

Commissioner's Office (802) 241-2610  
Developmental Services Division (802) 241-2614  
Legal Division (802) 241-2602  
Fax Number (802) 241-1129  
TTY Relay Service 1-800-253-0191

Mental Health Division (802) 241-2604  
Fax Number (802) 241-3052  
Vermont State Hospital (802) 241-1000  
Fax Number (802) 241-3001



State of Vermont  
Agency of Human Services  
Department of Developmental & Mental Health Services  
103 South Main Street  
Weeks Building  
Waterbury, Vermont 05671-1601

MEMORANDUM TO: Readers of *Vermont's Vision of a Public System  
for Developmental and Mental Health Services  
Without Coercion*

FROM: Rod Copeland, Commissioner

DATE: January 18, 2000

I am pleased to enclose a paper on a topic of exceptional importance for all of us in developmental and mental health services: a public system without coercion. I hope that you will find the ideas in the paper informative, stimulating, and useful as we move into the twenty-first century.

If you need additional copies, please write to me at the Department's address in Waterbury. You may also telephone your request to (802) 241-2722 or visit DDMHS's web site at [www.state.vt.us/dmh](http://www.state.vt.us/dmh). If you have ideas to add to the ongoing discussion of ways to reduce or eliminate coercion, let us hear from you at our e-mail address: [ideas@ddmhs.state.vt.us](mailto:ideas@ddmhs.state.vt.us).

Thank you for your interest in developmental and mental health services issues.

**VERMONT'S VISION OF A PUBLIC SYSTEM FOR  
DEVELOPMENTAL AND MENTAL HEALTH  
SERVICES WITHOUT COERCION**

**RODNEY E. COPELAND, Ph.D.  
COMMISSIONER**

**VERMONT DEPARTMENT OF DEVELOPMENTAL  
AND MENTAL HEALTH SERVICES**

**Fall-Winter 1999-2000**

**VERMONT'S VISION OF A PUBLIC SYSTEM FOR  
DEVELOPMENTAL AND MENTAL HEALTH  
SERVICES WITHOUT COERCION**

**RODNEY E. COPELAND, Ph.D.  
COMMISSIONER**

**VERMONT DEPARTMENT OF DEVELOPMENTAL  
AND MENTAL HEALTH SERVICES**

**Waterbury, Vermont**

**[www.state.vt.us/dmh](http://www.state.vt.us/dmh)**

**2000**

Commissioner's Office (802) 241-2610  
Developmental Services Division (802) 241-2614  
Legal Division (802) 241-2602  
Fax Number (802) 241-1129  
TTY Relay Service 1-800-253-0191



Mental Health Division (802) 241-2604  
Fax Number (802) 241-3052  
Vermont State Hospital (802) 241-1000  
Fax Number (802) 241-3001

**State of Vermont**  
**Agency of Human Services**  
**Department of Developmental & Mental Health Services**  
103 South Main Street  
Weeks Building  
Waterbury, Vermont 05671-1601

January 18, 2000

Dear Readers:

One of the biggest challenges facing us as we enter the twenty-first century is eliminating the coercion experienced by our most vulnerable citizens. Until we can eliminate coercion, we must reduce it to a minimum. Why do I believe this? One only has to look at the progress we failed to make in the last century to come to this conclusion.

Two very disturbing trends attracted my attention this past year. First, in Vermont and all across the nation, we are locking up juvenile offenders at rates much higher than previously. Nationally, we are building juvenile detention centers at a pace similar to the new construction of correctional facilities. Furthermore, in the midst of this increased rate of incarceration of youth, we learn through the Justice Department of disturbing incidents of abuse and mistreatment. Significant numbers of juvenile offenders have extensive histories of emotional and mental health treatment needs.

Second, seclusion and restraint are persistent national issues, even though we have known with certainty since the 1960s that their use is harmful, indeed life-threatening at times. In spite of that knowledge, a recent national exposé revealed alarming numbers of youth and adults with emotional disorders, mental illnesses and/or developmental disabilities dying as a result of seclusion and restraint in treatment programs.


