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TRANSFORMING MENTAL HEALTH CARE

Insights from the WPA Consultation on Implementing Alternatives to Coercion

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1. BACKGROUND

In 2022 the World Psychiatric Association (WPA) Working Group on Implementing Alternatives to Coercion launched consultations to inform action on addressing coercion in mental health care settings. In collaboration with the WPA Working Group on Partnerships with Service Users and Family Carers (SUC Working Group), parallel online consultations were held with:

- WPA Member Societies on behalf of the psychiatrists they represent
- People with lived experience of mental health conditions (PLEx),
- Family members and informal caregivers (FMIC) of PLEx,
- Organisations representing PLEx and FMIC.

The period for collecting survey responses concluded in May 2023.This report compiles insights gathered from all participant groups above. It provides an overview of the consultation methods and a demographics snapshot of who responded. It presents the findings at a glance, before delving into more in-depth exploration of responses to consultation questions followed by discussion of key learnings and recommendations.

This report reflects both overlaps and differences in perspectives, while concentrating on points of convergence across viewpoints expressed by the diverse range of consultation participants. Through a collaborative effort, this consultation has sought to spark conversations amongst psychiatrists while prioritising the voices of people with mental health conditions and recognising them as rights-holders whose needs and interests are central to quality of care. In doing so, we encapsulate a distinctive perspective on implementing alternatives to coercion in mental health care, whilst shedding light on the ways in which people have experienced disadvantage, discrimination and other forms of harm when coercive practices have been used in psychiatric settings around the world.

It is important to note that people with lived experience of mental health conditions (PLEx) and family members and informal carers (FMIC) were central to all stages of designing and delivering this consultation. Analysis of consultation responses from PLEx and FMIC was led by Guadalupe Morales (who is a PLEx) and Martha Savage (who is a FMIC) supported by professional social researchers (two of whom are also FMIC) and experienced psychiatrists.

2. DEFINITION OF KEY TERMS

Coercion:

The term 'coercion' describes a range of interventions, from involuntary treatment to forceful action and threats undertaken in the course of providing treatment. This includes:

- **Formal detention** (including involuntary hospitalisation): restricting the ability of an individual to leave a facility
- **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 prolonged or unsafe holding by other person(s), the use of any physical devices ('mechanical restraint', such as chaining) and the use of psychotropic drugs for the primary purpose of controlling movement ('chemical restraint').

People with lived experience of mental health conditions (PLEx):

This term refers to all people who have received a diagnosis of a mental health condition and/or have received treatment for mental health concerns, whether in the past or ongoing. Our choice of terminology is based on the Lancet Commission on Ending Stigma and Discrimination in Mental Health, which identified this as the most acceptable term through a survey of the lived experience community.[1] We acknowledge that there is no consensus on one universally preferred term. We also recognise people with lived experience as rights holders whose needs and interests should form the central concern of psychiatric practice.

Service Users:

Occasionally the term 'service users' is used to refer more specifically to people with lived experience who have used or are using mental health services.

Family members and informal caregivers (FMIC):

This refers to people who are close relatives and/or have been the primary carers of one or more person(s) with a mental health condition. 'And/or' is often used to acknowledge that not all informal caregivers are family members. It is worth noting that four family members who responded to this survey did so on behalf of loved ones who could no longer respond for themselves, having died as a result of coercive practices in mental healthcare settings.

3. FINDINGS AT A GLANCE

The diagrams below present a snapshot of core findings from two online consultation surveys: Survey 1 with WPA Member Societies on behalf of psychiatrists in their countries and regions and Survey 2 with PLEx, FMIC and organisations representing PLEx and/or FMIC.

Survey 1: WPA Member Societies

Increased awareness about the use of coercion

100%

of Member Society respondents reported that their country has **increased awareness or taken steps** to address coercion in mental healthcare.

Working with and engaging Service Users

94%

of Member Society respondents indicated that they **work with Service Users**, mostly through alliances with NGOs, advocacy groups and Service Users groups.

▶ 28%

of Member Society respondents indicated that they **directly engage Service Users** through mechanisms such as consultations and committees.

61%

of Member Society respondents indicated that they **work with FMIC**, mostly through alliances with NGOs, advocacy groups and Service Users groups.

16%

of Member Society respondents indicated that they **directly engage FMIC** in their activities.

Member Societies identify opportunities for support by the WPA

9

Member Societies **called for training and professional guidelines from WPA** to support delivery of treatment and care as outlined in the WPA Position Statement on Implementing Alternatives to Coercion.

▼

This included seeking support with the training and delivery of:

- trauma-informed care
- supported decision-making
- a set of international norms and guidelines (as set and produced by the WPA)
- other evidence-based protocols

Respondents also sought support with:

- the translation of guidelines
- investigate coercion on non-psychiatric wards

Steps being taken to address overuse of coercion

7

Member Society respondents **are taking a public position** or creating guidelines or programs in order to impact reform and legislation on coercion in mental health care.

3

Member Societies (Uganda, Cambodia and Croatia) noted there were **established or new hospital regulations and guidelines being implemented** across their institutions and regions.

Next steps for Member Societies in supporting alternatives to coercion in mental health care

100%

of Member Society respondents reported **planning to take action on supporting alternatives to coercion** in mental health care.

47%

of Member Societies noted having **planned or current involvement in alliances or working groups** to address coercion.

Service culture change

When asked what tools, resources, or actions by the WPA would help them enable changes in service cultures to address overuse of coercion, here is what three Member Societies said:

> "Although the WPA has stated that this is a particularly difficult subject, the **WPA could also lead an effort to guide the discussion from reducing coercion to improving human dignity**... In some situations, very careful and well thought use of coercion can actually improve human dignity more than not using coercion...Thus, thinking of alternatives for coercion is important, but only when these alternatives can increase the underlying values such as human dignity more than coercion."

> "We have experience with the WHO QualityRights initiative tools, however we will have a flexible approach and include some of the tools recommended by the WPA, especially the ones which have been proven as easily implementable in the regions of South/Eastearn Europe...**Raising awareness** of the problem of coercion in somatic wards (for patients with delirium after surgery in example, as stated before), may help equalize the problem among people with mental illness and without it and possibly help reduce the stigma around it."

Survey 2: PLEx, FMIC and organisations

We heard from 98 People with Lived Experience (PLEx), 33 Family Members and Informal Caregivers (FMIC), and 11 organisations representing one or both cohorts.

Who experienced coercion and how recently?

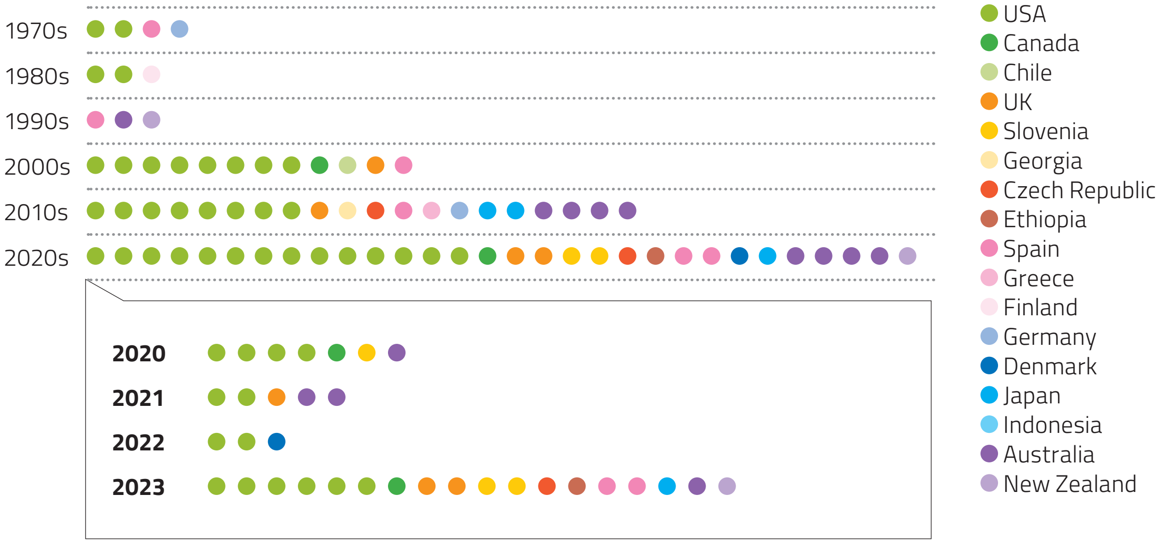
90%

of PLEx respondents **experienced or observed coercion** in a mental health service setting.

88%

of FMIC respondents reported that their loved ones **experienced or observed coercion** in a mental health service setting.

People with a mental health condition on the last time they experienced coercion in a mental health service setting



23

respondents had **experienced coercion in the last 12 months**

5

had **experienced coercion in the last 7 days**

4. FINDINGS AT A GLANCE continued

What types of coercion did people with mental health conditions experience?

Physical and Mechanical Restraints

12

PLEx described experiencing physical and/or mechanical restraints.

Involuntary Inpatient/Detention and hospitalization

37

PLEx indicated experiencing involuntary inpatient care, involuntary hospitalization or detention.

Threats of punitive measures and withholding of rights unless compliant

4

PLEx cited they were told they could reduce their inpatient stays or avoid being punished if they adhered to certain treatment or behaviours, such as agreeing to taking medication in exchange for time outside in the courtyard.

Electroconvulsive Therapy (ECT)

5

PLEx reported coercion involving ECT, including 4 cases where ECT was used and 1 case where ECT was threatened.

Chemical Restraint

40

PLEx stated that chemical restraint—drugs administered orally and intravenous—had occurred, involving the administration of sedatives and psychotropic drugs.

Physical Harm

4

PLEx described incidents of physical harm, including violence from mental health service staff resulting in permanent injuries.

Bullying

1

PLEx reported experiencing coercion in the form of bullying. In this instance they were coerced to take medication other than the one initially agreed upon as a means of weight loss and ridiculed by the psychiatrist for their appearance in front of other medical staff.

Police-enforced

3

PLEx reported the use of coercion by police, including as a means of transporting individuals with a mental health condition from their homes and into the hospital. In one instance a taser was used by the police officer, in another instance, handcuffs were used.

Strip Searches

1

PLEx mentioned strip searches as a form of coercion.

Seclusion

15

PLEx experienced seclusion as a coercive practice.

> "Most recently, [I was] pressured to sign a "care" contract. I have been incarcerated on psych wards where I experienced forced drugging and physical abuse. I also witnessed so much abuse, force and violence directed at other patients. Witnessing that is almost worse than when it happens to you. I'll never forget what I saw. They only had to do it to one of us to control all of us." – PLEx survey respondent

How has coercion affected the lives of people with mental health conditions?

Trauma or re-traumatisation

PLEx: Up to 63%
FMIC: 33%

Violation of Human Rights

PLEx: 24%
FMIC: 30%

Disruption of lives and healing

PLEx: 29%
FMIC: 54%

Death of a loved one

PLEx: 0%
FMIC: 11%

Loss of trust in and reduced engagement with medical services

PLEx: Up to 44%
FMIC: 15%

> "My experiences of forced and coerced treatment are some of the most traumatic experiences I've ever faced. **Abuse by the mental health system has become the primary thing I have to recover from.**" – PLEx survey respondent

39-63%*

of PLEx respondents said **(re)traumatisation** from experiencing coercion **affected their life and recovery**

Over one quarter

of PLEx respondents conveyed that their **human rights were violated or compromised** by coercion

> "Involuntary admissions are so crippling and brutal to the person… The shame of admitting they were in hospital is just the top layer and under it there are **layers of fear that your rights can be just taken from you and your voice is silenced** in case anything you say will add to a longer forced stay… He felt silenced, not cared for, unsupported and stripped of being human." – FMIC survey respondent

* Where more than one percentage is indicated, we have presented the range of interpretations by different members of the analysis team.

What could have been done in a better way?

Communication and respect
PLEx: 39-42%
FMIC: 33%

Holistic engagement
PLEx: 4%
FMIC: 41%

Care compassion and understanding
PLEx: 3%
FMIC: 24%

Autonomy in decision-making:
PLEx: 24%
FMIC: 0%

Peer-led support
PLEx: 7%
FMIC: 17%

Acknowledging necessity while condemning coercion
PLEx: 0%
FMIC: 10-14%

Family involvement
PLEx: 0%
FMIC: 21%

Better training
PLEx: 2%
FMIC: 24%

What can be done to avoid coercive measures such as seclusion and restraint?

36%

of PLEx respondents underscored the effectiveness of **community-based and peer-led interventions** and alternative settings in avoiding coercive measures.

30%

of FMIC respondents emphasised the role of **compassion and understanding**—especially from healthcare professionals—in avoiding coercive measures.

53%

of PLEx respondents suggested incorporating **shared decision-making** and involving individuals with mental health conditions in the decision-making process to avoid coercion.

37%

of FMIC respondents said that **improved communication**, enhanced listening skills, and increased dialogue among service providers, families, informal caregivers, and individuals with mental health conditions could mean avoiding coercive measures.

Over half

of FMIC respondents indicated that coercive measures could be avoided by using **alternative therapies and techniques** that go beyond medical and pharmaceutical approaches.

Almost one third

of PLEx and 37% FMIC respondents said that more targeted **education and training** for healthcare workers, police, FMIC and PLEx was essential to avoiding coercive measures.

"Everything! It should be after the last resort. Relationships, compassion, trust, sharing information and being guided by the person, ensuring their power and voice are centred, having options and opportunities that feel relevant. I have been working with people for 30 years and have only done 1 petition for involuntary treatment. It is unnecessary if we are in trusted, psychologically safe relationship (which can be established quickly!)" – an organisation representing PLEx

"Open dialogue, peer engagement but not from peers who are scared they will lose their jobs if they speak up, more time outdoors, time in a safe place with caring people who actually listen to what they are going through. Training parents in how to work with disruptive family behaviours, to name a few." – FMIC survey respondent

"Educate. Make hospitals and other services more [humane]. Involve people with lived experience into decision making processes, at least in this field." – PLEx survey respondent

"Trauma informed practices. Acknowledging the person vocally and listening. Perhaps even offering a meditation that any person would use and not withholding help unless the person accepts antipsychotics." – FMIC survey respondent

When asked about their most serious concerns stemming from the mental health condition they or their loved one has experienced, respondents noted:

Experiencing coercion
PLEx: 15%
FMIC: 13%

Financial hardship and job insecurity
PLEx: 11%
FMIC: 13%

Stigma and discrimination
PLEx: 18%
FMIC: 0%

Mental health record implications
PLEx: 7%
FMIC: 0%

Trauma and re-traumatization
PLEx : 4%
FMIC: 0%

Basic needs
PLEx: 0%
FMIC: 19%

Managing condition or symptoms
PLEx: 0%
FMIC: 13%

Receiving adequate care
PLEx: 0%
FMIC: 10% to 26%*

Advanced Directives
PLEx: 0%
FMIC: 6%

Lack of Trust
PLEx 0%:
FMIC: 6% to 13%*

"My most serious concerns are my suicidality and tendency to self harm, but I cannot be honest about these (and thus get adequate treatment) because I will be forcibly hospitalized if I mention them." – PLEx survey respondent

4. METHODOLOGY

A consultation process was carried out between October 2022 and May 2023 with participants invited through professional and advocate networks to respond to either Survey 1 or Survey 2 as depicted in figure 1 below.

