# WPA CONSULTATION ON IMPLEMENTING ALTERNATIVES TO COERCION IN MENTAL HEALTHCARE

Summary of responses from Member Societies and the Service Users and Family Carers Advisory Group

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## CONSULTATION PROCESS AND RESPONSE

Member Societies were asked to respond to six specific questions about the 'Implementing Alternatives to Coercion in Mental Health Care' discussion paper, plus a seventh open question inviting additional feedback:

1. Is the argument for implementing alternatives to coercion as presented in the background paper satisfactory? Why or why not?
2. Is this topic important to providing high-quality mental healthcare in your country? If so, please describe its relevance.
3. To what extent are the alternatives to coercion (discussed in Section 4) feasible to implement in your country or region?
4. Which, if any, of the alternatives to coercion discussed in Section 4 are being used in your country?
5. Does your Society/Association/College currently have an active role in supporting increased implementation of alternatives to coercion?
   a. (if yes) Please describe some of the ways in which your organisation is supporting 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?)
   b. (if no) What role can you see your organisation having in supporting 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?)
6. Can you please tell us about any examples of alternative practices being used in your country or region? Please include a brief summary along with weblinks to any publicly available documents, reporting, or other information that may be helpful for others working to minimise coercion.
7. Is there anything else that your Society/Association/College would like to say about this topic?

Sixteen Member Societies responded to the consultation, including fourteen substantial responses to discussion questions. They are:

1. Association For Research On Schizophrenia (ARS) **Italy**
2. Association Of **Argentinean** Psychiatrists (APSA)
3. **Lebanese** Psychiatric Society
4. **Korean** Neuropsychiatric Association
5. The Royal **Australian And New Zealand** College Of Psychiatrists (RANZCP)
6. **Portuguese** Society Of Psychiatry And Mental Health (SPPSM)
7. **Hellenic** Psychiatric Association
8. **Indian** Psychiatric Society
9. Society of Psychiatrists, Narcologists, Psychotherapists and Clinical Psychologists from Republic of **Moldova**
10. **Polish** Psychiatric Association
11. **Belarusian** Psychiatric Association

12. **Mexican** Psychiatric Association
13. **Canadian** Psychiatric Association (CPA)
14. **Japanese Society of Psychiatry and Neurology** (JSPN)
15. **American** Psychiatric Association (partial response without direct reference to questionnaire, plus questionnaire response from psychiatrist in Oregon which was also sent to the APA)
16. **German** Psychiatric Society (affirmation of the paper plus minor suggested edits)

Martha Savage of the **Service Users and Family Carers Advisory Group** led consultation with service users and family carers. The report she provided was considered alongside survey responses from Member Societies.

It is notable that the list above includes responses from **eight distinct geopolitical regions**: Eastern Europe, Western Europe, North America, South America, Middle East, South Asia, East Asia and Australasia/Pacific.

The summaries below list direct quotes from respondents in italics. Please note that all paragraph breaks in these lists denote a new source of the quote.

## QUESTION 1: ARGUMENT

| Is the argument for implementing alternatives to coercion as presented in the background paper satisfactory? Why or why not? |
|---|

The majority of Member Societies (twelve) expressed clear satisfaction with the argument presented in the paper. A thirteenth response (Germany) complimented the paper with specific reference to the argument.

Reasoning included the argument's handling of complexity (Portugal), its balanced approach to the topic (Belarus), its assertion of professional duty (Mexico), and its framing of the topic that allows for raising the issue globally (Greece).

In Argentina, the consultation has prompted a more in-depth national consultation:

> *We started a profound inquiry. Our first step was formalising a study commission. This process will take no less than six months.*

A need for action was also expressed in the response from Japan:

> *Japan needs to promote active measures, while advancing discussion on this point as well.*

Three Member Societies made reference to a need for coercion in some circumstances. (Canada, Greece, Belarus).

