Coercion in Contemporary Mental Health Services: Key Concepts, Historical Development and Contextual Factors

Deborah Oyine Aluh, José Miguel Caldas de Almeida, Dirk Richter, and Richard Whittington

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D. O. Aluh (✉)
Lisbon Institute of Global Mental Health, Comprehensive Health Research Centre, Nova Medical School, Lisbon, Portugal

Department of Clinical Pharmacy and Pharmacy Management, University of Nigeria Nsukka, Nsukka, Nigeria
e-mail: do.aluh@ensp.unl.pt

J. M. C. de Almeida
Lisbon Institute of Global Mental Health, Comprehensive Health Research Centre, Nova Medical School, Lisbon, Portugal

D. Richter
School of Health Professions, Division of Nursing, Bern University of Applied Sciences, Bern, Switzerland
e-mail: dirk.richter@bfh.ch

R. Whittington
Centre for Research and Education in Security, Prison and Forensic Psychiatry, St. Olav's hospital, Trondheim University Hospital, Trondheim, Norway

Department of Mental Health, Norwegian University of Science and Technology (NTNU), Trondheim, Norway
e-mail: richard.whittington@ntnu.no

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1 Terminology

Contemporary international health policy envisions a move towards reducing and eventually eradicating the use of coercion in mental health services around the world (Council of Europe, 2019). The World Health Organization (WHO) Quality Rights Initiative, for example, sets out a framework which places an obligation on all WHO member states to appraise their services and transform them in such a way that respect for human rights is at the core of their practice principles (World Health Organization, 2019). Such a shift requires a credible approach to monitoring coercion as the fundamental basis for national and international benchmarking which can, in turn, act as a baseline for measuring change over time. Setting up such monitoring is very much a work in progress internationally with huge variation in the quality of recording systems and currently little scope for meaningful international comparisons between rates using even the most robust national systems (Reid & Price, 2022; Savage et al., 2024). While it is easy to recognise coercion when you are the person being subjected to it, establishing international consensus on definitions that would enable valid benchmarking and monitoring against international standards is very difficult.

Various national initiatives have taken place since the first edition of this book was published to remedy this situation. In particular, national guidelines have become a key mechanism for standardising and improving many aspects of healthcare, including the minimisation of coercion in mental health services. Such guidelines usually attempt to specify key terms as a starting point for a shared understanding of the problem and its potential solutions. Two examples of such attempts within Europe (Germany and England & Wales) are given in Table 1.

These definitions are drawn from the national guidelines for clinical practice when encountering violence especially (although not exclusively) in mental health services in Germany and the UK (England & Wales) (NICE, 2015; German Psychiatric Association (DGPPN), 2018). Together they provide both a basis for understanding the concepts which will be discussed throughout this book, but they also illustrate some subtle differences between two near-neighbour countries in the same global region. It can be seen firstly that the overall concept of coercion in both countries specifies the core idea of restriction applied with force and without consent. With regard to particular types of coercion, there is also some clear consensus alongside some variation. It is noteworthy, for example, that manual restraint is not considered to be a technique suitable for inclusion in the German guideline. Such manual restraint must be used in Germany, as elsewhere, as a first response before other coercive interventions can be implemented but it is not defined here. The terms ‘isolation’ and ‘seclusion’ are conflated in the German guideline but isolation is not named at all in the UK document. The policy of locking the door and the level of contact with the patient when secluding is also emphasised differently with a slightly softer tone in the UK definition. With regard to forced medication, the German guideline is explicit about the lack of consent whereas in the UK this is, at most, implied.

These key coercive interventions are well-known and sometimes referred to collectively as formal coercion to distinguish them from other types of coercion designated as ‘informal’ (Hotzy & Jaeger, 2016). This designation as formal coercion

Table 1 Selected definitions of key coercive measures in two European countries (note: abbreviated in places)

	Germany[a]	England & Wales[b]
General terminology and definitions of coercion	**Freedom-depriving and restricting measures** Mechanical, spatial or chemical measures that restrict freedom of movement against the will of the person concerned and are of a certain intensity, for example, isolation, restraint, including with bed rails, chair tables, net beds	**Restrictive interventions** Interventions that may infringe a person's human rights and freedom of movement
Involuntary hospitalisation	Transfer to a (psychiatric) hospital under application of a legal provision	
Physical immobilisation	**Restraint** Restraining a mentally ill person with wide leather or fabric straps	**Manual restraint** A skilled, hands-on method of physical restraint used by trained healthcare professionals to prevent service users from harming themselves, endangering others or compromising the therapeutic environment **Mechanical restraint** A method of physical intervention involving the use of authorised equipment, for example, handcuffs or restraining belts, applied in a skilled manner by designated healthcare professionals
Isolation/ seclusion	Transfer of a mentally ill person to a locked room without direct contact with staff	The supervised confinement of a patient in a room, which may be locked
Involuntary medication	**Forced medication** The administration of medication against the expressed or even only unarticulated (natural) will of the mentally ill person	**Rapid tranquillisation** Use of medication by the parenteral route (usually intramuscular or exceptionally intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed

[a] German Psychiatric Association (DGPPN) (2018). S3-Guideline prevention of coercion: Prevention and therapy of aggressive behaviour in adults. https://register.awmf.org/de/leitlinien/detail/038-022. Accessed 7-2-2024. Deepl Pro Translation

[b] NICE Guideline (NG10) (2015). Violence and aggression: short-term management in mental health, health and community settings. Accessed 7-2-2024

means that their use is almost always based on a legal decision which has been informed by a medical assessment under the relevant mental health legislation operating in the country. This requirement of a formal procedure for permission to deploy these types of coercion (e.g. paperwork, public hearings) ensures that effective monitoring should be feasible and therefore any gaps in knowledge are likely to be due to inadequate recording systems rather than difficulties in definition.