These two disturbing trends come at the end of a century in which we have gained scientific and clinical knowledge that should lead us in exactly the opposite direction, toward care that is both effective and humane for individuals and society. With our knowledge and values, why are we not trying more aggressively to eliminate the need to lock up and seclude and restrain vulnerable people with significant developmental, behavioral and emotional needs? Why are we not more successful at using our many advanced tools and techniques to engage people in the treatment they need?

I believe a major part of the answer lies in the overemphasis, even dependency, in our treatment and rehabilitation practices on power, control, paternalism and, ultimately, coercion. Put another way, the mental health and developmental disabilities fields have

not clearly offered alternative practices to old styles of control, which can often lead to significant levels of coercion.

Deliberate examination of coercive practices viewed through the lenses of consumers in addition to scientific and clinical knowledge can, I believe, assist us in the shift away from coercion to positive practices. It is in that spirit that I conducted a study and wrote the enclosed paper to put a spotlight both on coercive practices and on ways we might move away from them. I am very interested in your reactions to this work. Please let me know what you think.

Sincerely,

A handwritten signature in cursive script that reads "Rod Copeland".

Rod Copeland  
Commissioner

## Contents

<b>Why Coercion Is an Important Issue .....</b>	<b>1</b>
<b>Spotlighting Coercion .....</b>	<b>3</b>
<b>Examples of Coercion .....</b>	<b>4</b>
<b>Factors Leading to Coercion.....</b>	<b>5</b>
<b>The Experience of Coercion and the Importance of Procedural Justice .....</b>	<b>6</b>
<b>Ideas for Eliminating Coercion.....</b>	<b>7</b>
<b>Selected Bibliography .....</b>	<b>10</b>

## Why Coercion Is an Important Issue

Consumer stories of experiencing coercion are very powerful. One only has to listen briefly to hear the pervasive chilling, and in reality killing, effect coercion has on the human spirit. None of us like coercion in any of its forms applied to us. All coercion, regardless of its form, damages and hurts.

Vermont has mature public systems of care for children and adults with developmental disabilities, serious mental illnesses, and emotional disorders. By statute (18 V.S.A. §7401), the Department of Developmental and Mental Health Services (DDMHS) is responsible for developing those systems of care. The same statute makes DDMHS responsible for the health and safety of individuals who are legally committed to the care and custody of the Commissioner. In fact, these legal powers to seek the commitment of citizens are exercised to protect both individuals and the general public. In spite of these statutory powers, which are by definition coercive, the Department's vision is to move toward care and supports free of coercion even though at present coercion may be used in the last resort when the life, health, and safety of the individual and/or the health and safety of the community are threatened.<sup>1</sup>

The outcomes DDMHS wants for the citizens who use its systems of care are the same outcomes Vermont wants for all citizens: namely, people enjoy lives of dignity and independence in settings they prefer. Families and all individuals live in safe, supportive communities. Mothers, newborns, infants, and children thrive. Children are ready for school and succeed in school. Children live in stable, supported families. Citizens choose healthy behaviors. Youth successfully transition to adulthood. Families, youth, and adults are engaged in their community's decisions and activities.<sup>2</sup>

---

<sup>1</sup>Vermont Department of Developmental and Mental Health Services (DDMHS), Division of Mental Health (DMH), "Involuntary Care: White Paper" (Waterbury, 1996, photocopied), 1. See also Vermont DDMHS, DMH, "A Position Paper on Recovery and Psychiatric Disability" (Waterbury, 1996, photocopied), 5-6.

<sup>2</sup> Vermont Agency of Human Services, *The Social Well-Being of Vermonters, 1999: A Report on Outcomes for Vermont's Citizens* (Waterbury, 1999).

Why, then, is coercion such an important issue? It is important because we must measure the success of DDMHS's systems of care by improvements in the well-being of our citizens. DDMHS believes that the various forms of coercion are powerful negative forces working against us as we strive to assist citizens to enhance the quality of their lives. We believe that if Vermont can achieve a real cultural shift so that systems of care move to eliminate coercion, we will see concurrent improvements in achieving our outcomes.