Member Societies expressed the following concerns and areas for improvement:

> *It's not easy to make a clear **distinction between 'therapeutic' use and 'non-therapeutic' use of medication** (South Korea)*

> *We think it is important to make a much **clearer distinction between psychotic disorders and non-psychotic disorders**. There is an important distinction between treating people mental disorders where reality testing is lost, and those where this does not occur… it is very important to identify the small subset of people with mental disorders where coercion may be justified, and only as long as it is accompanied by a clear and spelt out (social) contract… In addition, it is critical to separate out mental illness from broad use of mental disorders as that may easily slide into the political realm, a particularly dangerous place. (Canada)*

> *Argument **appears to be for the developed countries perspective** and does not take account of the available resources in developing countries… [concerns include] **human resources**… **insurance** to health care workers… **Governmental investment** in public mental health and community treatment… **Psychoeducation** of family members of persons with mental illness… Cultural and religious beliefs… Raising awareness against **stigma and discrimination**… **Benchmarking**, using validated tools to count and document coercive measures. (India)*

Service Users and Family Carers generally expressed satisfaction:

> *Many of the comments complimented the task force on the document. They reported that the discussion paper was well written and covered the issues well.* ***They felt that the WPA was genuinely concerned with advocating patient-centred practices*** *that respect human rights, and that they were interested in having representatives from service users and caregivers involved in change.*

It is important to note, however, that some concerns and areas for improvement were also raised by Service Users and Family Carers:

> *[Some] felt that legal and practice issues are over-emphasised and that there should be* ***more emphasis on alternative types of care****, such as peer support, indigenous practices, and recovery-oriented care. More early intervention was also advocated by several submissions.*
>
> *One carer in a high income country… felt that* ***psychiatrists might delay change, or twist ideas in the document*** *as well as laws and rules meant to help service users, into measures that are actually repressive.*
>
> ***The most common suggestion for new material to include or to emphasise more was to include examples of lived experience of coercion and its effects, and to advocate for more involvement of service users and carers in research as well as in practice.***

On that final point, several service users commented specifically on the need to highlight, examine, and pilot good practices, and also to encourage co-design of alternative practices together with people with lived experience.

**Key Implications:**

- There is broad support for the position expressed in the discussion paper.
- The complexity of the topic must be acknowledged.
- The PS should stress the relevance of this work in LMICs, while also acknowledging systemic barriers faced there.
- The PS should emphasise experiences of coercion and advocate clearly for cultural change, early intervention and involvement by people with lived experience in research and practice.

## QUESTION 2: IMPORTANCE

| Is this topic important to providing high-quality mental healthcare in your country? If so, please describe its relevance. |
|---|

All Member Societies that responded to the discussion questions described the topic as important or very important.

In describing its relevance in particular countries, many responses made reference to protecting **human rights**. In addition:

- Six Societies referred to transition toward **community- and/or recovery-oriented models** of treatment and care (Belarus, Poland, Moldova, Portugal, South Korea, Greece).
- Three Societies referred to recent or current **legal reforms and active national debates** (Mexico, Canada, Greece)
- Two Societies referred to **patient empowerment** (Portugal and South Korea)

The response from Japan framed the topic's importance in terms of **providing high-quality trauma informed care**:

> *This will force us to review coercive practices, which leads to envisioning better mental health and ultimately provision of high-quality mental health care in Japan. For example, the perspective of trauma informed care has been pointed out as necessary in the field of psychiatric emergency care.*

**Points of particular relevance** noted by Societies included:

> *Greece: A crucial problem in our country is the high percentage of **involuntary hospitalizations** that reaches about 50% of all non-coercive admissions. This is a serious problem. In some psychiatric hospitals, as well as psychiatric departments of general hospitals it reaches 60%, in others it is about 35-45%, depending on existing basic psychiatric care services and their accessibility. However, this is a rather complicated phenomenon to interpret. For example, high percentage of involuntary admissions and subsequent, hospitalizations might, substantially, reduce the revolving-door effect for the imprisonment of mentally ill patients*

> *India: With **80-90 percent treatment gap** in severe mental illnesses and very limited number of beds available in mental health institutions for treatment, majority of the patients are in the community without appropriate treatment. A large percentage of these visit faith healers and reportedly coercive measures are not uncommon there.*

The response from India also included strong acknowledgement of the harms of coercive practices, with a focus on physical, mechanical, and chemical restraint. In addition to a long list of physical consequences, the Society noted 'psychological trauma, feeling of shame or

guilt, loss of dignity and self-respect, and loss of autonomy. It also adds to stigma, discrimination and delay in treatment seeking.’

