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Reducing coercion in mental healthcare

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Abstract

Aims. To examine the extent and nature of coercive practices in mental healthcare and to consider the ethical, human rights challenges facing the current clinical practices in this area. We consider the epidemiology of coercion in mental health and appraise the efficacy of attempts to reduce coercion and make specific recommendations for making mental healthcare less coercive and more consensual.
Methods. We identified references through searches of MEDLINE, EMBASE, PsycINFO and CINAHL Plus. Search was limited to articles published from January 1980 to May 2018. Searches were carried out using the terms mental health (admission or detain* or detention or coercion) and treatment (forcible or involuntary or seclusion or restraint). Articles published during this period were further identified through searches in the authors' personal files and Google Scholar. Articles resulting from searches and relevant references cited in those articles were reviewed. Articles and reviews of non-psychiatric population, children under 16 years, and those pertaining exclusively to people with dementia were excluded.
Results. Coercion in its various guises is embedded in mental healthcare. There is very little research in this area and the absence of systematic and routinely collected data is a major barrier to research as well as understanding the nature of coercion and attempts to address this problem. Examples of good practice in this area are limited and there is hardly any evidence pertaining to the generalisability or sustainability of individual programmes. Based on the review, we make specific recommendations to reduce coercive care. Our contention is that this will require more than legislative tinkering and will necessitate a fundamental change in the culture of psychiatry. In particular, we must ensure that clinical practice never compromises people's human rights. It is ethically, clinically and legally necessary to address the problem of coercion and make mental healthcare more consensual.
Conclusion. All forms of coercive practices are inconsistent with human rights-based mental healthcare. This is global challenge that requires urgent action.

Introduction

Despite evidence from diverse settings that mental healthcare and treatment confer significant benefits, psychiatry remains a contentious area of medical practice. Questions regarding the status and usefulness of psychiatric diagnosis partly explain this. Uncertainties about the effectiveness of many psychiatric interventions, wide variations in clinical practice, poor patient safety (D'Lima *et al*., 2017) and lack of good quality outcome data on matters most relevant to service users (Thornicroft and Slade, 2014) all contribute to the generally negative perceptions of psychiatry. However, the most contentious aspect of contemporary psychiatry is its continuing reliance on coercion as part of clinical care, a legacy of its institutional history. Although the large majority who come in contact with mental health services do not experience coercive care, involuntary detention and forcible treatment are universal experiences in mental health services. Such involuntary treatment is often associated with the use of force, such as seclusion, restraint and forcible treatment. These coercive practices are legitimised, approved and routinely employed as part of mental healthcare in rich and poorer countries and in hospitals and community settings. They entail significant human rights violations which amount to 'an unresolved global crisis' (Drew *et al*., 2011) and remain some of the most controversial issues in mental health (Salize and Dressing, 2004).

Epidemiology of coercion

There are different forms and degrees of coercion in mental healthcare, some more explicit than others. They comprise a broad range of practices (Szmukler and Applebaum, 2008) including treatment pressures, interpersonal leverage, implicit or explicit threats and compulsion i.e. the use of force, usually governed by law, to make a person accept treatment or interventions that have been refused (Szmukler, 2015). Involuntary treatment may involve imposition of behavioural controls including different forms of restraint (mechanical, physical or pharmacological),

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forcible seclusion in confined spaces, treatment by administration of medication without the person's consent and restrictive conditions imposed as part of treatment and supervision in the community. Coercion in mental healthcare includes implied or actual threats, the 'fear that many patients have that non-compliance may lead to the use of compulsion', described as 'a coercive shadow' (Szmukler, 2015). Coercion in healthcare settings is not limited to mental healthcare but is widely used in care of the elderly, those with intellectual disabilities and children. Coercive practices are also not uncommon in intensive surgical and medical settings. However, no other healthcare setting is as ubiquitous and routinely employed as in mental healthcare.

Despite the ubiquitous nature of coercion in mental healthcare, the epidemiology of coercion is poorly understood. There is little systematic or reliable data on the extent of coercive practices in most countries. This includes the nature and extent of legally authorised sanctions such as involuntary admission, often relied on as a proxy measure for coercive care. Systematic information on more severe and explicit forms of coercion, such as the use of seclusion, forcible segregation and treatment, is more difficult to come by even in high-income countries with well-established mental health systems. When available, the data are often difficult to interpret and compare since they are linked to complex sets of patient-related, environmental and healthcare determinants and critically influenced by the local context (de Jong *et al.*, 2016). The lack of reliable and comparative information on coercive practices is a major barrier to reform and change. While more information, by itself, is unlikely to result in significant changes in clinical practice routinely available systematic data are useful in tracking the extent of coercive care and monitoring the effects of implementing specific, remedial interventions. In England, for example, the recent review of mental health legislation (Department of Health and Social Care, 2018) came about as a result of concern over the rising detention rates, based on national data. In Australia, a nationally reported system of data collection on seclusion and restraint has made it possible to measure the impact of policy directives to reduce coercive interventions across jurisdictions and services (Australian Institute of Health and Welfare, 2019). In Italy, following a national recommendation for the prevention of all mechanical restraint measures in 2010, there was a significant reduction in such practices, for example, a 62% reduction in Emilia-Romagna over the next five years, from 2011 to 2016 (Regione Piemonte, 2017).