In contrast, informal coercion, also known as 'soft coercion' (Allison & Flemming, 2019) is not accompanied by explicit medical or legal measures. Here, communicative pressure is usually exerted on a person by professionals or legal representatives in order to achieve a certain behaviour or outcome (Hotzy & Jaeger, 2016). This pressure may be exerted verbally or non-verbally through body postures or simply exposure to a gathering of staff on a ward. But such pressure is largely subjective in the minds of both patients and staff and can be manifested in many different ways that, unlike formal coercion, are hard to capture. Many hospital admissions that begin voluntarily can subsequently involve such informal, and indeed formal, coercion. Threats of physical violence by staff have also occasionally been observed (BBC, 2022), but such behaviour crosses the line from informal coercion to illegality and thus makes the individual and their employer liable to criminal proceedings. Overall, informal coercion occupies a grey zone between formal coercion and autonomy.

Alongside attempts to clarify the language of coercion, there have been recent efforts to build a consensus on the main provisions designed to prevent coercion. The UK guidelines cited above in Table 1 (NICE, 2015, pp. 18–19) specify positive engagement, for example, as an 'intervention that aims to empower service users to actively participate in their care' though negotiation; and de-escalation as the 'use of techniques (including verbal and non-verbal communication skills) aimed at defusing anger and averting aggression' that do not include restraint. In an alternative approach, a recent international consensus exercise drew upon the expertise of clinicians and researchers across Europe with the aim of clarifying the terminology of both coercion itself and coercion-prevention. This led to an agreed taxonomy with 32 concepts in six domains: general concepts, involuntary inpatient care, involuntary outpatient care, spatial isolation, restraint practices and rights protection and administrative tools (FOSTREN, 2023). An extract from the last section is provided in Table 2.

These and other consensus efforts are all a work in progress driven by the hope that they will eventually lead to international best practice standards. But it is

Table 2 Items from the FOSTREN Glossary Section 6: rights protection and administrative tools (FOSTREN 2023). NB: PMHC refers to a 'person with a mental health condition'

Term	Definition
Supported decision-making	The PMHC is supported by others in making decisions. This can be structured support by clinical staff or others to facilitate that the person's will and preferences are respected in treatment decisions
Advance directives	Refers to a written statement by a PMHC when well, which sets out the way in which they want to be treated and/or treatment they do not want for their mental health condition should they deteriorate
CRPD	Convention on the Rights of Persons with Disabilities. A United Nations Human Rights Treaty to protect the rights and dignity of people with disabilities, including disability resulting from mental health conditions
Decision-making-capacity	In some jurisdictions, the lack of decision-making capacity is a legal requirement for involuntary care. Decision-making capacity means the ability to make (treatment) decisions, and this is usually assessed by checking that the person is able to understand and retain information, weigh it up to make a choice and express this

important as well to consider this phenomenon within its historical context. Mental illness, medical treatment, care and coercion are all complex social processes that have challenged societies around the world and attitudes have evolved substantially but differently over time. An understanding of the changing narratives in this area is important to remind us that we are at one particular moment in history now and current approaches are only a temporary arrangement which may or may not provide the basis for future improvements.

2 Coercion in the History of Psychiatry

Throughout history, and into the present day, attitudes towards the use of coercive measures in the treatment of persons with mental disorders have always been closely associated with the prevailing cultural, religious and political context. In most of Europe, for centuries, persons with mental disorders were isolated, chained and victims of all kinds of violence and abuse (Shorter, 1997). It was in Classical Greece that madness was viewed for the first time as a strange phenomenon but nevertheless, one determined by natural causes and therefore part of the human condition (Thumiger, 2017). Different disorders were described, natural explanations were advanced for these disorders, and various therapeutic interventions were developed to mitigate the effects of the disorders. However, in Greece as well as in the Roman Empire, this medical interpretation always co-existed with magical and religious interpretations from the past. Those primarily responsible for caring for these persons were their families, who often limited themselves to isolating them and locking them up in their homes. The use of chains and other coercive instruments was common practice (Gonzalez de Chavez, 1980).

As early as the thirteenth and fourteenth centuries, there were examples of places in Europe where people with mental disorders were treated humanely and integrated into the community. In Geel, Belgium, persons with mental disorders began, in those days, to be accepted into the homes of farmers, where they lived as members of the family and participated in work and community activities, a practice that has survived until the present day (van Bilsen, 2016). In Granada, Spain, in the fourteenth century, at the Maristan hospital, the first European hospital created for the mentally ill, the patients were treated in a setting of tolerance and inclusion, which reflected the context that prevailed in that city at the time, marked by a peaceful and harmonious coexistence between Arabs, Christians and Jews that ushered a period of great progress in arts and science (Pérez et al., 2012).

In the Middle Ages, however, care for most persons with mental disorders continued to depend on families, except in the most serious cases. Then, if they were not abandoned and doomed to wander along with other beggars, they were locked up in cells located in hospices managed by monasteries and churches or in prisons administered by civil authorities (Gonzalez de Chavez, 1980). The growing influence of the Christian faith in this period also explains the occurrence of regular pilgrimages, involving thousands of mentally ill every year, to shrines believed to have miraculous powers in healing people with mental illnesses.