The following response from RANZCP contains **potentially useful wording the position statement**, complete with references (omitted here):

> *It is now well recognised that the use of coercive practices can be traumatic and may infringe on the rights of individuals with mental health conditions. [1, 2] In addition, the United Nations Convention of the Rights of Persons with Disability has highlighted the need for countries to implement steps to work towards protecting the rights of people with disabilities including those with mental health conditions engaging with mental health services. [3] Due to the potential trauma of providing care without consent on patients, families, whānau [community] and staff, it is important that mental health services in Australia and New Zealand work towards eliminating the use of restrictive practice. While steps are necessary to ensure coercive practices are minimalised, working towards elimination, it is important to do so in a manner which ensures individuals, families, staff and the public are protected. All alternatives to coercive practices should recognise the role of cultural bias and institutional racism in the use of coercive practices.*

Responses from Service Users and Family Carers generally noted the topic as important but one expressed concerns about potential for impact in her country:

> *Most replies considered the topic was important, but one user from Spain felt that the lack of resources and the **fragmentary nature of the psychiatric system** there made it irrelevant.*

One carer from a high-income country expressed the view that this work links to broader changes needed:

> *Strong arguments for the elimination of coercive practices **may be key to changing [the] mental health care sector**. In [my country], psychiatrists are in relationships of power over staff and patients, and in this basically paternalistic hierarchy, decision-making is top down.*

**Key Implications:**

- Member Societies across eight distinct geopolitical regions recognize the importance of this topic.
- The PS should state the role of this work in protecting human rights and empowering people with mental health disorders and psychosocial disabilities
- In addition, it should emphasise the alignment of this work with transitions to community- and recovery-oriented models of treatment and care
- The PS should note the topical nature of this debate in many Member countries
- The PS should clearly acknowledge the harms caused by coercive practices

- Noting the comment on treatment gaps, the PS should clearly state that it currently focuses on clinical settings, but acknowledges the importance of future work to address non-clinical and community-based settings.

## QUESTION 3: FEASIBILITY

| To what extent are the alternatives to coercion (discussed in Section 4) feasible to implement in your country or region? |
| --- |

Most Member Societies (twelve) felt that at least some of the alternatives discussed in the paper were feasible. Two Societies (Mexico and Poland) felt that further research and consultation would be needed nationally to determine this.

The most emphatically positive response came from Argentina:

> ***All alternatives are feasible*** *if a change in therapeutic practices is promoted. A new culture has to be built.*

One psychiatrist from the United States also emphasised their feasibility:

> *In Eugene, [Oregon] these options are quite feasible, and* ***versions of many have already been in effect for some years****. Our Behavioral Health Unit (inpatient), has seen a similar decline in use of seclusion and restraint to most units across the US. This has been accompanied by significant reduction in patient and staff injuries.*

Most Societies noted that **only some alternatives are currently feasible** in their country:

> *Overall, only few can be implemented. Prevention of Coercive measures practiced in UK, USA, Canada, and Australia is simply not applicable in India.* ***Lack of resources*** *plays a crucial role. (India)*
>
> *It is* ***not easy to apply 'open door policy'*** *in Korea right now. Otherwise we can apply other alternatives to coercive practice. (South Korea)*

Particular practices **noted as feasible** include:

> *Safewards (Belarus, Japan)*
>
> *Community-based services, 'Open Door Policy', home visits and treatment, legislative changes according to CRPD, deinstitutionalization (Moldova)*
>
> *Six Core strategies (Japan)*

