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Advance Psychiatry and Mental Health Across the World

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WPA Position Statement and Call to Action: Implementing Alternatives to Coercion: A Key Component of Improving Mental Health Care

Background

The purpose of this Position Statement is (1) to recognize the substantive role of psychiatry in implementing alternatives to coercion in mental health care and (2) to support action in this regard, essential to improving mental health treatment and care. The call for alternatives to coercion in mental health care is growing both within the profession and among people with lived experience of mental health conditions. There is widespread agreement that coercive practices are over-used.[i] Considerable work is warranted across the mental health sector and in communities and governments to ensure that people living with mental disorders and psychosocial disabilities uniformly have access to high-quality care and support that meet their needs and respect their personhood and rights.

Of central concern is the protection of human rights, and the extent to which coercive interventions violate these. These include rights to: life, liberty, and security of person; autonomy; freedom from torture, inhuman or degrading treatment; physical and psychological integrity of the person; non-discrimination; and a home and family life. These rights have been set out most recently in the UN Convention on the Rights of Persons with Disabilities (2006) as they apply specifically to people with disabilities, including those with psychosocial disabilities. The question of whether coercive interventions can ever be justified as part of mental health treatment, to protect rights holders' own interests or on other grounds, is highly contested.[ii,iii,iv] A similar question arises about coercion interventions used with persons with delirium or dementia in general health care systems .This Position Statement recognises the diversity of views and experiences among mental health professionals, people with lived experience of mental health conditions and their families and carers.

The WPA emphasises that this Position Statement and Call to Action is relevant and vital to

improving the quality of mental health care in low-, middle-, and high-income countries. It has been developed in consultation with member societies as detailed in the report found here. It marks an important step in a longer-term process, which will continue to engage with member societies, people with lived experience of mental health conditions, families, and other partners to encourage and support the implementation of alternatives to coercion in mental health care. This statement sets a direction and provides a guide for action, based on widespread agreement that coercion is overused in mental health systems and that implementing alternatives is crucial to improve quality of care and promote the human rights of people with mental disorders and psychosocial disabilities.

Complexity of Coercion in the Mental Health Sector

In this Position Statement, the term 'coercion' describes a range of interventions, from involuntary treatment to forceful action and threats undertaken in the course of providing treatment or addressing the perceived harm that a person poses to herself/himself or others due to a mental health disorder or psychosocial disability.

Practices that constitute coercion include:

- **Formal detention** (or 'involuntary hospitalisation') restricting the ability of an individual to leave a facility or treatment environment
- **Treatment without consent** (or 'compulsory treatment'), any form of treatment including the use of psychotropic medication
- **Seclusion** locking or confining a person to a space or room alone
- **Restraint** actions aimed at controlling a person's physical movement, including holding by other person(s), the use of any physical devices ('mechanical restraint', chaining etc.) and the use of psychotropic drugs for the primary purpose of controlling movement ('chemical restraint'). This applies irrespective of whether the action is considered "safe" or "unsafe". Note: chemical restraint does NOT include the appropriate use of medication prescribed for treatment purposes.

The use of coercive practices, such as those listed above, carries the risk of harmful consequences, including trauma and death.[v,vi,vii] People who have experienced coercion in mental health services, as well as their family members and supporters, and psychiatrists and other mental health professionals promoting quality care have drawn attention to some of the harms of those practices through testimony and advocacy.[viii] Individuals subject to physical coercion are susceptible to harms that include physical pain, injury and death. Individuals who have experienced trauma in the past (such as family violence, sexual assault or other abuse) are especially vulnerable to harm from coercive practices.[ix] The use of coercive measures can traumatise or re-traumatise patients, undermine therapeutic relationships, discourage trust in mental health systems, and dissuade service users and family members from seeking help in the future. Coercion may also traumatise other service users,

damage morale among or traumatise mental health workers, and contribute to tarnishing the image of psychiatry as a medical discipline.[x]

The WPA acknowledges the complexity of the use of coercion in clinical practice. There is a range of views among clinicians about the appropriateness and feasibility of completely abolishing the use of coercion.[xi] Some believe that judicious and limited use of some coercive practices, such as involuntary hospitalisation, is essential to: (1) protect patients from harming themselves or others or (2) provide treatment for people whose psychosocial disability may impede their capacity to make decisions about their treatment. This includes persons with life-threatening conditions such as delirium (e.g. during alcohol withdrawal) or malnutrition in dementia. Others believe that elimination is possible if recovery-oriented systems of care are established to effectively prevent the extreme crisis situations described above. This includes appropriate community responses and care for people who use licit and illicit substances. Community attitudes and law also play a critical role in regulating involuntary detention and treatment in mental health care.