At the beginning of industrialisation, only patients with a lot of resources were treated in small private institutions, known in England then as 'madhouses'. The poor did not have access to such specialised institutions. The vast majority were locked up in their homes, or placed in rooms of general hospitals or asylums, together with physically ill patients, elderly persons and persons with disabilities, in subhuman living conditions. Others wandered aimlessly or ended up in workhouses.

The increase in the influx of patients to these institutions and the growing denunciations of the terrible conditions in which they lived led to the creation, from the eighteenth century onwards, of new general hospitals in many cities in Europe and the appearance of institutions specially dedicated to various types of illnesses (Porter, 2002). Asylums for the 'insane' (as persons with mental disorders were designated) began to emerge in the eighteenth century and the first attempts to change attitudes towards mental illness were part of this movement (Gonzalez de Chavez, 1980). These changes, however, would not have been possible without the new ideas of the philosophers of the Enlightenment. It was these new ideas that contributed to lessening the grip of superstition and emphasising a rational approach to natural phenomena, thus making possible the dissemination of new ways of understanding mental disorders and their treatment.

2.1 Pinel and Moral Treatment

François Pinel, freeing the patients from the chains in Bicêtre in 1793, went down in history as the symbol of a new attitude towards the mentally ill and the author of the so-called moral treatment. However, similar innovations were at the same time being developed in other countries, and the concept of moral treatment was, in fact, first formulated by William Tuke in the UK, where he created The Retreat in 1792, an institution where the mentally ill were treated using moral management and with a minimum of mechanical restraint (Raad & Makari, 2010). At the Lincoln Hospital, Robert Gardiner Hill also managed patients without the use of mechanical restraint. John Connolly, at the Hanwell Hospital, not only abolished the use of restraint but also introduced many other ideas, then quite innovative, such as improving facilities and food and promoting occupational activities; and, in Italy, Chiarugi also promoted the abolition of chains at the Ospedale Bonifazio in 1788 (Shorter, 1997).

Pinel had the merit of having defended in a very clear way that 'the insane, far from being persons guilty of something which should be punished, are patients whose painful condition deserves all the consideration that is due to the humanity that suffers and for whom one must seek by the simplest means to restore the "deviated reason"' (Pinel, 1801). The 'moral treatment' proposed by Pinel was based on the conviction that it would be possible to introduce significant changes in the behaviour of patients via humane, though firm, attitudes on the part of the caregivers. Pinel's innovation, however, did not consist only of a therapeutic approach to patients but also in the association of a humanist stance with, on the one hand, the effort to study the phenomenon of madness rationally and methodically and, on the

other hand, the recognition of the importance of the patient's subjectivity (Pereira, 2004).

The new therapeutic approaches based on moral treatment played a fundamental role in the development of the psychiatric asylum model that would form the basis of psychiatric care throughout the world since the beginning of the nineteenth century. At the same time, the recognition of the need to study mental illnesses from a scientific perspective would allow the birth of psychiatry as a medical discipline and contribute to the developments that would come to be verified in the understanding of the causes of mental illnesses at a biological, psychological and social level.

Although this new approach had a significant impact in many countries, the discontinuation of shackles and the prohibition of systematic punishment did not imply the abandonment of compulsion and other forms of coercion. All people hospitalised in asylums continued to be committed involuntarily and had to be certified as mentally ill, which explains why most European countries began to create legislation to regulate psychiatric hospitalisation during the nineteenth century.

2.2 Post-War Health Service Reforms

The truth is that it took more than a century and two world wars for the understanding to develop that asylums also had important limitations in effectively responding to the needs of people with mental disorders. The main drivers for this move towards deinstitutionalisation were a growing awareness of overcrowding, financial shortages due to worsening economic conditions, reduced government expenditure and the availability of new pharmaceutical treatments. Governments and professionals realised that, to end the marginalisation and exclusion of persons with mental disorders, it was necessary to develop new models of care, better respond to the various needs of the mentally ill and promote their access to equal rights.

In terms of human rights, World War II and the impact of the Holocaust (Levav et al., 1998; Strous, 2007), responsible for the killing of hundreds of thousands of mentally ill persons in psychiatric hospitals, were the great turning point in this evolution. It was this impact born out of the horrors of the war and the experiences of solidarity with its victims that created the conditions for the emergence of a new recognition of the importance of respecting the political, social and economic rights of all individuals, including the ones belonging to the most vulnerable and excluded groups. This impact was also fundamental for the emergence of two movements that would constitute, and continue to do so until today, an essential driver of the fight against the use of coercion: the reform of mental health services and the international human rights mechanisms.

In both Europe and the USA, the argument against psychiatric asylums grew significantly after the war, contributing to the implementation of mental health service reforms based on three common elements: deinstitutionalisation and development of services in the community; involvement of primary health care; and protection of the human rights of persons with mental disorders.

These reforms were inseparable from other social movements that sprung up at the same time with the objective of fighting for the emancipation of groups that had been discriminated against and excluded until then because of their gender, sexual orientation or ethnicity. As Franco Basaglia, the leader of the Italian psychiatric reform, said, 'When we say no to the asylum, we say no to the world's misery, and we join all the people in the world who fight for the emancipation of human beings' (Basaglia, 2000). It was not by chance that the first mental health services reforms were initiated in countries that were engaged in political processes aiming at improving the social and economic conditions of their populations and ensuring better access to healthcare. Similar Reforms later developed in other countries (e.g. in Southern Europe, Latin America and Eastern Europe) when they experienced processes of democratisation. This could be seen in Spain (Vázquez-Barquero et al., 2001), Brazil and Chile (Caldas-de-Almeida & Horvitz-Lennon, 2010) and the Czech Republic (Pec, 2019). More recently, mental health reforms also developed in other parts of the world, among others, in Lebanon (Chammay et al., 2016), India (Gupta & Sagar, 2022) and South Africa (Kleintjes & Schneider, 2023).

