Implementing Alternatives to Coercion in Mental Health Care

Discussion Paper from the WPA Taskforce

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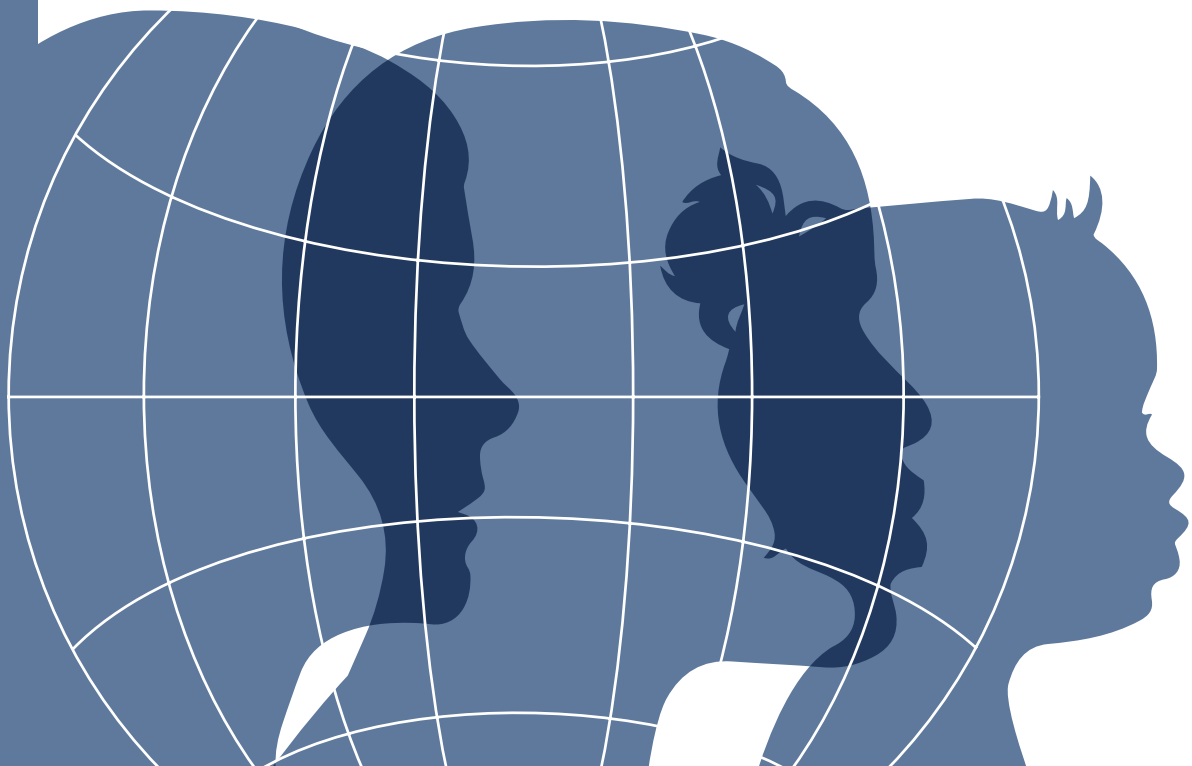

This paper was prepared by Dr Maria Rodrigues and Prof Helen Herrman, World Psychiatric Association (WPA) President, on behalf of the WPA Taskforce on Implementing Alternatives to Coercion in Mental Health Care and the Working Group for the WPA and Royal Australian and New Zealand College of Psychiatry (RANZCP) Joint Project on Implementing Alternatives to Coercion in Mental Health Care.

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WPA Taskforce on Implementing Alternatives to Coercion in Mental Health Care

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Martha Savage
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Member, WPA Service User and Carer Advisory Group

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King's College London, UK

Robert van Voren
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Wang Xiaoping
Central South University, China

Consultant

Neeraj Gill
Griffith University, Australia

Reference group

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WPA Standing Committee on Ethics and Review

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University of Toronto, Canada,
WPA Standing Committee on Ethics and Review

Silvia Gaviria
Universidad CES, Colombia
WPA Board

David Ndetei
Africa Division of Royal College of Psychiatrists, Kenya
WPA Board

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- The use of coercion in mental healthcare has long been subject to controversy, and the call for viable alternatives is growing both within the profession and among people with lived experience of coercion in mental healthcare.
- This Discussion Paper outlines recent developments in practice, research and international human rights law concerning coercion in mental health settings with the aim of supporting psychiatrists and other mental health professionals in their work towards improving the quality and safety of mental health services and putting sound alternatives to coercion in place.

2. Understanding coercion in mental health

- The terms 'coercion' and 'coercive practices' are used in this paper to describe a range of interventions authorised or enacted by mental health professionals, from involuntary treatment through to forceful action and threats undertaken in the course of providing treatment and/or where efforts are being taken to address the perceived harm a person poses to herself/himself or others due to a mental health condition.
- This paper focuses on supporting alternatives to coercion in formal health care settings, including both specialised mental health services and general medical settings, such as emergency departments where mental health treatment is provided.
- Coercion in informal settings, such as family homes, communal areas in villages and towns, including sheds, cages, 'prayer camps', or 'mandated re-education centres', also raises serious concerns (though will not be the focus of this paper).
- Common coercive practices include formal detention and treatment without consent (or 'compulsory treatment'), including the use of psychotropic medication and/or electroconvulsive treatment.
- Seclusion (locking or confining a person to a space or room alone) and restraint (actions aimed at controlling a person's physical movement) are also forms of coercion.
- There is widespread agreement that coercive practices are over-used and that considerable work is warranted in mental health systems to ensure that people with mental health conditions and associated psychosocial disabilities uniformly have access to high-quality support that manifests respect for their personhood and takes into account the full range of needs and rights.
- A focus on access to health, and particularly the need for sufficient mental health supports, invites attention to designing and resourcing mental health systems that take into account the full range of needs and rights.
- There is a considerable and growing evidence base to support the implementation of alternatives to coercion. These alternatives can support the rights of persons with mental health conditions and associated psychosocial disabilities without reducing access to effective care and/or increasing safety risks for themselves or staff.

3. Clinical, moral and legal grounds for alternatives to coercion

- Two justifications for the use of coercion are commonly invoked: to address the health interests of the patient; and/or the protection of patient and/or others.
- There is a growing list of reasons to implement alternatives to coercion in mental health treatment, including the following:
  - Clinicians, researchers, and people with lived experience of mental health conditions have questioned the clinical benefits of coercive treatment.
  - Some mental health service users, their families and supporters have called for these practices to be reduced and/or eliminated.
  - The use of coercive practices may also be traumatising or otherwise damaging for staff.
  - Physical coercion, even when used as a 'last resort', carries serious risks of pain, injury, trauma and even death.
  - Emerging service delivery models promote the avoidance of coercion, including recovery-oriented and trauma-informed approaches.
  - The passage of the United Nations Convention on the Rights of Persons with Disabilities (CRPD), and subsequent statements from international human rights bodies, have challenged nations worldwide to improve access to voluntary mental health supports and reduce, prevent and potentially even end coercive interventions.
- Some clinicians and other commentators have expressed reservations about (and in some cases, outright rejection of) moves to avoid coercion in mental health services. These include arguments that compulsory treatment must be available to protect individuals and/or those around them from harm, to protect individuals' other rights, and to ameliorate the negative impacts of certain mental disorders on individuals' wellbeing.
- There has also been divergence in the post-CRPD interpretive guidance offered by UN bodies, with some UN bodies and pronouncements appearing to share the concerns raised by many clinicians.
- These different views are reflected in debates by policymakers, government agencies and civil society organisations all over the world as well as among service users and persons with associated psychosocial disabilities. There is a risk that these debates are becoming intractable.
- What is often lost is the considerable agreement that exists across diverse perspectives, and the pathway that this creates for positive change.
- There is widespread agreement that coercive and compulsory practices are often over-used, and there is an evidence base to support the implementation of alternatives to coercion.