Of primary concern is whether it is possible without involuntary treatment to meet the needs and interests of some service users, such as those with suicidal intent, intent to harm others, acute withdrawal or other somatic complications who refuse or are unable to consent to treatment. Other concerns include the question of competing rights and the current state of mental health systems. In many parts of the world, health services face systemic challenges and barriers such as high demand, underfunding, a lack of mental health specialists, and very few clinical staff with training and experience in care for people with mental health problems. In many places there is neither access to care nor to professional support for family members providing care, and the facilities and resources that are available fail to meet basic standards of care.

Overuse of coercion in mental health care, however, is prevalent in high-income countries (HICs) as well as low- and middle-income countries (LMICs). A range of social, cultural, and economic barriers to implementing high quality alternatives may exist in all these settings irrespective of the level of resourcing. Despite these barriers, significant steps have been taken to implement alternatives to coercion and rights-based mental health treatment and care, including in places with few material resources. A case study of the Quality Rights Gujarat initiative, provided below, demonstrates a strong example of how this has been achieved in the public health system of one state in India. Patterns of practice across the mental health professions, attitudes toward care in health service management and workers, and the arrangement of facilities all act as facilitators or barriers to implementing alternatives to coercion in services across a wide range of settings.

WPA Call for Action

The WPA advocates a practical approach to implementing viable alternatives to coercion. Failing to put these in place poses risks for people in need of treatment, especially when stigma and discrimination surrounding mental disorder and psychosocial disabilities prompt fear, exclusion, sensationalised media coverage, and politicisation of efforts to stop coercive practices.

There is a considerable and growing evidence base to support the implementation of alternatives to coercion[xii]. Research and guidance are now available to support implementation in a range of social and cultural settings across low-income, middle-income and high-income countries. These alternatives support the rights of persons living with mental disorders and associated psychosocial disabilities without reducing access to effective care or increasing safety risks for themselves or staff. The WPA calls on psychiatrists, clinical care providers, and policymakers to:

- Consider the evidence base relating to alternatives to coercion (such as 'Safewards', 'Six Core Strategies', 'open door policies', and the WHO Quality Rights Initiative), and learn from the experiences of those who have generated change. An extensive list of resources can be found in the Discussion Paper and case studies linked to this document below.
- Identify alternatives that are feasible to implement.
- Take active steps to work with partners to develop and implement evidence-based alternatives to coercion in the delivery of mental health care. The importance of psychiatrists working with all stakeholders is exemplified by the WPA recommendations on best practices in working with service users and family carers that are now incorporated in the WPA ethical declarations.[xiii]

The Way Forward

The WPA wishes to emphasise that implementing alternatives to coercion is an essential element of the broader transition across the mental health sector toward recovery-oriented and trauma-informed systems of care. Recovery-oriented treatment and care require not only respect for human rights and service user involvement, but realisation of rights through sound pathways to non-coercive care. This includes attention to all the important steps along the way – prevention, early intervention, and continuity beyond clinical settings – to provide integrated and personalised care, maximise therapeutic outcomes and promote the rights and recovery of people with mental health conditions and psychosocial disabilities.

The WPA recommends a program of continuing work to support the following changes:

Changes to delivery of treatment and care

Psychiatrists in leadership roles, and all those working with other colleagues to provide treatment and care have a part to play in enabling changes so that:

1. Health services responsible for treatment and care examine existing evidence and successful experience elsewhere to identify, adapt and implement non-coercive and trauma-informed practices such as those described in 'Safewards', 'Six Core Strategies', 'open door policies', and the WHO Quality Rights Initiative.
2. Health service managers and training providers work together to equip all staff involved in mental health service delivery (including those working in general health and social care) to provide high-quality non-coercive treatment and care.
3. Mental health service providers ensure that service delivery staff are informed about and trained in the use of advance care directives and supported decision-making to empower mental health service users to make informed choices about their treatment and care.
4. Mental health care providers make use of evidence-based resources for implementing non-coercive practices and improving quality of care.
5. Mental health care providers adopt a recovery oriented and trauma informed approach to care which places emphasis on the experience and feedback from service users in finding alternatives to coercion and preventing problematic situations from arising.
6. Mental health care providers form meaningful partnerships with service users and families in governance and review of treatment and care which ensures that lived experience of coercion is properly considered.

