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EUFAMI is working with major European organisations, such as the EU and the World Health Organisation (WHO) to help improve the quality of life of persons affected by mental illness

EUFAMI Position Paper on Coercive Practice in Mental Health Services

EUFAMI · Martelarenplein 20E · Leuven 3000 · Belgium
Tel. +32 468 17 71 48 · project.admin.office@eufami.org · www.eufami.org

Introduction

Coercive practice, such as involuntary admission and coercive measures, such as seclusion, restraints and forced medication, are used in mental health services in all European countries. Compulsory treatment in the community is used in some countries. The rates of involuntary hospitalisations in Europe differ between countries[1]. Grounds for compulsory admission often include an identified need for treatment to which people are unable or unwilling to consent, and which cannot safely and effectively be delivered in the community. Concerns are often expressed that some people may be at risk of self-harm, or harm to others, if coercive measures are not enforced[1].

Although regulated by national law, involuntary admission and coercive measures conflict with treatment based on informed consent, shared decision-making and recovery-focused care.

The impact of coercive measures on the experience of individuals and their family members

Coercive measures are used in between 20% and 60% of individuals admitted to mental health services across various European countries. They are associated with longer duration of inpatient treatment and forced medication has a significant impact on a person's disapproval of treatment[2].

Although some individuals and their families will agree that coercive measures were justified, it is still a frightening and distressing experience for most with a number of negative consequences. There is some evidence that seclusion and restraint have deleterious physical or psychological consequences. Estimation of post-traumatic stress disorder incidence after intervention varies from 25% to 47% and, thus, is not negligible, especially for people with past traumatic experiences, however, there is little data on the benefit of coercive measures, regarding efficiency, efficacy, or effectiveness[2].

[1] Marie Chieze[1], Samia Hurst[2], Stefan Kaiser[1] and Othman Sentissi[1], "*Effects of Seclusion and Restraint in Adult Psychiatry: A Systematic Review*"

[2] Maria Rodrigues, Helen Herrman, Silvana Galderisi and John Allan, "*Implementing Alternatives to Coercion: A Key Component of Improving Mental Health Care: Position Statement*", World Psychiatric Association October 2020

Coercive measures can cause trauma, impede people's recovery, damage therapeutic alliances, discourage trust in mental health systems, repel service users and families from seeking help in the future and increase the stigma of mental ill health. Restraint also carries serious risks of pain, injury and even death.

People and their families who experience coercive measures report feelings of loss of dignity, degradation, demoralisation, humiliation, anxiety, disempowerment, helplessness and rejection by healthcare staff. Essentially, coercive practice is counter-therapeutic.

Staff shortages, poor staff training, poor communication and a lack of a therapeutic culture are associated with increased risk for coercive practice. The physical environment of a mental health unit, including insufficient space, disrepair and poor hygiene, noise, inactivity, lack of privacy and a hostile atmosphere, are influential factors in increasing the risk of coercive measures being used.

An additional concern is that many people with mental Illness may reside in prisons due to poor diversionary systems or insufficient mental health care facilities.

A fundamental transformation of mental health care systems is necessary to bring about the required service culture change that ends or reduces the use of coercive treatment. WHO recommend a change in organisation culture toward recovery, trauma-informed care and respect of human rights, where seclusion and restraint are viewed as a treatment failure with high risk to cause trauma and other negative consequences[3]. Service culture is difficult to change due to the long duration of pattern of shared values, beliefs, rules and practices. These need to be changed and that takes time.

The following principles should be followed to prevent or reduce coercive practice in mental health services

Treatment is provided on the basis of informed consent, respecting the autonomy of the person and where appropriate, involved families, to make decisions about the treatment[4].

[3]World Health Organisation, https://apps.who.int/iris/handle/10665/329582, "*Freedom from coercion, violence and abuse, WHO Quality Rights core training: mental health and social services*" Course Guide, Geneva

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

In the case when a person has difficulties to make decisions about treatment, the service will support them and/or will encourage people whom they trust to help them make an autonomous decision.

When support for decision-making has failed, the decisions of mental health service staff will be based on principles of medical ethics as well as on the best knowledge of the person's wishes or on the best possible interpretation of their wishes[4].

When autonomy, due to the mental health condition of people, cannot be respected in situations of involuntary treatment and use of coercive measures, the service will be guided by formal protocols that protect human rights and dignity.
Any legislative intervention authorising coercive practice should be up to date and based on human rights law.

Conclusion

EUFAMI believes that coercive practice, even when used as a necessary last resort based on national law, is essentially the failure of mental health services to respond with non-coercive alternatives. Looking for the alternative to coercion should be the rule. In order to minimize coercive practice in mental health, training should be mandatory on topics of de-escalation skills, human rights, medical ethics, mental health legislation, alternatives to involuntary admission and use of coercive measure as well as on recovery culture.

The effective protection of human rights and recovery for people with mental illness comes from access to voluntary mental health treatment and services that are comprehensive, community-based, recovery-oriented, trauma informed and culturally competent.

Coercive practice should only occur as a last resort in circumstances when no less restrictive alternative will respond adequately to the risk of physical harm to the person themselves or others.

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Annex 1

Coercive treatment comprises a broad range of practices, ranging from implicit or explicit pressure to accept certain treatment to the use of forced practices, such as involuntary admission, seclusion and physical and mechanical restraint. Coercion is common in mental health services with significant variation from country to country. Within Europe, the most recent research suggests that coercive practices are most common in Austria and least common in Italy (Rains et al, Lancet Psychiatry 2019, from Galderisi S.)

Recent research shows the **harmful effects** of coercive measures on people with mental health problems. Although coercive measures are sometimes described as providing a sense of control and safety for patients, many also describe feelings associated with fear, trauma, and disempowerment when experiencing these measures.

This annex provides a sample of research covering a variety of aspects of coercive practices consulted in the preparation of the Position Paper.

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