Survey 1

WPA Member Societies

Survey 2

Individuals with MH conditions (PLEx)

Family members or informal carers (FMIC)

Organisations representing PLEx and/or FMIC

Figure 1. Survey Structure Diagram

Survey 1 was designed to spark discussion amongst psychiatrists. An invitation to participate was circulated to WPA Member Societies, who were urged to discuss the questions with as many members of their local or regional professional association as possible, then complete the online form with a single response reflecting all information and ideas gathered. Member Society participation was called for by the WPA President through news pieces featured on the WPA website and e-newsletter, while members of the WPA Working Group on Alternatives to Coercion also promoted the consultation through their networks. A total of 19 responses were received by Member Societies representing psychiatrists across 20 countries.

Survey 2 was designed to gather perspectives from people who had personal experience interacting with mental health systems. Development of the survey was led by one person with lived experience of a mental health condition and one family member, supported by a social science researcher and three psychiatrists who chaired the Working Group. It entailed three sets of questions relevant to (1) PLEx (2) FMIC and (3) organisations that represent them. Participants were invited to respond to more than one set of questions if relevant to them. For example, a person with lived experience who also leads an organisation could respond to both the PLEx and organisation sections of the survey. The consultation team worked closely with the WPA Working Group on Partnerships with Service Users and Family Carers to dissemenate Survey 2 through their local and international networks. A total of 142 responses were received, including 98 from individual persons with lived experience (PLEx), 33 from individuals who are family members or informal carers (FMIC) of PLEx, and 11 organisations representing PLEx and/or FMIC across 22 countries and the EU region as a whole.

Analysis was conducted by a team led by two community researchers (one person with lived experience of a mental health condition and one family member) supported by three professional social science researchers (two of whom also have family members with mental health conditions). The social science researchers first analysed open-ended responses using NVivo qualitative analysis software to code and count references to key topics, such as human rights. Based on this process, a document was produced summarising an initial set of key themes and messages identified. This document, alongside an Excel spreadsheet containing all raw data, was then handed over to the community researchers who conducted their own coding exercise and examined the responses against three questions:

1. What is being repeated over and over again?
2. What is something surprising or different for you?
3. What quotes do you see as most important for psychiatrists to read?

The entire research team then participated in a collaborative online workshopping session to discuss key messages and learning points emerging from the consultation.

It is important to note that much of the consultation data was qualitative and sometimes open to interpretation. In some instances, the researchers held different perspectives on how to code responses. Rather than debate this, the research team opted to present the full range of views held across our team which brought rich, diverse and equally valid perspectives to the analysis through our combination of professional and lived experience. This is why, throughout this report, some findings are presented as a range rather than one specific number.

5. PARTICIPANTS

Who participated in the consultation?

Survey 1

19	Responses
19	WPA Member Societies

Survey 2

142	Responses
98	Individuals with MH conditions (PLEx)
33	Family members or informal carers (FMIC)
11	Organisations representing PLEx and/or FMIC

Survey 1.

Participating WPA Member Societies

The 19 responses received from WPA Members Societies represented psychiatrists from the following 20 countries:

Country	Name of the WPA Member Society
Australia and New Zealand	The Royal Australian and New Zealand College of Psychiatrists
Austria	Austrian Association for Psychiatry, Psychotherapy and Psychosomatics
Cambodia	Mental Health Association of Cambodia (MHAC)
Croatia	Croatian Psychiatric Association
Finland	Finnish Psychiatric Association
Georgia	Society of Georgian Psychiatrists
Hungary	Hungarian Psychiatric Association
Israel	Israeli Psychiatric Association
Italy	Italian Psychiatric Association (SIP, Società Italiana di Psichiatria)
Japan	The Japanese Society of Psychiatry and Neurology (JSPN)
Lebanon	Lebanese Psychiatric Society
Moldova	Society of Psychiatrists, Narcologists, Psychotherapists and Clinical Psychologists (Moldova)
Norway	Norwegian Psychiatric Association
Slovakia	Slovak Psychiatric Association (SPsA)
South Africa	South African Society of Psychiatrists (SASOP)
Tunisia	Tunisian Society of Psychiatry
Turkey	Turkish Neuropsychiatric Society
Uganda	Uganda Psychiatric Association
United Kingdom	Royal College of Psychiatrists (RCPsych) UK

Figure 2.

The 19 WPA Member Societies responded across 4 regions, as demonstrated in figure 3.

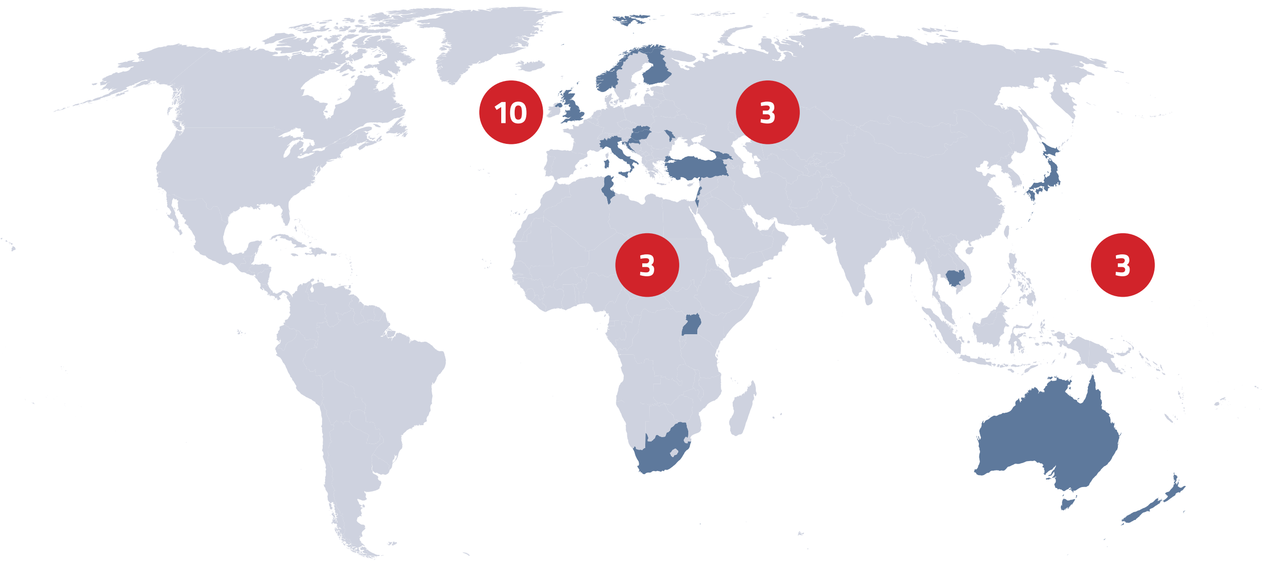


Figure 3. Member Society participation by geographical region

5. DEMOGRAPHICS SNAPSHOT continued

Survey 2.

PLEx, FMIC and Organisations representing PLEx and/or FMIC respondents

130 participants across the three cohorts indicated their gender. 81 respondents were women (62.3%), 37 respondents were men (28.5%), and 12 respondents were gender diverse (10.8%), as shown in figure 4.

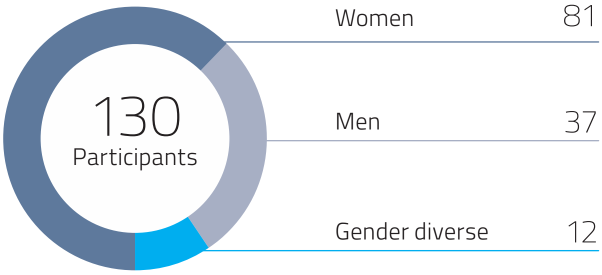


Figure 4.

132 participants across the three cohorts provided their age. More than half (52.3%) of all respondents were aged between 45 and 64. The number of respondents by age range in years is shown in figure 5.

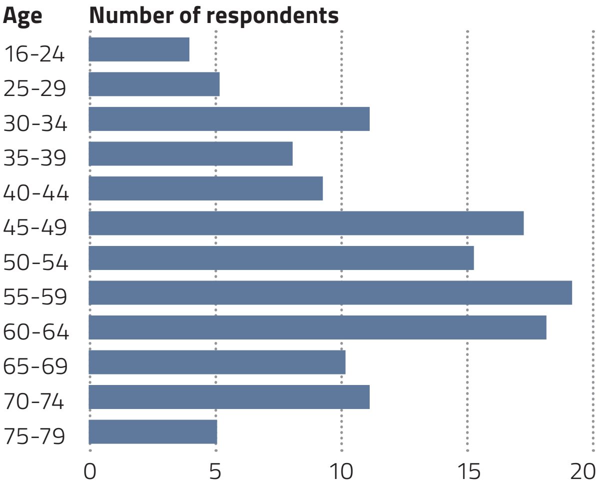


Figure 5.

130 respondents from Survey 2 disclosed their country, as indicated by region and shown in figure 6.

Country or region	**130**
USA	58
Australia	12
Japan	11
Spain	8
New Zealand	8
Canada	5
Slovenia	5
Germany	4
México	2
Greece	2
England	2
Chile	2
South Africa	1
Ireland	2
Indonesia	1
Hungary	1
Finland	1
Ethiopia	1
Denmark	1
Czech Republic	1
EU	1
Gambia	1

Figure 6.

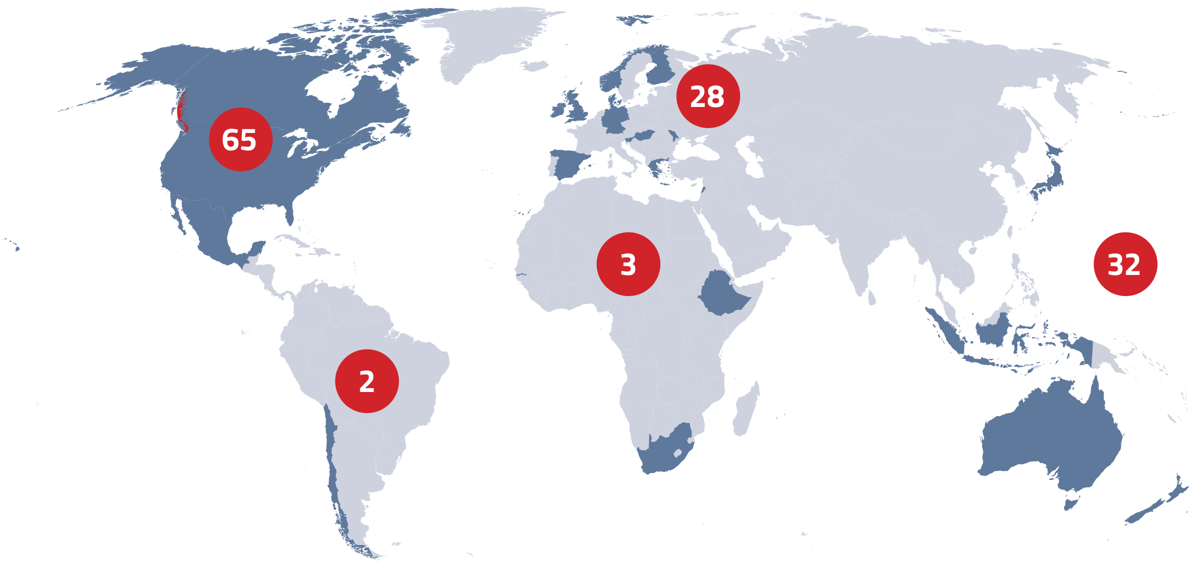


Figure 7. PLEx and FMIC participation by geographical region

11 organisations representing PLEx and/or FMIC responded to Survey 2, as shown in the table provided (see figure 8).

Country or region	Name of the organisation representing PLEx and/or FMIC	11
Aeotearoa/ New Zealand	Mental Health Foundation of New Zealand	1
EU	European Network of (Ex-) Users and Survivors of Psychiatry (ENUSP)	1
Gambia	International Voluntary Mental Health Organisation	1
Ireland	IMPERO (Irish Mental Patients' Educational and Representative Organisation)	1
Japan	Resource of Poverty, Women, Children, and People with Disability in Japan (RPWCDJ)	1
Slovenija	Poglej! Društvo za pomoč in samopomoč v duševnem zdravju	1
Spain	Fundación Mundo Bipolar	1
USA	Promise Resource Network (PRN) New York Lawyers for the Public Interest Aciu! Institute, LLC	3
N/A	One organisation asked to remain anonymous	1

Figure 8.

Of the 11 respondents, 7 people (63.6%) answered on behalf of an organisation that represents PLEx. 4 people (36.4%) answered as an organisation that represents both PLEx and FMIC. 0 (0.0%) answered as an organisation that represents FMIC only. This data is shown in figure 9 below.

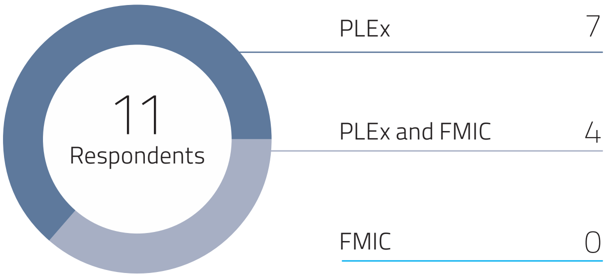


Figure 9. Organisations that responded to Survey 2

6. CONSULTATION FINDINGS

This section summarises consultation responses. Findings from the consultation with WPA Member Societies are discussed first to examine psychiatrists' responses to the WPA's 2020 Position Statement and Call to Action on Implementing Alternatives to Coerion as a key component of improving mental health care. Consultation questions focused on generating discussion about next steps needed and how the WPA can support action to address overuse of coercion in mental health settings.

We then shift focus to responses from people with lived experience of mental health conditions, many of whom have also experienced coercion first-hand. These first hand perspectives are considered alongside those of family members and informal carers, some of whom have lost loved ones to coercive practices in mental health care. It is in these responses that the urgent need for implementing alternatives to coercion becomes clear.

The diverse range of perspectives, experiences and insights shared here hold crucial implications for improving mental health systems and providing care while upholding the dignity and rights of people with mental health conditions.

6.1 WPA Member Society Consultation

Consultation questions and responses

Question 1: National and regional efforts to address coercion

The WPA Position Statement notes widespread agreement that coercion is overused in mental health systems all around the world. Are there any steps being taken in your country or region to address this situation?

19 WPA Member Societies responded to this question.

All 19 WPA Member Societies (MS) that took part in the consultation indicated **increased awareness** and/or **steps being taken** in their country to address the coercion in mental health care. The extent of these changes, however, varies greatly.