Policy Changes

Psychiatrists have an important role in persuading policymakers to

1. Give priority to supporting the implementation of alternatives to coercion in mental health care and regard successful implementation as an indicator of mental health service performance. This support includes allocating appropriate resources for implementation.
2. Work with health facilities to establish public databases to record the frequency and duration of detention and involuntary treatment, and of seclusion and restraint used in mental health services for benchmarking and accountability.
3. Support legislative change by governments and lawmakers to strongly regulate coercive measures, and to promote incentives to find alternatives to coercion.

4. Give priority to supporting intervention early in the onset of an episode of mental ill health. This is crucial to avoiding situations in which coercion is perceived as necessary.

Psychiatrists also have a key role to play in:

5. Supporting advocacy in communities and with politicians to generate political will for change, including the development and introduction of evidence-informed policy.
6. Advocating for the involvement of service users and their families and carers in policy-making and in implementing change in services to ensure that measures are practical, effective, and informed by people with lived experience of mental health conditions.
7. Sharing experiences with colleagues and partners in other settings and countries.

Changes in service culture and attitudes

Psychiatrists need to work with

1. Health institutions, such as government agencies, treatment facilities, professional organisations/societies, and with training institutions such as universities to shift professional, sectoral, and public norms surrounding the use of coercion in mental health services.
2. Other mental health professionals and policy-makers to raise awareness about the availability of alternatives to coercion and the risks involved with using coercive practices, and to increase understanding of the circumstances in which coercion is most likely to be used and how those circumstances may be altered. Families and informal carers of people with a lived experience of mental health conditions also need greater knowledge in these spheres.
3. Mental health professionals, policy-makers and media outlets to reduce stigma and discrimination against people with mental ill health. Stigma feeds misguided perceptions that widespread use of coercive mental health practices is necessary for public safety, and places undue pressure on service providers to overuse coercive practices.
4. Health services responsible for treatment and care to establish a culture of participation, in which meaningful involvement of mental health service users and their families and carers is the norm when it comes to decision-making.

Changes in professional training

1. Curricula of medical schools and training schools for psychiatrists and other mental health professionals should include ethical principles and human rights in medicine and address the need for implementing alternatives to coercion in mental health care and include mental health service users and their families and carers in the development and delivery of training.

Research

1. Research institutions and funding bodies should prioritise development and testing of alternatives

to coercion and prevention of coercion appropriate to a wide range of settings, including settings with vastly different access to resources.[xiv]

2. Researchers should aim to contextualise existing resources, diversify the evidence base, and generate a better understanding of barriers, enablers, and consequences of change.
3. Researchers should engage people with lived experience of mental health conditions and their families and carers, as people with lived experience of coercion bring insight that is crucial to successful development and evaluation of non- coercive mental health care.
4. In addition to investigating formal health care settings, research institutions and funding bodies should address coercion in informal settings, such as family homes, communal areas in villages and towns, including sheds, cages, 'prayer camps', or 'mandated re-education centres', as a matter of serious concern, especially in countries with significant mental health treatment gaps. More work is needed to understand how to eliminate such practices.

Resources Produced by the WPA

The WPA is committed to supporting mental health professionals and their organisations to implement alternatives to coercion. To this end, the WPA has produced the following resources in partnership with the RANZCP and in consultation with our member societies:

- Implementing Alternatives to Coercion in Mental Health Care – This Background Paper from the WPA Taskforce outlines recent developments in practice, research and international human rights law concerning coercion in mental health settings with the aim of supporting psychiatrists and other mental health professionals in their work towards improving the quality and safety of mental health services and putting sound alternatives to coercion in place.
- Implementing alternatives to coercion in mental health care: A growing list of tools and resources – Findings from a review conducted on behalf of the WPA to identify existing tools and resources available to support implementation of non-coercive practices. This document will be extended and updated in 2023.
- Implementing Alternatives to Coercion: Examples from Practice – A set of three case studies that examine how progress has been achieved in different settings, including those in three geopolitical regions and two low- and middle-income countries.
    - Campo Abierto, Colombia – an example of a mental health facility implementing alternatives to coercion
    - Quality Rights Gujarat (India) – an example of implementing alternatives to coercion at the state level
    - Towards eliminating coercion in Australia and New Zealand – an example of implementing alternatives to coercion at the national level

All of the resources above are available on the WPA website.

[i] See for example Dinesh Bhugra et al, 'The WPA- Lancet Psychiatry Commission on the Future of Psychiatry' (2017) 4(10) The Lancet Psychiatry 775; Faraaz Mahomed, Michael Ashley Stein and Vikram Patel, 'Involuntary Mental Health Treatment in the Era of the United Nations Convention on the Rights of Persons with Disabilities' (2018) 15(10) PLOS Medicine e1002679, 3.

