.

^v Ibid.