Available data indicate considerable variation in rates of involuntary admission between different countries and regions and hospitals in the same country (Weich *et al.*, 2014). International comparisons of involuntary admission rates are rare. In Europe, vast differences in involuntary admissions were noted by Salize and Dressing (2004) and a further review confirmed a thirty-fold difference in rates of compulsory admission in European countries, from 6/100 000/year in Portugal to 218/100 000 in Finland, with a median of 74/100 000 (De Stefano and Ducci, 2008). The increasing harmonisation of mental healthcare in Europe and similar legislative reforms may have diminished such differences more recently. International variations in involuntary admission rates are unlikely to be the result of differential morbidity or wide disparity in the availability of mental health resources in high-income countries. Differential rates are more likely to be the result of differing legal criteria, variable compliance with agreed policies and standards, professional ethics and attitudes, sociodemographic factors and public perceptions about risk arising from mental illness (Zinkler and Priebe, 2002). However, a recent study that compared annual involuntary hospitalisation rates over a 7-year period in 22 high-income countries (in Europe, Australia and New Zealand) found no relationship between annual involuntary hospital rates and any aspects of legal framework. Higher rates were associated with a large number of psychiatric beds, higher GDP and health care spending per capita although the associations were weak (Rains *et al.*, 2019). It would appear that the psychiatric detention rate is increasing in most Western countries. For example, in England, in the ten-year period between 2006 and 2017, the use of the Mental Health Act (MHA) increased by 43% (NHS Digital, 2016). Similar trends have been reported in several other European countries, for example, in Scotland, Ireland, Belgium and France (Turnpenny *et al.*, 2018). A consistent and pervasive pattern of human rights violations in psychiatric institutions is also reported across several European countries (WHO, 2018).

It is estimated that over a third (38%) of involuntarily admitted patients are subjected to further coercive measures, such as enforced medication, seclusion and restraint within four weeks of admission (Raboch *et al.*, 2010). As with detention in hospital, large variations in the use of restraint and seclusion are reported, for example, up to a ten-fold difference among hospitals in the same country (Bak and Aggernaes, 2012). These are more likely to be used in secure or forensic mental health settings, against children and adolescents and those with learning difficulty (NSU/MIND, 2015; Care Quality Commission, 2017). People of non-European origin are particularly at risk of coercive interventions in European settings (Kelly *et al.*, 2015). In many countries, coercive practices are no longer confined to involuntary hospital admissions; they are becoming increasingly prevalent within community-based care and during 'voluntary' admission to hospitals. Although compulsory treatment options in the community, such as Community Treatment Orders, are largely ineffective in preventing re-admission to hospital and restrict patient autonomy (Burns *et al.*, 2013) they remain a 'rapidly expanding form of involuntary treatment in many countries' (Turnpenny *et al.*, 2018).

We are rightly concerned with evidence-based medicine in psychiatry. It is paradoxical that coercive interventions in mental healthcare continues to be used extensively although there is little evidence they confer any clinical benefits (Sailas and Fenton, 2000; Wright, 2003). Available research does not suggest they are clinically effective, improve patient safety or result in better clinical or social outcomes (Luciano *et al.*, 2014; McLaughlin *et al.*, 2016; D'Lima *et al.*, 2017). In contrast, coercive practices are often associated with negative outcomes for patients with significantly adverse impacts on satisfaction and quality of life (Kallert *et al.*, 2008). While a significant proportion of those subjected involuntary treatment retrospectively acknowledge that such treatment was necessary many have strong negative perceptions about the use of forcible treatment as they wish to be treated with respect rather than being subjected to the professionals' control (Tingleff *et al.*, 2017; Turnpenny *et al.*, 2018). Many of those subjected to involuntary admission do not feel it is justified or beneficial (Katsakou and Priebe, 2006; Priebe *et al.*, 2008) and tend to recall their experience as highly distressing and even traumatic (Paksarian *et al.*, 2014; Rose *et al.*, 2017; Turnpenny *et al.*, 2018; Akhter *et al.*, 2019). Coercive interventions can weaken or damage therapeutic relationships and dissuade people from seeking further treatment thus increasing the risk of non-adherence and involuntary treatment, particularly those with long-term mental health problems (Swartz *et al.*, 2003; Jaeger *et al.*, 2013; Rose *et al.*, 2017). It is likely that coercive practices contribute

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to social stigma against people experiencing mental health problems. The persistent and ubiquitous nature of coercion in mental healthcare suggests that 'the human rights of users of psychiatry are systematically ignored' (Turnpenny *et al.*, 2018). This is in sharp contrast to general health care and undermines psychiatry's claim that it is akin to other medical disciplines which, in turn, raises questions about the legitimacy of the current rhetoric around 'parity of esteem'.

Reducing coercion in clinical practice

There is increasing recognition that we need to make mental healthcare more consensual and ensure that the human rights of people with mental health problems are always respected (Szmukler *et al.*, 2014; Pūras, 2017). However, little attention is given within current mental health policies and programmes to reducing coercion in clinical practice despite our commitment to clinical safety. Unfortunately, there is very little research in this area. This is surprising considering the ubiquitous nature of the problem and the negative perceptions of forcible treatment among service users, professionals and the wider public (Salize and Dressing, 2004). While a number of clinical strategies are considered useful in reducing coercion in mental health, such as 'front loading' of services, independent patient advocacy and increased involvement of friends and family (Molodynski, 2017), large scale, operational or empirical evidence of their effectiveness is lacking.

A systematic review and meta-analysis of interventions to reduce compulsory admissions (de Jong *et al.*, 2016) found only 13 randomised controlled trials (RCTs) in which intention to reduce compulsory admission was the first or secondary outcome measure. This study found that compulsory community treatment, compliance enhancement and integrated treatment had little impact on reducing involuntary admissions. Advanced directives and joint care plans are potentially powerful tools in avoiding non-consensual treatment as they result in service users feeling more in control over their mental health problems and feeling respected and valued as a person. There is some evidence that joint decision making, involving service user and professionals in the context of detailed care planning, could potentially avoid the need for compulsory treatment in the event of a psychiatric crisis (Thornicroft and Henderson, 2016). Joint crisis plans (JCP) include elements of advanced directives. Unlike advanced directives, the content of which are solely determined by the service user, a JCP is the product of shared decision making between the service user and relevant professionals. A pilot RCT of JCPs for people with psychotic or bipolar disorders found reduced involuntary hospitalisation associated with their use (Henderson *et al.*, 2004) although a subsequent, larger multisite trial delivered in routine practice failed to replicate this (Thornicroft *et al.*, 2013). However, JCPs were found to be associated with a positive effect on service user-rated therapeutic relationships and cost-effectiveness. Yet, the 'culture of professional dominance in decision making' may impede effective joint decision making (Newton-Howes and Mullen, 2011). Overall, current evidence on the effectiveness of specific interventions to reduce involuntary admissions is limited and there is a pressing need for evidence-based remedies for the 'rising tide of compulsory admissions' (Johnson, 2013).