[ii] United Nations. Committee on Convention on the Rights of Persons with Disabilities. *General Comment on Article 12: Equal recognition before the law*; 2014

[iii] Freeman MC, Kolappa K, Caldas de Almeida JM et al. Reversing hard won victories in the name of human rights: a critique of the General Comment on Article 12 of the UN Convention on the Rights of Persons with Disabilities. Lancet Psychiatry 2015;2:844-50

[iv] Dawson J. A realistic approach to assessing mental health laws' compliance with the UNCRPD. Int J Law Psychiatry 2015;40:70-9.

[v] Wright M. Review of seclusion, restraint and observation of consumer with a mental illness in NSW Health facilities. December 2017.

[vi] World Health Organization. Freedom from coercion, violence and abuse, WHO QualityRights core training: mental health and social services. Course Guide. Geneva: World Health Organization. https://apps.who.int/iris/handle/10665/329582.

[vii] Kersting XAK, Hirsch S, Steinert T. Physical harm and death in the context of coercive measures in psychiatric patients: A systematic review. Frontiers in psychiatry. 2019;10:400

[viii] Spandler H, Anderson J, Sapey B (eds). Madness, distress and the politics of disablement. Bristol: Policy Press, 2015; Farbis E. Tranquil prisons: Mad peoples experiences of chemical incarceration under community treatment orders. Toronto: University of Toronto Press, 2011; Flynn E, Arstein-Kerslake A, De Bhalis C et al (eds). Global perspectives on legal capacity reform: Our voices, our stories. London: Routledge, 2018.

[ix] Jennings A. Models for developing trauma-informed behavioral health systems and trauma-specific services. Alexandria, VA: National Association of State Mental Health Program Directors, National Technical Assistance Center for State Mental Health Planning, 2004

[x] Bonner G, Lowe T, Rawcliffe D et al. Trauma for all: A pilot study of the subjective experience of physical restrain for mental health inpatients and staff in the UK. J Psychiatr Ment Health Nurs 2002;9:465-73.

[xi] See, eg, Tilman Steinert, 'The UN Committee's interpretation of "will and preferences" can violate human rights' (2019) 18(1) World Psychiatry 45–46; Paul Appelbaum, 'Saving the UN Convention on the Rights of Persons with Disabilities – from Itself' (2019) 18(1) World Psychiatry 1.

[xii] World Psychiatric Association Taskforce on Minimising Coercion (2020) Implementing Alternatives to Coercion in Mental Health Care: Discussion Paper from the Taskforce. Consultation Draft, World Psychiatric Association.

[xiii] Wallcraft J, Amering M, Freidin J, Davar B, Froggatt D, Jafri H, Javed A, Katontoka S, Raja S, Rataemane S, Steffen S, Tyano S, Underhill C, Wahlberg H, Warner R, Herrman H 2011. Partnerships for better mental health worldwide: WPA recommendations on best practices in working with service users and family carers. *World Psychiatry* 10: 229-236

[xiv] Faraaz Mahomed, Michael Ashley Stein and Vikram Patel, 'Involuntary Mental Health Treatment in the Era of the United Nations Convention on the Rights of Persons with Disabilities' (2018) 15(10) PLOS Medicine e1002679, 5; Dinesh Bhugra et al, 'The WPA- Lancet Psychiatry Commission on the Future of Psychiatry' (2017) 4(10) The Lancet Psychiatry 775, 797.

*This Position Statement arises from the work of "The WPA program on Implementing alternatives to coercion in mental health care", established in accordance with the WPA Action Plan 2017-2020 approved by the WPA General Assembly in October 2017. A WPA Task Force has guided the work, co-chaired by Prof Silvana Galderisi (representing the WPA Standing Committee on Ethics and Review) and A/Prof John Allan (President, Royal Australian and New Zealand College of Psychiatrists [RANZCP]) and drawing from valuable contributions by two members of the WPA Service Users and Family Carers Advisory Group. [The members of this Task Force, and its reference group are listed in the attached documents.] Since this statement was issued in 2020, a WPA Working Group (listed below) has been established to continue consultation and development of tools and resources to support implementation of alternatives to coercion. This work has benefitted from funding and in-kind support granted by RANZCP and the Japanese Society of Psychiatry and Neurology as well as technical support by Community Works, an organisation that specializes in participatory approaches to implementing community mental health initiatives, and by the Melbourne Social Equity Institute, The University of Melbourne.

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