Echoing a concern from South Korea in response to Question 1, the RANZCP noted **chemical restraint** as a practice that is particularly complex:

> *Implementation of alternatives to coercion are ongoing in Australia and New Zealand. However, the purpose of administering pharmaceuticals to people experiencing an*

> *acute mental health condition varies and **it can be hard to identify intent**. [4] Circumstances may require pharmacological intervention to protect the safety of an individual, staff and the community. Despite the development of guidance and protocols, psychiatrists still face significant challenges in undertaking this in practice due to the nuances of balancing the rights of individual autonomy with the wishes of the family and friends of the individual, and the rights and safety of staff and the community. [5] For example, the treatment of an acute mental health condition at a mental health facility of psychosis, may result in restrictive practices being used as in these instances, consent may be difficult to obtain… Whilst committed to working toward eliminating the need for coercive practices in mental healthcare, the RANZCP acknowledges the immense complexities of this issue including the **practice can be subjective** and is misused in many areas such as aged care. [8] This is further complicated by the many **gaps and resourcing issues** (staffing, training, culture, etc) within the current healthcare system which requires addressing to support changes to coercive practices.*

One Society noted that the alternatives discussed in the paper could help inform locally-developed resources:

> *Given the complex nature of mental health legislation and mental health service provision in Canada, we believe they **could form the basis for a Canadian tool kit**.*

There was a range of responses from service users and family carers:

> *This varied by country. Some felt it would be feasible with more money and resources. Others were concerned that alternatives might be resisted by powerful organisations.*

**Key Implications:**

- The PS should urge Member Societies to identify alternatives that are currently feasible and concentrate on implementing those as a starting point.
- It will be important for decision-makers in the mental health sector to examine the experiences of other countries to understand where alternatives may be more feasible than initially thought. We should refer to the case studies currently being researched. The WPA may also want to consider continuing work to document successful implementation of alternative practices.
- It is worth considering whether to acknowledge the particular complexities involved with addressing chemical restraint
- Lack of resources is a recurrent theme, mentioned as a barrier in both LMICs and HICs (Australia, New Zealand, India, Greece [see Question 4 below]) and also by multiple Service Users and Family Carers.

## QUESTION 4: ALTERNATIVES IMPLEMENTED

Which, if any, of the alternatives to coercion discussed in Section 4 are being used in your country?

Alternatives to coercion named by Member Societies include:

- **Legislation and policy reform** – in 6 countries (Greece, Italy, South Korea, Portugal, Moldova, Japan)
- **Open door policy** – in 4 countries (Mexico, Moldova, Italy, Canada)
- **Six Strategies** – in 5 countries (Belarus, Poland, South Korea, Italy, New Zealand)
- **Informed consent, supported decision-making, and advanced care directives** – in 2 countries (Australia and New Zealand)
- **Trauma-informed practice** – in 2 countries (Australia and New Zealand)
- **Safewards** – in 2 countries (South Korea and Australia)
- **Community treatment orders** – in 1 country (Greece)

One country (Lebanon) noted that the **Quality Rights Initiative** is being implemented in some hospitals. It is also being implemented in the Indian state of Gujarat, though this was not mentioned in its survey response.

Two Member Societies (India and Greece) also noted increased **involvement by service users and families** in determining personalized approaches for treatment and care.