Almost half (9 Member Societies) mentioned **current legislation or proposed legislative change** to reduce the use of coercion in their country or region, including:

- Norwegian Psychiatric Association – Noted policy agenda focus on reducing coercive practices.
- Slovak Psychiatric Association – Engaged in negotiations for a parliamentary proposal on restrictive and coercive measures
- The Royal Australian and New Zealand College of Psychiatrists – Was involved in implementing new legislation in the region.
- Israeli Psychiatric Association – Noted a "directive from the Director General of the Ministry of Health aimed at this goal".
- Italian Psychiatric Association – "The Italian Ministry of Health the last July launched a governmental initiative aiming at overcoming the use of physical restraint within the next three years."
- Austrian Association for Psychiatry, Psychotherapy and Psychosomatics – Engaged in discussions on how to adapt legislation to reduce coercion.
- Society of Psychiatrists, Narcologists, Psychotherapists and Clinical Psychologists (Moldova) – "Promote a Mental Health law that clearly regulates when and how coercion can be used to protect human rights."
- The Japanese Society of Psychiatry and Neurology – The "law Related to Mental Health and Welfare of the Person with Mental Disorder" directs that "only certified psychiatrists who have undergone a certain period of training can make decisions on whether to exercise coercive measures."
- South African Society of Psychiatrists – There are "legal protections against overuse of coercion and there are Mental Health Review Boards that are established in law to monitor assisted and involuntary mental health care as prescribed in the Mental Health Care Act. Anecdotally, we are aware that these Mental Health Review Boards are not performing well."

3 Member Societies (in Uganda, Cambodia and Croatia) noted **new or established hospital regulations and guidelines**.

For example, the response from the Croatian Psychiatric Association highlighted new regulations in some institutions and regions. These include: the development of **implementation plans** for the prevention of coercive measures and respect for human rights; **training for clinicians** in the WHO QualityRights Initiative, and **changes of the physical environment** in some hospitals, such as "large separate rooms for female and male patients … and a backyard in which patients are able to spend their time. To date we have managed to reduce coercion measures and its lengthiness up to 40-50%."

7 Member Societies noted current **monitoring practices and research into coercive practices and/or alternatives to coercion**. For example:

- The Royal College of Psychiatrists noted 'The mental health safety improvement programme: a national quality improvement collaborative to reduce restrictive practice in England'.
- Finnish Psychiatric Association said, "Many official bodies … follow the use of coercion in psychiatry (both as statistics and individual decisions) and Finnish hospitals and other facilities are also under the supervision of other national and international bodies (such as the CPT and the Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment)."
- South African Society of Psychiatrists notes it is in the process of collecting baseline information on the use of coercion.
- Tunisian Society of Psychiatry noted commissions responsible for requiring psychiatric hospitals to check the conditions of hospitalisation and the respect for human rights at least once a year, remarking that "Unfortunately, these commissions are not very functional."

While some Member Societies noted that movements away from overuse of coercion are well established in their countries, others acknowledged that they are in the very early stages of change.

For example, in Lebanon it was observed that change has been mainly limited to increased awareness. In Turkey it was noted that **enacting any change is difficult due to an absence of mental health legislation**: "despite [our] intense efforts, together with the professional stakeholders of mental health practices, for the enactment of the mental health bill at the level of official authorities, especially in the last few years." This has left **individual institutions as the main locus of change**, with "many centres working to seek patients' consent before involuntary treatments are applied".

Question 2: Member Society efforts to address coercion

Have members of your Society/Association taken any **steps to implement alternatives to coercion and ensure that mental health treatment and care upholds the human rights of people with psychosocial disabilities**? Please describe.

19 WPA Member Societies responded to this question.

A majority of Member Societies consulted (80%) reported having taken steps to implement alternatives to coercion.

Four of these Societies mention **supporting legislation** in their country to address coercive practices. For example, the Austrian Association noted that it has contributed to adapting legislation through an expert group for the Ministry of Health. Likewise, the Royal College of Psychiatrists has contributed to legal reform processes pertaining to reducing restrictive practices in the UK.

Uganda Psychiatric Association noted a new national mental health act that is human rights focused. In Croatia it was noted that legislation regulates the types and methods of applying coercive measures in cases of severe mental illness. It wasn't noted how the Societies of these two countries impacted the legislation.

Seven Societies noted that they are taking a **public position or creating guidelines or programs** in order to impact reform and legislation. These were:

- Royal Australian and New Zealand College of Psychiatrists (RANZCP) – created a Position Statement to minimise and, where possible, eliminate the use of seclusion and restraint in people with mental illness.
- Italian Psychiatric Association – developed a National Protocol regarding Physical Restraint (PR).
- Moldova Society of Psychiatrists, Narcologists, Psychotherapists and Clinical Psychologists – supports mental health reform and the development of community mental health centres that "protect human rights of people with psychosocial disabilities through prevention of accusations and multidisciplinary approach, including support for employment, home visits and human rights protection."
- Slovak Psychiatric Association – established a Working Group for Humanization in Psychiatry composed of psychiatrists, patient organisations and people with lived experience to impact legislation.
- Finnish Psychiatric Association – led formation of the *Finnish Institute for Health and Welfare Guidebook*, and the Schizophrenia Coalition, which aims to inform and influence policy makers to improve the use of evidence-based treatment practices in schizophrenia.
- Turkish Neuropsychiatric Society – drafted a mental health act including alternative treatment modalities in involuntary care, which is yet to be enacted.
- The Japanese Society of Psychiatry and Neurology – implemented programs such as the Comprehensive Violence Prevention and Protection Program (CVPPP) to raise awareness on the use of alternative techniques to restraints.

Multiple Societies noted that taking active steps towards reduction in coercive practices and improved human rights in mental health care involves Society members and other clinicians **leading by example**.

On this, Lebanese Psychiatric Society notes that: "There are efforts from different mental health specialists in the settings where they work. The level of application of alternatives to coercion and the outcomes vary from one setting to another."

Norwegian Psychiatric Association notes that "we are discussing these topics on a regular basis," while, in Italy, "members … working as psychiatrists within the public Mental Health Departments adopt a recovery-oriented approach to severe mental disorders. The widespread network of community services in Italy made possible the reduction of hospital coercive admissions in the last 15 years from approximately 15% to approximately 5% of all admissions at a national level."

Question 3 – Next steps for Member Societies to address coercion

What do you see as the next steps for your Society/Association in supporting alternatives to coercion in mental health care?

19 WPA Member Societies responded to this question.

All 19 Member Societies noted plans to continue action or take new steps to support alternatives to coercion in mental health care.

9 Societies mentioned current involvement or plans for creating alliances or working groups to lead progress (in Italy, Norway, Lebanon, Finland, Turkey, Croatia, Hungary, UK and South Africa).

The Royal College of Psychiatrists (UK) acknowledged the value of collaborative efforts to address coercion, noting that they are "currently setting up a group with cross-specialty involvement which will expedite the discussion and action on this very important task."

The majority of these working groups have or will be formulated to advise on, and progress, legislation for the reduction of coercive practices and increased human rights in mental healthcare.

In some countries, the next steps involve **advocating for change**, such as in Lebanon where the Psychiatric Society is "arranging a formal committee to work on and advocate for alternatives to coercion". In Italy, "the SIP is engaged in the elaboration of a joint document with other psychiatric associations and experts in the field regarding the Government initiatives, asking for some modifications [to the] Ministry Policy document".

Some associations, such as Croatian Psychiatric Association, noted that **a working group is the next step**. "A leadership group formed on a national level integrating psychiatry experts from all parts of the country and different institutions in order to form a clear and preferably simple algorithm for reduction of coercive measures may provide a good starting point."

For the South African Society of Psychiatrists, the plan is to create a working group to kick start the agenda. "We are in the process of forming a Special Interest Group of the SASOP on Alternatives to Coercion in South Africa. We are also **developing a protocol to do a study that will inform us on the status of use or overuse of coercive treatment in South Africa**. Thereafter we will explore feasible ways of implementing alternatives to coercion.

5 Societies (in Australia/NZ, Finland, Turkey, Croatia and Hungary) stated intentions to contribute to practitioner **guidelines, education and training** to advance alternatives to coercion in their country.

For example, the Royal Australian and New Zealand College of Psychiatrists is "developing professional practice guidelines and additional training resources." The Croatian Psychiatric Association recognises "a need to ensure continuous and uniform education for all profiles of health care professional... and education in crisis communication. This should be dispersed to every region in Croatia."

A need for education in Japan was also expressed but focusing on the school system. "The next steps may include providing educational materials as part of physical education in high schools to improve mental health literacy, anti-stigma, early intervention, etc."

3 Societies (in Uganda, Cambodia and Lebanon) mentioned **awareness raising activities such as lectures and news updates.**

Other steps noted by Member Societies were **striving to improve patient to staff ratios** (in Israel) and **continuing to develop community mental health centres which protect the human rights of people with psychosocial disabilities** (in Moldova).

Question 4 – Opportunities to support improvements in treatment and care

Please consider the recommendations from the WPA regarding delivery of treatment and care on page 5 of the Position Statement. **What tools, resources, or actions by the WPA would help support work by psychiatrists and other colleagues in your country to enable these changes**?

19 WPA Member Societies responded to this question.

Nearly half of responding Members Societies (9) called for training and professional guidelines from WPA to support delivery of treatment and care as outlined in the WPA Position Statement on Implementing Alternatives to Coercion.

These responses came from:

- Tunisian Society of Psychiatry is eager for training on treatment delivery, **trauma-informed measures, supported decision-making processes and human rights principles** in general.
- Society of Psychiatrists, Narcologists, Psychotherapists and Clinical Psychologists (Moldova) would like to see **training of trainers** on WHO Quality Rights initiative, as they "have just one psychiatrist in Moldova that took this training from WHO."
- Society of Georgian Psychiatrists requested **evidence-based protocols**, guidelines and training materials.
- Finnish Psychiatric Association are interested in seeing the WPA "produce **international norms and guidelines** for different aspects of psychiatric care, such as minimum resources/staffing, minimum services that should be provided, and maximum waiting times for receiving treatment."
- Turkish Neuropsychiatric Society requested that training **clearly define the responsibilities of health providers and managers** and to help mental health service providers determine appropriate and correct strategies for their approach to patients, especially with regard to human rights. "In order for such training to be implemented as a health policy, the Psychiatric Association of Turkey and the Ministry of Health should collaborate on such projects."
- Croatian Psychiatric Association included a request for more structured and yet dispersed **training among all levels of health professionals** emphasising **advanced care directives** as well as **supported decision-making**. "Training and education should properly assess knowledge on **crisis communication, de-escalation measures** and it all should be done with real-life exercises."
- Hungarian Psychiatric Association aspires to behold training for service delivery staff on **trauma free service** and care.
- Royal College of Psychiatrists has looked into "the presentation of **successful service models and interventions** that have been developed elsewhere, together with an analysis of the socio-cultural contexts that would make a model likely to succeed in clinical practice in a country like the UK."
- The Japanese Society of Psychiatry and Neurology desires to see all resources and **tools translated** into Japanese. "It would also be effective to post the translated tools to the JSPN Conference website and invite WPA members to Japan to present at conferences organised by JSPN."

Slovak Psychiatric Association noted it would specifically embrace support and discussion on the **"open door" model**, as one of its members is involved in the project **Fostering and Strengthening Approaches to Reducing Coercion in European Mental Health Services (FOSTREN)**. "So, we would welcome support in terms of supporting opinions or online meetings to implement further steps."

Croatian Psychiatric Association noted that **coercive measures are also used in non-psychiatric wards for elderly patients** (for example after anaesthesia, surgery, infection) by staff not trained in alternatives to coercion and suggested the WPA could look into whether this is happening in other countries, also, and include it in future actions.

Question 5 – Opportunities to support improvements in policy

Please consider the recommendations from the WPA regarding policy on pages 5-6 of the Position Statement. What tools, resources, or actions by the WPA would help support work by psychiatrists and other colleagues in your country to enable these changes?

19 WPA Member Societies responded to this question.

Member Societies commented on multiple ways in which the WPA could support policy changes to address coercion in mental health care.

3 Member Societies (in Tunisia, Croatia and Hungary) called for **help with awareness raising efforts to enlighten policy makers.** For example, the Tunisian Society of Psychiatry suggests sensitising policy makers through written correspondence or by organising a live session with policy makers and leading psychiatrists.

6 Member Societies (in Georgia, Finland, Croatia, Israel, the UK and Japan) called for **advice on standards and best practice to support policy development**.

For example, Israeli Psychiatric Association comments that if the goal is to reach almost zero restraint, a statement along these lines that the state would agree to – and which would encourage an increase in resources for mental health – could help.

The Finnish Psychiatric Association suggests that the WPA could direct policy makers on **proactive measures** that service providers should take to help Finland **move away from post-hoc surveillance and correcting.**

The Croatian Psychiatric Association requests WPA **statements on the need for lived experience involvement in policy decision-making,** and documents outlining **economic analysis** demonstrating recovery-oriented care as a model with benefits outweighing its costs. Since the time of consultation, the WPA has issued a Position Statement on Partnerships with Service Users and Carers that calls for "meaningful, authentic and sustainable involvement of persons with a personal experience of mental health conditions, family and informal carers and their representative organisations in all training, research, decision-making processes and policy and practice developments concerning mental health."

2 Societies (in Turkey and South Africa) comment that they would like support with **data collection** to impact policy in their country. The South African Society of Psychiatrists notes that access to "a data collection tool that has been used by other countries that will assist us to establish the extent of use or overuse of coercive treatment" would be helpful.

The Moldovan Society calls for support to **increase collaboration** with other countries in the European Union and also the US.

Question 6 – Opportunities to support improvements in service culture

Please consider the following recommendations from the WPA regarding service culture on page 6 of the Position Statement. What tools, resources, or actions by the WPA would help support work by psychiatrists and other colleagues in your country to enable these changes?

18 WPA Member Societies responded to this question.

One third of responding Member Societies (6) suggested that **awareness-raising** support from the WPA would improve service culture and reduce the stigma of mental health in their countries (Tunisia, Italy, Moldova, Georgia, Slovakia and Croatia).

Of these, 2 Member Societies requested **support with media**. Tunisian Society of Psychiatry asks that the WPA "provide us with your guidance and experience on how to deal with media and how media could be a collaborator in stigma reduction." The Moldovan Society requested examples of anti-stigma campaigns.

2 Member Societies (in Turkey and Lebanon) noted they would appreciate **support with all service culture recommendations in the WPA Position Paper** (excerpt in figure 10), while the Hungarian Psychiatric Association noted support with points 1 and 3 would be most appreciated.

Psychiatrists need to work with:

1. Health institutions, such as government agencies, treatment facilities, professional organisations/societies and training institutions, 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 risks involved with using coercive practices, as well as greater understanding about the circumstances in which coercion is used. Families and carers of mental health service users, especially, need greater knowledge about these aspects.
3. Mental health professionals, policy-makers and media outlets together 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 to 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.