4. The research base for implementing alternatives to coercion

- Research, policy and law reform initiatives indicate that practical steps can be taken to implement alternatives to coercion.
- Governments, service providers or community advocates have been effective — to varying degrees — when taking steps to implement alternatives to coercion
- Efforts include:
  - Hospital and individual service-based changes;
  - Legislation that limits the use of coercion;
  - National policy seeking to reduce seclusion and restraint in mental health settings, including public databases that record the frequency and duration of their use for benchmarking and accountability; and
  - The World Health Organization (WHO) QualityRights Initiative
- Hospital-based efforts, including 'Safewards', 'Six Core Strategies' and 'open door policies', indicate a reasonably high degree of evidence for effectively reducing the use of coercive measures in clinical practice.
- Policy changes include national initiatives to reduce the use of seclusion and restraint, with moderate success indicated in countries such as the Netherlands.
- However, overall, and despite the promising evidence-base, there are relatively few initiatives worldwide that are explicitly aimed at reducing coercion.
- Most empirical studies that examine efforts to minimise coercion focus on high-income, 'Western' countries.
- In 2019, the WHO QualityRights Initiative released a comprehensive set of resources for improving quality of care and reducing coercive practices. The resources have been piloted and launched in low-, middle- and high-income countries and are designed for use by a range of actors, including service providers, individual healthcare practitioners, as well as national bodies. Implementation findings are beginning to emerge.

5. Conclusions: Opportunities for improving practice, conditions, care and links with community supports

- There is growing momentum to develop and implement alternatives to coercion in the delivery of mental health services. Service managers, clinicians, and people with lived experience and their families all can play a central role in leading change.
- Further research is needed to shed light on the processes that have been effective in bringing about change within the confines of prevailing social, cultural, and economic barriers.
- The next phase of this project will develop a set of case studies to examine how progress has been achieved in different settings, including those in three geopolitical regions and two low- and middle-income countries. It will produce a set of resources designed to support mental health professionals and their organisations to translate the research considered in this Discussion Paper into support for alternatives to coercion in practice.

1. Introduction

The use of coercion in mental healthcare has long been subject to controversy, and the call for viable alternatives is growing both within the profession and among people with lived experience of coercion in mental healthcare. History records efforts by psychiatrists and their colleagues and predecessors to work with mental health systems and communities across time and place to support rights-based clinical and societal practices. On the other hand, there are tragic examples of coercive practices that constitute large-scale human rights violations.[1] Despite high-level agreement on key components of good mental health policy around the globe — from promotion, to prevention, treatment and rehabilitation — the use of coercion in mental health settings remains controversial.

In recent years, international human rights bodies have issued statements challenging the appropriateness and lawfulness of compulsory treatment and hospital detention and have called for their replacement with voluntary service provision based on informed consent.[2] Professional groups have expressed concern about these statements, pointing to ethical challenges and questions of competing rights in clinical practice.[3] At a minimum, there appears to be general agreement that many coercive practices are unacceptable, can cause serious harm (regardless of intent) and should be viewed as 'a system failure', and that more could be done to shift mental health care toward a system based on voluntary support.[4] In the expression "system failure" we also refer to systems in which the implementation of mental health care is not recovery oriented.

This Discussion Paper aims to support this shift by examining relevant debates in policy and practice, and consolidating the emerging evidence base on alternatives to coercion in mental health care.

Very few published studies provide practical guidance for ensuring that treatment, care, and support are available in ways that avoid coercion and uphold rather than restrict or violate human rights. This Discussion Paper outlines recent developments in practice, research and international human rights law concerning coercion in mental health settings with the aim of supporting psychiatrists and other mental health professionals in their work towards improving the quality and safety of mental health services and putting sound alternatives to coercion in place. It aims to recognise the diversity of views and experiences among mental health professionals, people with lived experience and their families and supporters, and to address some of the practical questions that may arise. It reflects a desire to demonstrate and test the substantive role for psychiatry in implementing the 'positive' rights set out in the United Nations *Convention on the Rights of Persons with Disabilities* ('the CRPD').

2. Understanding coercion in mental health

The Oxford English Dictionary defines *coercion* as 'the action or practice of persuading someone to do something by using force or threats'.[5] Another common term, *compulsion* is defined slightly differently, as 'the action or state of forcing or being forced to do something; constraint'.[5]

For the purposes of this Discussion Paper, the terms 'coercion' and 'coercive practices' are used to refer to a range of interventions by mental health professionals, from involuntary treatment through to forceful action and threats undertaken to address the perceived harm a person poses to herself/himself or others.[6,7] The types of practices associated with coercion are listed below. Wayne Martin and Sándor Gurbai have proposed that a distinction should be drawn between 'non-consensual' and 'coercive' treatment.[2] They argue that 'non-consensual' treatment — whether in the mental health or general healthcare — could include 'any treatment that is undertaken in the absence of valid consent (Non-Consensual = Without Consent).'[2] They stress that not all non-consensual treatment is coercive or forced, and point to several examples from the general health context — for example, where a person is receiving treatment while in a coma, or a health professional (for example, a paramedic or nurse) is tending to an unconscious person. This paper is not directly concerned with non-objecting, non-consensual encounters between health practitioners and persons with mental health conditions and associated psychosocial disabilities. Although this broader class of *non-consensual* interventions raise important human rights issues, they are not always the same as the narrower subset of persons who experience what is aptly described as *coercion*.[2]

Coercive practices might be permitted under legislation or policy or might be performed 'unofficially'.[8] Whether a particular intervention is coercive will depend both on the objective nature of the intervention and how it is subjectively perceived by the person experiencing it. Some coercive practices are objectively measurable, such as the use of mechanical restraint, while other forms of coercion have a subjective component that may vary from culture to culture and person to person, as discussed below.[9] George Szmukler and Paul Appelbaum have called for a taxonomy of coercion and compulsion along a spectrum of morally relevant distinctions, from persuasion through 'interpersonal leverage', inducements (or offers), and threats, to the use of formal, legal compulsion or informal deprivations of liberty.[6] This level of precision is likely to assist practical efforts to identify and implement alternatives to particular *types* of coercion, and may also assist in evaluating the acceptability of the various grades of coercion. However, for the purposes of this Background Paper, the aim is to discuss coercion in a general sense.

This Discussion Paper focuses on coercion in *formal* healthcare settings, including both specialised mental health services and general medical settings, such as emergency medical departments, where mental health treatment is provided. We are not referring in this report to services that are specifically designed for persons with intellectual and/or cognitive disability, even though such differentiation can be misleading. Neat distinctions are rarely possible. For example, people with intellectual or cognitive disabilities may also use or require mental health care services.

Coercion in non-clinical settings is an important human rights concern, but falls outside the scope of the research presented here. It is important to acknowledge the serious concerns raised by coercive practices in informal settings, such as family homes, communal areas in villages and towns, including sheds, cages, 'prayer camps', or 're-education centres'.[10,11,12,13,14] This Discussion Paper does not include examination of these settings because its chief purpose is to inform and influence clinical policy and practice. To this purpose it does, however, include the use of compulsory treatment in the community that is *imposed by formal mental health services* (for example, in the form of 'community treatment orders' and 'assisted' or 'mandated' outpatient treatment).