The Canadian Psychiatric Association emphasised the impact of **monitoring** mechanisms:

> *Multiple groups have attempted to monitor the use of seclusion and restraint, evaluate the justification for the use of seclusion and restraint, and have built in reviews of decision-making for seclusion and restraint. All of these have had a positive impact. In other words, merely shining the light in this area, demanding justification, and implementing a review process has reduced seclusion and restraint.*

The response from Canada also noted room for improvement:

> *we still think there is still room for* ***more sustained and cohesive initiatives*** *to reduce coercive practices in mental health treatment in Canada*

The Hellenic Psychiatric Association notes **economic restraints** and the importance of **political will** in implementing alternatives:

> *We should also emphasize the facts about the economical crisis,* ***shortage of available funds and personnel*** *in mental health and social services. It is difficult to implement shared decision models and community treatment without the presence of community mental health services across the whole country… there are not enough funds that will allow a full transformation of mental health provision to a non- coercive direction. Steps are being taken and the Hellenic Psychiatric Association will certainly assist all these efforts. Additionally, the Association is pushing the Government to accept the scientific evidence indicating that prevention and treatment in the long run* ***cost less***

***than non-prevention and non-treatment. This is a language that politicians understand.*** *If we persuade them, then it will be easier to obtain funding that will allow wider implementation of non-coercive management of our patients.*

**Monitoring mechanisms** were noted by the Service Users and Advisory Group in:

- Japan, which has tracked rates of seclusion and restraint since 2004 and
- New Zealand, which has incorporated tracking of seclusion into key performance indicators, as well as providing de-escalation training for all mental health workers.

A psychiatrist practicing in Oregon, also commented on the **importance of monitoring mechanisms in the US and internationally.** Other key factors he noted in reducing coercion were: (1) including family members closely in the patients admission, treatment, and discharge planning; (2) keep hospitalizations as short as possible; (3) coordination with justice system to protect patients' legal rights; (4) a free standing crisis short term stabilization unit which patients can access on their own or by referral; (5) non hospital resources for mental health care and support.

The same individual emphasised **training and trauma-informed care** as crucial:

> *A hallmark of important initiatives for reducing coercion in treatment is widespread training of… all staff: nurses, doctors, mental health aides, social work and clerical staff. Our unit requires all staff to participate in a training program of non violent intervention called Pro-Act.*
>
> *Also, it is impossible to overestimate the importance of trauma informed care provision, as it is so true that the majority of mental health patients have trauma as part or wholly explaining their condition. It is also true that being hospitalized can add to the patients trauma.*

Additional comments from Service Users and Family Carers:

> *Three submissions answered this—there are none in Japan, some in New Zealand, and they have been resisted in Spain.*

One respondent from New Zealand recommended that the mental health sector should:

> *Learn from indigenous health care practices. E.g., Māori mental health specialists have a whole new evidence-based approach, focussing on educating patients about their ancestral inheritance and intrinsic value to 'center' them before commencing healing*

**Key Implications:**

- The PS can confirm that the alternatives listed in the paper are being implemented in a variety of different social, cultural, and economic contexts.
- There is still, however, much room for improvement, both in HICs and LMICs.
- Resource barriers, again, must be acknowledged.
- The role of political will is another emerging theme, and one that will be highlighted when it comes to the case study of Gujarat

## QUESTION 5: ROLE

Does your Society/Association/College currently have an active role in supporting increased implementation of alternatives to coercion?

→ (if yes) Please describe some of the ways in which your organisation is supporting 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 no) What role can you see your organisation having in supporting 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?)

Twelve Member Societies responded that 'yes' they have an active role in supporting increased implementation, and two responded 'no' (Mexican Psychiatric Association and the Association for Research on Schizophrenia Italy). One Society (India) did not respond.

For the Societies that responded 'yes', their roles have involved:

| **Policy-making** | **Cooperation with service users and their families** | **Training** | **Advocacy** (e.g. position papers) |
|---|---|---|---|
| 1. Belarus<br>2. Moldova<br>3. Poland<br>4. Portugal<br>5. Australia / NZ<br>6. South Korea<br>7. Argentina<br>8. Greece<br>9. Canada | 1. Belarus<br>2. Poland<br>3. Portugal<br>4. Australia / NZ<br>5. South Korea<br>6. Greece<br>7. Canada<br>8. Japan | 1. Portugal<br>2. Australia / NZ<br>3. Argentina | 1. Portugal<br>2. Canada<br>3. Japan |

| **Direct project implementation** | **Anti-stigma campaign** | **Support for project implementation** (non-specific) |
|---|---|---|
| 1. Australia / NZ - 'RANZCP Enabling Supported Decision-making project')<br>2. Lebanon – 'Prevention to aggression' | 1. Portugal | 1. Moldova |