Put another way, we do not believe that we can achieve the highest quality of care and supports without paying close attention to the presence of coercion in its various forms in our systems of care. Spotting coercion and working to eliminate it, in conjunction with achieving good outcomes, is not just the right thing to do, it is essential. Through this spotlight Vermont can continue its proud history of leading the nation in putting in place complete and effective community systems of care for our citizens.



## Spotlighting Coercion

How do we put a spotlight on this issue? How do we begin a serious dialogue in Vermont to eliminate coercion from the system? As Commissioner of Developmental and Mental Health Services, I decided to assist in this process by reviewing the literature on coercion to determine if any significant findings were emerging. I then conducted interviews with Vermont consumers, family members, professionals, advocates, and policy makers. Through this report, I am disseminating my findings. Finally, I will describe a course of action that DDMHS is initiating to bring about a significant increase in our efforts to eliminate coercion from our systems of care.

The results of both the literature review and interviews with Vermont stakeholders are encouraging in terms of developing new action steps to eliminate coercion. A unified picture emerges and the findings appear to be applicable across DDMHS's three systems of care for developmental disabilities, serious mental illnesses, and childhood emotional disturbances.

In the literature, coercion can range from its most severe and obvious forms (forced medication, seclusion, restraint, physical and emotional abuse) to less severe and far more subtle forms (paternalism, professional control, forced choice, threats, intimidation, and inappropriate persuasion).<sup>3</sup> In short, coercion encompasses a wide range of actions taken without the consent of the individual.<sup>4</sup> Moreover, "at exactly what point influence becomes coercion is difficult to determine. Similarly, it is difficult to determine when an attempt to influence or control becomes 'excessive.'"<sup>5</sup>

In spite of our best efforts, my interviews with over forty Vermonters documented the occurrence of coercion throughout the public system of care for mental health and developmental services. This finding is particularly troubling in light of Vermont's collective vision of humane and just systems of care for our citizens. There is also consensus that no sectors (consumers, family members, providers, and/or policymakers) are purposefully trying to increase coercion.

---

<sup>3</sup>See Laurie C. Curtis and Ronald J. Diamond, "Power and Coercion in Mental Health Practice," in *Treatment Compliance and the Therapeutic Alliance*, ed. Barry Blackwell (The Netherlands: Harwood Academic Publishers, 1997), 97-122.

<sup>4</sup>Andrea K. Blanch and Jacqueline Parrish, eds., *Reports of Three Roundtable Discussions on Involuntary Interventions* (Boston: Boston University Center for Psychiatric Rehabilitation, 1993), 1-42.

<sup>5</sup>Curtis and Diamond, "Power and Coercion," 108.

### **Examples of Coercion**

Examples of coercion and factors associated with it, as reported by Vermonters, appear to be consistent with the definitions in the literature. Vermonters mentioned the following:

- Addressing individuals in a patronizing and disrespectful manner
- Not giving individuals the opportunity to communicate
- Putting pressure on individuals so that they feel their ideas or ways of doing things are not respected
- Withholding services if citizens do not agree to engage in certain actions
- Arresting and locking up children/adults
- Involuntarily hospitalizing citizens
- Involuntarily medicating citizens
- Using seclusion and restraint
- Controlling a citizen's choice of agencies or service providers
- Not having access to information
- Speaking on behalf of people with developmental disabilities in paternalistic, controlling ways

### Factors Leading to Coercion

- ⇒ Coercion can occur at all levels of residential care and congregate living, particularly when the decisions on where a person is going to live, and with whom, are controlled by others.
- ⇒ Children by law have no rights; thus almost all decisions are made on their behalf. By definition, children are always in a status of coercion.
- ⇒ People who experience stigma for whatever reason are more likely to experience coercion from others.
- ⇒ Power in any relationship can lead to coercion. Professionals often have power and control over the lives of others. How, when, and why this power is used were critical factors in perceptions of coercion.
- ⇒ The very act of using a diagnosis to refer to people can lead to assumptions about an individual's ability to make decisions.
- ⇒ Professionals, providers, and policy makers often see people in a very narrow light through the service system and do not really view people who use services as having the same wants, desires, and needs as themselves.
- ⇒ Our pessimistic views about recovery and self-determination lead to over-control, coercion, and neglect.
- ⇒ Acting out by children can lead to severe forms of coercion.
- ⇒ Guardianship can lead to over-control, paternalism, and coercion.
- ⇒ The conflict between healing and public safety can lead to coercion.
- ⇒ Fears in the provider community of being sued for failing to keep citizens healthy and safe can lead to over-control.