A Cochrane Review (Sailas and Fenton, 2000) found no controlled evaluations of the value of seclusion or restraint in those with serious mental illness and noted serious adverse effects of such interventions. The review suggested that 'continuing use of seclusion or restraint must therefore be questioned' and sought well-designed randomised trials that are generalisable to routine practice. Nearly two decades later, there are still no controlled studies of these coercive practices although they continue to be employed widely in mental healthcare. There is little evidence that prevention or de-escalation of aggressive behaviour in mental health settings, often used in inpatient psychiatric settings, is effective (Gaynes *et al.*, 2017). The value attached to seclusion and restraint, as with the need for involuntary treatment in general, is influenced by beliefs and habits rather than any empirical evidence. This makes it difficult to change these clinical practices (Sailas and Wahlbeck, 2005). Local initiatives to reduce coercion in hospital settings can be effective but these tend to be uncontrolled interventions with limited information regarding clinical outcomes, long-term sustainability or the extent to which they are integrated into routine clinical practice. Mostly, such interventions are introduced as 'alternatives' or stand-alone programmes rather than part of more generalised or systemic changes in care and treatment. A more recent systematic review of seclusion and restraint reduction programmes since 2010 found some evidence that they may enhance the quality and safety of care but do not reduce the use of coercion (Goulet *et al.*, 2017).

We agree that the use of compulsion in mental healthcare amounts to a 'system failure' (Bhugra *et al.*, 2017). It is likely that its persistence is linked to entrenched problems within organisational structures and the culture and ethos of prevailing clinical care (Szmukler, 2015). This makes it difficult to change such practices (Gaynes *et al.*, 2017). It is clear that individual 'stand-alone' programmes or situation-specific training to reduce coercive interventions are not sufficient by themselves. They rarely result in significant changes in the organisational and clinical culture of mental health systems.

A fundamental transformation of mainstream care may be necessary to bring about the required organisational and cultural change. It is suggested that alternatives to forcible psychiatric admissions and coercive care will need to be integrated into 'whole system' changes to make mental healthcare more consensual; such as an emphasis on hospitality and support in community mental health centres, community-based crisis intervention and recovery homes, early support, personalised and shared care plans (Mezzina and Vidoni, 1995; Rosen *et al.*, 2012). The effectiveness and impact of such innovations will depend on their ability to deal with power dynamics between service users and professionals. Their success will also be dependent on a willingness to manage microsocial stressors and conflicts that trigger or reactivate deviant behaviours. To achieve this, it is important to build therapeutic alliances that respect people's will and preferences, developed in their living environments in the community, that is, on 'their turf and terms' (Mezzina *et al.*, 2019).

This suggests the need for a profound cultural change. A review by Mezzina (Mezzina *et al.*, 2019) identifies several components necessary to preventing and ending coercive care comprising a broad suite of practices, policies and interventions. There should also be 'top down' and local-level leadership to create and maintain cultural change in organisations informed by human rights principles, service user involvement and the availability of community-based crisis services. Such a mental health system has the potential to minimise involuntary treatment and foster meaningful alternatives to coercion (Gooding *et al.*, 2018). These are the same values and principles that more generally underpin effective mental healthcare; equitable access to least restrictive environment, ensuring service users' self-determination

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and participation in his/her treatment and the involvement of families in decisions concerning assessment and treatment (Mezzina, 2014, 2016). This means a fundamental shift in psychiatry's current focus, from patient to citizenship (i.e. being concerned with persons with mental disorders as citizens and not, merely, as patients), guardianship to free will, substituting decision making to supported decision making and shared responsibility. In this way, the social mandate of psychiatry changes, from controlling behaviour to social mediation between stakeholders and the community. The ethos of mental healthcare becomes truly 'person-centred' with a 'rights-based' approach and vision (Thornicroft *et al.*, 2010).

Reducing secure care – rethinking service delivery

Calls for a paradigm shift in psychiatry are as old as psychiatry itself. While this is a worthy objective, it is unlikely to happen any time soon (WHO, 2013). In the meantime, it is incumbent upon us to work towards reducing coercion in mental health services worldwide, in its totality and a whole phenomenon. The most obvious and entrenched form of coercive care in high-income countries is in the field of forensic psychiatry. Since the 1990s forensic psychiatry has burgeoned as part of mainstream mental healthcare in most of Western Europe, an unintended consequence of the deinstitutionalisation process (Jansman-Hart *et al.*, 2011). The substantial reduction in the number of psychiatric hospital beds following the closure of mental hospitals was accompanied by an increase in the prison population as well as forensic beds and inconsistent changes in the availability of protective housing, including residential care (Chow and Priebe, 2016). In England, there are currently 7000 to 8000 secure care (forensic) beds. This includes over 750 beds in three high security hospitals, 3500 beds in medium secure care and a similar number in low-secure care ('locked rehabilitation' units) (National Mental Health Development Unit, 2010). Increasing demand for forensic services has also been noted in other countries in Western Europe (Salize *et al.*, 2005).