2.3 Key Statements on Human Rights Since 1945

The Universal Declaration of Human Rights (UDHR), adopted by the United Nations General Assembly in 1948 in response to the atrocities committed during World War II, marked the beginning of a movement that led to the creation of a comprehensive set of international human rights mechanisms, which had, and still have, a key role in attitudes towards the use of coercion in mental health services. The UDHR does not mention mental health, but Article 25 says that 'Everyone has the right to a standard of living adequate for the health and well-being of themselves and of their family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control' (UN General Assembly, 1948).

The first official document that directly and explicitly refers to mental health is the WHO definition of health in 1948 as 'a state of complete physical, mental and social well-being [which] is not just the absence of illness or infirmity' (World Health Organization (WHO), 1946). The International Covenant on Economic, Social and Cultural Rights (United Nations, 1966) is especially important because it recognises the right of all persons to enjoy the 'best possible physical and mental health status', and because, for the first time, the right to health was recognised in a legally binding pact.

Another document relating to the rights of persons with mental disorders is the UN General Assembly Resolution 'Principles for the protection of people with mental illness and the improvement of mental health care' (United Nations, 1991). Approved on 17 December 1991, it describes fundamental freedoms and basic rights—access to quality care, internationally recognised rights, protection of dignity and prohibition of discrimination—as well as principles related to consent,

involuntary treatment regulation (decision, review, procedural safeguards), community life and access to information, among others.

The most recent and most important international treaty that is relevant to the use of coercion is the Convention for the Rights of Persons with Disabilities (CRPD), approved in 2008 (United Nations, 2008). The purpose of the Convention 'is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms for all persons with disabilities,' which includes persons with serious mental disorders.

The approval of the CRPD represents a great advance in the promotion of the rights of persons with mental disorders, as it is based on a consensus of the international community (governments, NGOs and citizens) on the need to effectively ensure respect for the integrity, dignity and individual freedoms of persons with mental disabilities and to strengthen the prohibition of discrimination against these citizens via laws, policies and programmes that specifically meet their needs and promote their participation in society. It includes several articles especially relevant to the reduction of coercion. Article 12, on equal recognition before the law, places the legal capacity of persons with disabilities on an equal footing with others. According to this article, people with disabilities have the right to maintain and exercise their legal right to make decisions and should have access to the support they may need in their decision-making process from people they trust who may be legally recognised or informally designated. Consequently, this could mean that people with disabilities can legally reject coercive measures that are justified by a mental disorder.

According to the CRPD Committee's interpretation, any form of substitute decision-making is considered a violation of the Convention's guarantee of legal capacity on an equal basis, meaning that involuntary treatment is prohibited. This position is supported by some UN bodies and not by others, a split that is also found among users and professionals (Freeman et al., 2015; Caldas de Almeida, 2019) who, although believing that supported decision-making is, in general, the best way of respecting the rights of persons with mental conditions, consider that, with the mental health services currently available in most countries, it is impossible to completely rule out the use of substitute decision-making in every circumstance. However, despite these differences of interpretation on this specific point, there is now a broad consensus on the importance of joining efforts on concrete actions that may contribute to effectively reducing coercion in mental health services—at the policy and legislation level, the incorporation of evidence-based interventions in clinical practice, the reform of mental health systems, and research.

3 Are Coercive Measures Ever in the Best Interest of the Person Being Coerced?

A key ethico-legal justification for the utilisation of coercive measures in healthcare settings is that the intervention is in the best interests of the person subjected to it. This means that, in hindsight, people who have experienced coercion should

provide consent and should be able to report that they benefited from the intervention (Taylor, 2016).

Numerous studies deal primarily with the effects of direct coercion and many of these have been summarised in various systematic reviews. A qualitative meta-synthesis examined the experiences of people who were initially hospitalised against their will and then had to experience further coercive measures such as isolation and fixation (Akther et al., 2019). The authors concluded that 'patients…believed that their involuntary admission had kept them safe at a time when they could not recognise the severity of their illness, but negative experiences were commonly described' (Akther et al., 2019, p. 7).

Additionally, this review found physical interventions, such as restraint and seclusion, were experienced particularly negatively by many patients and played an important role in the negative experiences reported in the majority of studies. This review also highlights the lasting impact of detention with patients across studies reporting feelings of shame and marginalisation, particularly those in forensic settings who had also committed an offence (Akther et al., 2019).

Another systematic review analysed the consequences of restraint and seclusion for the people affected (Chieze et al., 2019). These authors concluded that.