Several Societies gave relatively detailed accounts of their roles in **policy reform processes**, which could make for an interesting compilation of examples if the WPA wishes to produce a series of brief case studies on change-making processes in future. For example, the Hellenic Psychiatric Society has been closely involved with policy reform and concludes that:

> *In the proposed act [reforming mental health care in Greece]… there is a gradual shift towards a limited inpatient compulsory treatment combined [with] a more extended non-coercive community treatment… all parties recognize the urgent need for the reformation of the current… legislation… and hopefully that would be done by the end of 2020. There is a crucial debate on coercive treatment in the community, its means of application and the debate on the respect of human rights.*

The Member Societies that responded 'no' could see themselves having an active role by:

- **Mexican Psychiatric Association** – getting involved in policy-making, organising training workshops and courses, and exploring what other tools and resources they could provide
- **The Association for Research on Schizophrenia Italy** – supporting their parent organization, the Italian Society of Psychiatry

Several Societies that responded 'yes' also expressed a desire to play a more active role. For example:

- The Lebanese Psychiatric Society stated an interest in **working more closely with service users**
- The Korean Neuropsychiatric Association noted prospect of further involvement in policy reform, and '**providing support for initiatives**'.
- The Belarusian Psychiatric Association said they can get more involved in supporting application of alternatives in practice, such as by **supervision**
- The Canadian Psychiatric Association wrote that:

> *The CPA feels **the time is right to take a more active position** on alternatives to coercion and welcomes working with the World Psychiatric Association in **developing clear standards and processes** for the development of and implementation of alternatives to coercion.*

**Key Implications:**

- Policy-making and cooperation with service users and their families are key roles played by WPA Member Societies across a multiple geopolitical regions.
- There is enthusiasm for playing a greater role in change.

## QUESTION 6: EXAMPLES

| Can you please tell us about any examples of alternative practices being used in your country or region? Please include a brief summary along with weblinks to any publicly available documents, reporting, or other information that may be helpful for others working to minimise coercion. |
| --- |

Examples specified in responses from Member Societies include:

In Australia

- **Peninsula Health Psychiatric Service** (Victoria) – implemented alternatives to coercive practices. Further information can be found at: https://www.ranzcp.org/RANZCP/media/Conference-presentations/Congress%202009/Richard-Newton-Values-Add-Value.pdf.
- **Safewards** (Victoria) – implemented to reduce conflict and containment and increase safety for staff and patients in mental health services in Victoria. Further information on this model can be found at: https://www2.health.vic.gov.au/safewards.
- **Advance Care Planning** – program funded by the Australian Government of Health aiming to empower individuals to make choices about their health care. Advanced care directives, which allow individuals to state the care they wish to receive if they are unable to make decisions about their health in the future, are an example of alternative coercive practices. Rules around advanced care directives differ between state and territories. Further information can be found at: https://www.advancecareplanning.org.au/about-us.

In New Zealand

- **The Six Core Strategies** – an adaption of these strategies to reduce the use of restrictive practice suitable for the New Zealand context. [reference in RANZCP response]
- **Takarangi Competency Framework** – addresses the overrepresentation of Māori experiencing restrictive practice and acknowledges the importance of practitioners understanding fear triggers and the influence of history on current engagement in health services. [reference in RANZCP response]
- New Zealand has been keeping track of many **statistics about seclusion** since 2009. They are part of the key performance indicators that the country considers: https://www.mhakpi.health.nz/

