



Short Guide to Ending Coercion and Restraint in Mental Health Services

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WELCOME!

INTRODUCTION

This guide is the fourth publication in our series of short guides. 'A Short Guide to Ending Coercion and Restraint in Mental Health Services' follows ['A Short Guide to Psychiatric Drugs'](#), ['A Guide to Personal Recovery in Mental Health'](#) and ['A Short Guide to Psychiatric Diagnosis'](#).

This guide aims at helping people who come into contact with the mental health system, either as service users or indirectly as friends or family of users, to investigate, understand and be active participants rather than passive recipients of care.

For many people, the experience of becoming a psychiatric patient can be lonely, humiliating, and frightening. This can be made worse if the process is involuntary or coercive, leading to added distress and lasting trauma.

Unfortunately, most countries still allow for some form of coercion and restraint in mental health services, seen as justified when the person is deemed a danger to themselves or others.

Nowadays, coercive measures tend to be framed as a "last resort", with guidelines and mandatory training, but its use as a first or emergency response continues to be widespread and even increasing in services under pressure.

This short guide aims to suggest ways in which people who have experienced mental health crises and their supporters could be able to make their voices and views heard, taking control of their bodies and their lives.

1. What forms do coercion and restraint take?

Coercion and restraint in mental health practice has a long, and frankly dark, history. Restraint can involve:

- ✗ **Physical restraint:** manually holding a person to prevent or restrict movement.
- ✗ **Mechanical restraint:** the use of devices (e.g., straps, belts, cage beds, etc.) to prevent or subdue movement.
- ✗ **Chemical or pharmacological restraint:** the use of sedative drugs to control or subdue behaviour (e.g., rapid tranquillisation).

- ✗ **Seclusion:** confinement in a room or secluded area from which a person cannot freely exit.



COERCION REFERS TO WAYS IN WHICH THE NORMAL MEDICAL PRINCIPLE OF REQUIRING FULLY INFORMED CONSENT TO TREATMENT IS BREACHED OR BYPASSED.

This can be done through threatening consequences for non-compliance, such as forcible readmission to hospital or any other way of disregarding the expressed wishes of the person receiving treatment (for example, forced injections or community treatment orders).

2. Are there alternatives to the use of coercion and restraint?

In 2017, Mental Health Europe (MHE) adopted a position on Article 12 of the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD), which supported the transition of all mental health services and legislation towards totally consensual practices, which are free from coercion and substitute decision-making. Two years later, we produced a report on [Promising practices in prevention, reduction and elimination of coercion across Europe](#).

This report provided a list of alternatives currently used in European countries collected by MHE members and partners. A few examples are included here to illustrate the principles on which they work.

ITALY

Psychiatric units of general hospitals SPDCs (Servizi Psichiatrici di Diagnosi e Cura)

SPDCs were established in 1978 during the deinstitutionalisation process in Italy by the same law which ordered the closure of the psychiatric hospitals at national level, thus giving a strong message about the transition of the centre of gravity of services from the hospital to the community and a social rather than a medical paradigm.

SPDCs are psychiatric units of general hospitals aimed at hosting people in a critical condition, both voluntary and involuntary, when the support of the community services has been unsuccessful.

There are SPDCs that have completely open wards and that have abandoned the use of restraint for many years ('no restraint SPDC'), while other SPDCs still have locked wards and aim to reduce or eliminate restraint. The no restraint SPDCs are based on a policy of open doors and respect for the rights, freedom and dignity of persons. The programme is based on dialogue and stimulating people to take responsibility for their recovery.

Becoming a no restraint SPDC is a long process, which requires education and new skills for mental health professionals but also new attitudes towards persons with mental health problems in the wider community. Openness, trust, and cooperation with people both inside and outside the hospital are essential. The no restraint SPDC involves a large network of organisations and services both at the hospital and community level, such as user and family

organisations, local authorities, and the police and justice systems. The better organised and coordinated the local services are, the less hospitalisation is required.

FINLAND

Open Dialogue Approach to Acute Psychosis

This is a model originally developed in Finland in which care decisions are made with the personal input of the individual concerned, together with wider networks of their choice. The Open Dialogue Model was initially designed as a treatment alternative to avoid hospitalisation. As such, there is less likelihood of coercion being used, including seclusion and restraint.