2.1 Types of coercion

Common coercive practices include detention and treatment without consent (or 'compulsory treatment'). Treatment may involve the use of medications, compulsory surgery and/or other biological treatments. Other common forms of coercion used in mental health settings are seclusion (locking or confining a person to a space or room) and restraint (one of a number of actions with the purpose of controlling a person's physical movement). Restraint can take several forms. Physical or manual restraint involves physically holding a person (for example, by the arms or on the ground) in order to administer medication or otherwise control the person. Mechanical restraint involves the use of devices like straps, belts or jackets to restrict a person's immediate movement.[15,16] A third form of restraint is 'chemical restraint'. This is typically defined as the use of psychotropic drugs for a non-therapeutic purpose, for example, to discipline a person or make them more compliant to accepting treatment.[17,18] The extent to which therapeutic and non-therapeutic purposes can be distinguished in relation to mental health treatment is contested. For example, there may be differing views about whether a person's agitation is a symptom of a mental health condition or a response to the environment. Factors such as the nature of medication being used and whether non-pharmacological interventions are available and have been tried first may be relevant in distinguishing between the therapeutic use of medication and chemical restraint.[19]

Coercion can also occur in nominally 'voluntary' service provision. The MacArthur Coercion Study, for example, which involved over 1500 adults admitted both voluntarily and compulsorily to hospitals in three US jurisdictions over a 10-year period, reported that a 'significant minority of legally "voluntary" patients experience coercion, and a significant minority of legally "involuntary" patients believe that they freely chose to be hospitalized'.[20] In other words, legal status under mental health legislation may not necessarily correlate with whether a patient reported being coerced in being admitted to a psychiatric service. Similar studies in other parts of the world have indicated comparable results, in which coercion of nominally 'voluntary' patients included the use of threats of civil commitment, incarceration, or refusal of services for non-compliance.[21,22,23] Outside of hospitals and other clinical settings, coercion can take place in individual and family homes, residential facilities, community services and elsewhere — for example, via 'community treatment orders' and 'assisted' or 'mandated' outpatient treatment — particularly in high-income countries.

2.2 Finding common ground to support alternatives to coercion

There is a range of views among clinicians about the appropriateness and feasibility of completely abolishing the use of coercion.[24,25,26,27,28] The World Psychiatric Association (WPA) has appointed a Taskforce and is working with the Royal Australian and New Zealand College of Psychiatrists (RANZCP) in a Joint Project on this topic. Of primary concern is whether it is possible without involuntary treatment to meet the needs and interests of some service users, such as those with suicidal intent or intent to harm others, who refuse treatment. Other concerns include the question of competing rights and the current state of mental health systems. In many parts of the world, health services face systemic challenges and barriers such as high demand, underfunding, a lack of mental health specialists, and very few clinical staff who are trained and experienced in care for people with mental health problems. In these circumstances, community action and societal change is just as important as changes in service policy and practice.

The Working Group concluded that a pragmatic approach to mental health policy and practice is needed to support increased use of alternative practices, such as supported decision-making and advance care directives. Practical guidance and support for implementing alternatives to coercion is especially crucial in settings where people with mental health conditions and associated psychosocial disabilities can only access professional care at health facilities with scarce resources and few trained staff. Pressure to eliminate coercion in such settings *without putting adequate alternatives in place* could pose risks for people in need of treatment, especially when stigma surrounding mental health disorders prompts fear, exclusion, sensationalised media coverage, and politicisation of efforts to stop coercion.

There is widespread agreement that coercive and compulsory practices are over-used, and also concern about the clinical validity of treatment that involves coercion. [See eg.4,29] Although the United Nations Human Rights Committee, the body that monitors the implementation of the International Covenant on Civil and Political Rights, contemplated the valid use of compulsory treatment and detention in circumstances of last resort in mental health contexts, it emphasised in the same statement the 'harm inherent in any deprivation of liberty' and the 'particular harms that may result in situations of involuntary hospitalization'.[30, para 19] The Committee further noted States' obligation to 'provide less restrictive alternatives'.[30] In 2017, 40 psychiatrist authors of the WPA-Lancet *Commission on the Future of Psychiatry* stated that:

> For too long, involuntary hospitalisation and treatment has taken centre-stage in mental health legislation to the detriment of the rights of people with mental illness, and pitting mental health professionals and people with mental illness against one another. Involuntary hospitalisation is based on ideas of decisional incapacity and so-called best interests rather than focusing on decision-making ability and respecting the will and preferences of people with mental illness.[4,p.797]

Efforts therefore need to turn, according to the authors:

> ...away from involuntary hospitalisation and instead focus on enabling decision-making capability, which is a combination of the unique decision-making ability of the individual, understanding of the will and preferences of the individual, and decision-making support and adjustments to enable people with mental illness to make legally competent decisions.[4]

Those on all sides of this debate share a common sentiment that people with mental health conditions and associated psychosocial disabilities must have access to various forms of high-quality support. Some commentators have argued that the United Nations Convention on the Rights of Persons with Disabilities (CRPD) places obligations on governments to go beyond avoiding coercion in mental health treatment and support. Rather, it requires governments to increase the provision of and adequately resource voluntary services and supports, as well as develop alternative models of care with service users, persons with mental health conditions and associated psychosocial disabilities, and other affected parties. The common concern for access to health, and particularly the need for sufficient mental health supports, invites a focus on designing and resourcing mental health systems that take into account the full range of needs and rights.[31] These include the right to the enjoyment of the highest attainable standard of health, freedom from cruel, inhuman or degrading treatment and the right to life.[31,32,33]

There is a considerable and growing evidence base to support the implementation of alternatives to coercion. These alternatives can support the rights of people with mental health conditions and associated psychosocial disabilities without reducing access to effective care and/or increasing safety risks for themselves or staff. There is also wide agreement that more research and testing of alternatives to coercion appropriate to a wide range of settings is required, including research in settings with vastly different access to resources. Section 4 of this Discussion Paper examines the emerging evidence base following the next section, which considers contemporary debates surrounding the use of coercion in mental healthcare settings.

3. Clinical, moral and legal grounds for alternatives to coercion

Two justifications for the use of coercion are commonly invoked. George Szmukler and Paul Appelbaum define them thus:

1. treatment is in the health interests of the patient; and/or
2. treatment is needed for the protection of others.[7]

In the first category, a 'health interest' intervention may derive from 'paternalistic actions', that is, an action that 'involves the violation of a moral rule but with the intention of preventing a harm to the person', regardless of whether a person is deemed to have decision-making ability (often referred to as 'hard paternalism'), or from an evaluation that a person lacks mental capacity (frequently denoted as 'soft paternalism').[7] In the 'protection of others'-based interventions, the relevant justification is not a person's impaired ability to make treatment decisions, but rather a determination about the magnitude of the risk of harm to others and the potential seriousness of the harm. The exact circumstances in which coercion is considered to be clinically appropriate (for example, what constitutes a 'risk of harm' and what constitutes a person's 'best interests') may vary. These justifications remain controversial to a degree, but they ultimately form the basis for laws governing mental healthcare that are adopted by many governments worldwide. Legal authorisation for such measures typically emphasise the proportionality of restrictions, procedural safeguards such as expert evidence, periodic review and rights of appeal, and often, the importance of a "presumption of capacity".[34]