Clearly, there are significant factors leading to coercion and real coercion is occurring in Vermont. Where does the literature point us for corrective action and what did Vermonters say we should do?

## **The Experience of Coercion and the Importance of Procedural Justice**

Through the leadership of John Monahan, the John D. and Catherine T. MacArthur Foundation has done some excellent research on how recipients of coercion have viewed it. Their work has rigorously captured how consumers and family members perceive the experience of coercion in the hospital-admitting process for psychiatric care. This work in progress has led to the important conclusion that procedural justice is pivotal in determining whether or not a person experiences a hospital admission as coercive. In other words:

The amount of coercion experienced is strongly related  
to the person's belief about the justice of the process.

That is, a person's beliefs that others acted out of genuine concern, treated him or her respectfully and in good faith, afforded the chance to tell his or her side of the story, and respected the recipient's autonomy, are correlated with low levels of experienced coercion. This is true for both voluntary and involuntary admissions.<sup>6</sup>

In talking to Vermont stakeholders, whether consumers, professionals, or policy-makers, I heard the same themes expressed. Vermonters indicated that it is critical that people are listened to, respected, treated as you would have others treat you, given choice, and fully participate in decisions about themselves. There appears to be a strong consensus that we must consciously and vigilantly pay attention to our interactions with the people we are supporting. All interactions should be scrutinized as to whether or not coercion is present in any of its forms.

---

<sup>6</sup>Joseph P. Morrissey and John Monahan, eds., *Coercion in Mental Health Services: International Perspectives*, Research in Community Mental Health, vol. 10 (Stamford, Conn.: JAI Press, 1999), 25-27.

## **Ideas for Eliminating Coercion**

Vermonters have many excellent ideas about how to eliminate coercion. In fact there is a reservoir of ideas and energy that give us ample ammunition to mount a campaign to eliminate coercion in DDMHS's systems of care. For example, here are some ideas that emerged from my informal interviews:

- ☑ It is important that consumers have control over their own treatment and recovery.
- ☑ Educate providers and hospitals on the importance of the "partnership concept" with consumers.
- ☑ Separate the issues around medications that "control behavior" versus the ones that "make people feel better."
- ☑ One size does not fit all. There are unique paths to recovery.
- ☑ Make full use of self-determination principles that allow citizens to take control of their system of care and support.
- ☑ Make better use of each consumer's knowledge of himself or herself.
- ☑ Make full use of informal alternatives, natural supports and family/consumer-run supports.
- ☑ Emphasize prevention and public health approaches.
- ☑ Adults with severe mental illness and developmental disabilities could benefit from a prevention approach.
- ☑ Encourage ambitious public involvement and education for the community at large regarding natural supports.
- ☑ Develop informal, and if necessary, formal systems to engage early on with citizens who have previously experienced very coercive situations in our formal systems of care. This early intervention and engagement would have the goal of preventing individuals from experiencing the formal system as they had in the past.

- ☑ Once involved with the formal system, have more choice and chance to do the consumer's own work toward recovery.
- ☑ Positively address the culture of agencies regarding professional control.
- ☑ Develop grievance procedures that have strong procedural justice.
- ☑ Encourage the employment of consumers at all levels, including involuntary care settings.
- ☑ Have the option of peer support and self-advocacy support coming into the formal system.
- ☑ Train staff on the importance and value of communication skills and recovery.
- ☑ Encourage self-advocates to articulate clearly where and when paternalism and control take place.
- ☑ Find examples in agencies where best practices are being followed and actively disseminate those findings to others.
- ☑ Follow the strengths-based approach with children and give children a real voice in individualized plans.
- ☑ Develop a system of care approach within juvenile justice that focuses on reducing the number of children and youth in lock-up and in forced treatment programs.
- ☑ DDMHS should not blame agencies for the use of coercion but, rather, take responsibility with the agencies for engaging in positive improvement strategies.