Open Dialogue is based on support in people's homes and communities. Service providers aim to facilitate regular 'network meetings'

between the person and his/her choice of an immediate network of friends, carers or family, and several consistently attending members of the healthcare team. A strong emphasis is placed on an equal hearing of all voices and perspectives as both a means and an objective of treatment. The emphasis is on transparency with the person, empathy, and positive regard.

There has not yet been a major evaluation on the direct impact of Open Dialogue on the use of coercion, but in Lapland, the Model has entirely replaced emergency, medicalised treatment. Overall benefits of a two-year follow-up were less hospitalisation, more family meetings, less medication, fewer relapses and better employment status.



UNITED KINGDOM (UK)

The No Force First initiative

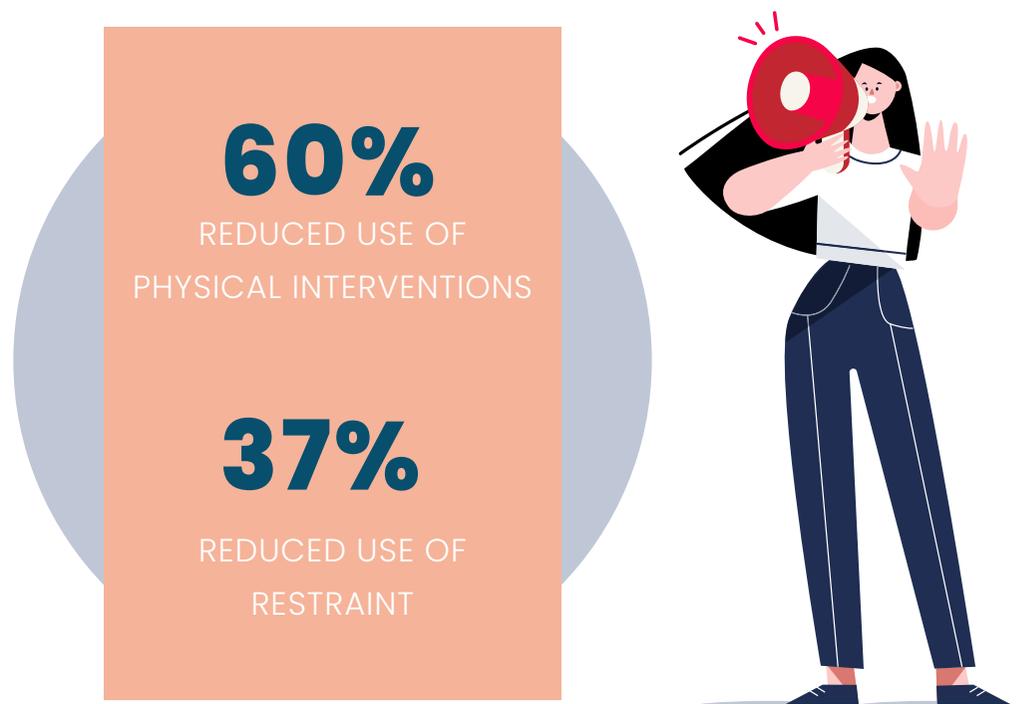
This initiative aims to change ward cultures from containment to recovery and ultimately create coercion-free environments. This approach, which comes from the United States, is being adopted by some UK based mental health Trusts.

The underlying idea is that 'there is no such thing as a forced recovery'. The 'No Force First' policy aims to create coercion-free environments through the following initiatives:

- ✓ promoting collaboration between users and staff members to make wards more recovery-focused;
- ✓ developing training programmes in collaboration with users and promoting training in de-escalation techniques;

- ✓ developing a cooperative culture, rather than a restrictive culture, to reduce incidents of aggression, self-harm and physical intervention;
- ✓ developing a deeper understanding of users to see their experiences in a trauma-informed, empathetic manner, and working together to build resilience;
- ✓ including the experiences of service users and engaging in co-production work;
- ✓ awareness-raising among users and relatives;
- ✓ recording of data on the use of coercion and immediate analysis after an incident.