Forensic psychiatric practice is not uniform or consistent. Admission criteria to secure care vary widely between countries and within same jurisdictions, dependent on a range of factors from the severity of the offending behaviour to the absence of alternative provisions. People tend to stay in these facilities for a long time, not necessarily because of clinical needs (Duke *et al.*, 2018). According to some estimates, a significant proportion of patients in secure settings in the UK, between 20 and 60%, do not need such a high level of security (Shaw *et al.*, 2001). This form of psychiatric care is extremely expensive. Medium secure units in England, for example, cost £1.2 billion in 2009/10 and, on average, £ 175 000 per patient per annum. This amounts to 1% of the entire NHS expenditure, corresponding to 18.9% of all public expenditure on adult mental healthcare (National Mental Health Development Unit, 2010). These are also extremely restrictive forms of care. Most of those detained in forensic hospitals live in circumstances that amount to being under 'suspended citizenship', that is, their full rights as citizens are either limited or compromised as result of their detention. Decisions regarding treatment and discharge from secure services are determined primarily by presumed risk rather than healthcare needs. Secure services offer little in the way of psychosocial rehabilitation or recovery focused care which is inevitable given the high levels of restrictions under which patients are managed. Often these services are remote and disconnected from community resources and services.

Despite the significant investment in the secure care sector its continuing expansion within current models of service delivery, there is a surprising lack of basic information and outcomes about the quality and effectiveness of forensic care provisions in most countries (Shaw *et al.*, 2001). Domains such as quality of life, social function and psychosocial adjustment, which are relevant to those who use the services, are rarely addressed in forensic mental health research (Fitzpatrick *et al.*, 2010). Policies and programmes in relation to secure care do not address the extent to which human rights of service users are routinely compromised in such settings. Available research suggests that the long-term outcome of treatment of mentally disordered offenders (the main client group in forensic psychiatry) is generally poor (Davies *et al.*, 2007). As with involuntary treatment in general, there is hardly any evidence-base for forensic psychiatric interventions including the central tenets of secure care i.e. risk prediction and management.

The entrenchment of the secure care sector within mental health is indicative of a trend towards greater convergence of public protection functions and treatment of mental disorders in many high-income countries (Rutherford, 2010). For example, there is increasing overlap of legislation (in the criminal justice system and mental healthcare), professional practices and patient/offender management although there are fundamental distinctions between mental health services and criminal justice. There is a danger that such convergence will increase the stigma attached to offenders and those with mental health problems and adversely affect their resettlement and reintegration into society. The primary purpose of mental health services is the provision of care and treatment for people with mental health problems and not public protection or managing criminal recidivism. According to Rutherford (2010), it is vital therefore that the lines between prisons and hospitals do not become overly blurred. Prisons should never become a substitute for hospitals, and hospitals should not be designed, managed or function like prisons. It is unethical and anti-therapeutic to combine long-term psychiatric care and forcible detention for the purpose of public protection. Unfortunately, the primary purpose of secure units has become risk management and public protection rather than treatment of mental illness. This has meant the introduction of increasing sanctions and punitive interventions within mental healthcare based on risk profiling rather than as an aide to treatment or to facilitate recovery. If psychiatry wants to position itself as a truly medical discipline, our primary objective should remain the care and treatment of people with mental health problems.

We believe that dismantling the current apparatus of forensic mental healthcare will go a long way towards making psychiatry less coercive and more akin to other healthcare disciplines. Recent experience from Italy shows that this is possible. In the last six years all forensic psychiatric hospitals in Italy have been closed through the creation of new care pathways involving small-scale and high-intensity therapeutic facilities (*Residenze per la Esecuzione della Misura di Sicurezza,* REMS) as part of local community mental health services (Barbui and Saraceno, 2015; De Ambrogi, 2017). This integration of 'forensic care' within general mental healthcare has allowed the adoption of a rehabilitation model to help and support people with long-term mental health problems and a criminal history (or otherwise considered as 'socially dangerous') instead of their long-term containment for public protection. Italy now relies on fewer secure psychiatric beds (1/100 000) compared to most other European countries (Mezzina, 2018).

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Reducing coercion through legislation and policies

Although mental health laws are thought necessary for protecting the rights of people with mental disorders in just under a third of the countries (31%) worldwide have legislation fully implemented. These are mostly high-income countries (WHO, 2014). The availability of mental health legislation does not prevent psychiatric abuse or reduce coercion. For example, maltreatment and violence towards people with mental health problems are reported in countries with well-established mental health legislation and well-resourced mental health systems.

The two most common grounds for authorising involuntary admission of people with mental disorders in most jurisdictions are 'serious likelihood of immediate or imminent danger' and 'the need for treatment' (WHO, 2005). For example, in 12 European member states, dangerousness/safety criteria are still the main conditions for justifying involuntary placement, while in Italy and Spain involuntary treatment is based on 'need for treatment' with no specific reference to classification of danger with regard to risk levels or thresholds (FRA, 2012). The need for treatment should be connected to the right to health and healthcare. This is highlighted in a number of international covenants and standards and is included in the promotion and protection of all human rights including the right to personal, social, economic, cultural and political development. However, ensuring that these needs are protected or facilitated through mental health legislation remain 'controversial topics in the field of mental health' as coercive interventions 'impinge on personal liberty and the right to choose, and they carry the risk of abuse for political, social and other reasons' (WHO, 2005). Current laws embedded in the criminal justice system in many countries regarding 'fitness to plead' and 'fitness to stand trial' also have serious implications for persons with cognitive disabilities. Such laws can result in the denial of equal access to justice, such as fair trial, liberty, legal capacity and equal recognition before the law and may result in long-term psychiatric care and forcible detention.