Obviously, there is a rich array of thinking on how to approach the task of eliminating coercion. Strong emphasis is placed on starting with and drawing on the experience and wisdom of the recipients of our services, whether in developmental disabilities, children's services, or adult mental health. There appears to be a strong consensus on the notion of procedural justice, as defined by Monahan and others. That is, dignity, respect, fairness, choice, being listened to, and autonomy are all important concepts. Self-scrutiny by professionals, agencies, systems, and

DDMHS is important. Developing an educational approach to eliminate coercion appears to have support, as does the dissemination of best practices.

This rich array of thinking appears to lead to some very obvious actions. The DDMHS management team believes it makes sense to develop, in collaboration with our stakeholders, action plans to reduce coercion across all of DDMHS's systems of care. To that end, the Developmental Services Division, the Adult Mental Health Services Unit, and the Child, Adolescent, and Family Unit will begin working with their constituent groups to develop action plans aimed at reducing coercion in their respective systems.

In an effort to enrich the dialogue on coercion, I invite citizens to share their thoughts with DDMHS. I am especially interested in continuing to generate ideas on what we need to do to take positive concrete actions to improve our efforts on eliminating coercion. In order to make communicating with us easier, the Department has established an e-mail address: [ideas@ddmhs.state.vt.us](mailto:ideas@ddmhs.state.vt.us). You may also call me at (802) 241-2610, or write me at DDMHS, 103 South Main Street, Waterbury, VT 05671-1601.

Please help us bring about our vision of a public developmental and mental health services system that is free of coercion.

## SELECTED BIBLIOGRAPHY

These sources of information, debate, and research on coercion include the works cited in this paper as well as other materials that are important and relevant. This list is not exhaustive; rather, it should be regarded as a beginning reader's guide for others who want to find out more about the subject on their own.

Bennett, Nancy S., et al. "Inclusion, Motivation, and Good Faith: The Morality of Coercion in Mental Hospital Admission." *Behavioral Sciences and the Law* 11 (1993): 295-306.

Biss, Susan M., and Laurie C. Curtis. "Crisis Services Systems: Beyond the Emergency Room." *In Community* 3, no. 2 (1993): 1-4.

Blanch, Andrea K., and Jacqueline Parrish, eds. *Reports of Three Roundtable Discussions on Involuntary Interventions*. Psychiatric Rehabilitation and Community Support Monograph Series, vol. 1. Boston: Boston University Center for Psychiatric Rehabilitation, 1993.

Bloom, Sandra L. "Creating Sanctuary: Practicing Nonviolence in a Psychiatric Setting." Quakertown, PA, 1998. Photocopied.

\_\_\_\_\_, and Lyndra J. Bills. "From Chaos to Sanctuary: Trauma-Based Treatment for Women in a State Hospital System." In *Women's Health Services: A Public Health Perspective*, ed. Bruce Labotsky Levin, Andrea K. Blanch, and Ann Jennings. Thousand Oaks, CA: Sage Publications, 1998.

Chamberlin, Judi. *On Our Own: Patient-Controlled Alternatives to the Mental Health System*. New York: McGraw-Hill Paperbacks, 1979; New York: Hawthorn Books, 1978.

Curtis, Laurie C., and Ronald J. Diamond. "Power and Coercion in Mental Health Practice." In *Treatment Compliance and the Therapeutic Alliance*, ed. Barry Blackwell, 97-122. The Netherlands: Harwood Academic Publishers, 1997.

Dennis, Deborah L., and John Monahan, eds. *Coercion and Aggressive Community Treatment: A New Frontier in Mental Health Law*. New York: Plenum Publishing Corporation, 1996.