The UK Mersey Care NHS Foundation Trust used the 'No Force First' policy along with other initiatives and recorded a reduction of approximately 60% in the use of physical interventions during the first two years of implementation. The approach was then implemented across all wards of the Trust and, between April 2016 and August 2017, there was a 37% reduction in the use of restraint, as well as a reduction in sick leave and staff turnover.



3. Supporting choice and informed consent

The programmes described above are about changing the culture of mental health services and, in the case of the first two, the culture of the whole community and its institutions in which services are embedded.

However, there is also the need for the individual to be supported to make their preferences and choices known and acted on when the culture is not so accommodating.

Having a person of trust, a peer advocate, or an advanced directive to support these preferences and choices can be of great help, as seen in the following programmes.

SWEDEN

The Swedish Personal Ombudsman Programme

'Personligt Ombud Skane' or 'PO' is a programme started in 1995 by people with psychosocial disabilities, as a 'User-controlled Service with Personal Agents'. The aim is to facilitate the decision-making of persons with psychosocial disabilities, and in vulnerable situations when it comes to the support they need from public authorities and social services. The Ombudsman is a professional, highly skilled person, usually a lawyer or social worker who works only for his/her client and does not work in alliance with psychiatric or social services or any other authority, nor with the client's relatives or any other person. The Ombudsman takes great care and time to build trust and to ensure that these persons

receive the help and services to which they are entitled and that they want. It is considered an appropriate model for supported decision-making by the United Nations Committee on the Rights of Persons with Disabilities and the World Health Organization (WHO), as the Ombudsman enables persons to make and communicate decisions concerning personal or legal matters. As such, the Personal Ombudsman is a way to limit coercive practices and to reduce the number of mental health crises.

Since the year 2000, the PO system has been expanded to the whole country. Although there is no evidence available yet on its impact on coercion, a five-year Government evaluation of the programme has shown that the scheme is less costly in socio-economic terms since individuals with PO support quickly become less dependent on psychiatric services, it gives them more control over their lives, and their psychosocial situation improves. As a result, the National Board of Health and Welfare began to promote the PO as a new social profession, and in 2013 a new regulation entered into force that established permanent funding for the PO system. The system has received great interest and inspired outreach services in other countries.

Advance Planning

Advance Planning, through advanced directives or advance statements, means that a person makes decisions designed in advance for him/herself or to direct others, particularly during times of crisis.

Advance planning may relate to treatment preferences, information on adverse reactions to previous medication and any other information, such as who to contact or not to contact. It can help respect the will and preferences of the person.

A formal type of advance planning is the representation agreement, through which the person appoints another person to assist them in the event of a future crisis. An informal type of advance planning is the joint crisis plan, consisting of a plan formulated by the user, together with health professionals, a person of trust, peers, or relatives, if desired or required. The plan contains advance statements of preferences for care in the event of a future relapse.

ADVANCE PLANNING IS CONSIDERED A MEANS OF REDUCING COMPULSORY ADMISSION AND COMPULSORY TREATMENT AS USERS FEEL MORE IN CONTROL AND EMPOWERED, MORE COMFORTABLE ABOUT THE FUTURE AND RESPECT FOR THEIR NEEDS.

Advance Directives are always not acted upon, with health professions often overriding the wishes of their client/patient in their 'best interest'. It is important to remember, however, that service users have the same right to change their mind as anyone else and that this should not be used as an excuse to deprive them of advance planning measures, which depending on the country, could be enforceable by law and must be complied with by health professionals.

Intentional Peer Support

Intentional Peer Support is a way of thinking about and inviting the building of relationships that are mutual, explorative, and conscious of power. Peers come together around shared experiences and often a desire

to change their lives. They learn to use relationships to see things from new angles, develop greater awareness of personal and relational patterns, and support and challenge each other in trying new things.

Among others, Intentional Peer Support promotes a trauma-informed way of relating: instead of asking "What's wrong with you?", the question is "What happened to you?". Intentional Peer Support provides a powerful framework for creating relationships where both people learn and grow together. Thus opportunities to find and create new meaning through relationships and conversations are offered, which leads to new ways of understanding crisis. Mutuality and shared power are put forward as contributing to the prevention of coercive interventions.