(Excerpt)

Figure 10. Excerpt from 'Implementing Alternatives to Coercion: A Key Component of Improving Mental Health Care'**, WPA Position Statement, October 2020**

The Royal College of Psychiatrists (UK) commented that **analysis of the resources required for successful implementation** of alternatives to coercion – considering the resources and culture of the country – would be extremely useful. This was noted in light of systematic underinvestment driven by political priorities in mental health services that both inhibits cultural change and increases involuntary detentions.

The response from the Finnish Psychiatric Association on this question requested a shift in focus from coercion to human dignity:

> Although the WPA has stated that this is a particularly difficult subject, t**he WPA could also lead an effort to guide the discussion from reducing coercion to improving human dignity**. The ethical questions related to the use of coercion are often related to the tension/debate between increasing safety and prosperity in society vs. increasing self-determination in an individual. Both of these goals are ways to increase the underlying value of human dignity. However, reducing self-determination can also increase human dignity, especially in instances where individuals use their self-determination to harm or degrade others or themselves…
>
> Promoting self-determination to the same level as human dignity can lead to insults of human dignity… Reducing coercion in itself should not be (and is not) a value. It is a means to increase and support important values such as human dignity. In some situations, very careful and well thought use of coercion can actually improve human dignity more than not using coercion. This could be a case for the patients who are very unwell, but do not themselves realize their disorder and need for help, such as very suicidal patients. Thus, thinking of alternatives for coercion is important, but only when these alternatives can increase the underlying values such as human dignity more than coercion.

Question 7 – Opportunities to support improvements in research

Please consider the following recommendations from the WPA regarding research on pages 6-7 of the Position Statement. What tools, resources, or actions by the WPA would help support work by psychiatrists and other colleagues in your country to enable these changes?

18 WPA Member Societies responded to this question.

A majority of Societies (68%) either requested support with research or acknowledged the importance of intensifying research to further develop alternatives to coercion.

Of these, five Member Societies requested **support with data collection** (Italy, Moldova, Slovakia, Israel and South Africa).

For example, South African Society of Psychiatrists commented that it would be useful to have "a person we can liaise with as we develop our research questions so that our research methodology and findings are comparable with our peers in other countries.' The Italian Psychiatric Association noted there is a lack of information about the **use of physical restraints** and data about **consequences of physical assaults** to staff members in their country, so they would like to see "well designed, national studies".

Eight Societies indicated how contributions by the WPA and Member Societies can **generate knowledge** about the impacts of coercion and alternatives to coercion.

Some noted the importance of amplifying scientific data to encourage funding. For example, the Finnish Psychiatric Association suggested funding could be strengthened by "giving **statements to indicate that these topics should be further researched**, setting up **prizes for significant research projects** or by instigating **collaborative funding efforts**." The Royal College of Psychiatrists (UK) would "value recommendations on how to build the strongest possible **case to induce bodies funding mental health research to support this area**".

Other comments were from:

- Tunisian Society of Psychiatry, offering to participate in any research groups.
- Society of Georgian Psychiatrists "**monitoring tools and questionnaires**, which may be used in the member countries to study coercive practices."
- Turkish Neuropsychiatric Society, expressing a desire to see "**support for scientific research** on compulsory treatments, organizing sessions on this subject in national and international congresses, and collaborating with mental health service stakeholders."
- Croatian Psychiatric Association, advocating for **internationally led research** by the WPA and "the promotion of implementation research, incorporating the perspectives of service users, service providers, and mental health policy makers."
- Austrian Association for Psychiatry, Psychotherapy and Psychosomatics, hoping for research institutions and funding agencies to prioritize the **development and testing of alternatives to coercion** suitable for various settings. They suggest that researchers should contextualize existing resources, diversify the evidence base, and gain a better understanding of barriers, enablers, and consequences of change.
- Hungarian Psychiatric Association, wishing for research that identifies the **existing barriers** which make adapting new principles so difficult – including social and monetary causes – and research that explores coercion in informal settings.

Question 8 – Working with service users and advocacy groups

Does your society work with service users or advocacy groups for people with mental ill-health and/or psychosocial disabilities? If so, can you please describe this work?

18 WPA Member Societies (MS) responded to this question.

All but one responding Member Societies (17) indicated that they **work with service users.** Most reported that they do this through alliances with NGOs, advocacy groups, and formal or informal service user groups. One Member Society responded that they are not currently working with service users (Tunisia).

5 Member Societies noted that they **engage service users directly, often through consultations and committees** (UK, Hungary, Norway, Cambodia and Uganda).

5 Societies mentioned **alliances with advocacy organisations involving service users**, which are dedicated to improving mental healthcare and reducing stigma (South Africa, Finland, Japan, Austria and Croatia).

For example, the Finnish Psychiatric Association commented that one of their partners, Mieli, is the world's oldest non-governmental organisation dedicated to mental health. The Austrian Association works on **educating journalists** about reporting without stigmatizing, while the Japanese Society noted involvement with the Committee on Anti-Stigma Activities, which has been working on a **video of interviews** with affected individuals to provide education on, and overcome prejudice against, mental illness.

The Turkish Society and Croatian Association both noted **drafting legislation** through alliances with mental health organisations (some of which have service user engagement). The Croatian Association noted that the alliance's involvement in developing a **national action plan for the prevention of coercive measures**.

Other collaborative activities were noted by:

- Italian Psychiatric Association, where Society Members are working with stakeholder representatives in the context of a "technical table" on mental health system which is active in support of the Ministry of Health.
- Moldovan Society, which has partnerships with a few NGOs that are working with service users including Family Federation and Somato.
- Society of Georgian Psychiatrists, which engages with the Georgian Network of Users and Survivors of Psychiatry (GNUSP), an organisation of people with experience in receiving psychiatric services.
- Slovak Psychiatric Association, which has pilot projects through the League for Mental Health including: the Commissioner for Persons with Disabilities; No more stigma; and Psychiatry is on its head.
- Israeli Psychiatric Association noted that "every forcibly hospitalised person has a lawyer who represents him at the expense of the state. In addition, there are rights organisations (such as Bizchut) that follow this closely".

Question 9 – Working with family members of mental health service users

Does your society work with family members of service users and, if so, can you please describe this work?

18 Member Societies responded to this question.

Nearly half of responding Member Societies (8) stated that they work with family members through alliances with other organisations (in Austria, Israel, Turkey, Finland, Slovakia, Georgia, Moldova and Italy).

An additional 3 Member Societies commented that they directly engage family members of service users in their activities (in the UK, Cambodia and Norway).

Member Societies described working with family members and informal caregivers through:

- **advocacy and human rights** (in Georgia, Turkey and Austria)
- **counselling and support** (in Georgia)
- **representation on committees and boards** (in Israel and the UK),
- **participation in expert groups** (in Italy)
- **collaboration on service planning** (in Austria).

3 Member Societies commented that they **work indirectly or informally with family members** (in Hungary, Croatia and Uganda). This included work through Society Members' own engagement with family members or on the periphery of carer groups.

Two Societies noted that they do not work directly with family members of service users (Tunisia and Lebanon) while two additional Societies described work they are undertaking in advocacy and education, but didn't explicitly note involvement of family members (Japan and South Africa).

Question 10 – Seclusion and restraint databases

Do the countries in your jurisdiction have public databases that record the frequency and duration of seclusion and restraint? If so, how can we access the database(s)?

18 Member Societies responded to this question.

The majority of responding Member Societies (14) reported that there is **no national database on seclusion and restraint** in their country**.** Some indicated that specific regions or hospitals may track their own data but it is not compiled in a public database.

Four Societies do have a national database in their countries:

- The Finnish Psychiatric Association noted that the Finnish Institute for Health and Welfare has published statistics in psychiatric care yearly from 2017 onwards, including information on use of coercion. A link to the report from 2020 can be found here: www.julkari.fi/handle/10024/143510
- The Japanese Society mentioned the database can be found in the 630 Survey (mental health and welfare surveys conducted as of June 30 of each year), which was made publicly available by the National Center of Neurology and Psychiatry (NCNP). It can be accessed via the website: www.ncnp.go.jp/nimh/seisaku/data/
- The Norwegian Psychiatric Association noted that their national database sits with the Directorate of Health but did not include a link.
- The Austrian Association noted that the database in their country is not publicly accessible.

Question 11 – Additional comments from Member Societies

Is there anything else you would like to tell us about Implementing Alternatives to Coercion in your country, **and/or how the WPA can support the changes described in the Position Statement and Call to Action?**

Three Societies requested support from the WPA on advocacy (Uganda Psychiatric Association), information on best practice (Croatian Psychiatric Association, Uganda Psychiatric Association), and training with practitioners (Turkish Neuropsychiatric Society).

The Italian Psychiatric Association noted they are ready to collaborate on any WPA initiative in this area, while the Finnish Psychiatric Association requested further dialogue exploring the reduction of coercion as well as alternatives.

> "The WPAs stance to talk about alternatives to coercion rather than reducing coercion is appreciated."

Finally, the Royal College of Psychiatrists (UK) request dialogue to address discrimination in the criminal justice system:

> "The intersection between mental health care and the criminal justice system necessarily revolves around coercive practices and in the vast majority of jurisdictions involves unfair discrimination towards offenders with mental health problems: for example, periods of deprivation of liberty, such as indeterminate detention, that are far in excess of the normal prison sentence for non-disordered offenders who have committed the same crime with a similar level of seriousness. Would a dialogue between the WPA Working Group and the UN CRPD Committee be possible on steps that might be taken to resolve [this]?"

Summary of key findings from WPA Member Society consultation

Awareness of coercive practices and the need to address their overuse in mental health systems is perceived to be increasing across a variety of national contexts. Still, when asked about access to national databases compiling information about the use of seclusion and restraint only four participating Member Societies reported such a database existing in their countries.

Efforts to address overuse of coercion have tended to focus on legislative change, hospital regulations and monitoring practices. The extent of progress has varied across countries, with some Member Societies noting that a lack of national mental health legislation has left individual facilities on their own to generate change.

Most of the WPA Member Societies that participated in this consultation reported taking steps to make change. These steps have included:

- supporting legislation and legal reform to address coercive practices,
- taking a public position on coercion in mental health
- creating guidelines and programs for reform
- psychiatrists leading by example
- discussing ways to address overuse of coercion in professional settings
- implementing recovery-oriented approaches to treatment and care.

All participating Member Societies noted plans to support alternatives to coercion in mental health care, with half noting current or future involvement in alliances and working groups to foster collective action. Additional next steps for these Societies include national studies to understand the extent of the problem, creation of practitioner guidelines, training and education, awareness raising activities, improvement of patient to staff ratios, and development of community mental health centres.

Training and education featured heavily in consultation responses when discussing opportunities for the WPA to support alternatives to coercion. Participating Member Societies expressed enthusiasm for the following topics in particular:

- Trauma-informed care
- Supported decision-making
- Human rights principles in practice
- Training of trainers
- Evidence-based protocols, norms and guidelines
- Responsibilities of health care providers and managers
- Crisis communication and de-escalation
- Examples of successful service models and interventions

Member Societies also called for advice on standards to support policy development, and help with awareness raising efforts to enlighten policy makers. The need for proactive measures to move away from post-hoc surveillance approaches, and the importance of involving service users in policy-making were both noted. There was also a call for economic analysis to consider the cost-benefit ratio of recovery-oriented approaches to inform policy.

Awareness-raising was another strong theme emerging from discussion about how WPA can support Member Societies to address coercion. Some called for advice and guidelines for engaging with the media to reduce stigma, while others noted they would appreciate support for changing mental health service cultures and changing norms to address discrimination. The ultimate aim of preserving human dignity was emphasised.

Finally, the majority of participating Member Societies requested support from the WPA to improve research and development of alternatives to coercion. Ideas for support including:

- nominating a person to liase with Member Societies to develop methodologies that will enable comparable findings across countries
- issuing statements to indicate that alternatives to coercion should be further researched
- advising how to build a strong case for research funding on key topics
- setting up prizes for significant research projects
- instigating collaborative funding efforts for international studies.

The consultation also established that almost all participating Member Societies work with mental health service users, and over half also work with family members and informal carers. Most reported that they do this through alliances with NGOs, advocacy groups, and formal or informal groups and networks. Actions taken in collaboration with service users and family members included educating journalists about stigma-free reporting, producing educational videos interviewing service users, and drafting legislation and action plans.

6.2 Perspectives from people with lived experience, family members & carers, and organisations representing them

PART A: Responses from individuals

This section presents a summary of responses to the questions on Survey 2 that invited people with lived experience (PLEx) and family members & informal caregivers (FMIC) to share their perspectives as individuals. Survey 2 also included questions designed for orgnisations that represent these groups, which will be presented along with a summary of their responses in Part B.

Question 1 – Experiences of coercion

Have you or your loved one experienced or observed coercion in mental health services?

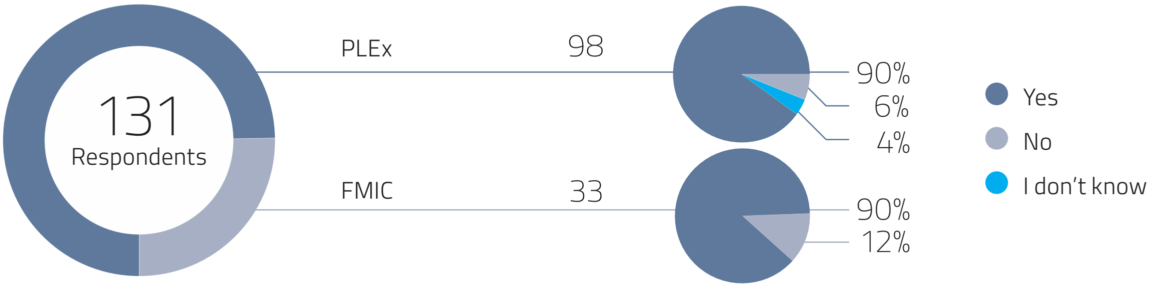


Figure 11.

98 people with lived experience of a mental health condition (PLEx) responded to this question.

33 family members or informal carers (FMIC) responded to this question.

The vast majority of people with lived experience (PLEx) responding to this survey (90%) reported having experienced or observed coercion in mental health services. Roughly 6% (6 of 98 respondents) said they had not experienced or observed coercion, while 4% (4 of 98 respondents) said they didn't know.

Most family members and informal carers (88% of FMIC respondents) also reported having observed or experienced coercion in mental health care services. Four of 33 FMIC who responded to this question (12%) said they hadn't experienced or observed coercion, while none (0%) responded 'I don't know'.

Question 2 – Last experience of coercion

When was the last time that you or the person you care for experienced or observed coercion in mental health services?