Reforming mental health legislation may help in decriminalising those with mental health problems and can further protect the rights of those subject to such legislation but revising the law on involuntary treatment by itself is unlikely to change current patterns of coercive care (Care Quality Commission, 2018). This is because changes in legislation alone seldom affect prevailing clinical practices and institutional processes related to the treatment and management of people with mental health problems. For example, attempts at reforming existing mental health legislation in many high-income countries have so far failed to halt or reverse the inexorable increase in the trends of increasing psychiatric detention and continued reliance on coercive care. In England, there has been a 43% increase in psychiatric detentions since 2007 following changes to the 1983 Act (Care Quality Commission, 2018). By contrast, in Finland and Germany, there was a decrease in compulsory admission rates following changes in legislation (Turnpenny *et al.*, 2018). The implementation of Law 180 that closed all psychiatric hospitals in Italy was also followed by a substantial reduction in involuntary treatment rates, currently at 16/100,000, one of the lowest in Europe (Starace *et al.*, 2018).

According to the UN Convention of Rights of People with Disabilities (UNCRPD), current mental health laws are fundamentally discriminatory and inconsistent with the human rights principles (Pūras, 2017). In the wake of the UNCRPD and the increase in coercive care (and discriminatory practice) in many high-income countries it is argued that mental health laws are no longer 'fit for purpose' (Szmukler and Kelly, 2016). It is, therefore, unsurprising that international organisations, service users, politicians and legal experts are all calling for the reappraisal of current mental health legislation and, in particular, abandoning laws applicable only to those considered to have psychosocial disability. What is striking in this context is the lack of any commitment from the psychiatric profession, so far, to address this challenge.

The European Parliament Resolution of 2006 declared that 'the use of force is counterproductive', as is compulsory medication. A Parliamentary Assembly Recommendation of the Council of Europe in 2016 concluded that 'any legal instrument that maintains a link between involuntary measures and disability will be discriminatory and thus violate the CRPD' (Council of Europe, 2016). Instead, it recommended that the Committee of Ministers 'instruct the Committee on Bioethics to focus its work on promoting alternatives to involuntary measures in psychiatry, including by devising measures to increase the involvement of persons with psychosocial disabilities in decisions affecting their health.'

International experiences

The *QualityRights* initiative of the WHO has been at the forefront of ensuring human-rights compliant mental healthcare in several countries. This is a systematised programme that includes assessment, training and quality improvement measures that focus on the human rights in mental health and social care facilities (Funk and Drew, 2017). Forced confinement and the use of physical restraints of people with severe mental health problems within family settings are an endemic problem in several sub-Saharan Africa and Asian countries (Human Rights Watch, 2015, 2016, 2017). In Indonesia, for example, it is estimated that 19 000 people with mental illness are physically restrained in the community. Through a systematic programme, *Bebas Pasung* (free from restraints), involving the provision of community-based mental health services alongside intensive education campaigns, it has been possible to free people from restraints (*pasung*) (Puteh *et al.*, 2011). The chain free initiative in Somalia, supported by the WHO, aims to reduce the number of people restrained in community settings and in hospital through increasing access to mental healthcare (WHO, 2010). In China, a national mental health programme, the '686 program', provides a package of interventions including 'unlocking' by a team of mental health professionals, admission to a psychiatric hospital and community follow up for those restrained in the community. The initial results indicate that 92% of patients remained restraint-free after 7 years (Guan *et al.*, 2015). However, in most of these countries the successful reduction in community-based coercion is not replicated in hospital settings. More often than not, *pasung* is re-imposed following admission to hospital, under the medical guise of psychiatric treatment. It is important that programmes such as *Bebas Pasung* and the Chinese 686 initiatives are not confined to the community and are extended to mental healthcare facilities where compulsion, restraint and seclusion remain the norm.

Conclusion

Most medical care attempts to strike a balance between the benefits of treatment and the risks consequent upon it. When significant numbers of people are harmed or otherwise disadvantaged

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by a clinical intervention it is both unethical and clinically inappropriate to persist with such treatment. Coercive interventions in psychiatry, legitimised by mental health legislation tilts the cost-benefit balance for psychiatric patients in the wrong direction. If we want to comply with the UNCRPD, reduce coercion in mental health services and rehabilitate psychiatric practice, there is an urgent need to re-evaluate current mental health legislation and the practices that follow from it. It is time for the psychiatric profession 'to stand up to this outrage and ensure that no one with mental disorder is chained, literally or symbolically…' (Patel and Bhui, 2018). This will require reliable and comparative information on coercive practices across the spectrum of mental healthcare as well as investment in research and innovation to reduce them. While innovative policies and plans, changes in legislation and re-configuring mental health services are all important they are unlikely to have a significant impact in reducing coercion without fundamental changes in clinical practice and culture of psychiatry.

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References

Akhter SF, Molyneaux E, Stuart R, Johnson S, Simpson A and Oram S (2019) Patients' experiences of assessment and detention under mental health legislation: systematic review and qualitative meta-synthesis. *BJPsych Open* **5**, e37, 1–10. doi:10.1192/bjo.2019.19.

Australian Institute of Health and Welfare (2019) Mental Health Services in Australia. Available at https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/restrictive-practices/seclusion.

Bak J and Aggernæs H (2012) Coercion within Danish psychiatry compared with 10 other European countries. *Nordic Journal of Psychiatry* **66**, 297–302.

Barbui C and Saraceno B (2015) Closing forensic psychiatric hospitals in Italy: a new revolution begins? *The British Journal of Psychiatry* **206**, 445–446.

Bhugra D, Tasman A, Pathare S, Priebe S, Smith S, Torous J, Arbuckle MR, Langford A, Alarcón RD, Chiu HFK and First MB (2017) The WPA-lancet psychiatry commission on the future of psychiatry. *The Lancet Psychiatry* **4**, 775–818.

