

Coercion in mental healthcare: time for a change in direction

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Coercion has always been integral to the care and treatment of people who are mentally ill and there is no 'perfect' model in which coercion is absent. A number of interventions have shown promise in reducing the use of coercion, however, and we believe the evidence points to ways forward that may improve both the experience and the outcome of care.

Historical background

Coercion (including legal processes and measures used by families and others 'unofficially') has always been integral to the care and treatment of people who are mentally ill. Reports on early 'facilities' revealed shocking practices and deprivations of liberty (Porter, 2004) and these continue (Department of Health, 2012). There are also many instances of humane and person-centred care. When Pinel and Pussin famously unlocked the shackles at Bicêtre and the Salpêtrière (Goldstein, 1987), and the York Retreat opened (Tuke, 1892), it was clear that even the very distressed could be effectively cared for without high levels of coercion.

The move towards community care and the closure of institutions has led to many units becoming smaller and focused on rehabilitation. This has occurred at different rates internationally. Many countries still have long-term care concentrated in large institutions, and have little community provision (World Health Organization, 2005; Muijen, 2008). Such practices run counter to the United Nations Convention on the Rights of Persons with Disabilities (CRPD) (ratified by 147 countries since 2008), which recognises 'the equal right of all persons with disabilities to live in the community, with choices equal to others'. While hailed by many as an enormous step forwards for the rights of those with mental health problems, the CRPD has some controversial implications (Kayess & French, 2008).

Legislation and legal process

Legislation exists in most countries to allow for the involuntary treatment of those deemed to be unwell and at risk. Such legislation should always provide rights of appeal and safeguards such as independent review. Countries that do not have adequate legislation should be supported and encouraged to develop it (World Health Organization, 2005). The World Health Organization has campaigned on human rights issues for many years and in 2012 released its *Quality Rights Toolkit*, a manual to allow for the assessment and improvement of services to protect rights better (World Health Organization, 2012).

Most people accept the existence of mental illness and the need, in some situations, for intervention without the patient's consent. There is agreement that such treatment should be given in the least restrictive manner but there is divergence in practice. Although due legal process and best clinical practice should always be followed (Prinsen & van Delden, 2009), there are substantial disparities internationally in the legal and clinical aspects of care (Newton-Howes, 2010). This may reflect differences in societal and clinical attitudes (Lay *et al.*, 2012). The 'heterogeneity of coercion' remains poorly understood.

Coercion

There is no 'perfect' model in which coercion is absent. For instance, in the UK there have been concerns regarding the use of 'face-down restraint' (Easton, 2013). In the USA and some Scandinavian countries physical restraint with magnets or straps is used. In countries with little overall healthcare and long-established mistrust of people who are mentally ill, those in distress or 'at risk' may simply be tied or chained up (Human Rights Watch, 2012; Mental Disability Advocacy Center, 2014a, 2014b).

Research in this field is challenging and robust evidence is hard to come by. It is obvious that certain practices – for example chaining someone up – constitute grave human rights abuses. Beyond that, the evidence in this area, with few randomised controlled trials (for understandable ethical reasons), suggests that coercion in most definable and measurable forms is not associated with improved outcome and may negatively affect the individual (Wallsten *et al.*, 2006; Kallert *et al.*, 2011; Burns *et al.*, 2013). It may be traumatic (Paksarian *et al.*, 2014), dissuade people from further treatment (Swartz *et al.*, 2003), increase the risk of non-adherence (Jaeger *et al.*, 2013) or increase further involuntary treatment.

The current adoption of increasingly coercive regimes in some countries does not follow the evidence, although it is understandable in the context of political and media-driven concerns regarding risk. A number of interventions have shown promise in reducing the use of coercion. While the evidence is relatively undeveloped, we believe it points to ways forward that may improve both the experience and the outcome of care.

Rapid clinical and risk assessment

The pathway to receiving support in a crisis can be complicated, chaotic and unnerving. It may lead to admission to hospital and will frequently lead to coercive measures such as forced or covert medication and restriction of freedoms by family

or statutory carers. This can be the case in areas with high levels of provision and those without, but variability may be greater where services are fragmented or absent. The practice of psychiatry in some systems uses coercion early on, with people being admitted to locked units pending assessment.