23

PLEx respondents had **experienced coercion in the last 12 months**

5

PLEx had **experienced coercion in the last 7 days**

See figure 12 for a detailed breakdown of when respondents last experienced coercion and in which country

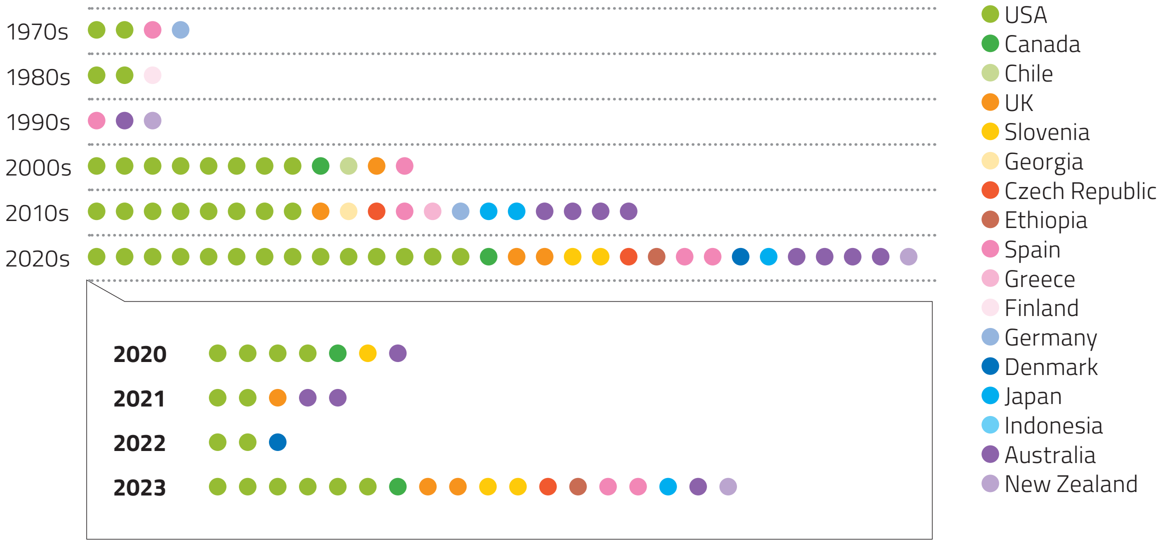


Figure 12. People with a mental health condition on the last time they experienced coercion in a mental health service setting

Question 3 – Type(s) and length of coercion

What type(s) of coercion and for how long?

83

PLEx respondents

25

FMIC respondents

Respondents were asked what types or forms of coercion had been experienced, and what the duration of these experiences had been.

Respondents answered with open-ended responses that the research team coded for, identifying 10 types of coercion:

1. Physical and mechanical restraints:

- 12 PLEx (15% PLEx of respondents to this question) described experiencing physical and/or mechanical restraints. This included PLEx encountering physical coercion by law enforcement, including tasering and handcuffing.
- 12 FMIC (41% of FMIC respondents to this question) indicated experiences relating to both physical and mechanical restraints.

2. Involuntary inpatient/detention and hospitalization:

- 37 PLEx (45% of PLEx respondents to this question) indicated experiencing involuntary inpatient care, involuntary hospitalization or detention.
- 11 to 16 FMIC (38-55% of FMIC respondents to this question) indicated experiencing involuntary inpatient care, involuntary hospitalization or detention. This included 1 compulsory treatment order.

3. Sustained Physical Harm:

- 4 PLEx (5% of PLEx respondents to this question) described incidents of sustained, long-term physical harm, including violence from mental health service professionals resulting in permanent injuries.
- 2 FMIC (7% of FMIC respondents to this question) described incidents of sustained, long-term physical harm. 1 FMIC reported being 'refused medical care for end stage liver disease' and forced 'covert psych drugging', and 1 FMIC reported that the physical harm sustained by the individual with a MH condition through being in restraints and inadequately cared for while in seclusion had resulted in death.

4. Coerced Electroconvulsive Therapy (ECT):

- 5 PLEx (6% of PLEx respondents to this question) reported coercion involving ECT, including 4 cases where ECT was used and 1 case where ECT was threatened.
- 0 FMIC (0% of FMIC respondents to this question) reported coercion involving ECT.

5. Chemical restraint:

- 40 PLEx (48% of PLEx respondents to this question) stated that chemical restraint—drugs administered orally and intravenous—had occurred, involving the administration of sedatives and psychotropic drugs.
- 10 FMIC (35% of FMIC respondents to this question) stated that chemical restraint—drugs administered orally and intravenous—had occurred, involving the administration of sedatives and psychotropic drugs.

6. Seclusion:

- 15 PLEx (18% of PLEx respondents to this question) experienced seclusion as a coercive practice.
- 9 FMIC (31% of FMIC respondents to this question) mentioned individuals with mental health conditions experiencing seclusion, including isolation within confined spaces and within a Closed Ward.

7. Police-enforced coercion:

- 3 PLEx (4% of PLEx respondents to this question) reported the use of coercion by police, including as a means of transporting individuals with a mental health condition from their homes and into the hospital. In one instance a taser was used by the police officer, in another instance, handcuffs were used.
- 2 FMIC (7% of FMIC respondents to this question) indicated the use of coercion by police, including one instance of threatening FMIC with the prospect of calling Child and Family Services on the FMIC if they took their child home with them who was not displaying harmful behaviour at the time.

8. Strip Searches:

- 1 PLEx (1% of PLEx respondents to this question) mentioned strip searches as a form of coercion.
- 0 FMIC (0% of FMIC respondents to this question) mentioned strip searches as a form of coercion.

9. Coerced activities in exchange for rewards or to avoid punitive measures:

- 4 PLEx (5% of PLEx respondents to this question) cited that they were told they could reduce their inpatient stays or avoid being punished if they adhered to certain treatment or behaviours, such as agreeing to taking medication in exchange for time outside in the courtyard.
- 3 FMIC (10% of FMIC respondents to this question) cited coercion through the promise of rewards or in exchange for avoiding punitive measures. This included 1 FMIC threatened by police with the prospect of calling Child and Family Services on the FMIC if they took their child home with them who was not displaying harmful behaviour at the time; 1 FMIC who was 'Refused Medical care for end stage liver disease' until they agreed to see a psychiatrist as part of their medical care team; and, 1 FMIC threatened of a much longer court order if their daughter did not continue with their involuntary hospitalisation or medication that 'made her condition much worse'.

10. Bullying:

- 1 PLEx (1% of PLEx respondents to this question) reported experiencing coercion in the form of bullying. In this instance they were coerced to take medication other than the one initially agreed upon as a means of weight loss. The participant provided a direct quote from staff, saying they were told: "you are lying about your weight, there is no way you weight less then 275lbs. Get on the scale, and we'll see" before 'he [the doctor] then proceeded to gather all of his nurses, nursing assistants, medical assistants and even the college interns, to stand around me as I shamefully, in tears stepped onto the scale'.
- 0 FMIC (0% of FMIC respondents to this question) cited bullying as a form of coercion.

How long the coercion lasted varied by respondent and type of coercion, with some PLEx and FMIC indicating the coercion was practiced in one continuous in-patient stay, whilst others mentioned multiple instances across years and decades.

For instance, some respondents indicated they experienced coercion continuously for '8 hours', '2 days', '9 days', '60 days', '3 months' and '5.5 months'. Other respondents reported experiencing coercion intermittently for 'the past 23 years' and 'multiple times throughout... [their] life'.

Question 4 – What could have been done better?

Considering the last time you experienced coercion in mental health services,
what do you think could have been done in a better way?

83

PLEx respondents

29

FMIC respondents

Communication and respect
PLEx: 39-42%
FMIC: 33%

Holistic engagement
PLEx: 4%
FMIC: 41%

Care compassion and understanding
PLEx: 3%
FMIC: 24%

Autonomy in decision-making:
PLEx: 24%
FMIC: 0%

Peer-led support
PLEx: 7%
FMIC: 17%

Acknowledging necessity while condemning coercion
PLEx: 0%
FMIC: 10-14%

Family involvement
PLEx: 0%
FMIC: 21%

Better training
PLEx: 2%
FMIC: 24%

Figure 13. Core themes from PLEx and FMIC responses to the question of what could have been done better

People with lived experience of mental health conditions (PLEx) and family members and informal caregivers (FMIC) cited multiple ways in which things could have been done better to improve or change the quality of their treatment and care.

The research team coded PLEx and FMIC participants' open-ended responses, grouping these into the following core themes also shown in figure 13: **(1) communication and respect, (2) holistic engagement, (3) care, compassion and understanding, (4) autonomy in decision-making**, and **(4) peer-led support.**

A fifth theme **(5) autonomy in decision-making** emerged from responses by PLEx, with no mentions from FMIC respondents.

Three additional themes emerged from responses by FMIC respondents, with no mentions from PLEx. These were: **(6) family involvement, (7) training for health workers** and **(8) acknowledging the need for care**.

Overall, responses from family members and informal carers (FMIC) highlighted the importance of exploring a range of **alternative techniques, tools, methods, and resources**. These included de-escalation techniques by medical healthcare professionals, counselling, and community-based support. FMIC respondents also noted that while certain aspects of care were viewed as necessary, **better training, more empathetic healthcare workers** and **greater family involvement** could have enabled services to avoid the use of coercion.

Communication and Respect

PLEx: 39-42% individuals with mental health conditions (between 32 and 35) emphasized the need for better communication. This included a desire to feel heard, provide informed consent, and be considered experts in their own experiences. Furthermore, more effective communication within and between health services could have spared individuals with mental health conditions from the burden of repeating painful stories, reducing the risk of re-traumatization and confusion among patients with diverse histories and needs.

FMIC: Similar responses were received by family members and informal caregivers, where 45% of FMIC respondents (13 individuals) identified improved communication as a crucial factor in achieving better outcomes. This encompassed greater transparency about care methods adopted by medical professionals, increased communication at all stages of the process with individuals and their support networks, enhanced education and resources for families and individuals, and the allowance of communication between the individual and their network, including between PLEx and FMIC, during their treatment.

> "They could have spoken to him instead of tying him down, since he was obeying all instructions at the time, they tied him to his bed."

> "If things had happened in a more compassionate way, I believe the outcome could have been better at that time."

> "According to my family member, almost everything [could have been done better]. There was no attention paid to people, rude comments by staff, lack of privacy, often forced medication on patients (injections) in front of other patients that was distressing."

"I could have been asked questions about what I was experiencing, allowing a dialogue to develop."

"Psychiatrists could have not assumed they knew was best for me, but asked me instead."

"The communication was wrong… different agencies and parties thought different things, I had attempted suicide but both one hospital and one jail thought I was drunk."

Holistic Engagement

PLEx: 3.6% of PLEx (3 respondents) said that therapeutic activities and engagement beyond drug-based treatment was one way in which things could have been done better. This includes access to diverse activities, meaningful engagement, outdoor spaces, and alternative activities promoting healing.

FMIC: Significantly, 41.4% of FMIC (12 respondents) suggested exploring a range of alternative techniques, tools, methods, and resources would have contributed to a better experience. Alternatives described included de-escalation techniques, counselling, community-based support models like Open Dialogues and the Soteria House Approach, Open Wards, and the establishment of independent information centres to disseminate information on safe methods for discontinuing psychotropic drugs.

"The forcefulness [of] the initial hospitalization caused trauma and seemed to create more problems."

"In short, any treatment that is non-coercive, respectful and compassionate [should have been given]".

"Assisting the person in a hospital setting to de-escalate the stress and using suitable language to convince them that medication was necessary. Giving an explanation of why this was being offered; making sure they understood why medication was being offered."

Care, compassion and understanding

A total of 26 individuals with lived experience (31% of PLEX respondents) highlighted that better outcomes could have been achieved through enhanced care, compassion, and understanding. A range of therapeutic approaches were mentioned, including the cultivation of trust-based relationships, embracing human rights principles, and adopting a trauma-informed care approach. Some respondents stressed the importance of promoting culturally-inclusive communication that acknowledges potential variations in communication styles and adopting a humility-based collaborative care approach that recognizes the limitations of knowledge. Additionally, it was noted that the creation of a welcoming and secure environment to facilitate open conversations, attentive listening, and collaborative work serves to enhance and enrich this approach.

In addition, 24% of family members and informal caregivers (7 respondents) agreed, with emphasis on the importance of respectful, compassionate, and empathetic communication from healthcare workers, law enforcement, and staff.

"My aggression could have been understood as distress."

"Listening to my concerns and experiences and responding with kindness not violence."

"I sought out support because I was struggling, but I do not actually receive support at any point in the process - actually getting support would have been helpful, being asked about what I would have found helpful, someone I could have talked to about what I was feeling at the moment"

Autonomy in decision-making

This category was exclusively mentioned by people with lived experience and highlights the importance of autonomy in treatment decisions. Nearly a quarter of people who responded to this question (20 PLEx) emphasized the significance of having a say in their treatment choices. They expressed a desire for more options and collaborative engagement with mental health professionals, ultimately providing alternatives to coercion. These alternatives included options such as support from chosen providers, participation in treatment decisions, and the ability to review and approve personal medical therapy, medications, and records.

> "When I was upset it could have been de-escalated without forcing me to take medication. I should have been given a real choice about whether to take Lithium, rather than being deprived of privileges to make me comply."

> "I couldn´t decide anything about my own life, as if I had no ability to think... Many decisions about my own life were made for me, without even asking."

Peer-led support

Seven percent of individuals with lived experience (6 respondents) and 17% of family members and informal caregivers (5 respondents) emphasized the value of peer-led support and connections with informal and formal caregivers as alternatives to coercion. This encompassed community-based or peer-led respite options that would have provided care within familiar networks. While the percentage of people who named peer support in response to this question was relatively low, it is highly significant considering that access to peer support is relatively low worldwide and many people with mental health conditions may be unaware that this option even exists.

> "Seeing my pain and distress and offering me connection to others with similar experiences in recovery, trauma-based therapy, teaching me about my nervous system and resiliency skills"

> "More alternative peer led support"

> "There are community-based supports and peer run options"

Acknowledging the need for care

To varying degrees, FMIC expressed that they perceived mental health treatment as necessary for their loved one at the time. At the same time, many FMIC respondents called for better-trained and more empathetic healthcare workers (20% of respondents), and family involvement (20% of respondents) to deliver treatment with greater care.

> "Although, I believe that my son did need emergency mental health care the experience was more traumatic than it needed to be and there was very little education or information once he was admitted."

> "The psychiatrist/doctors at the hospital refused to communicate at all with families so I was left completely in the dark despite him being a minor at the time".

Additional Insights

Other notable comments from FMIC highlighted the need for accountability within the legal framework for medical malpractice, addressing resource shortages and staff training in mental healthcare facilities, broader improvements in service provision, enhanced privacy for individuals with mental health conditions, and considerations about treatment duration, particularly for persistent symptoms.

Question 5 – Life and recovery

If you are comfortable sharing your experience, please tell us briefly how coercion has affected your own or your family member's life and recovery.