> The identified literature strongly suggests that seclusion and restraint have deleterious physical or psychological consequences. The incidence of PTSD after seclusion or restraint ranges from 25% to 47% which is not negligible…Subjective perception has high interindividual variability and can be positive, with feelings of safety, help, clinical improvement or evaluation as necessary. However, seclusion and restraint are mainly associated with negative emotions, particularly feelings of punishment and distress. Conclusions on protective or therapeutic effects of seclusion and restraint are more difficult to draw. Our results provide little evidence for these outcomes, but further research is clearly necessary (Chieze et al., 2019, p. 13; citations not reproduced here)

Another review looked at the experiences of people who have had to undergo coercive measures (Aguilera-Serrano et al., 2018). These authors come to a similar conclusion, that the experiences associated with coercive measures are predominantly negative, regardless of the type of measure. The described experiences include anxiety and post-traumatic stress; powerlessness, neglect, mistrust and loneliness; punishment, abuse and pain; anger, rage and bitterness; depression, powerlessness and sadness; humiliation and shame; loss of freedom and coercion. However, according to the study, positive experiences such as help, necessity, reassurance, time for reflection, safety, control and the prevention of violence were also reported in a few original studies. Furthermore, it should not be forgotten that physical restraint not only has psychological consequences but can also lead to physical harm and—albeit rarely—even death (Kersting et al., 2019; Steinberg, 2021). The latter are usually caused by cardiac arrest as well as by pulmonary and thromboembolism.

Other reviews on individual aspects of the experience of coercion largely point in the same direction (Tingleff et al., 2017; Cusack et al., 2018; Sugiura et al., 2020; Modini et al., 2021; Muir-Cochrane & Oster, 2021). The majority of people affected do not experience psychiatric coercion as benevolent. However, there is a minority

who view coercive measures as positive in retrospect, and there are certain situations in which people experience hospitalisation as a form of security.

It must be noted that all of these conclusions relate to direct and ultimately physical coercion. However, there is some evidence that the situation is similar to informal coercion, and there is also a feeling of inferiority when those affected are granted fewer rights and less freedom of choice than other people (Allison & Flemming, 2019).

4 The International Epidemiology of Coercion

With an awareness of both this historical context and the difficulties of benchmarking due to the terminological issues noted above, it is important to establish where we are now in terms of estimating the frequency with which coercion is used in mental health services around the world. Over the past 15 years, there has been a series of international studies on this topic which enable some meaningful, although imperfect, international comparisons. This enables us to identify some international averages and outliers in terms of both best practice and over-use of coercion.

There has been substantial progress made in estimating the proportion of patients exposed to inpatient coercion worldwide with a series of studies (Steinert et al., 2010; Lepping et al., 2016; Gowda et al., 2018; Savage et al., 2024). The most comprehensive review (Belayneh et al., 2024) estimates the following rates for the proportion of inpatients subjected to each type of inpatient coercion: 0.14 (95% CI: 0.13–0.16) for physical/mechanical restraint; 0.15 (0.14–0.16) for seclusion; and 0.25 (0.18–0.31) for chemical restraint. The latter term is roughly synonymous with the descriptions of forced medication and rapid tranquillisation in Table 1. These estimates were based on more than 70 studies published in just over a decade after 2010, which indicates the concerted recent international efforts in this area to establish the prevalence of inpatient coercion as a baseline for mounting reduction strategies.

However, a key finding of this and most other reviews is the huge variability between rates in different samples. Physical/mechanical restraint ranged from 0.3% in one sample from the USA to 54% in Italy; seclusion rates from 0.2% in one service in the USA to 56% in Japan; and chemical restraint from 2% in Norway to 58% in India (Belayneh et al., 2024). It is important to note that these are not nationally representative samples so conclusions about the overall national profile in any country cannot be deduced from these figures. Such deductions require a standardised data-collection process within countries, and international comparisons also require a population denominator for meaningful comparisons. Savage et al. (2024) achieve the latter goal by reporting a median figure across nine countries of 29 restrictive practice interventions per 100,000 population per year with the highest rate in the Netherlands (42/100,000) and the lowest in the UK (England; 18/100,000).

Looking beyond the hospital inpatient setting the same variability phenomenon arises with involuntary admissions (Salize & Dressing, 2004) and compulsory community treatment. With regard to involuntary hospitalisation, Sheridan Rains et al.

(2019) report a median rate of 106 compulsory admissions per 100,000 population across 22 countries in Europe and Australasia but the rate was 20 times higher in the country with the highest rate, Austria, than it was in neighbouring Italy which had the lowest rate. There was also some variation over time with rates increasing year-on-year—between 2008 and 2017—on average by more than 5% in the Netherlands and Spain and decreasing by 3–4% in Italy and Finland.

Community Treatment Orders (CTOs) are ambiguous in the context of debates about the meaning of coercion as they are both a coercive intervention per se and an alternative to the arguably more severe coercive interventions related to hospitalisation. As such they have been developed and evaluated as an intervention which is deemed successful if it is associated with reductions in compulsory admissions, and there are mixed results on this question (Rugkåsa, 2016). Notwithstanding the debate on effectiveness, a variable pattern in the use of CTOs, similar to that observed with other coercive measures, has been observed within and between countries. Relatively high rates of CTO use have been reported in Australia and New Zealand compared to samples in Canada, Israel, the USA and the UK (Scotland) (O'Brien, 2014), but once again caution is advised due to the reliance on unstandardised data across studies, which complicates any attempt to make meaningful comparisons.