3.1 Motivations for finding alternatives to coercion

There are several motivations for finding and implementing alternatives to coercion. Some clinicians and researchers have questioned the clinical benefits of treatment premised on coercion.[35,36] In the WPA-Lancet *Commission on the Future of Psychiatry* report by Dinesh Bhugra and colleagues mentioned above, the authors noted that:

> [t]he need for legal compulsion should not be taken for granted: it might really be possible to do things differently. Development of alternatives to compulsion requires research, of which little has been done.[4]

The authors suggested that 'compulsion' arises from a lack of resources for mental healthcare more generally (including resources that promote 'good practice, high standards, and well trained mental health professionals')[4] as well as 'wider societal issues, particularly access to housing, resources, and employment'.[4] However, the authors also challenged the view that governments will support coercion-reduction initiatives and noted that psychiatrists face 'increasing pressure by some governments and the media... to protect society from potentially dangerous behaviour of people with mental disorders' — a pressure they present as a countervailing force to the CRPD.[4] Perhaps for this reason, citing the risk of being 'stuck in the middle', the authors also call for research into whether coercive practices have produced benefits for people who have experienced them.

Coercive mental health treatment may also take place outside hospital through, for example, 'community treatment orders' or 'compulsory treatment orders' that mandate compulsory treatment in community settings.[37] As with other forms of coercive treatment, there is ongoing debate about the ethical and human rights implications of these practices,[38] and indeed about their effectiveness.[36,39,40]

Many clinicians consider coercion to be a necessary last resort, for the reasons noted in Section 2. However, it is also generally acknowledged that individuals subject to physical coercion are susceptible to harms that include physical pain, injury and even death. People who have experienced coercion first-hand in mental health services, as well as their family members and supporters, have drawn attention to some of the harms of those practices through testimony and advocacy.[41,42,43] Trauma related to the use of coercive measures can undermine therapeutic relationships, discourage trust in mental health systems, and repel service users from seeking help in the future. Coercion may also damage staff morale, and traumatise other service users and staff members.[44]

Some governments have supported approaches that minimise coercive practices. Local initiatives based in hospitals, services and the community have also generated momentum for implementing alternatives to coercion. Two prominent service delivery models which promote minimising coercion are 'recovery-oriented' and 'trauma-informed' services. Recovery-oriented practice generally focuses on a person's ability to 'recover a fulfilling, satisfying and meaningful life, whether or not they experience symptoms'. High priority is placed on respect for self-determination, and interventions that are 'done to' people are avoided. Trauma-informed approaches emphasise the social determinants of distress and mental health conditions, and inquire 'sensitively about trauma in order to understand a person's life circumstances and to provide services sensitive to trauma and associated vulnerabilities'. Trauma-informed services are designed to ensure that 'every interaction [within services] is consistent with the recovery process and reduces the possibility of re-traumatization', and often promote 'no-force' forms of care and support.

The introduction of the CRPD poses 'major challenges to long-established, conventional ideas about involuntary treatment', according to George Szmukler.[45] The main purpose of the CRPD is to promote and protect the rights and dignity of all persons with disabilities, including persons with mental health conditions and associated psychosocial disabilities.[33] A total of 180 states and regional integration organizations (like the European Union) have, at the time of writing, agreed to be bound by the CRPD.[46] Signing and ratifying the CRPD signals a commitment to adopt the laws and other measures that are necessary to give effect to the CRPD's provisions [See CRPD, article 4(1)(a)]. Ninety-six states have agreed to additional obligations under the Optional Protocol to the CRPD, meaning they agree that the Committee on the Rights of Persons with Disabilities ('CRPD Committee'),[26] the United Nations body established to monitor the implementation of the CRPD, can receive and consider 'communications' from individuals or groups of individuals claiming that the state has committed a violation of the CRPD Protocol, and can make suggestions and recommendations to the involved State party.[47] Under the Optional Protocol, the CRPD Committee may also examine 'reliable information indicating grave or systematic violations by a State Party', conduct an inquiry, make comments and recommendations, and monitor the actions implemented by the State party to respond to the recommendations.[47]

The CRPD confirms that 'persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life', and obliges States to provide access to 'the support they may require in exercising their legal capacity'.[33] Bernadette McSherry describes the two constituent elements of legal capacity. The first is '"legal standing", in the sense of being viewed as a person before the law'. The second is '"legal agency" or what is sometimes referred to as "active legal capacity".'[48] In many legal systems, legal capacity is contingent on a person having 'mental capacity', or the ability to make decisions.[49]

The support that the state is obliged to provide must respect the 'rights, will and preferences' of the person,[33,50] and has been summarised as requiring a shift to 'systems of supported decision-making'.[51,52] The CRPD states that the 'existence of a disability shall in no case justify a deprivation of liberty', and affirms the rights of all persons with disabilities to respect for 'physical and mental integrity on an equal basis with others', the enjoyment of the highest attainable standard of health without discrimination, and freedom from torture or cruel, inhuman or degrading treatment or punishment [See CRPD, articles 14, 16, 17 and 25]. The CRPD has challenged nations worldwide to improve access to voluntary mental health supports and reduce, prevent and potentially even to end coercive interventions.

However, the extent to which this endeavour can and should aim to eliminate coercion completely is controversial. Several commentators have noted the ambiguity in the text of the CRPD itself about whether or not practices such as compulsory treatment are permitted, which appears to have motivated some of the declarations entered into by several governments.[28,53,54] A small number of states have entered 'reservations and declarations' to the CRPD concerning coercion in the mental health context. 'Reservations' refer to statements by a state that 'purports to exclude or to modify the legal effect of certain provisions' of the CRPD as they apply to that state.[46] 'Declarations', in contrast, set out the state's interpretation of a particular provision when it seems unclear, but they do not purport to alter the legal effects of the CRPD.[55]

Szmukler has pointed out that claims that the CRPD requires abolition of coercion do not stem directly from the text of the CRPD, but from the interpretations provided by the CRPD Committee.[26] The CRPD Committee has insisted that compulsory treatment and detention of people with psychosocial disabilities is prohibited under the terms of the CRPD,[51] including 'forced treatment, seclusion and… restraint in medical facilities, including physical, chemical and mechanic restraints'.[56]

The former United Nations Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan Méndez, went a step further in a report in 2013 that stated 'that involuntary treatment and other psychiatric interventions in health-care facilities are forms of torture and ill-treatment'. Méndez urged the 'revision of domestic legislation allowing for forced interventions'[57] and recommended States to '[i]mpose an absolute ban on all forced and non-consensual medical interventions against persons with disabilities, including the non-consensual administration of psychosurgery, electroshock and mind-altering drugs such as neuroleptics, [and] the use of restraint and solitary confinement, for both long- and short- term application.'[58] Méndez later relativized his position in a letter to the WPA and APA.[59]

Other bodies within the United Nations have disagreed with these interpretations, as we will discuss below.