Burns T, Rugkåsa J, Molodynski A, Dawson J, Yeeles K, Vazquez-Montes M, Voysey M, Sinclair J and Priebe S (2013) Community treatment orders for patients with psychosis (OCTET): a randomised controlled trial. *The Lancet* **381**, 1627–1633.

Care Quality Commission (2017) The state of care in mental health services 2014 to 2017. *Care Quality Commission, Newcastle-upon-Tyne*, Available at www.cqc.org.uk/sites/default/files/20170720_stateofmh_report.pdf.

Care Quality Commission (2018) Mental Health Act - the rise in the use of the MHA to detain people in England. Available at https://www.cqc.org.uk/sites/default/files/20180123_mhadetentions_report.pdf.

Chow WS and Priebe S (2016) How has the extent of institutional mental healthcare changed in Western Europe? Analysis of data since 1990. *BMJ Open* **6**, e010188.

Council of Europe: Parliamentary Assembly Recommendation n. 2091. Recommendation 2091 (2016) The case against a Council of Europe legal instrument on involuntary measures in psychiatry.

Davies S, Clarke M, Hollin C and Duggan C (2007) Long-term outcomes after discharge from medium secure care: a cause for concern. *The British Journal of Psychiatry* **191**, 70–74.

De Ambrogi M (2017) REMS, a new chapter in Italian psychiatry. *The Lancet Psychiatry* **4**, 589–590.

de Jong MH, Kamperman AM, Oorschot M, Priebe S, Bramer W, van de Sande R, Van Gool AR and Mulder CL (2016) Interventions to reduce compulsory psychiatric admissions: a systematic review and meta-analysis. *JAMA Psychiatry* **73**, 657–664.

Department of Health and Social Care (2018) Modernising the Mental Health Act. Increasing choice, reducing compulsion. Final report of the Independent Review of the Mental Health Act 1983. Available at https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review.

de Stefano A and Ducci G (2008) Involuntary admission and compulsory treatment in Europe: an overview. *International Journal of Mental Health* **37**, 10–21.

D'Lima D, Crawford MJ, Darzi A and Archer S (2017) Patient safety and quality of care in mental health: a world of its own? *BJPsych Bulletin* **41**, 241–243.

Drew N, Funk M, Tang S, Lamichhane J, Chávez E, Katontoka S, Pathare S, Lewis O, Gostin L and Saraceno B (2011) Human rights violations of people with mental and psychosocial disabilities: an unresolved global crisis. *The Lancet* **378**, 1664–1675.

Duke LH, Furtado V, Guo B and Völlm BA (2018) Long-stay in forensic-psychiatric care in the UK. *Social Psychiatry and Psychiatric Epidemiology* **53**, 313–321.

Fitzpatrick R, Chambers J, Burns T, Doll H, Fazel S, Jenkinson C, Kaur A, Knapp M, Sutton L and Yiend J (2010) A systematic review of outcome measures used in forensic mental health research with consensus panel. *Health Technology Assessment* **14**(18). https://www.journalslibrary.nihr.ac.uk/hta/hta14180/#/full-report

FRA–European Union Agency for Fundamental Rights (2012) Involuntary placement and involuntary treatment of persons with mental health problems. Luxembourg: Publications Office of the European Union; 2012. ISBN 978-92-9192-949-8. https://doi.org/10.2811/87077.

Funk M and Drew N (2017) WHO qualityrights: transforming mental health services. *The Lancet Psychiatry* **4**, 826–827.

Gaynes BN, Brown CL, Lux LJ, Brownley KA, Van Dorn RA, Edlund MJ, Coker-Schwimmer E, Weber RP, Sheitman B, Zarzar T and Viswanathan M (2017) Preventing and de-escalating aggressive behavior among adult psychiatric patients: a systematic review of the evidence. *Psychiatric Services* **68**, 819–831.

Gooding P, McSherry B, Roper C and Grey F (2018) *Alternatives to Coercion in Mental Health Settings: A Literature Review*. Melbourne: Melbourne Social Equity Institute, University of Melbourne.

Goulet MH, Larue C and Dumais A (2017) Evaluation of seclusion and restraint reduction programs in mental health: a systematic review. *Aggression and Violent Behavior* **34**, 139–146.

Guan L, Liu J, Wu XM, Chen D, Wang X, Ma N, Wang Y, Good B, Ma H, Yu X and Good MJ (2015) Unlocking patients with mental disorders who were in restraints at home: a national follow-up study of China's new public mental health initiatives. *PloS One* **10**, e0121425.

Henderson C, Flood C, Leese M, Thornicroft G, Sutherby K and Szmukler G (2004) Effect of joint crisis plans on use of compulsory treatment in psychiatry: single blind randomised controlled trial. *BMj* **329**, 136.

Human Rights Watch. 'Chained Like Prisoners' Abuses Against People with Psychosocial Disabilities in Somaliland (2015) Avialable at https://www.hrw.org/report/2015/10/25/chained-prisoners/abuses-against-people-psychosocial-disabilities-somaliland.

Human Rights Watch (2016) "Like Living in Hell". Abuses against people with Psychosocial disabilities in Indonesia. Available at https://www.hrw.org/report/2016/03/20/living-hell/abuses-against-people-psychosocial-disabilities-indonesia.

Human Rights Watch (2017) "Like A Death Sentence". Abuses against Persons with Mental Disabilities in Ghana. Available at https://www.hrw.org/report/2012/10/02/death-sentence/abuses-against-persons-mental-disabilities-ghana.

Jaeger S, Pfiffner C, Weiser P, Längle G, Croissant D, Schepp W, Kilian R, Becker T, Eschweiler G and Steinert T (2013) Long-term effects of involuntary hospitalization on medication adherence, treatment engagement and perception of coercion. *Social Psychiatry and Psychiatric Epidemiology* **48**, 1787–1796.