5 Contextual Factors Influencing Coercion

These global variations in rates of coercion indicate the importance of considering the social, political and economic factors that may impact the decision to use coercion. The prevalence of coercion in mental health care is influenced by various contextual factors that are interrelated and not necessarily associated directly with service users. Although clinical and sociodemographic features of patients are well-established risk factors for the use of coercion (Aguilera-Serrano et al., 2018; Walker et al., 2019; Beames & Onwumere, 2021), contextual factors such as service-related characteristics and the characteristics of mental healthcare professionals appear to be influential as well (Wierdsma & Mulder, 2009; Beghi et al., 2013; Dahan et al., 2018; Barnett et al., 2019; Walker et al., 2019; Newton-Howes et al., 2020; Mann et al., 2021). Factors such as economic conditions and the impact of COVID-19 have the potential to augment the demand for mental health services. Additionally, the design, efficiency and staffing levels of these services play a crucial role in determining their ability to meet increased demands. Staff attitudes have been associated with the use of coercion, and these attitudes usually reflect the prevailing mental health laws (Brooks, 2006), policies and public perceptions towards individuals with mental health conditions. (Brooks, 2006) It is crucial to recognise contextual factors since they could guide the development and implementation of interventions to reduce coercion in specific settings. Contextual factors are particularly important to note since the strategies aimed at minimising coercive practices in mental health settings are often developed and tested in relatively controlled, idealised environments that do not fully mirror the complexities

of many mental health systems. Consequently, the recommendations that arise from these studies are often too generic to effectively address the specific practical barriers that mental health professionals encounter when attempting to adapt these strategies to their particular organisational contexts. Moreover, they fail to account for changes that affect services, such as the effects of austerity measures and regulatory changes on public services (Fletcher et al., 2019). Few studies have specifically assessed the influence of contextual factors on the use of coercion (Schön et al., 2018).

5.1 Service Design

Considering that involuntary legal status at the time of admission predicts the use of other coercive measures (Korkeila et al., 2002; Bilanakis et al., 2010; Raboch et al., 2010), it seems reasonable to assume that contextual factors that influence involuntary admission indirectly contribute to the use of additional coercive measures such as restraints and seclusion. The organisation of mental health services influences the quality of mental health care, and since the use of coercive measures is an indication of the quality of mental health treatment (Hermann, 2005), the same variable should indirectly influence it. The recommended approach for organising mental health care services is to close large, independent psychiatric hospitals and instead establish psychiatric departments within general hospitals and community-based mental health services (World Health Organization, 2022). This model is preferred as it promotes continuity of care, increases user satisfaction, enhances human rights protection and decreases the stigma surrounding mental health (World Health Organization, 2022).

Deinstitutionalisation is a sensitive process that needs to be managed with caution to avoid negative consequences on the quality of care, including the use of coercive measures. Decreasing psychiatric beds without a corresponding development of community resources could lead to adverse outcomes, such as a rise in involuntary admissions. An ecological study in England found a synchronous increase in the rate of involuntary admissions with decreasing available beds between 1988 and 2008 (Keown et al., 2011). Smith et al. (2020) also found that a decreased availability of psychiatric beds amplified the impact of austerity measures on the rates of involuntary admissions and ‘Place of Safety’ detentions in England. In Italy, however, a reduction of psychiatric beds led to a reduction in the rates of involuntary admissions within the 18 years following the implementation of the new Mental Health Law in 1979 (Guaiana & Barbui, 2004). The parallel expansion of community mental health care, the legal framework and the nationwide movement for the rights of people with mental health conditions in Italy may explain the disparity in the impact of reducing psychiatric beds.

The availability of alternative services to inpatient care has been shown to significantly reduce the rates of involuntary admission in a given location (Gandré et al., 2017), especially in intensive crisis teams in the community (McGarvey et al., 2013; Aagaard et al., 2017). The extent to which available mental health services are

utilised has significant effects on the risk of involuntary admissions (van der Post et al., 2009). The importance of a functional primary care network that is adequately integrated into the mental health care system is highlighted by the association between referrals from general practitioners and a decreased incidence of involuntary admissions (van der Post et al., 2009). To meet the non-clinical needs of people with mental health conditions, social services that are complementary to the services offered by psychiatric care are required and have been reported to have a protective effect on acute psychiatry (Emons et al., 2013).

The use of seclusion and restraint are also known to be influenced by organisational factors, such as ward characteristics. Wards located in metropolitan areas have been reported to use more isolation and restraint (Husum et al., 2010), possibly due to a higher demand for services. Ward size, male-to-female staff ratio and staff experience have also been linked to the use of seclusion (Janssen et al., 2007, 2013; van der Schaaf et al., 2013) with mixed results (Doedens et al., 2020). In addition, factors like staffing levels, staff training and attitudes are connected to the use of coercive measures. Nurses from countries with a varying range of resources report how insufficient resources, especially human resources, contribute to the use of coercive measures (Gagnon et al., 2013; Wilson et al., 2018; Krieger et al., 2021; Navarro et al., 2021; Aluh et al., 2023). Staffing levels have been reported to be related to perceived concerns about the causes and responses to conflict and aggression (McKeown et al., 2019). However, it is possible that increasing staffing levels in a ward may not necessarily lead to a reduction in the use of coercion, as a recent study reported that both seclusion and mechanical restraint were utilised more frequently in wards with more nurses (Fukasawa et al., 2018).

5.2 National Legislation and Policy

The use of coercive measures in mental health care can also be viewed as an indicator of the underlying characteristics of mental health legislation and policies in a specific jurisdiction. Studies on the impact of legislation on rates of involuntary admission have shown mixed results. The most effective legal framework that can safeguard the rights of people with mental health conditions and the general public while also minimising coercion is yet to be determined. In Italy, a new mental health legislation was associated with a lower proportion of involuntary admissions (Guaiana & Barbui, 2004), while the reverse was the case in China (Zhang et al., 2016). The increase in involuntary admission rates after a change in mental health legislation in China was attributed to the comparatively low number of psychiatric beds and the cultural stigma there. A review of the mental health laws in European countries revealed that those that demanded the participation of independent legal representatives had lower involuntary admission rates (Salize & Dressing, 2004). However, a more recent comparison of involuntary admission rates in 22 countries found no association with any characteristics of the legal framework (Sheridan Rains et al., 2019). Cultural norms have an impact on the laws regulating coercive measures, which may explain why some restrictive practices are legally regulated and monitored in some countries but not in others.