3.2 Concerns about the push to minimise or end coercion in mental health treatment

Several prominent psychiatrists and representative bodies have responded critically to moves to end coercion in mental health care. Clinicians and other commentators have expressed several reservations about (and in some cases, outright rejection of) such changes, including on the basis that:

- compulsory treatment must be available to protect individuals and/or those around them from harm in some cases;[60,61]
- compulsory treatment is sometimes necessary to protect and secure an individual's other rights and freedoms, for instance, the right to life, right to health, the right to liberty and autonomy;[3,32]
- the CRPD Committee promotes an 'impoverished account of autonomy' that ignores the 'known volitional effects (literally, affects [sic] on the will)' of certain mental disorders and the impact of those disorders on 'the understanding and processing of information upon which a 'will' is formed';[62]
- some circumstances will simply not permit 'supported decision-making' and informed consent to medical treatment — whether in mental *or* general health emergencies — such as critical encounters where a person's 'will and preferences' are unclear or contradictory; [29,49,63]
- some acute situations, in which a person's wishes are unknown, generate immediate dangers in ways that raise distinct issues compared to long-term encounters with service providers;[63] and
- even if limiting and preventing coercion *is* possible, there is a general lack of guidance on how to implement evidence-based, therapeutic and safe practices that are compliant with the CRPD and clinicians' legal and ethical obligations.[31,64]

It is also notable that there has been divergence in the post-CRPD interpretive guidance offered by United Nations bodies, with some bodies and mandates appearing to share the concerns raised by many clinicians. The Human Rights Committee and the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment have declared that certain types of coercive practices can — in some circumstances — uphold the rights of people with severe mental health conditions.[65,66] In 2014, the Human Rights Committee adopted General Comment 35 on Article 9 of the International Covenant on Civil and Political Rights (addressing liberty and security of the person), which contemplated the use of the deprivation of liberty in the mental health context.[65] As touched on in Section 2 above, the Human Rights Committee deemed coercion justifiable where it is:

> necessary and proportionate, for the purpose of protecting the individual in question from serious harm or preventing injury to others [...] [if applied] only as a measure of last resort and for the shortest appropriate period of time [and with appropriate safeguards].[30]

This is a framework, as Wayne Martin and Sándor Gurbai have pointed out, that reflects 'existing legislation in many jurisdictions around the world — legislation that authorises coercive medical interventions when certain legal conditions are met and appropriate safeguards are in place'.[2]

The CRPD Committee and Human Rights Committee appear to have presented conflicting interpretive guidance on the application of human rights in relation to coercion in the mental health context. Both positions are articulated in 'General Comments'. General Comments are documents produced by United Nations treaty bodies for which there is a broad global 'presumption in favour of [the] substantive correctness of such views', even as those views can be challenged by governments and contested with good counter-arguments.[67] States that have ratified the CRPD — and the mental health professionals who work within them — therefore face the challenge of navigating this apparent stalemate.[2] Martin and Gurbai characterise the challenge as the 'Geneva Impasse', describing it in the following terms:

> The watershed question might be posed as follows: *Can coercive treatment ever comply with UN human rights standards?* The answer from one part of the UN human rights system seems to be: "Yes, provided that certain conditions are met." But another part of the same system seems to be pointing towards an exceptionless "No".[p.118]

This apparent impasse is reflected in debates in legislatures, government agencies and civil society organisations all over the world,[2] including among service users and persons with psychosocial disabilities.[58,68,69] There is a risk that these debates are becoming intractable.

In addition, the debate is somewhat skewed by a tendency to concentrate upon the interpretation of one right, the right to equal recognition before the law under Article 12 of the CRPD, rather than taking into account over twenty other substantive rights and the purpose of the CRPD as a whole. What is often lost, therefore, is the considerable agreement that exists across diverse perspectives, and the pathway that this creates for positive change. As we outlined in Section 2, this includes a common concern with access to health services and support and universal agreement that people with mental health conditions and associated psychosocial disabilities must have access to various forms of high-quality support that takes into account the full range of a person's rights and needs. Indeed, Martin and Gurbai, after analysing the diverging positions of the CRPD Committee and the Human Rights Committee, ultimately conclude that the 'impasse' is less intractable than first appears, and that there is 'real prospect for generating a broad consensus moving forward'.[2] Others have made similar comments, particularly around the point of expanding the range of voluntary options for support,[29,70,71] as shall be discussed in the next section. It is outside the scope of this Discussion Paper to set out the detailed points of Martin and Gurbai's findings, and that of others (such as George Szmukler, whose detailed engagement with the 'impasse' and the subsequent commentaries published alongside it, provide a noteworthy resource).[26] Instead, the remainder of this Discussion Paper highlights existing evidence for implementing alternatives to coercion and identifies opportunities to pilot promising initiatives in different settings.

Discussion Questions:

- Is the argument for implementing alternatives to coercion presented here satisfactory? Why or why not?
- Is this topic important to providing high-quality mental healthcare in your country? If so, please describe its relevance.

4. The research base for implementing alternatives to coercion

In formal health settings, there is a growing research base for practical steps to develop and implement viable alternatives to coercion. A range of policy and law reform initiatives also exist that have been implemented at local, national and regional levels, most of which show promising results. Local initiatives based in hospitals, services and the community have generated momentum for implementing alternatives to coercion. Two prominent service delivery models which promote minimising coercion are 'recovery-oriented' and 'trauma-informed' services. Recovery-oriented practice generally focuses on a person's ability to 'recover a fulfilling, satisfying and meaningful life, whether or not they experience symptoms'. Trauma-informed approaches emphasise the social determinants of distress and mental health conditions, and inquire 'sensitively about trauma in order to understand a person's life circumstances and to provide services sensitive to trauma and associated vulnerabilities'. Trauma-informed services are designed to ensure that 'every interaction [within services] is consistent with the recovery process and reduces the possibility of re-traumatization', and often promote 'no-force' forms of care and support. Some governments have also supported approaches that minimise coercive practices.[72,73,74] A range of policy and law reform initiatives also exist which have been implemented at local, national and regional levels, most of which show promising results.

A recent scoping review by Piers Gooding, Bernadette McSherry and Cath Roper of over 121 empirical, English-language studies on initiatives to reduce and prevent coercive practices, for example, found that:

> In general terms, the studies that focused on explicit efforts to prevent or reduce coercion reported 'positive' results in almost every instance; that is, coercion was effectively prevented, reduced and even completely discontinued. Prominent practices included 'Six Core Strategies for Restraint Minimisation', 'No Force First' initiatives, advance-planning to avoid or better respond to crises, 'open door' policies in hospitals and other facilities, the use of 'crisis respite houses', family-based interventions… and so on. There were very few neutral or adverse outcomes caused by such efforts (four studies reported neutral impact, and two reported adverse findings [..]).[75,76]

The authors noted the potential for the influence of 'publication bias'[77] in their review, in which negative results as a general rule are less likely to be submitted for publication in journals.[75] However, despite this possibility, the authors suggested the literature offered cause for optimism.

The studies in the scoping review typically focused on services for adults. A small number of studies concerned specific groups, such as prisoners or forensic mental health patients,[78,79] children and adolescents,[80] older adults,[81,82] and ethnic minorities or migrant groups.[83] Most studies specifically concerned coercion/restrictive practices in high-income countries in Europe, North America, Australia and New Zealand, but there are other initiatives in low and middle-income countries that have benefits in reducing changing attitudes and practices.[11,14,84] While research design varied, several study types emerged, the most pertinent here being the following:

- studies concerning practices (whether in law, policy or practice) that were *explicitly* designed to minimise or eliminate coercion (42 studies);[85,86,87]
- studies to evaluate the effectiveness of practices that could be broadly considered 'alternatives' to acute hospital treatment, including crisis respite houses, intensive home-based support and supported decision-making, in which coercion minimisation or elimination was one (often tacit) underlying aim (29 studies);[See eg.88,89,90]
- studies to identify factors that contributed to higher or lower rates of coercion, with the aim of using findings to reduce or eliminate coercion (for example, comparing hospital wards that had high rates of mechanical restraint to those with low or no rates;[91] or seeking to understand whether ethnic minorities experienced coercion at higher rates and, if so, why).[82,92]

The authors categorise the initiatives into changes to practice at the service-level (including both hospital-based and community settings), legal change, and national policy change. These categories are considered below, with a focus on hospital rather than community-based settings, following discussion of limitations to the studies reviewed.