Intentional Peer Support was developed as an alternative to traditional peer support practices within mental health services. It has been advanced by the Centre for the Human Rights of Users and Survivors of Psychiatry and the European Network of (Ex-)Users and Survivors of Psychiatry as a good practice on 'Supported decision-making and Alternatives to Coercion'.

4. What is needed for reducing or eliminating coercion and restraint?

The use of coercion and restraint is embedded within the culture and procedures of mental health and community services. However, it does not go unchallenged.

In 2019, the former UN Special Rapporteur on the Right to Physical and Mental Health, Dainius Puras, made the groundbreaking proposal of a [Rights-first approach](#), to counter the increasing reliance on forced treatment worldwide.

THE FIRST STEP TOWARDS CHANGE IS A SHARED RECOGNITION THAT COMPULSORY TREATMENT IS WRONG AND A COMMITMENT AT LEADERSHIP LEVEL TO ELIMINATE ALL FORMS OF COERCION AND RESTRAINT.



Actions will include:

FOCUS ON SERVICE USERS

focusing on the preferences of service users, devoting more time, and involving staff and peers in initiatives

BUILD CAPACITY OF STAFF & PUBLIC OFFICIALS

training staff members, but also police forces and other public officials, with the involvement of experts by experience

IMPROVE COMMUNICATION WITH USERS

devoting time to improving communication with users in the context of their families and social networks and focusing on collaboration in a recovery-based approach

PHYSICAL ENVIRONMENT MATTERS

improving physical environments

ENSURE INTERAGENCY COLLABORATION

implementing effective work at the local community level and collaboration between different services (for example, social services, health authorities, employment services, local leisure opportunities)

MONITOR THE USE OF COERCION

monitoring and data collection on the use of coercion and jointly reviewing incidents to see what can be learned.

5. What can we do as users of services or supporters?

FIND ALLIES

Research and join with local and/or national groups, especially those led by persons with lived experience, who are committed to a human rights-based approach to alleviating mental distress.

COLLECT STORIES

Nothing speaks louder than experience. Sharing when things have gone wrong and pointing out examples where a different approach can work are both powerful motivators of change. The rise of social media provides tools for both collecting and disseminating information and ideas.

COLLECT DATA

Many countries require services to collect and publish data on the use of coercion in its various forms. If you can find out what is happening, this gives a baseline against which progress can be measured.

IDENTIFY AND TALK TO PEOPLE IN LEADERSHIP ROLES IN YOUR LOCALITY

Find out who is interested in making changes, as there may be allies, including organisations of health professionals, lawyers, human rights bodies and policymakers, who are committed.

No one likes using force, and as well as being incredibly damaging to those on the receiving end, it is also a cause of significant stress to those who feel they must use it. The 'No Force First' philosophy has not only improved patient experience dramatically but has also been positive for staff.

The continuing use of forcible restraint and compulsory treatment is an international scandal. There are always possible alternatives, and every instance is an opportunity for learning about what could have been planned or done better.

Join us in changing our culture into one where it is no longer acceptable to disregard the principle of informed consent to treatment and where signing up to the UNCRPD means a commitment to respecting the rights of persons with disabilities at all times and especially in moments of crisis.

Mental Health Europe is committed to reducing and eliminating any form of coercion in mental health, both by monitoring the use of coercion and encouraging experiences of alternative ways.

JOIN US IN CHANGING OUR CULTURE INTO ONE WHERE IT IS NO LONGER ACCEPTABLE TO DISREGARD THE PRINCIPLE OF INFORMED CONSENT TO TREATMENT.





ABOUT MENTAL HEALTH EUROPE (MHE)

With 70+ organisations in 30+ countries, MHE is the largest independent network working to advocate for positive mental health and wellbeing and to protect the rights of people with mental ill-health. We continuously champion social inclusion, deinstitutionalisation and respect for the human rights of people with psychosocial disabilities. We raise awareness to end mental health stigma throughout Europe.

For more information, please see:



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