While involuntary admissions are regulated by mental health legislation in most European countries, the use of mechanical restraints, seclusion and other coercive measures is not regulated by law in some countries and is left to the discretion of hospitals and regional authorities (Navarro et al., 2021). An international evaluation of restraints conducted more than 10 years ago indicated that there was insufficient information available and that national databases were necessary (Steinert et al., 2010). Differences in the prevalence of restraints used in Dutch and British services were attributed to Dutch psychiatric professionals' opinion of involuntary medication being more invasive and threatening to personal integrity to a higher degree than the application of seclusion or mechanical restraint. This is reflected by the Dutch mental health legislation, which is very restrictive regarding involuntary medication, permitting its use only in cases of acute emergency (Steinert et al., 2010). In traditional acute settings in the UK, physical restraints tend to be preferred over mechanical restraints, which are rarely used. However, if mechanical restraints are used, they are carefully observed and recorded (Nijman et al., 2005; Steinert et al., 2010). This has important implications since mandatory review of all mechanical restraint episodes has been reported to be associated with low rates of use (Bak et al., 2014), and hospitals using detailed guidelines for seclusion and restraint have been reported to use fewer of these coercive measures (Steinert et al., 2007).

5.3 Economic Factors

Economic recessions and austerity measures often lead to an increased need for mental health care. A study conducted in Florida confirmed that declining regional economies reduce community tolerance for people seen as a threat to others, leading to an increase in involuntary psychiatric admissions (Kessell et al., 2006). Similarly, in the UK, the recent rise in involuntary admissions has been attributed to the economic recession, legislative changes and the impact of austerity measures on health and social care services (Smith et al., 2020). Previous studies have highlighted the two opposing trends of funding reductions with ensuing staff shortages and growing demand to minimise the use of coercive measures notwithstanding these insufficiencies (McKeown et al., 2017, 2019). These pressures have been linked to the emergence of 'defensive psychiatry', a term coined to describe the practice of healthcare professionals making decisions to reduce their legal liability while ensuring the safety of patients and others. This phenomenon has been reported among both psychiatrists and nurses (Sattar et al., 2006; Bifarin et al., 2022).

5.4 COVID-19

The impact of the COVID-19 pandemic on the use of coercive measures has been contradictory across different countries, as some have documented changes during lockdowns while others have reported no changes. In Portugal, although there was a decrease in overall psychiatric admissions, the proportion of involuntary admissions increased during the pandemic (Rodrigues et al., 2022). In Italy, all psychiatric

admission rates significantly decreased in the 40 days after the start of the pandemic, but involuntary admission rates remained unchanged (Clerici et al., 2020). In Canada, a reduction in the use of restraints and seclusion was reported during the COVID-19 pandemic due to organisational changes that were made to foster service users' well-being (Martin et al., 2022), while in Germany, an increase in these coercive measures was reported during the pandemic due to rules made to prevent infection (Flammer et al., 2022).

5.5 Staff Attitudes and Training

The duration and frequency of restrictive practices vary across countries, organisations, and individuals and this cannot be explained solely by differences in legislation (Husum et al., 2011; Boumans et al., 2012; Laiho et al., 2014). Evidence increasingly suggests that staff attitudes, particularly those of nurses, could have a direct impact on the prevalence and continued use of restrictive practices (Husum et al., 2010; Bregar et al., 2018). The variation in the thresholds for using restrictive practices among staff members (Price et al., 2018) implies that there are differences in how staff perceive violence (Happell & Koehn, 2010) and how much agitation and disturbed behaviour they are willing to tolerate (Jalil et al., 2017). It is challenging to determine the actual need for restrictive practices when they are used routinely rather than as a last resort for safety purposes (Slemon et al., 2017). Nurses often have to make decisions about restrictive practices, which can result in inconsistency and an underestimation or exaggeration of risk, leading to unnecessary or prolonged seclusion or restraint (Looi et al., 2014). These individual differences were highlighted as reasons to avoid using ward culture as an explanation for the adoption of restrictive measures in psychiatric wards (Laiho et al., 2014). Since each staff member has a unique perspective on aggressiveness, training for dealing with aggression or violent occurrences should be done, at least in part, on an individual basis. A lack of training on the alternative approaches to coercion is also implicated in the use of coercion, as many mental health professionals tend to perceive coercion as an inherent part of care (Husum et al., 2011). This argument is supported by evidence highlighting the effectiveness of training in reducing the occurrence of coercion (Barbui et al., 2020).