Discussion Question:

- Does your Society/Association/College currently have an active role in supporting increased implementation of alternatives to coercion? (For example: involvement in policy making? Support for initiatives to apply in practice? Collaboration with service user and family groups? Other roles?)
- If so, please describe.
- If not, what role can you see it having?

4.1 Limitations of existing studies

The studies reviewed for this paper are heterogenous and complex. They address highly varied and context-specific alternatives to coercion. Variable confounding factors posed challenges for researchers and differences in terminology, aims, scale, sampling and research quality make it difficult to compare or generalise results.

Consider, for example, the challenge of comparing a study on the impact of temporary invalidation of civil commitment powers in Germany, with a study on advance directive measures within mental health legislation elsewhere; or a community-based initiative to reduce 'shackling' of individuals in Indonesia compared to a UK-based initiative to eliminate physical and mechanical restraint in state-run crisis centres.

Most studies reviewed here are relatively small-scale and use quantitative methodologies to analyse data from specific services: that is, reports of seclusion or restraint incidents, rates of leave being restricted, or rates of involuntary detention derived from small convenience samples. There are a few national surveys that provide valuable generalisable data.

Qualitative studies are fewer in number and typically consist of interviews. They provide insight into the subjective experiences of participants, and detailed understandings of enablers and barriers to reducing coercive practices in a variety of settings. Many of these studies have limitations in terms of size, design, length of trial periods and settings.

Methodological challenges to conducting studies on coercion pose further limitations, and contribute to the paucity of literature on the topic. In studies from service settings, selection bias can affect and often reduce the rates of seclusion and restraint recorded in the study, regardless of the intervention being tested. Large national datasets, which account for service users across a broad range of facilities, reach beyond this limitation. This underscores the value of establishing systems for sustained national measurement and benchmarking to understand the impact of alternatives to coercion when they are trialled and implemented.

Notwithstanding these caveats, the existing empirical studies of the range of efforts to implement alternatives to coercion offer valuable lessons for practice at the service-level, legal change, and policy change.

4.2 Evidence for Implementing Alternatives to Coercion in Hospital-Based Settings

For inpatient settings, Gooding and colleagues' scoping review suggests that the studies on 'Safewards', 'Six Core Strategies' and 'open door policies' indicate a reasonably high degree of evidence for effectively reducing the use of coercive measures in clinical practice.

Safewards

The 'Safewards' model is an approach to reducing conflict, restraint and seclusion on psychiatric wards.[93] The model comprises interventions designed to help staff manage 'potential flashpoints'. The Safewards approach places a strong emphasis on the culture of hospital settings, including staff interactions with patients, family/friends and the physical characteristics of wards. Len Bowers and colleagues undertook a cluster randomised controlled trial of the Safewards model in 2015, and reported an estimated 15% decrease in conflict and 24% decrease in 'containment' across 31 wards in England.[94] Notably, however, Feras Ali Mustafa has criticised the methodology used for this evaluation, suggesting that the use of RCT in the study was inappropriate because of the complex nature of Safewards and the impossibility of blinding assessors.[95] He also critiqued the 'remarkably low exposure to the intervention in the experimental group (38%) compared with the control group (90%)'. In Victoria, Australia, an evaluation of a Safewards trial found a clear reduction in the use of seclusion across the 13 wards that have implemented the approach.[96] The authors concluded that 'Safewards is appropriate for practice change in… inpatient mental health services more broadly than adult acute wards, and is effective in reducing the use of seclusion'.[96]

'Six Core Strategies to Reduce the Use of Seclusion and Restraint'

Several empirical studies suggest the *Six Core Strategies to Reduce the Use of Seclusion and Restraint* show promising results. The efforts reflect strategies set out in a 2005 document entitled *Six Core Strategies to Reduce the Use of Seclusion and Restraint Planning Tool* published by the National Technical Assistance Center in the United States.[97] These strategies are:

- 'Leadership towards organizational change' — articulating a philosophy of care that embraces seclusion and restraint reduction;
- 'Using data to inform practice' — using data in an empirical, 'non-punitive' way to examine and monitor patterns of seclusion and restraint use;
- 'Workforce' — developing procedures, practices and training that are based on knowledge and principles of mental health recovery;
- 'Use of seclusion and restraint reduction tools' — using assessments and resources to individualise aggression prevention;
- 'Consumer roles in inpatient settings' — including consumers, carers and advocates in seclusion and restraint reduction initiatives; and
- 'Debriefing techniques' — conducting an analysis of why seclusion and restraint occurred and evaluating the impacts of these practices on individuals with lived experience.[78,97,98,99,100]

These strategies have been used in services in the United States, Canada, Australia and New Zealand and several studies have tested the strategy, mostly in relation to the first strategy of leadership.[101] Much of the literature on this topic deals with the importance of top-down organisational leadership *in conjunction with* local level leadership (for example, at ward level) in order to create and maintain culture change. The emphasis on leadership as a strategy for change may reflect the fact that a lot of the research in the field is management-driven rather than service user-driven, although there are several notable examples of nurse-driven initiatives.[78,102,103,104] Many seclusion reduction projects feature the strategy of staff training and the use of new assessment, review and debriefing tools.

Very few reported projects incorporate consumer/service user roles, as recommended in the Six Core Strategies, though some notable exceptions did appear.[73] For example, Bradley Foxlewin conducted an empirical study examining seclusion-reduction interventions at a single Australian hospital, commissioned by the Australian Capital Territory (ACT) Mental Health Consumer Network. An advisory group of fellow service users monitored and guided the research. In that study, seclusion incident rates reportedly fell from 6.9% in 2008/9 to less than 1% in 2010/11.[73] Although the report of the findings was not formally peer reviewed, it is valuable for the added description of a service user-led strategy.

Although the pool of empirical research on Six Core Strategies is relatively small, the approach appears to have diverse application, with moderate success reported in adult, child and adolescent and forensic mental health services.[78,105] The six empirical studies that examined the use of the Six Core Strategies approach, and one notable grey literature study, all reported a significant decrease in the use of seclusion and restraint,[78,98,99,105,106] suggesting that the approach can serve to reframe seclusion and restraint as avoidable interventions that largely, and perhaps in some cases entirely, can be replaced by other non-coercive practices where there is sufficient knowledge, support and resources.

The empirical research studies and grey literature analysed by the research team also suggest the following interventions may reduce the use of seclusion and restraint, and broader hospital-level coercive practices:

- national oversight;
- organisational culture change through an emphasis on recovery, trauma-informed care and human rights; and
- advocacy directed at public opinion, politicians, policymakers and service providers.

One further intervention that does not appear in the Six Core Strategies that shows promise relates to physical changes to the environment. Borckardt and colleagues observed that physical changes to the environment such as using warm paint colours on walls and rearranging furniture, are some of the easiest changes to implement,[72] though these are only intended as a small, easily-achievable initiative alongside broader material changes to professional practice and service settings.