Jansman-Hart EM, Seto MC, Crocker AG, Nicholls TL and Côté G (2011) International trends in demand for forensic mental health services. *International Journal of Forensic Mental Health* **10**, 326–336.

Johnson S (2013) Can we reverse the rising tide of compulsory admissions? *The Lancet* **381**, 1603–1604.

Kallert TW, Glöckner M and Schützwohl M (2008) Involuntary vs. Voluntary hospital admission. *European Archives of Psychiatry and Clinical Neuroscience* **258**, 195–209.

Katsakou C and Priebe S (2006) Outcomes of involuntary hospital admission–a review. *Acta Psychiatrica Scandinavica* **114**, 232–241.

Kelly BD, Emechebe A, Anamdi C, Duffy R, Murphy N and Rock C (2015) Custody, care and country of origin: demographic and diagnostic admission statistics at an inner-city adult psychiatry unit. *International Journal of Law and Psychiatry* **38**, 1–7.

Luciano M, Sampogna G, Del Vecchio V, Pingani L, Palumbo C, De Rosa C, Catapano F and Fiorillo A (2014) Use of coercive measures in mental health practice and its impact on outcome: a critical review. *Expert Review of Neurotherapeutics* **14**, 131–141.

McLaughlin P, Giacco D and Priebe S (2016) Use of coercive measures during involuntary psychiatric admission and treatment outcomes: data from a prospective study across 10 European countries. *PloS One* **11**, e0168720.

Mezzina R (2014) Community mental health care in Trieste and beyond: An "Open Door–No Restraint" system of care for recovery and citizenship. *The Journal of Nervous and Mental disease* **202**, 440–445.

Mezzina R (2016) Creating mental health services without exclusion or restraint but with open doors Trieste, Italy. *L'information Psychiatrique* **92**, 747–754.

Mezzina R (2018) Forty years of the Law 180: the aspirations of a great reform, its successes and continuing need. *Epidemiology and Psychiatric Sciences* **27**, 336–345.

Mezzina R and Vidoni D (1995) Beyond the mental hospital: crisis intervention and continuity of care in trieste. A four-year follow-up study in a community mental health centre. *International Journal of Social Psychiatry* **41**, 1–20.

Mezzina R, Rosen A, Amering M and Javed A (2019) The practice of freedom: Human rights and the global mental health agenda. In Javed A and Fountoulakis KN (eds), *Advances in Psychiatry*. Cham: Springer, pp. 483–515.

Molodynski A (2017) Coercion in mental healthcare: different perspectives, similar concerns and a united call for action. *BJPsych International* **14**, 55–56.

National Mental Health Development Unit (2010) *Pathways to unlocking secure mental healthcare*. London: Sainsbury Centre for Mental Health. Available at https://www.centreformentalhealth.org.uk/Handlers/Download.ashx?IDMF=c651bae2-a910-4b3b-b788-136b66ec0966.

National Survivor User Network/MIND (2015) Restraint in Mental Health Services. What the Guidance Says. MIND, London. Available at https://www.mind.org.uk/media/3352178/restraintguidanceweb.pdf.

NHS Digital (2016) Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment. Uses of the Mental Health Act: Annual Statistics, 2015/16. Health and Social Care Information Centre. November 2016. Available at https://files.digital.nhs.uk/publicationimport/pub22xxx/pub22571/inp-det-m-h-a-1983-sup-com-eng-15-16-rep.pdf.

Newton-Howes G and Mullen R (2011) Coercion in psychiatric care: systematic review of correlates and themes. *Psychiatric Services* **62**, 465–470.

Paksarian D, Mojtabai R, Kotov R, Cullen B, Nugent KL and Bromet EJ (2014) Perceived trauma during hospitalization and treatment participation among individuals with psychotic disorders. *Psychiatric Services* **65**, 266–269.

Patel V and Bhui K (2018) Unchaining people with mental disorders: medication is not the solution. *The British Journal of Psychiatry* **212**, 6–8.

Priebe S, Frottier P, Gaddini A, Kilian R, Lauber C, Martínez-Leal R, Munk-Jørgensen P, Walsh D, Wiersma D and Wright D (2008) Mental health care institutions in nine European countries, 2002 to 2006. *Psychiatric Services* **59**, 570–573.

Pūras D (2017) Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. UN General Assembly A/HRC/35/21. March 2017. Available at http://undocs.org/A/HRC/35/21.

Puteh I, Marthoenis M and Minas H (2011) Aceh Free Pasung: Releasing the mentally ill from physical restraint. *International Journal of Mental Health Systems* **5**, 10.

Raboch J, Kališová L, Nawka A, Kitzlerová E, Onchev G, Karastergiou A, Magliano L, Dembinskas A, Kiejna A, Torres-Gonzales F and Kjellin L (2010) Use of coercive measures during involuntary hospitalization: findings from ten European countries. *Psychiatric Services* **61**, 1012–1017.

Rains LS, Zenina T, Dias MC, Jones R, Jeffreys S, Branthane-Foster S, Lloyd-Evans B and Johnson S (2019) Variations in patterns of involuntary hospitalisation and legal frameworks: an international comparative study. *Lancet Psychiatry* (published online April 3, 2019). Available at http://dx.doi.org/10.106/S2215-0366(19)30090-2.

Regione Piemonte (2017) Commissione parlamentare per la tutela e la promozione dei diritti umani - audizione nell'ambito dell'indagine conoscitiva sui livelli e i meccanismi di tutela dei diritti umani, vigenti in Italia e nella realtà internazionale, sulla contenzione meccanica. Regione Piemonte, 6 dicembre 2017. http://www.quotidianosanita.it/allegati/allegato2867110.pdf.

Rose D, Perry E, Rae S and Good N (2017) Service user perspectives on coercion and restraint in mental health. *BJPsych International* **14**, 59–61.