Elsewhere

- **“Hourglass”** (Eugene, Oregon, USA) - a free standing crisis short term stabilization unit, which patients can access on their own, or on referral from ED, medical facilities, agencies, or psych unit.
- **PeaceHealth** (USA) **–** a non-profit health organisation that includes psychiatric services. Dr. Brasted, the former Medical Director of their Behavioral Health Services in the Oregon Region, has described implementing a variety of alternatives to coercion in his response to the WPA questionnaire. This may make an interesting case study in future. https://www.peacehealth.org
- **Japanese Ministry of Health, Labour and Welfare Monitoring Mechanism** - keeping track of the numbers of people in restraints and seclusion on June 30 of every year since 2004 (https://www.ncnp.go.jp/nimh/seisaku/data/).
- **Moldovan Law** on the social inclusion of people with disabilities, low of implementation of CRPD: https://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_329337.pdf

## QUESTION 7: ADDITIONAL COMMENTS

Five Member Societies (Mexico, Australia/NZ, South Korea, Argentina, and Canada) responded to the final survey question by **expressing strong support** for this work, and **willingness to play an active role** in future. For example, the response from Mexico reads:

> *We appreciate the opportunity to participate. The current APM executive committee has just started its term and these activities guide us to issues that we must work on.*

Responses from Canada, the US, and India **stipulated the aim to reduce, rather than eliminate, coercion:**

> *Overall, the argument for implementing alternatives to coercion are generally satisfactory and the methods described would likely be feasible. However - REDUCTION in coercion is 100% a worthy goal, but total ELIMINATION of coercion based on where our mental health care and legislative systems are at is probably unlikely in a short time frame. (Canada)*
>
> *An important caveat I wish to point out, is that I believe that in spite of trauma, many patients benefit from psychiatric hospitalization. Additionally, some patients require and ultimately benefit from some aspect of coercion as part of their treatment. (Dr. Bradford, Oregon USA, as part of his submission to the APA and the WPA)*
>
> *We believe legally sanctioned coercive measures should be practiced. In an earlier study Psychiatrists perceived a relative lack of resources as the main reason for coercion and believed that it could be reduced in clinical practice by giving more time and improving personal contact with the patients and their care givers. (India)*

At least two people consulted through the Service User and Family Carer Advisory Group also noted the **complexity of eliminating coercion**:

> *When you have a loved one in a situation where they are in danger but are still refusing treatment, it is a very difficult position. They see family members who are angry if coercion is not used: 'My loved one is in danger but you are doing nothing.' (com)*
>
> *From a user who became a psychiatrist: As for my lived experience : I was involuntarily hospitalised three times. It was extremely traumatic for me, but I totally agree that it was necessary. I think it's an abuse not to involuntarily hospitalise patients with mania and/or psychosis even though my experience as a patient in an involuntarily – admitted ward was horrific. Tied to a bed in a room with 16 other people with no supervision and was afraid that they would be hurt by another patient. Psychiatrists were unsympathetic and some laughed at the patients. But many hospitals also have psychiatrists and nurses who are attacked by patients. (Romania)*

The response from the Indian Psychiatric Society included **advice on additional factors** that would complement the alternatives to coercion discussed in the paper:

- *Availability of Trained Mental Health Manpower*
- *Strong political will*
- *Investment in public mental health*
- *Availability and provision of treatment in primary health care settings*
- *Eradication of stigma and discrimination*
- *Active involvement of patients (and family) in decisions made about them and improving community participation.*
- *Reduction of treatment gap,*
- *Raising awareness amongst patients and their families.*
- *Research from developing countries on coercive measures*
- *Benchmarking regular analysis of data, regional, national and*
- *International comparisons and transparency can help to raise awareness and allows key stakeholders to prioritize funding where deficiencies are identified.*

Comments from the American Psychiatric Association were received in a brief email from its president, who wrote:

> *We are the World PSYCHIATRIC Association. Why are we talking about ""Mental Health Care""? Why aren't we talking about ""Psychiatric Treatment""?... Are we ever using coercion when we take care of someone's ""mental health""?*

Comments from Service User and Carers stressed the importance of:

1. **Meaningful involvement of services users and their families** (e.g. peer support practices, co-design of non-coercive interventions and research to test them)