5.6 Public Attitudes

Public attitudes towards coercive measures in psychiatric care are important in understanding the context of their use. These attitudes can range from stigmatising and fear-based perceptions of people with mental health conditions to more empathetic and supportive attitudes that prioritise human rights and recovery-oriented care. Cultural factors can also play a role, as collectivist cultures often emphasise family involvement in decision-making, while individualistic cultures may prioritise individual autonomy and self-determination (Erez, 1993). Increasingly, there is a reduced

tolerance for deviant behaviours, which can lead to pressure for inpatient care and the subsequent use of other coercive measures (Gravier & Eytan, 2011). Empirical evidence suggests that public attitudes towards coercive measures vary by country and are influenced by existing laws and regulations. In Norway and France, the majority of participants agreed that involuntary hospitalisation was acceptable in certain circumstances (Guedj et al., 2012; Joa et al., 2017). From 1993 to 2011 in Germany, the percentage of individuals who endorsed involuntary admissions remained steady despite the presence of mental health awareness initiatives and anti-stigma campaigns during that time. However, there was a decrease in opposition to involuntary admissions for reasons not aligned with legal criteria, suggesting a shift towards a more liberal perspective on patient rights while displaying reduced tolerance for inappropriate behaviour (Angermeyer et al., 2014). These findings highlight the necessity of incorporating specific elements pertaining to the rights of people with mental health conditions into stigma reduction campaigns. Similarly, a US study found that support for involuntary admissions increased steadily over the 22 years from 1996 to 2018 for various mental health conditions (Pescosolido et al., 2019).

Measuring the impact of contextual factors is challenging; nonetheless, they play a significant role in the problem and present possibilities for long-term interventions. Since contextual factors do not act independently and often reinforce one another, effective strategies to reduce coercion must address these contextual factors using multiple approaches. Given the involvement of various stakeholders, it is crucial not to leave the responsibility for reducing coercion in mental health care solely to mental health professionals. The complexity of the problem calls for collaborative efforts involving various stakeholders, such as policymakers, mental health professionals, service users and the broader community.

6 Some Promising Innovations

The growth in knowledge on contextual factors in coercion has led to a step-change in ideas and initiatives to tackle the issue. Many new initiatives recognise the need, noted above, to locate change at the team and organisational level rather than leaving it to individual staff to change their practice regardless of the larger culture in which they are operating. We are still nowhere near possessing a road map towards the ultimate goal of services that are entirely free of coercion, but there has been a noticeable shift in how much attention and money society as a whole is willing to pay to address the problem in the past decade. It is too soon to say that there is zero tolerance for coercion in services but judging by the growing attention devoted to considering the problem, there is certainly significant discomfort among many decision-makers, which differs from earlier widespread obliviousness. People with lived experience of mental disorders who have suffered more than discomfort when subjected to coercion may be frustrated by the slow pace of change, but there are grounds for optimism now that did not exist 20 years ago.

Three recent systematic reviews, in combination, provide an indication of the state of the art in this area which can support decision-makers in the task of

choosing innovative interventions to reduce coercion in their service (Gooding et al., 2018; Barbui et al., 2020; Baker et al., 2021). All three reviews adopted a systematic approach to gathering relevant empirical evidence and focused on interventions to reduce inpatient coercion and/or community-based coercion (i.e. involuntary admission) in mental health services. Each had distinctive aims and adopted a different approach to analysing their included studies, but taken together, their conclusions on certain key aspects are in harmony and provide a credible basis for the next stage of clinical development and research. A summary of their combined conclusions is reported in Table 3.

It should be noted that inclusion in this table indicates that an intervention has, at the very least, been widely implemented based on relevant publications reporting on the intervention. Inclusion here does not, however, on its own indicate that the intervention has been found to be effective or that it has even necessarily been tested in a trial.

It can be seen here that two specific organisational and/or team-level interventions—Six Core Strategies and Safewards (Huckshorn, 2006; Bowers et al., 2015)—have been extensively tested and have shown promising results for inpatient services. In the community, joint crisis plans and shared decision-making also have evidence of effectiveness. Several of these interventions are discussed elsewhere in this book.

Table 3 Promising interventions that have been implemented to reduce coercive practice in mental health services

Community services	Inpatient services	Both
Advance directives/ planning[a]	**Six core strategies**[b,c]	Medication discontinuance[c]
Joint crisis plans[a]	**Safewards**[b,c,d]	Peer support[c]
Crisis plan/card[a]	Talk First[b]	Recovery models[c]
Early warning symptoms[a]	ResTrain Yourself[b]	Representation agreements[c]
Community treatment order[a]	Scottish Patient Safety Programme[b]	**Shared decision-making**[a,c,d]
Treatment adherence therapy[a]	Seclusion Reduction Programme[b]	Trauma-informed[c]
Financial incentives[a]	Sensory Modulation[b]	
Crisis resolution team[a]	**Restraint education**[a]	
Integrated treatment[a]		
Club house[c]		
Hearing voices network[c]		
Respite houses[c]		
Soteria house[c,d]		
Trialogue[c]		

Bold: Intervention with evidence of effectiveness in at least one RCT

[a] Cited as an intervention tested in at least one RCT reported by Barbui et al. (2020)

[b] Cited as an 'intervention family' in four or more empirical studies analysed by Baker et al. (2021)

[c] Cited as a 'prominent measure or approach' which has been implemented 'internationally' or in at least five countries by Gooding et al. (2018)

[d] Intervention implemented at least once in a low- or middle-income country

7 Conclusions

In the last few decades, there have been important conceptual developments in the way we approach the nature and causes of mental illness, the factors involved in disabilities and the organisation of services. Important paradigm shifts took place and are still occurring, moving from a custodial paradigm to a care paradigm, then to a recovery paradigm and now to a human rights paradigm. The goal of reducing coercion continues to face important obstacles. However, because of the increasing awareness of the risks involved in using coercive practices, the increasing knowledge of the current availability of alternatives to coercion, and the challenges associated with implementation, never have there been such favourable and fertile conditions to reach these goals. The project of a more humane and multi-faceted conception of mental health patients and their care continues to advance and is going through a particularly exciting phase.

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