The 'front loading' of the assessment process with early involvement of senior clinicians should allow for a reduction in admissions, the rapid deployment of evidence-based interventions and the minimisation of coercion (Eytan *et al.*, 2013). 'Front loading' is already used in systems where in-patient care is expensive (Harrison, 2004) and where risk and the need for restrictive measures are rapidly assessed. Assertive community treatment (ACT) may help to decrease coercive interventions and increase the likelihood of further voluntary treatments. It may also improve outcome, although some regard the intensive contact integral to ACT as itself being coercive.

Advance directives

Advance directives allow individuals to record their wishes regarding treatment in advance. They are often completed between episodes of illness rather than in relation to first episodes. They are generally not legally binding. Uptake is often low, even when they are actively promoted. They may, however, prove to be a useful means of reducing coercion in individual cases and form part of a package to increase autonomy (La Fond & Srebnik, 2002; Khazaal *et al.*, 2014). There is some evidence that such collaborative agreements can reduce the use of compulsory treatment (Henderson *et al.*, 2004) and improve satisfaction with care (Thornicroft *et al.*, 2013).

Advocacy

Independent advocacy can increase patient knowledge, empowerment and involvement in care. Although some models are expensive and therefore unattainable outside wealthy nations, there are examples of low-cost implementable schemes (Lefley, 2008) such as self-advocacy projects in low-income countries (Kleintjes *et al.*, 2013) and initiatives in psychiatric hospitals in Central Europe (Cutler *et al.*, 2006) in which service users have representatives on the hospital board.

Increased involvement of patients and families

In places where there is limited visiting from families and others and care decisions are made by clinicians alone (often doctors alone) there is the potential for coercion to be extended in terms of both intensity and duration, especially if that is part of the culture of practice (Fiorillo *et al.*, 2011). This is compounded by the closed nature of such facilities.

The simple step of inviting families and friends to be involved is free and should lead to a more informed and holistic approach. A patient reference group could work with senior clinicians

and managers. Involvement may reduce costs or increase activity by encouraging volunteering.

The recent Francis inquiry in England (Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013) highlighted sustained mistreatment and neglect. One of its core recommendations was astonishingly simple: to allow for routine extended visiting hours. This would serve to reduce closed institutional cultures, reduce the use of stigmatising interventions, and challenge prolonged and entrenched coercive practice.

Introduction of observation procedures

When the American Psychiatric Nurses Association (APNA) introduced the guideline that stipulated that all patients in seclusion had to be reviewed by senior staff at regular intervals (APNA, 2014), the use of seclusion decreased significantly. Similar guidelines exist elsewhere and contribute to a culture where seclusion is used as a last resort. The conditions and safety of those under restraint should always be subject to mandatory review by a senior resident doctor.

Legislative and policy changes

Legislation is the most challenging potential remedy. While there are levers in the form of international law and case judgements, it is hard to translate these into practice. Modest legislative changes could, however, combat the use of such restrictions as cage beds and straps. Many systems manage without and alternatives could be found quickly. This is also true for powers to compel in the community, as most countries manage without and there is no evidence base for effectiveness. However, legislative change needs to be accompanied by concerted advocacy to ensure that one kind of coercion is not simply replaced by another (Mental Disability Advocacy Center, 2014a,b). In recent years there have been louder calls to combine incapacity and civil commitment laws in a bid to achieve ethical and legal parity between mental and physical health treatment (Dawson & Szmukler, 2006). Other interventions may be introduced more quickly while fundamental legislative change is pushed for over a longer period.

Conclusion

The trend over recent years of pursuing increasingly coercive measures that lack evidence is damaging patient care. It would be more humane, just and effective to implement alternatives that serve to reduce experienced and actual coercion, promote the wider involvement of people in their care, and potentially improve outcome. If you are driving along in a car and the evidence suggests you are going in the wrong direction you pull over, check, and turn around – why should psychiatry be any different?

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