'Open Door Policy'

'Open door policy' is another area of developing research in this field. Several German researchers undertook two largescale studies of service data for 349,574 admissions to 21 German psychiatric inpatient hospitals from 1998 to 2012.[107,108] They sought to compare hospitals without locked wards and hospitals with locked wards. They tested the hypothesis that locked wards reduced the rates of adverse incidents, like suicides, suicide attempts, and so on. However, Christian Huber and colleagues' findings indicated that hospitals with an 'open door policy' did *not* have increased numbers of suicide, suicide attempts, and absconding with and without return.[108] In contrast, treatment on open wards was associated with a *decreased* probability of suicide attempts, absconding with return, and absconding without return, but not completed suicide.[108] In a second study using the same dataset, Schneeberger and colleagues measured the effects of 'open versus locked door policies' against rates of 'aggressive incidents' and restraint/seclusion[107] and found that '[r]estraint or seclusion during treatment was less likely in hospitals with an open door policy', as was aggressive behaviour.[107] Again, the study is not without its critics. One critic raised the concern that the term 'open door policy' was classified arbitrarily, and that the original study interpreted the results as if the patients had been randomly allocated to these hospitals, when that may not have been the case, with selective admissions based on different criteria.[109]

It remains difficult to conduct research on the causative relationship of initiatives such as locked doors and the prevention of suicide, conflict, seclusion and restraint. Challenging ethical and methodological issues immediately arise when testing such effects. Establishing trials concerning the impact of particular practices on rates of suicide, for example, poses immediate ethical challenges. From a methodological perspective alone, complex variables associated with interventions such as open door policies can have an impact on the effectiveness of quantitative methods such as randomised control trials, in which variable confounding factors can make replication difficult.[110] This is a persistent issue concerning research on coercion more generally, though it is only part of the explanation for the relatively small body of research concerning efforts to reduce coercion in mental health settings.[75,111]

Having considered several hospital-based efforts to implement alternatives to coercion, the next sections turn to law and policy reform efforts.

4.3 Evidence for Legislative Change

One prominent example of law reform concerning coercion in mental health care since the CRPD came into force in 2008 occurred in Germany. In 2011 and 2012, several landmark decisions by the German Federal Constitutional Court (*Bundesverfassungsgericht*) and Federal Court of Justice (*Bundesgerichtshof*) narrowed the grounds for compulsory psychiatric interventions to 'life-threatening emergencies' only, though these court decisions were wound back some months later.[74] (In other words, the original grounds for compulsory treatment were re-established). In one German state, according to Erich Flammer and Tilman Steinert, 'involuntary medication of psychiatric inpatients was illegal during eight months from July 2012 until February 2013'.[112] Flammer and Steinert undertook a study to examine the impact of the changes during the eight-month period, and in the proceeding months. Using routine data on 2,644 'treatment cases', they provided some evidence showing that the legal reform led to a reduction in the use of compulsory medication even after the court changes were wound back.[111] However, they reported that the 'number of mechanical coercive measures increased by over 40% in the cross-sectional analysis' during the period of restricting grounds for compulsory treatment'. Further, '[i]n the longitudinal analysis… the increase of both aggressive incidents and coercive measures was over 100%'. These findings seem to support the view that legal change alone, without system change, and resources for support, training and implementation of alternatives to coercion, are unlikely to be successful. The authors of the WPA/Lancet *Commission* noted that 'there is a caveat' to recommendations for law reform; namely, that 'law can provide frameworks, but passing of laws does not necessarily change much without the political and social will to implement the law'.[4]

However, another study, by Martin Zinkler, has partly challenged Flammer and Steinert's findings. Zinkler found that the legal change brought briefly by the *Bundesverfassungsgericht* and *Bundesgerichtshof* led to 'examples where clinicians put an even greater emphasis on consensual treatment and did not return to coercive treatment'.[74] Zinkler observed the following in a case study concerning one mental health service, Heidenheim, that services a population of 130,000:

> the frequency of violent behavior and the frequency of other forms of coercion did not increase in Heidenheim once coercive use of antipsychotic medication was abandoned. During this period however, a shift in the therapeutic culture led to a reduction in the use of antipsychotic medication of more than 40%.[74]

Zinkler and Sebastian von Peter have since presented an outline of what they argue would be required to reform mental health services to follow 'the will and preferences of those who require support' without recourse to coercion.[27] Their study is premised on the tacit acceptance of the CRPD Committee's approach — again, an approach that is greatly contested by other psychiatrists. Paul Appelbaum, for example, in an article entitled 'Saving the UN Convention on the Rights of Persons with Disabilities — from Itself',[25] calls for Article 12 of the CRPD to be re-written in its entirety.

Other law reform initiatives noted in the scoping review include the following measures introduced prior to the CRPD coming into force, which appear to have resulted in a reduction (but not elimination) of various forms of coercion:

- Italy's well-known 'Law 180', which mandated the creation and public funding of community-based therapeutic alternatives to institutional settings and affordable living arrangements;
- California's *Mental Health Services Act 2004* (MHSA), which entailed a USD$3·2 billion tax revenue investment, which resulted in a 10% reduction in quarterly rates of '14-day psychiatric hospitalizations';
- a 2006 Swiss law that restricted the authority to order compulsory admission only to certified psychiatrists, with one study showing an approximately 20% reduction in compulsory admissions (in one hospital) in the following two years;
- a Finnish law reform initiative aimed at reducing the use of seclusion and restraint over a 15-year span, which reportedly resulted in a decline in the total number of patients secluded and restrained, and the number of all inpatients.

4.4 Evidence for National Policy Initiatives

Several studies have analysed national practices and policies aimed at reducing and preventing coercion. In the Netherlands, for example, Eric Noorthoorn and colleagues studied the result of more than 100 seclusion reduction projects in 55 hospitals, following €35 million in funding from the Dutch government. The average yearly nationwide reduction of patients who were secluded recorded by this study was about 9%. Another internationally comparative study compared disparities between mechanical restraint use from all psychiatric hospital units in Denmark (87) and Norway (96) and found that three mechanical restraint preventive factors were significantly associated with low rates of mechanical restraint use.

Practical guidance and empirical studies may also emerge from very recent law and policy reform initiatives developed in response to the CRPD. In Peru, for example, a new law introduced as reform of the Peruvian Civil Code and Civil Procedure Code on 3 September 2018, prohibits restriction of capacity on the basis of disability (including the restriction on capacity that occurs in typical mental health legislation) and specifies a 'wide and flexible model of support' for the exercise of legal capacity. However, Peru retains a generic health law, Health Law 26842, and a 2012 amendment concerning mental health (Law 29889) appears to retain some scope for treatment without consent in 'emergencies' concerning imminent risk of life. It remains unclear how this emergency provision will interact with the more recent legal capacity reforms to the Peruvian Civil Code and Civil Procedure Code. Other countries, such as India, the Philippines, and Australia have sought to *revise the terms of mental health legislation* in an effort, broadly, to increase the threshold for compulsory intervention, improve procedural oversight through quasi-judicial review, and introduce mechanisms that are presented as 'supported decision-making' in line with the CRPD, including advance directives, nominated persons schemes, and so on. The practical impact of this type of post-CRPD mental health legislative reform, which again would seemingly comply with the Human Rights Committee interpretive guidance but *not* that of the CRPD Committee, does not appear to have examined at the time of writing.