*Maybe develop interventions together with service users and universities. Also interesting to take into account peer-support practices, where service users look after each other. (com)*

**2. Cultural change to improve systems of care**

*The alternatives discussed are at the practice or legislative level. The paper could signal more strongly the need for research and change of systems and cultures (service user, NZ)*

**3. Early intervention**

*Preventive measures should be used more—if children with autism or other psychiatric symptoms could be treated with therapy early, they might never grow to be violent adults with severe aggression and agitation in need of coercive measures such as chemical restraint. The early treatment may be considered too expensive, but in the long term it would be worth it. (Romania)*

**4. Raising awareness among families of service users and the general public**

*Considering the family carers view, they often don’t have enough knowledge and understanding about the circumstances in which coercion is used. (com)*

*WPA member organisations and their representatives should be encouraged to take initiative in raising public awareness about the problems and dangers of coercive practices in mental health care. (Japan)*

**5. Testimonials that give voice to people with lived experience of coercive practices**

*Include testimony in the document from people with lived experience of coercion. (suggested by several people, including com, )*

It should be noted that the quotes above are only some examples of comments received along these lines.

**Key Implications:**

- There are at least a handful of Member Societies that are keen to play an active role in leading change.
- The positive framing of 'implementing alternatives' is effective in unifying Societies toward movement in a common direction, even where there is disagreement or scepticism about the ultimate goal of elimination.
- The list of complementary factors provided by India is useful guidance for the case studies. We are already seeing many of these factors at play in the early stages of that research, and will be able to provide some useful insights from that work.
- The comment from APA shows how important it will be for the Position Statement to clarify the role of psychiatrists in change-making processes, and connect that role to the mental health sector more broadly. Emphasising alternatives to coercion as a key element of the broader transition to recovery-oriented systems of care may help.

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*Community Works, August 2020*

## APPENDIX: TESTIMONIALS FROM SERVICE USERS AND CARERS

In response to the call for the Position Statement to give voice to people with lived experience of coercion in mental health care (exerted on themselves or loved ones), the WPA could consider including one or more of the quotes below from the consultation. **Please note**: to my knowledge, the people quoted below have not yet been asked whether this information can be used in this way, so it would be important to first request consent.

From a NZ carer:

*New Zealand psychiatric facilities have problems with not enough people willing to listen to the users and families. If we can have more staff, independent peer supporters and independent advocates on the wards then we are more likely to have people that feel listened to and respected. I think one of the basic problems that I have come across is the attitude and culture that clinicians have towards their patients. Their rough way of working with a (young man who had a peer supporter) made him angry and explosive. When the peer supporter works with this man she has no problem because she listens and ask what he wants. His family asked for a meeting but was ignored until the peer supporter intervened. When you speak up you are labelled as aggressive. Usually people are not able to speak up for themselves and need the support from families and advocates. To listen and to validate people's feelings is key to keeping people calm and relaxed. When my son became unwell I was pleased that he was in a secure ward. I thought he was safe but he no doubt hated it. In fact he didn't want to ever go back there again. (He later committed suicide.)*

From a service user in Romania who became a psychiatrist:

*As for my lived experience : I was involuntarily hospitalised three times. It was extremely traumatic for me, but I totally agree that it was necessary. I think it's an abuse not to involuntarily hospitalise patients with mania and/or psychosis even though my experience as a patient in an involuntarily – admitted ward was horrific. Tied to a bed in a room with 16 other people with no supervision and was afraid that they would be hurt by another patient. Psychiatrists were unsympathetic and some laughed at the patients. But many hospitals also have psychiatrists and nurses who are attacked by patients.*

From a respondent in India (not specified whether this was a service user or family member):

*Normally when a service user becomes violent they sometimes become difficult to handle without using force such as giving medicine, isolating, keeping tied up etc. Normally, if the service user is properly listened to patiently in early stage they respond well peacefully. But normally caretakers don't do that.*