82

PLEx respondents

27

FMIC respondents

Trauma or re-traumatisation

PLEx: Up to 63%
FMIC: 33%

Violation of Human Rights

PLEx: 24%
FMIC: 30%

Disruption of lives and healing

PLEx: 29%
FMIC: 54%

Death of a loved one

PLEx: 0%
FMIC: 11%

Loss of trust in and reduced engagement with medical services

PLEx: Up to 44%
FMIC: 15%

Over one quarter

of PLEx respondents conveyed that their **human rights were violated or compromised** by coercion

39–63%

of PLEx respondents said **(re)traumatisation** from experiencing coercion **affected their life and recovery**

When individuals with lived experience of mental health conditions and family members and informal caregivers were asked about the impact of coercion on their lives, recovery, or the lives and recovery of their loved ones, they shared several common themes.

They described how coercion led to **trauma and traumatization**, leaving lasting emotional scars and negatively affecting their mental wellbeing. Additionally, coercion often involved the violation of their or their loved ones' **human rights**, including compromises to autonomy and dignity. Coercion disrupted their **daily lives**, making it challenging to maintain routines and carry out regular activities. It also had a detrimental impact on the **recovery process**, hindering progress toward improved mental health and wellbeing, and making it more difficult to achieve and sustain recovery goals.

Furthermore, respondents expressed that their experiences of coercion eroded **trust in medical services and healthcare professionals**, resulting in hesitance to seek help and engage openly in conversations about mental health. FMIC also mentioned that in some tragic cases, coercion resulted in deaths, some due to the physical consequences of coercive measures and some choosing to end their own lives rather than face further coercive treatment.

Each of these impacts is described in more detail below.

Trauma or Re-traumatisation

According to the data analysis, between 39% and 63% (32 to 52 individuals) PLEx expressed that traumatization or re-traumatization resulting from coercion has significantly impacted their lives and recovery.

This encompassed enduring triggers generated by everyday events that mentally take them back to the instances of restraint or seclusion. Nightmares, night terrors, deep depression, and PTSD, sometimes linked to historical trauma like sexual abuse, were also reported. The repercussions extended to an aversion to voluntary restraint methods, such as wearing masks or undergoing MRI scans.

Out of the respondents, 33% of FMIC (nine respondents) agreed that coercion had inflicted trauma and re-traumatisation on the individuals with mental health conditions. This encompassed firsthand experiences or witnessing physical or chemical restraints, resulting in psychological trauma.

Additionally, two FMIC revealed their own trauma arising from their involvement with their family member's experience, with one indicating the development of PTSD.

> "My experiences of forced and coerced treatment are some of the most traumatic experiences I've ever faced. Abuse by the mental health system has become the primary thing I have to recover from."

> "When I hear the sound of the locks closing, I shudder, remembering the nurses and doctors locking me in my room when I was hospitalised. When I get in the car and fasten my seatbelt, I also remember when I was physically restrained. Everywhere in my daily life I remember my hospitalisation and tears come on their own"

> "My son was angry that he was threatened, and when injected to subdue him his parents were shocked and traumatised on his behalf."

"I… developed an irrational fear of doctors and hospitals, and had a panic attack when I visited doctor's office. This fear went away after I've seen a therapist for a PTSD that I apparently developed as a result of my daughter's hospitalization."

Violation of Human Rights

More than one quarter of PLEx, (20 individuals) conveyed how their human rights were violated by coercive practices. Instances included the lack of autonomy over decisions about their bodies, brutality and dehumanization within the care environment, and the curtailment of rights once categorized with a mental health condition. As a consequence, 11% of the respondents (nine individuals) answered that now they advocate for human rights in mental health settings, driven by their own experiences.

About 30% of FMIC, (eight participants) expressed concerns about the acute and long-term physical and cognitive harm sustained by individuals with mental health conditions. This harm was linked to physical injuries from restraints, negative impacts of prescribed medications leading to long-term brain damage, and exacerbated stress responses.

"Coercion immediately made me understand that now I belong to another category of people, who do not have the same rights as others and to whom any sort of things can be done with no clear borders where are the rights exactly. Staff was not speaking to me, like if I was an object, sometimes they were laughing at me or making comments in my presence about my behavior like I was not there or not capable of understanding" – PLEx survey respondent

"After being compulsorily detained and treated annually for 6 weeks over a 13 year period I ended up working in the mental health system using those experiences to inform a human rights/ ethics perspective. The experiences changed everything" – PLEx survey respondent

"I survived and dedicated the rest of my life for those who die from the treatment or remain trapped in the psychiatric system for the rest of their lives" – PLEx survey respondent

"My son was physically constrained for a week. He was forced to have a diaper. Later he told [me] that he almost lost his ability of walk. The doctor who used coercion continued to be his doctor for a year." – FMIC survey respondent

Disruption of Lives and Healing

Between 29% and 54% of individuals with lived experience (24 to 44 participants surveyed) mentioned that coercive experiences resulted in significant disruptions to various aspects of their lives. These disruptions included alterations in life trajectory, social interactions, and work-related matters. Respondents recounted financial hardships, career setbacks, and detrimental impacts on self-growth and self-perception. Coercion was associated with disrupting their overall healing journey and progress, particularly during crucial formative years.

26% of FMIC (7 respondents) indicated that their loved one's life or healing was disrupted by coercion, including loss of cognitive abilities, trust, independence and sense of safety.

This figure rises to 11 respondents or 41% when we include 4 additional FMIC respondents who indicated that the lives of their loved ones ended abruptly as a result of coercion or fears of coercion happening again.

"I wasn't sure who I was even more & had to rebuild my life after that." – PLEx survey respondent

"The humiliation, damage to my self confidence and gap in my CV mean that I have not been able to find work since." – PLEx survey respondent

"I have never recovered from what was done to me in the name of "mental health." Effects included massive life disruption during my formative years (my education and relationship with family were among the casualties), disfiguring dystonia and lifelong trauma." – PLEx survey respondent

"In Japan, 18 months after my daughter's discharge from the locked psychiatric ward where she had been unconscious, restrained on the bed and secluded, she suffered another manic episode. I believe she feared a repeat of this treatment so chose to commit suicide on a railway track, aged 29."

Loss of trust and engagement with Medical Services

Between 25% and 44% of PLEx (21 to 36 individuals) conveyed that their experiences with coercion led to a loss of trust in medical services. Consequently, they changed the way they engage with the healthcare system and its practitioners. This change included avoiding seeking help from mental health professionals or downplaying symptoms due to the fear of being coerced or experiencing similar treatment. The coercion also impacted how they discuss their symptoms with medical professionals, potentially leading to concealed or modified communication.

15% of FMIC (four respondents) mentioned that erosion of trust had implications for the individual's life and recovery. Loss of trust extended to the medical field, clinical staff and the assurance of human rights being upheld within psychiatric settings, among others.

Finally, seven percent of FMIC (two respondents) expressed concern regarding potential deterrence from accessing medical services or disclosing symptoms due to the fear of encountering further instances of coercion, potentially leading to death.

"It [the coercion] was brutal and exacerbated his stressed state of mind. It has led to increased distrust of clinical staff – this severe coercion was administered by a staff nurse who became impatient." – FMIC survey respondent

"None of the memories vanish and what it does it make a person feel unsafe and afraid to share if their symptoms are still affecting them after they discharge so at times they are quietly in pain trying to manage everything alone." – FMIC survey respondent

"Even if I needed their help, I might not ask for it. I did not have that concern before this incident!" – PLEx survey respondent

"I am often dishonest about my emotions and behaviours in order to avoid psychiatric coercion, be it involuntary hospitalization during outpatient treatment, or physical and chemical means of psychiatric coercion during inpatient stays." – PLEx survey respondent

"So, I [have] to stay silent and try hard not to express anything that may be a sign of a problem in the presence of medical staff. Of course, I had no trust in smiles of the staff asking me how I am now after they have restrained me a few days ago. I had to stay patient and silent while in institution because people who were complaining sometimes were punished in my presence." – PLEx survey respondent

Among all PLEx who responded to the survey, only two individuals noted positive aspects of their experiences. One mentioned that the process provided her with space to desire and accept treatment. The second person highlighted the fact that she was for the very first time seen and listened to by professionals and treated as an equal while being treated. This participant also noted that a non-governmental organisation had supported her throughout the process.

"I do have to say that if I hadn't been sectioned in February, I probably would have committed suicide. It was horrible but it gave me time and space to get to a point where I wanted to accept help and to engage in treatment." – PLEx survey respondent

"I was helped by professionals in a rehabilitation center, where they for the first time communicated the message that I am the same human as them, and I still have a life to live and it is all possible. Iwas helped by a non governmental organisation with persons with lived experience themselves being in the leading structures. They helped me with finding a new role in the human rights movement." – PLEx survey respondent

Death and Coercion

Tragically, 15% of FMIC (four people) described the death of a loved one, with all of these respondents attributing the outcome to coercion experienced during the course of psychiatric treatment. Three of these instances took place in Japan.

Four FMIC share their story on death and coercion:

"After 10 days continuously in restraints and forced medication his heart stopped beating. They sent him to a cardiac ward of another hospital and eventually started the heart after 45 minutes, but he never regained consciousness and he died a week later."

"In Japan, 18 months after my daughter's discharge from the locked psychiatric ward where she had been unconscious, restrained on the bed and secluded, she suffered another manic episode. I believe she feared a repeat of this treatment so chose to commit suicide on a railway track, aged 29."

"After the death of my sister, I have seen many Japanese ex-patients who have experiences of hospitalization, who are very dependent and always demanding other person's care from the self-stigma... who look traumatized and discouraged... Compared with these of French patients I know, Japanese ex-patients look more deprived of their rights. I think it's because in Japan, the right of access is extremely limited."

"I have been the victim of multiple acts of obstruction of justice along with multiple acts of medical malpractice...including the permanent disability of our oldest daughter due to psych-drug induced brain damage and the psych-drug induced death of our son."

Question 5 – Alternatives

What can be done to avoid coercive measures such as seclusion and restraint?

91
PLEx respondents

30
FMIC respondents

Community-based and peer-led interventions
PLEx 36%
FMIC 17% to 27%

Compassion and understanding
PLEx 27% to 37%
FMIC 30%

Education and training
PLEx 24% to 31%
FMIC 37%

Changes to laws and legal framework
PLEx 16%
FMIC 13%

Effective communication
PLEx 30%
FMIC 37%

Shared decision-making
PLEx 53%

Alternative therapies and techniques
FMIC 37% to 63%

Preventative measures
FMIC 10%

Protecting Human Rights
PLEx 43%

The responses from individuals with lived experience of mental health conditions (PLEx) and family members or informal caregivers (FMIC) shed light on a spectrum of strategies and principles aimed at mitigating coercive measures in mental health care. Among the noteworthy themes that emerged, **community-based and peer-led interventions** were seen as effective approaches, emphasizing the value of peer support in the recovery process. Additionally, respondents stressed the critical importance of **compassion, understanding, and empathy** in providing quality care. Education and training were recognized as essential tools for equipping both professionals and individuals involved in mental health care. Responses also touched on the necessity of **legal reforms** to safeguard against coercive practices. **Effective communication, shared decision-making, alternative therapies and preventative measures**, were also suggested to reduce reliance on coercive interventions, collectively contributing to a multifaceted approach to enhance the mental health care experience.

It is crucial to highlight that a member of our analysis team, who has lived experience of a mental health condition, categorized many of these strategies and principles under the umbrella of **human rights**. As her analysis concentrated on responses by PLEx, this is reflected in the data above. The principle, however, also applies to statements by both PLEx and FMIC emphasising the need for legal reforms to safeguard individuals with mental health conditions and stressing the critical importance of compassion, understanding, and empathy to provide high quality care. These statements all align with human rights principles, as they underscore the significance of respecting individuals' autonomy, dignity, and rights throughout their mental health journey.

The ways of preventing coercion brought up in responses from PLEx and FMIC are examined further below.

Community-Based and Peer-Led Interventions

Approximately 36% (33 individuals) of PLEx underscored the effectiveness of community-based and peer-led interventions and alternative settings in preventing coercive measures. These respondents noted the establishment of warm, inviting, home-like environments for individuals in distress (such as "Soteria"-inspired residences), peer-run respites, community-based mental health support networks, and broadening treatment options. Additionally, there was recognition of the importance of trauma-informed care counselling within the community, day centres, and providing support for basic needs.

Similarly, between 17% and 27% of FMIC (five to eight individuals) highlighted the value of community-based and peer-led interventions as a strategy to deter coercive measures. This includes advocating for peer support roles within hospitals, adopting fewer formal positions within patient groups, implementing approaches like Open Dialogues and models akin to Soteria houses, as well as supporting peer-run respites.

> "[We need] widespread training in Open Dialogue; Soteria houses; peer-run respites; switching focus from medications to social and psychological approaches."

> "We need home environments run by non-medicalized peers who are just willing to sit with people in distress."

> "Professional mental health clinical staff and Certified Peer Specialists with lived experience should engage frequently and meaningfully with the individual and respect person-centered principles and 'Nothing about me without me'!"

> "The volatile and counter-therapeutic environment created by throwing together – with no exit – stressed strangers, often in psychological and/or situational crises...[and] confining people with histories of serious violence together with vulnerable, easily victimized people [contribute to violence perpetrated against individuals with a MH condition].

Compassion Understanding and Empathy

Compassion and understanding were key themes mentioned by both Plex and FMIC. Among PLEx, approximately 27% to 37% (25 to 34 respondents) stressed the importance of these qualities in relation to individuals with mental health conditions to prevent coercive measures. Measures discussed by respondents included providing compassion training to healthcare providers, fostering meaningful relationships, communicating respectfully and kindly, and adopting a strengths-based approach. Additionally, training in trauma-informed care and focusing on human engagement were suggested.

Among FMIC respondents, 30% (nine individuals) emphasized the role of compassion and understanding, especially from healthcare professionals, in avoiding coercive measures. This entails addressing and preventing dismissive, bullying, or patronizing behaviour by medical staff, recognizing affirmation, communication, and inclusion as keys to recovery, and building reliable relationships between mental health professionals and individuals with a mental health condition.

> "Ensure that staff act with empathy and kindness and censor them if they don't. I've seen nursing staff being patronising, bullying and dismissive of the needs of a hospital patient who was accused of "playing up" when they were fearful and anxious."

> "Good and reliable human relationship. Psychiatrists and mental health care system should support the patients to have that."

> "De-escalation just talk to people and be honest. Don't treat me as an idiot. Explain why you are doing things. Give me a coloring book and sit and listen to me."

> "Talk to the person. Show them respect and treat them the way you would want to be treated."

> "People need to be listened to for however long it takes to calm the nerves of that person."

> "Assume that someone in distress has inner resources and guide that you can connect with if you wait and respond to cues with respect."

> "I think speaking with the individual at their level, with respect and dignity and treatment them fairly and kind can go a long ways... I often saw staff members holding medications over a patients head (not literally - figuratively) if you don't go to AA and do so many meetings within this time frame... you won't be prescribed your... assisted treatment medications (such as methadone...)... the staff knows these individuals will do anything to keep getting their medications and they use this to their advantage."