4.5 The World Health Organization (WHO) QualityRights Initiative

The World Health Organization (WHO) QualityRights Initiative is a global program to improve the quality of care provided by mental health and related services by supporting implementation of policies, strategies, laws, and services that comply with international human rights standards.[113] It draws heavily on the interpretation of the CRPD Committee and the recovery approach to promote services that respect and uphold the human rights of people with psychosocial, intellectual and cognitive disability, as well as mental health and related service users who do not identify as having a disability. The program offers resources, including assessment and training materials, for practitioners to work in collaboration with service users, staff, families and other stakeholders towards the reduction of the use of various forms of coercion in mental health settings in low-, middle- and high-income countries. The resources were developed in consultation with a broad range of stakeholders, including advocacy groups, NGOs, government bodies and authorities, United Nations actors, clinicians, professional associations and academics.[114] They were piloted in a variety of settings internationally. Since publication of its resources, QualityRights projects or initiatives have been launched in over 20 countries and the WHO European Region, and implementation findings are beginning to emerge.

The first element of the resources is the 'WHO QualityRights Tool Kit'. It offers detailed guidance for conducting evaluations of the human rights compliance of mental health and related services within a country or local area. It is designed to be used in 'any place where people with mental disabilities live or receive care, treatment and/or rehabilitation', including hospitals, outpatient services, day centres and social care homes.[114] The Tool Kit addresses five themes, each of which highlights one or more of the rights set out in the CRPD (arts 28, 25, 12 and 14, 15 and 16, and 19). The Tool Kit identifies standards associated with each theme, and within each standard a set of criteria. Tool Kit users are instructed to use the criteria to guide the assessment of a facility or facilities, via a combination of interviews with service users, staff and families, observation of conditions in the facility or facilities, and reviews of documentation such as policies, guidelines, administrative records, records of events and service users' personal files (with consent). See 114 pp.6-8, 20, 28, 30

The Tool Kit encourages an explicit focus on coercive practices, and notes the importance of informed consent in relation to admission to facilities and the administration of medical treatment.See 114 pp.4-5 The aim to reduce coercion is embedded across multiple standards and criteria through, for example, a focus on identifying the use of particular forms of coercion and possible alternatives (standard 4.2).See 114 Standards 2.4, 3.2, 4.3, 4.5, pp. 79, 81-4 The Tool Kit provides detailed guidance on setting up and conducting an assessment, including adapting the themes, standards and criteria to the local context. It also highlights several potential uses of assessment results, including to inform policy, planning and law reform, to understand human rights violations, raise awareness of them among authorities and other stakeholders, and advocate for change, for quality improvement activities, and to build human rights capacity through training and education. Additional training and guidance materials are also available to guide the service-transformation process either before or after an assessment has been conducted (see https://qualityrights.org/). An online 'Country Implementation Portal' provides links to resources, training and details on the use of WHO QualityRights in over 20 countries and regions.

In addition to the training and guidance on assessment and service transformation in the Toolkit, a further eight modules of QualityRights training materials are provided by the program.[115] The training modules are intended for a wide audience. They are designed to be delivered over a period of months by a multi-disciplinary team including people with disabilities and mental health service users, DPO representatives, professionals working in mental health or related services, families and others. Each module includes definitions and discussions of key concepts, and exercises and activities for participants to interrogate these concepts, discuss how they may apply in their specific contexts and roles, and explore some of the challenges and disagreements that may arise.

Several of the training modules offer detailed guidance on the use and avoidance of coercion in mental health services, notably the 'Legal capacity and the right to decide' module[116] and the 'Freedom from coercion, violence and abuse' module. This includes detailed guidance and activities to demonstrate key strategies to avoid and defuse situations of conflict that services and individuals can implement,[117] including many of the elements of the 'Six Core Strategies' and other alternatives to coercion discussed earlier in this Discussion Paper. See 117 pp.43-4 A specialised module, 'Strategies to end seclusion and restraint', provides additional guidance on the reduction of these forms of coercion.[118]

The WHO QualityRights Tool Kit was piloted in low-, middle- and high-income countries prior to its publication. In the years since, QualityRights projects have been launched in Ghana, Kenya, the Philippines, Lebanon, Gujarat (India), Turkey, Czech Republic, Chile, Greece, and the WHO European Region, and others. For example, a project was launched by the Ministry of Health and Family Welfare of Gujarat in 2014 to assess and transform mental health services throughout the state. A smaller project conducted at a psychiatric hospital in Egypt in 2013 demonstrated the application of the Tool Kit in a single service.[119]

Discussion Questions:

- To what extent are the alternatives to coercive practices discussed here feasible to implement in your country or region?
- Which, if any, of the alternatives to coercion discussed here are being used in your country?
- Can you please tell us about any examples of alternative practices being used in your country or region? Please send a brief summary with any publicly available documents, weblinks or other information that may be helpful for others working to implement alternatives.

5. Conclusions: Opportunities for improving practice, conditions, care and links with community supports

There is growing momentum to develop and implement alternatives to coercion in the delivery of mental health services. Advocates for change aim to maximise therapeutic outcomes and promote the rights and recovery of people with mental health conditions and associated psychosocial disabilities. Research and guidance is now available to support the implementation of alternatives to coercion in low-income, middle-income and high-income countries. Service managers, clinicians, and people with lived experience and their families all can play a central role in leading change. With appropriate resources the services can, for example, pursue WHO QualityRights assessment and transformation processes and promote initiatives explicitly aimed at implementing alternatives to coercion. An effective and long-lasting change can only take place in a recovery oriented system of care, in which respect for human rights and service user involvement are not only required, but realised through sound pathways to noncoercive care. This includes attention to all the important steps along the way – prevention, early intervention, and continuity beyond clinical settings to provide integrated and personalised care. Meaningful involvement by persons with lived experience of mental health problems and psychosocial disabilities and their families bring crucial insight and momentum irrespective of where the services are in their development.

Further research is needed to contextualise existing resources, diversify the evidence base, and generate a better understanding of barriers, enablers, and consequences of change. Coercion in mental healthcare cannot be addressed in isolation, it must be considered in the context of the particular cultural, social, and economic settings in which it occurs. To date, the overwhelming majority of evidence and resources available to assist change has been developed in high-income country settings, highlighting important gaps in research. Another gap is evident in the types of information available from studies conducted to date. This Discussion Paper identifies a range of findings from research into policy outcomes, patient outcomes, perceptions of staff, service users and those subject to coercive practices, rates of coercion and restraint, and other relevant topics. However, systems for sustained measurement, benchmarking and accountability for change are rare; as is substantial qualitative analysis of how clinicians and advocates have successfully achieved change, the challenges they faced, how they managed those challenges, and what factors were crucial to enabling their success.

An early draft of this paper was discussed at a workshop convened by the Royal Australian and New Zealand College of Psychiatry (RANZCP) and World Psychiatric Association (WPA) Joint Project on Minimising Coercion in Mental Healthcare. The group consists of clinicians, academics, service users and family carers who are leading change in a range of settings across the globe. A key point emerging from that discussion was that the rich, contextual analysis currently missing from the literature is needed to shed light on the processes that have been effective in bringing about change within the confines of prevailing social, cultural, and economic barriers. The next phase of this project will address this gap by developing a set of comprehensive case studies to examine how progress has been achieved in different settings, including those in three geopolitical regions and two low- and middle-income countries. This next phase will produce a set of resources designed to further support mental health professionals and their organisations to translate the research presented here into support for alternatives to coercion in practice.

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