Diamond, Ronald J. "Coercion in the Community: Issues for Mature Treatment Systems." In *Maturing Mental Health Systems: New Challenges and*



- Opportunities*, edited by Leonard I. Stein and Ellen Jane Hollingsworth. New Directions for Mental Health Services, ed. H. Richard Lamb, no. 66. San Francisco: Jossey-Bass, 1995.
- Farber, Seth. *Madness, Heresy, and the Rumor of Angels: The Revolt Against the Mental Health System*. With a foreword by Thomas S. Szasz. Chicago: Open Court Publishing Company, 1993.
- Gardner, William, et al. "Two Scales for Measuring Patients' Perceptions of Coercion During Hospital Admission." *Behavioral Sciences and the Law* 20 (1993): 307-321.
- \_\_\_\_\_. "Patients' Revisions of Their Beliefs about the Need for Hospitalization." Forthcoming.
- Hoge, Steven K., et al. "Patient, Family and Staff Perceptions of Coercion in Mental Hospital Admission: An Exploratory Study." *Behavioral Sciences and the Law* 20 (1993): 281-293.
- \_\_\_\_\_. "Perceptions of Coercion in the Admission of Voluntary and Involuntary Psychiatric Patients." *International Journal of Law and Psychiatry* 20 (1997): 167-181.
- \_\_\_\_\_. "Family, Clinician, and Patient Perceptions of Coercion in Mental Hospital Admission: A Comparative Study." *International Journal of Law and Psychiatry* 21 (1998): 1-16.
- Lidz, Charles W. "Coercion in Psychiatric Care: What Have We Learned from Research?" *Journal of the American Academy of Psychiatry and the Law* 26 (1998): 631-637.
- \_\_\_\_\_, et al. "Coercive Interactions in a Psychiatric Emergency Room." *Behavioral Sciences and the Law* 11 (1993): 269-280.
- \_\_\_\_\_, "Perceived Coercion in Mental Hospital Admission: Pressures and Process." *Archives of General Psychiatry* 52 (1995): 1034-1039.
- \_\_\_\_\_, "The Validity of Mental Patients' Accounts of Coercion-Related Behaviors in the Hospital Admission Process." *Law and Human Behavior* 21 (1997): 361-376.

- \_\_\_\_\_, "Factual Sources of Mental Patients' Perceptions of Coercion in the Hospital Admission Process." *American Journal of Psychiatry* 155 (1998): 1254-1260.
- \_\_\_\_\_, "Sources of Coercive Behaviors in Psychiatric Admissions." Forthcoming.
- MacArthur Research Network on Mental Health and the Law. 1999. <http://ness.sys.virginia.edu/macarthur/coercion.html> (August 3, 1999).
- Monahan, John, et al. "Coercion and Commitment: Understanding Involuntary Mental Hospital Admission." *International Journal of Law and Psychiatry* 18 (1995): 249-263.
- Morrissey, Joseph P., and John Monahan, eds. *Coercion in Mental Health Services: International Perspectives*. Research in Community Mental Health, vol. 10. Stamford, CT.: JAI Press, 1999.
- Rooney, Ronald H. *Strategies for Work with Involuntary Clients*. New York: Columbia University Press, 1992.
- Siebert, Lawrence A. *Peaking Out: How My Mind Broke Free from the Delusions in Psychiatry*. By Al Siebert as told to Sam Kimball. Portland, Oregon: Practical Psychology Press, 1995.
- Szasz, Thomas S., *Law, Liberty, and Psychiatry: An Inquiry into the Social Uses of Mental Health Practices*. New York: Collier Books, a Division of Macmillan Publishing Co., Inc., 1979 [1968]; New York: Macmillan, 1963.
- \_\_\_\_\_. *Psychiatric Justice*. Westport, CT.: Greenwood Press, Publishers, 1978; New York: Macmillan, 1965.
- \_\_\_\_\_. *Psychiatric Slavery: When Confinement and Coercion Masquerade as Cure*. New York: The Free Press, a Division of Macmillan Publishing Co., Inc., 1977.
- Vermont Agency of Human Services. *The Social Well-Being of Vermonters, 1999: A Report on Outcomes for Vermont's Citizens*. Waterbury, VT: 1999.

Vermont Department of Developmental and Mental Health Services. Division of  
Mental Health. "Involuntary Care: White Paper." Waterbury, VT, 1996.  
Photocopied.

\_\_\_\_\_. "A Position Paper on Recovery and Psychiatric Disability."  
Waterbury, VT, 1996. Photocopied.