Rosen A, O'Halloran P and Mezzina R (2012) International trends in community mental health services. In McQuistion HL, Sowers WE, Ranz JM and Feldman JM (eds), *Handbook of Community Psychiatry*. New York, NY: Springer, pp. 389–404.

Rutherford M (2010) *Blurring the Boundaries*. London: Sainsbury Centre for Mental Health.

Sailas EE and Fenton M (2000) Seclusion and restraint for people with serious mental illnesses. *Cochrane Database of Systematic Reviews*, Issue 1. Art. No.: CD001163. doi: 10.1002/14651858.CD001163.

Sailas E and Wahlbeck K (2005) Restraint and seclusion in psychiatric inpatient wards. *Current Opinion in Psychiatry* **18**, 555–559.

Salize HJ and Dressing H (2004) Epidemiology of involuntary placement of mentally ill people across the European Union. *The British Journal of Psychiatry* **184**, 163–168.

Salize HJ, Lepping P and Dressing H (2005) How harmonized are we? Forensic mental health legislation and service provision in the European Union. *Criminal Behaviour and Mental Health* **15**, 143–147.

Shaw J, Davies J and Morey H (2001) An assessment of the security, dependency and treatment needs of all patients in secure services in a UK health region. *The Journal of Forensic Psychiatry* **12**, 610–637.

Starace F, Baccari F and Mungai F (2018) Salute Mentale Italia. La Mappa della Disuguaglianze. SIEP – Quaderni di Epidemiologia Psichiatrica. N.2/2018 http://siep.it/wp-content/uploads/2018/07/La-Salute-Mentale-in-Italia-SIEP-02-2018.pdf.

Swartz MS, Swanson JW and Hannon MJ (2003) Does fear of coercion keep people away from mental health treatment? Evidence from a survey of persons with schizophrenia and mental health professionals. *Behavioral Sciences and the Law* **21**, 459–472.

Szmukler G (2015) Compulsion and "coercion" in mental health care. *World Psychiatry* **14**, 259.

Szmukler G and Appelbaum PS (2008) Treatment pressures, leverage, coercion, and compulsion in mental health care. *Journal of Mental Health* **17**, 233–244.

Szmukler G and Kelly BD (2016) We should replace conventional mental health law with capacity-based law. *The British Journal of Psychiatry* **209**, 449–453.

Szmukler G, Daw R and Callard F (2014) Mental health law and the UN convention on the rights of persons with disabilities. *InternationalJjournal of Law and Psychiatry* **37**, 245–252.

Thornicroft G and Henderson C (2016) Joint decision making and reduced need for compulsory psychiatric admission. *JAMA Psychiatry* **73**, 647–648.

Thornicroft G and Slade M (2014) New trends in assessing the outcomes of mental health interventions. *World Psychiatry* **13**, 118–124.

Thornicroft G, Alem A, Dos Santos RA, Barley E, Drake RE, Gregorio G, Hanlon C, Ito H, Latimer E, Law A and Mari J (2010) WPA guidance on steps, obstacles and mistakes to avoid in the implementation of community mental health care. *World Psychiatry* **9**, 67–77.

Thornicroft G, Farrelly S, Szmukler G, Birchwood M, Waheed W, Flach C, Barrett B, Byford S, Henderson C, Sutherby K and Lester H (2013) Clinical outcomes of Joint Crisis Plans to reduce compulsory treatment for people with psychosis: a randomised controlled trial. *The Lancet* **381**, 1634–1641.

https://doi.org/10.1017/S2045796019000350 Published online by Cambridge University Press

Tingleff EB, Bradley SK, Gildberg FA, Munksgaard G and Hounsgaard L (2017) "Treat me with respect". A systematic review and thematic analysis of psychiatric patients' reported perceptions of the situations associated with the process of coercion. *Journal of Psychiatric and Mental Health Nursing* **24**, 681–698.

Turnpenny A, Petri G, Finn A, Beadle-Brown J and Nyman M (2018) Mapping and understanding exclusion: institutional, coercive and community-based services and practices across Europe. Mental Health Europe & University of Kent, December 2017.

Weich S, McBride O, Twigg L, Keown P, Cyhlarova E, Crepaz-Keay D, Parsons H, Scott J and Bhui K (2014) Variation in compulsory psychiatric inpatient admission in England: a cross-sectional, multilevel analysis. *Health Services and Delivery Research* **2**, 90. Available at https://doi.org/10.3310/hsdr02490

World Health Organization (2005) Resource Book on Mental Health, Human Rights and Legislation. WHO, Geneva. Available at https://ec.europa.eu/health/sites/health/files/mental_health/docs/who_resource_book_en.pdf.

World Health Organization (2010) A situation analysis of mental health in Somalia. Available at http://applications.emro.who.int/dsaf/EMROPUB_2010_EN_736.pdf.

World Health Organization (2013) The European Mental Health Action Plan 2013 −2020. WHO, Copenhagen. Available at http://www.euro.who.int/en/publications/abstracts/european-mental-health-action-plan-20132020-the.

World Health Organization (2014) Mental Health Legislation worldwide: WHO Mental Health Atlas. https://www.Mindbank.Info/Item/5648.

World Health Organization (2018) Mental health, human rights and standards of care [cited 2018 Jul 25]. Available at http://www.euro.who.int/en/publications/abstracts/mental-health,-human-rights-and-standards-of-care-2018.

Wright S (2003) Control and restraint techniques in the management of violence in inpatient psychiatry: a critical review. *Medicine, Science and the Law* **43**, 31–38.

Zinkler M and Priebe S (2002) Detention of the mentally ill in Europe–a review. *Acta Psychiatrica Scandinavica* **106**, 3–8.

https://doi.org/10.1017/S2045796019000350 Published online by Cambridge University Press