Education and Training

According to 24% to 31% of PLEx respondents (22 individuals), and 37% of FMIC (11 individuals), training initiatives should encompass a range of strategies aimed at improving crisis intervention and mental health support. These initiatives include de-escalation techniques training for staff, involving individuals with lived experience in prevention and advocacy education, providing community training for frontline workers and police, and promoting peer-led harm reduction training. Furthermore, efforts extend to educating family members and informal caregivers to better support individuals during periods of illness and disruptive family behaviours. There is also a focus on enhancing staff training with network-focused practices such as Open Dialogue and providing protocols or guidance for individuals with mental health conditions to proactively seek help, thereby preventing situations from escalating further.

"Widespread training in Open Dialogue..."

"De-escalation techniques, sensory and relaxation. Calming spaces. Further staff training. Education for patients. Adequate staffing and resources."

"... education for carers/ family on how better to manage the person when illness occurs."

"Sometimes it's as simple as providing some rationale, tools and practice - people need to be able to move beyond their fear of the unknown, and oftentimes that requires being able to talk it through."

"Educate over the noise of the medical model to raise awareness that mental health challenges are NOT permanent brain disorders but responses to stress and trauma."

Legal Measures

According to 16% of PLEx (15 respondents) and 13% of FMIC (four respondents), suggested changes to laws and legal frameworks as a means to prevent coercive measures. Proposed suggestions included reforming mental health laws, enforcing stricter regulations and law enforcement, providing legal representation for patients, and revising laws related to involuntary commitment. Other measures mentioned involved revoking medical licenses for malpractice or administering psychotropic drugs without informed consent, banning dangerous medications, and eliminating psych evaluation questions from medical health questionnaires. Additionally, legal consequences for pharmaceutical companies and the legal binding of psychosocial advanced directives were also mentioned.

"Withdrawal of the medical licence if doctors administer psychotropic drugs without informed consent even in the absence of acute danger to life."

"Give people their rights. That's it. Make this illegal, because [in] any other circumstances this is."

Effective Communication

According to 30% of PLEx (27 respondents) and 37% of FMIC (11 respondents), there is a strong emphasis on the significance of improved communication, enhanced listening skills, and increased dialogue among service providers, families, informal caregivers, and individuals with mental health conditions. This entails mental health professionals actively listening to individuals with mental health conditions and their families, including families in decision-making processes, effectively communicating treatment risks, providing a safe space for the expression of thoughts, and implementing training based on the Open Dialogue approach.

"LISTEN to people and understand that their behaviors are a way of communicating something that maybe they can't put into words. Use your de-escalation skills (ask for training or get a different job if you lack such training.) If you end forced admissions to hospitals, you reduce a lot of the opportunity for seclusion and restraint to happen. Open more peer run respites"

"identify the patients main concern as soon as possible, taking long time to make the patient volunteer to accept treatment and try with different professionals with different skills /approaches"

"Affirmation, communication and inclusion are the keys to recovery."

Shared Decision-Making

53% of PLEx (16 people) suggested incorporating shared decision-making and involving individuals with mental health conditions in the decision-making process to reduce coercion. Collaboratively working on plans and therapies, involving people with lived experience, and ensuring informed consent throughout the process were mentioned.

> "Always have respect for the patient, ask for their opinions, and never make them be in a private facility without consent. I did not care about being in a nice accommodation, would rather have been in a public hospital and not have to sacrifice my children's life to be able to pay a huge bill later."

Alternative Therapies and Techniques

Between 37% to 63% of FMIC (11 and 19 participants) highlighted the importance of alternative therapies and techniques that go beyond medical and prescription drug-focused approaches. This includes music therapy, meditation, outdoor exercise, psychological therapy sessions with psychologists, art therapy, talking groups, and creating safe and calming spaces that address sensory and relaxation needs.

> "Open dialogue, peer engagement but not from peers who are scared they will lose their jobs if they speak up, more time outdoors, time in a safe place with caring people who actually listen to what they are going through. Training parents in how to work with disruptive family behaviours, to name a few."

> "Trauma informed practices. Acknowledging the person vocally and listening. Perhaps even offering a meditation that any person would use and not with holding help unless the person accepts antipsychotics."

Preventative Measures

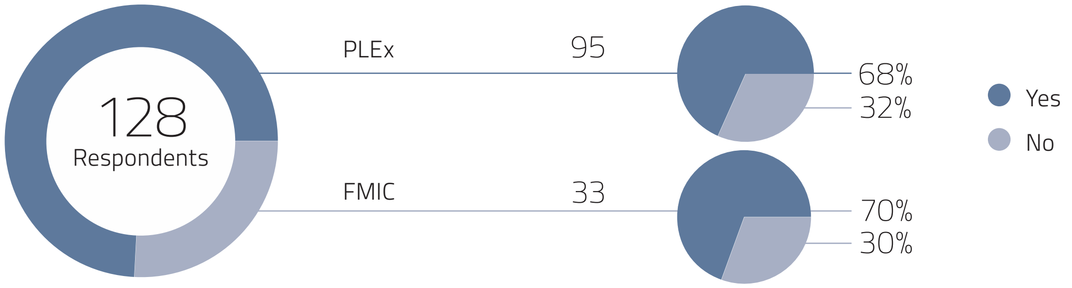
Ten percent of FMIC (three people) indicated that taking preventative measures to address behaviours before they escalate could help avoid coercion. This involves creating protocols or guidance for individuals with mental health conditions to communicate their needs before crises occur, developing advanced plans with individuals, and identifying triggers and minimizing their impact within facilities.

> "Have a better protocol or guidance for mental health patients so they can ask for help before they get to the peak of their crisis."

6. CONSULTATION FINDINGS continued

Question 6 – Human Rights bodies

Are you familiar with any Human Rights bodies or organisations in your country?



Question 7 – Most serious concerns

What are the most serious concerns you have right now because of your mental health condition or the mental health condition of the person you care for?

94

PLEx respondents

31

FMIC respondents

Experience of Coercion
Plex 15%
FMIC 13%

Financial Hardship and Job Insecurity
PLEx 11%
FMIC 13%

Stigma and Discrimination
PLEx 18%

Mental Health Record Implications
PLEx 7%

Trauma and Re-traumatization
PLEx 4%

Basic Needs
FMIC 19%

Managing Condition or Symptoms
FMIC 13%

Receiving Adequate Care
FMIC Between 10% to 26%

Lack of Trust
FMIC 6% to 13%

When asked about their current concerns regarding mental health conditions experienced by themselves or the person they care for, both sets of respondents highlighted two main areas of concern: **experiences of coercion and financial hardship including job insecurity**.

PLEx respondents brought attention to the enduring challenges of **stigma**, **discrimination**, implications related to their **mental health records**, and the **risk of trauma and re-traumatization**.

FMIC also shared distinct concerns, including worries about managing **the condition or symptoms**, **basic needs**, and **receiving adequate care**. A subset of FMIC respondents also expressed concerns about lack of trust in the mental health care system.

Below we examine in more detail the concerns expressed by the 94 individuals with a mental health condition and the 31 family members or informal carers who responded to this question.

Experience of Coercion

15% of PLEx (14 respondents) indicated that their most serious concern revolved around the experience of coercion, including apprehension of encountering coercive practices in mental healthcare settings again. They emphasized the importance of ensuring physical and psychological safety within the mental health system.

Similarly, this concern was echoed by 13% of family members and informal caregivers (FMIC), with four respondents noting that the individuals they cared for had expressed concerns about coercion. This included worries about being medicated against their will or not having their advance directives respected.

The most serious concern I have right now is:

> "That she will be medicated against her will and she will not be able to experience any emotions." – FMIC survey respondent

> "Not being heard and someone coming and deciding he can be taken again." – FMIC survey respondent

> "I fear slipping up and getting locked up again." – PLEx survey respondent

> "Someday being in a position again of being at risk of forced treatment." – PLEx survey respondent

> "My most serious concerns are my suicidality and tendency to self harm, but I cannot be honest about these (and thus get adequate treatment) because I will be forcibly hospitalized if I mention them." – PLEx survey respondent

> "I'm worried because I would rather kill myself than ask for help from MH services. I worry if I felt I was going to get seriously unwell again, I'd rather run away or just die than go through it all again in the wards." – PLEx survey respondent

Financial Hardship and Job Insecurity

A total of 11% of individuals with lived experience of mental health conditions (PLEx), specifically ten respondents, expressed concerns about financial difficulties related to medical expenses. Concerns were expressed about respondents' ability to work and maintain job security due to their mental health condition, including other peoples' and prospective employers' perceptions of them.

Similarly, among family members and informal caregivers (FMIC), 13% of respondents (four individuals) noted financial hardship as a top concern for the individuals they care for. These fears encompassed worries about employment, financial responsibilities related to mental health care, and inability to work due to a mental health condition.

> "Negative symptomatic Schizophrenia which exhibits as inability to work or support herself." – FMIC survey respondent

> "That I won't be able to find a new job and have to continue to put up with bullying in employment until I can." – PLEx survey respondent

Stigma and Discrimination

18% of PLEx who responded to this question (17 participants) expressed deep concerns about the stigma they face in various aspects of life, including the workplace and mental healthcare settings. They highlighted the need for humane treatment and the upholding of human rights, with some feeling that physical health concerns were being dismissed as mental health issues.

> "Stigma and discrimination are worse than the health problem itself."

> "When I talk to doctors that they see my mental illness so they tell me that my concerns are not valid.

Mental Health Record Implications

Seven percent of PLEx (seven respondents) conveyed apprehensions regarding their mental health records affecting how they are treated in medical settings. They worried that their mental health history might negatively impact the diagnosis and treatment of other health conditions.

> "I'm no longer involved in the system, so I am not that worried about myself except for the fact that my past record of mental health treatment often means that I'm gaslit by doctors when I seek treatment for physical health complaints."

Trauma and Re-traumatization

Four percent of PLEx (four respondents) highlighted their concerns about trauma and re-traumatization, emphasizing the need to work through and recover from past traumas while rebuilding trust in health professionals.

> "Working through and recovering from the trauma and learning how to trust health professionals again."

Other areas of concern from people with lived experience of mental health condition included the lack of an advocate to help understand and explain their condition, worries about the longevity of their recovery, the impact of long-term medication use, difficulties in tapering off medications, worsening symptoms, interpersonal stressors, accessing help before crises, lack of support in old age, and loss of autonomy in decision-making.

Basic Needs

19% of FMIC, consisting of six participants, noted that their loved ones' most serious concern was having their basic needs met, including a stable place to live, access to food, and long-term security.

> "Staying alive and having a place to live and food to eat."

> "He fears he will never have his own small place to call his home.

Managing Condition or Symptoms

13% FMIC (four respondents) mentioned that their loved ones were primarily concerned with managing their mental health condition or symptoms, including avoiding triggers that worsen their mental health and dealing with conditions like depression or schizophrenia.

> "[The] personality of others sometimes takes over him."

Receiving Adequate Care

Among family members and informal caregivers (FMIC), a range of three to eight participants, accounting for approximately 10% to 26% of responses, highlighted their loved ones' concerns about receiving adequate and safe mental health care that respects their privacy and human rights.

> "That she can have adequate care and that her rights are respected." – FMIC survey respondent

> "There are Concerns about the future when I am no longer here to advocate or oversee his care" – FMIC survey respondent

Lack of Trust

Among family members and informal caregivers (FMIC), between 6-13% (2-4 participants) mentioned concerns that their loved ones lack trust in medical professionals and support workers due to their previous experiences.

> "That she can have adequate care and that her rights are respected... Even though her fears are grounded in evidence-based facts – they will not admit her to a hospital for life saving treatment" – FMIC survey respondent

> "Right now, some residual fear and mistrust of all doctors, but otherwise, she recovered completely - no concerns." – FMIC survey respondent

Additional concerns from FMIC included worries about the future when the caregiver will no longer able to advocate for the individual, paranoia experienced by the individual, delays in receiving treatment for other health conditions, and challenges with online medical appointments during COVID-19.

Notably, eight PLEx indicated that they **did not currently have serious concerns** in relation to their mental health condition, or solely focused on their recovery and achievements in their response. This included:

- that they were already in recovery
- that their situation had improved since ceasing medication
- that their situation had improved since their compulsory treatment order had ended
- that they had supports and plans in place

> "I'm not too worried now, because I have supports and plans in place."

> "I am in a good condition, a great improvement of my life the last fourteen years. Studying a university degree, working in a good job professional position. I don't use psychiatric drugs at all nowadays. But it was a journey of suffering, pain and solitude during decades."

PART B: Organisations representing PLEx and/or FMIC

Survey 2 included questions that invited perspectives from organisations representing people with lived experience of mental health conditions (PLEx) and/or and family members and informal caregivers (FMIC). There were 11 responses to this part of the survey from 7 organisations representing PLEx and 4 organisations that represent both PLEx and FMIC.

Question 1 – Policy position (part one)

Does your group have a policy position on coercive practices?

11 organisations representing PLEx and/or FMIC responded to this question.

As shown in figure 14, a total of 72.7% (8 organisations representing PLEx and/or FMIC) indicated that they have a policy position on coercive practice, whilst 27.3% (3 organisations representing PLEx and/or FMIC) indicated that they did not have a policy position on coercive practices.

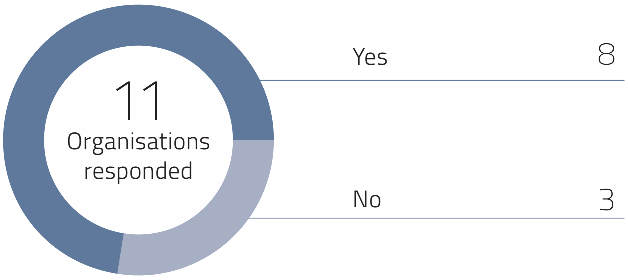


Figure 14.

Question 2 – Policy position (part two)

If yes, would you please describe it briefly?

Of the 8 organisations who responded yes that **their organisation does have a policy position on coercive practice**, when asked to describe their position they said:

> We are a zero coercion, zero force organisation

> We fully support and advocate for implementation of guidelines of the UN CRPD Committee to article 14…

> [We are] health crisis responders and ensuring that forced outpatient commitment is not expanded in NY

> We oppose all coercion; key current advocacy centers around removing police as mental

> We recommend our government change our mental health laws to absolutely minimise use compulsory treatment orders (involuntary treatment) and restraint (except in the rarest of circumstances), and to eliminate seclusion. We are currently working towards updating this position for the next stage of consultation on our government's reform of our mental health laws.

Question 3 – Knowledge and practice around alternatives to coercion

Is there anything that you know has worked well in your country to provide safe and effective alternatives to coercive practices?

8 organisations representing PLEx and/or FMIC responded to this question.

Eight organisations indicated knowledge of something that has worked well in their country or region to provide safe and effective alternatives to coercive practices.

Two organisations answered 'no' that they did not know something that has worked well in their country or region to provide safe and effective alternatives to coercive practices.

One organisation did not respond to this question.

Question 4 – Knowledge and practice around alternatives to coercion

If yes, would you please describe it briefly?

8 organisations representing PLEx and/or FMIC responded to this question.

Of the eight organisations that responded yes, these alternatives included:

- Supported decision-making
- Peer-run respite services
- Online resources and websites, like "Mad In America"
- Attention to the right quantity and quality of adequate personnel
- Access to basic needs like housing, employment, food
- Group gatherings of people with lived experience of MH conditions

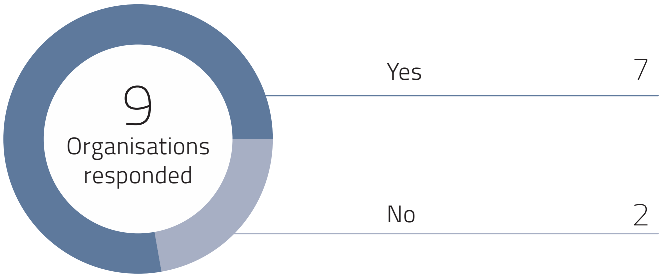
"The success is not full, because services need to be expanded and their quality has to be improved. However, there are many alternatives in European countries that can provide support without coercion. Mostly it is all about attention, adequate personnel, both in quantity and in quality. Peer support plays a significant role, however it can be misused"

Question 5 - Interactions or collaborations with mental health organisations

Does your organisation interact or collaborate with any psychiatric or mental health organisations?

Of the 8 respondents that indicated they interacted with or worked in collaboration with psychiatric or MH organisations, the ways in which they worked with these groups included:

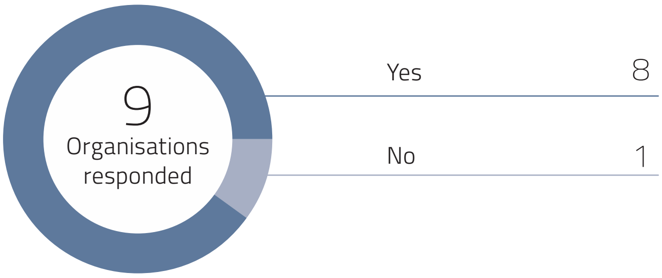
- Side-by-side in campaigns
- As lived experience advisors or consultants to other organisations, clinicians and students
- In the making of joint statements
- At all stages of a project including in system design and outcome measurement
- To investigate coordinated services for reducing/withdrawing safely from psychiatric drugs
- Collaborating in seminars, congresses and research among other initiatives.



Question 6 - Interactions or collaborations with Human Rights organisations

Does your organisation interact or work with Human Rights organisations?

Nine organisations indicated they worked or interacted with Human Rights organisations through:



- Organisational boards, like the board of one respondent's disability rights organisation
- Networks, like *Pravna mreža za varstvo demokracije* (the Legal Network for Democracy)
- Joint campaigns
- Advocacy work
- Legislator education
- Implementation of federal rights protections
- Exchange of case notes
- Engaging with country-specific, governmental Human Rights bodies, like the Human Rights Commission and the Health and Disability Commissioner in New Zealand. Spanish Ombudsman, United Nations Human Rights, Unit Head of the WHO Policy, Law and Human Rights team in the Department of Mental Health and Substance Use, Human Rights Watch.

Question 7 – Psychiatrists working with organisations representing PLEx and FMIC

What should psychiatrists do to improve their way of working with members of your group?

Ten organisations indicated that psychiatrists could improve how they work with members of their organisations, noting the following ways:

- Recognising trauma and preventing re-traumatisation in the name of treatment
- Acknowledging diverse worldviews regarding the causes and treatment of mental health conditions, beyond a chemical brain imbalance paradigm
- Listen to and be led by people with lived experience
- Engage peer support workers
- Recognizing psychotropic medications as tools, not a universal solution, and allowing individuals to determine their usefulness
- By actively opposing or seeking alternatives to coercion
- Through engaging with training that challenges out-dated attitudes and approaches to treating mental health conditions, including the WHO Quality Rights Training
- Prioritising informed consent
- Involving family and friends as supports where appropriate and desired by the person with a mental health condition
- Involving peer support workers where appropriate and desired by the person with a mental health condition

> "...recognize that there are various worldviews regarding causes and treatment of mental illness. A chemical brain imbalance paradigm alone does not value the impact of poverty, trauma, oppression, culture, and other drivers of health as causes and interventions"

> "Speak and communicate appropriately with your patient. ask him, establish the essential therapeutic alliance, and if you don't feel up to it, refer this patient to another colleague (...) without the participation of the patient there is no possibility of improvement or recovery."

7. CONSULTATION FINDINGS

This section summarises key findings of the consultation based on responses received from individuals with lived experience, family members, organisations that represent these two groups and psychiatrists via their WPA Member Societies.

The following points raised by consultation participants provide important insights for addressing coercive practices and improving the quality of mental health care:

Coercive mental health practices carry serious risks of harm to people who require care.

People with lived experience of mental health conditions (PLEx) and family members and informal carers (FMIC) repeatedly described the detrimental impacts of these practices, including:

- Trauma and re-traumatisation, which is especially dangerous for people whose symptoms are triggered by memories of historical trauma such as sexual abuse;
- Disruption of healing and recovery;
- Lack of trust in the health system and decreased willingness to seek treatment, with fear often deterring them even in times of severe distress
- Lasting physical injuries; and
- Death, either as a direct result of physical restraint or by taking one's own life to avoid experiencing coercive practices again.

Coercion in mental health care is a human rights issue; implementing alternatives is key to the ethical practice of psychiatry.

Participants across all consultation groups stressed the importance of acknowledging the human rights of individuals with mental health conditions and emphasizing their legitimacy even during times of crisis. The complexity of coercion in mental health care was reflected in the variety and depth of viewpoints expressed.

Partnerships between psychiatric organisations and people with lived experience are emerging around the world.

Almost all Member Societies that participated in the WPA survey reported working with mental health service users, with over half working also with family members and informal carers. Likewise, most of the organisations representing PLEx and/or FMIC that responded to the survey are working with psychiatric and mental health organisations. Collaborative work has included educating journalists about stigma-free reporting, producing educational videos, campaigining for and drafting legislation, lived experience advisories, training clinicians and students, project design and outcome measurement, and research.

There are many ways to avoid coercion while improving people's experiences of mental health treatment and care

Psychiatrists, people with lived experience of mental health conditions and family members & informal carers voiced numerous example of what can be done better to provide treatment and care without coercion. These include:

- Effective and compassionate communication is a cornerstone of quality care. Active listening and the avoidance of assumptions were repeatedly noted as essential components to enabling mental health treatment without coercion.
- Peer support was identified as a valuable way of avoiding coercion, fostering recovery and understanding.
- The need for comprehensive training and education was a strong common thread across all consultation groups. Participants noted the need to provide training to a range of people involved in delivery of mental health services, including psychiatrists, medical professionals, family members, and health facility staff. Skills noted as essential to build included communication, understanding individual needs, de-escalation techniques, trauma-informed practices and recovery-oriented care.
- Autonomy and person-centred care were emphasised, as was the need to empower individuals to make informed decisions by supporting voluntary, self-directed management of their own treatment.
- Creation of safe and quiet spaces for open dialogue between individuals and their families was recognized as an important step towards addressing coercion and improving quality of mental health care.

These findings collectively emphasize the significance of respectful and rights-based mental health care, collaboration, and a holistic approach that prioritizes individual autonomy and well-being.

8. RECOMMENDATIONS

Foster rights-based communication and compassionate care

Across all consultation groups, there was strong acknowledgment of the fundamental importance of aligning communication practices with human rights. The need for respectful and transparent communication with individuals and their families was emphasised, underlining the pivotal role of rights-based interactions.

Furthermore, there is consensus on the need to treat individuals with mental health conditions with respect, dignity and compassion. Empathetic care is recognized as a critical factor in motivating individuals to seek help voluntarily and engage willingly in treatment and care.

Informed consent across all aspects of mental health care is understood as an important way of ensuring that respect for autonomy and rights remains central to the treatment process. Developing strong partnerships between psychiatrists, people with lived experience of mental health conditions, and family & informal carers can be a way of achieving this. National legislation, in addition to the policies of individual mental health facilities, and de-stigmatisation of mental health conditions in the media are also important conduits for change.

Enhance training and education

FMIC, PLEx, the organisations representing them and WPA Member Societies share the perspective that better training for mental health professionals and staff is vital to implementing alternatives to coercion. All consultation groups called for better education in areas such as respectful treatment, trauma-informed care, and examples of successful alternatives to coercion.

Across all groups, there were calls for more comprehensive sharing of information with people with lived experience of mental health conditions and their families. These emphasized the need for training that encompasses family support, self-care, and effective communication, while concurrently raising awareness about the substantial risks of coercion. Testimonies from people with lived experience and family members provide a wealth of insight on these risks, which include traumatization, erosion of trust in health professionals, avoidance of treatment, lasting physical injuries and death.

There is a consensus among FMIC, PLEx, organisations, and member societies regarding the significance of promoting readily accessible resources and tools for training and education within mental health care settings. The WPA Working Group on Implementing Alternatives to Coercion provides a list of such resources already on the WPA website, and the findings of this consultation suggest that further development and promotion of these would help advance progress on this important issue.

Review protocols to ensure that coercion is not used as a default approach

This consultation has demonstrated broad consensus across all surveyed groups that existing protocols surrounding mental health need comprehensive review, and there should be a shift away from coercion as the default approach. Prioritizing voluntary treatment over coercion is a common goal.

Promote collaboration and peer support

FMIC, PLEx, organisations, and member societies are united in their call for the promotion of peer support programs and collaboration among psychiatrists, community professionals, and families. They stress the value of diverse perspectives in all stages of designing, implementing and evaluating treatment and care.

Listening to and being guided by individuals with lived experience is another shared recommendation, with the engagement of peer support workers to strengthen the support network.

Recognizing psychotropic medications as tools rather than universal solutions was additionally emphasized by organisations and FMIC, empowering individuals to ultimately determine their appropriateness in their treatment.

Advocacy for involving family and friends as support when desired by the person with a mental health condition, along with engaging peer support workers when suitable, is also encouraged.

Promote delivery of trauma-informed care

Addressing trauma and preventing re-traumatization in the course of mental health treatment is called for by people and organisations across all consultation groups.

Diversify understanding of mental health treatment and care

Individuals and organisations across all consultation groups acknowledged diverse perspectives and worldviews on the causes and treatment of mental health conditions. Respondents demonstrated interest in complexifying delivery of treatment and care beyond conventional medical models and overreliance on pharmacueticals and hospitalisation. This indicates the importance of expanding research to better understand what works when it comes to delivering high quality treatment and care free from coercion in a variety of different settings and situations.

APPENDIX: LIST OF RESOURCES CONTRIBUTED BY PARTICIPANTS

Uploaded attachments Service users and carers:

1. https://drive.google.com/open?id=1Fmner5D4YZaRb6rog4aW_SByeJm55OHh
2. https://drive.google.com/open?id=13ew_8K-L3VFepNCX3l5r9ABq9JmpM9Dd
3. https://drive.google.com/open?id=1uGVPETPiLhgZPJyT0Jzzy5AhH8DYs8ST
4. https://drive.google.com/open?id=160ejHIGoH8L-o06DLL5QZ18LZHkpw5Wm
5. (https://docs.google.com/forms/d/1X-22IR5bJGOGmgCfUFF_J5MzUlCfCMgkBslVuHdS5s/edit) and to a petition about unethical human experimentation (https://docs.google.com/forms/d/1X-J-DGJLNC_j o2F0K9cGVV_E3ifP87mnlqEANiqeg/edit), and attached are letters to the media with a detailed account (the second one is specific to college policies)
6. Lehmann, Peter / Newnes, Craig (eds.): "Withdrawal from prescribed psychotropic drugs", ebook, original in 2021, updated edition, Berlin / Lancaster: Peter Lehmann Publishing 2023 – http://www.peter-lehmann-publishing.com/ppd-withdrawal.htm
7. Stastny, Peter / Lehmann, Peter (eds.): "Alternatives Beyond Psychiatry", Berlin / Eugene / Shrewsbury: Peter Lehmann Publishing 2007 – http://www.peter-lehmann-publishing.com/alternatives-beyond-psychiatry.htm
8. Lehmann, Peter (ed.): "Coming off psychiatric drugs. Successful withdrawal from neuroleptics, antidepressants, lithium, carbamazepine and tranquilizers", Berlin / Eugene / Shrewsbury: Peter Lehmann Publishing 2004 – http://www.peter-lehmann-publishing.com/withdraw.htm
9. Lehmann, Peter: "Securing human rights in the psychiatric field by advance directives", in: Journal of Critical Psychology, Counselling and Psychotherapy, Vol. 15 (2015), pp. 1-10 – http://www.peter-lehmann-publishing.com/articles/lehmann/pdf/lehmann_advance-directives-2014.pdf
10. Lehmann, Peter: "About the intrinsic suicidal effects of neuroleptics: Towards breaking the taboo and fighting therapeutical recklessness", in: International Journal of Psychotherapy (Vienna), Vol. 16 (2012), No. 1, pp.
11. 30-49 – http://www.peter-lehmann-publishing.com/articles/lehmann/pdf/neuroleptics-suicide.pdf
12. Lehmann, Peter: "Paradigm shift: Treatment alternatives to psychiatric drugs, with particular reference to low- and middle-income countries", in: Laura Davidson (ed.): "The Routledge Handbook of International Development, Mental Health and Wellbeing", London / New York: Routledge 2019, pp. 251-269 – http://www.peter-lehmann-publishing.com/articles/lehmann/pdf/sdg3-psychiatry-treatment-alternatives.pdf
13. https://drive.google.com/open?id=1b7HI0Iv7Q_imqu5zR6ltnFpVfoTCbLCz
14. https://drive.google.com/open?id=10GJLkEnTbtssEeZ2qy9ZEavTFzhgsZx4, https://drive.google.com/open?id=1p0hjjUp3c1Gze4qiYWsjv8PQOqHuW55Y
15. UN CRPD Guidelines for Deinstitutionalization
16. Article/testimony I wrote: https://www.madinamerica.com/2023/02/legal-protections-forced-ect/

ENDNOTES

1 Thornicroft G, Sunkel C, Alikhon Aliev A, Baker S, Brohan E, El Chammay R, Davies K, Demissie M, Duncan J, Fekadu W, Gronholm PC, Guerrero Z, Gurung D, Habtamu K, Hanlon C, Heim E, Henderson C, Hijazi Z, Hoffman C, Hosny N, Huang FX, Kline S, Kohrt BA, Lempp H, Li J, London E, Ma N, Mak WWS, Makhmud A, Maulik PK, Milenova M, Morales Cano G, Ouali U, Parry S, Rangaswamy T, Rüsch N, Sabri T, Sartorius N, Schulze M, Stuart H, Taylor Salisbury T, Vera San Juan N, Votruba N, Winkler P. The Lancet Commission on ending stigma and discrimination in mental health. Lancet. 2022 Oct 7:S0140-6736(22)01470-2. doi: 10.1016/S0140-6736(22)01470-2. Epub ahead of print. PMID: 36223799.

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ASSOCIATION