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THEMATIC PAPER

Key international themes in coercion

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Coercion remains a dominant theme in mental healthcare and a source of major concern. While the presence of coercion is ubiquitous internationally, it varies significantly in nature and degree in different countries and is influenced by a variety of factors. Recent reports have raised concerns about physical restraint and the increasing use of legislation in high-income countries. At the same time, a recent Human Rights Watch report on *pasung* (the practice of tying or restricting movement more generally) in Indonesia has served to highlight the plight of many in middle- and lower-income countries who are subject to degrading and dehumanising 'treatment'.

and concerns shifted to the quality of care, legal rights and institutionalisation of residents. Most care in these countries is now delivered outside institutions and though concerns persist regarding in-patient care, there is also more focus on coercion in the community. Coercion can be formal (the use of legal sanctions) or informal (the use of 'softer', less easily measurable pressures to bring about compliance) (Szmukler & Appelbaum, 2008). Coercion in institutions is often divided into categories: legal, chemical and/or physical restraint, and the restriction of movement and association. This brief overview will not consider medication, although the coerciveness of surreptitious medication should be noted, and is an area of particular concern in India (Rao et al, 2012).

In HIG countries there has been a move towards increased scrutiny of coercive measures in hospitals and an extension of legal powers and informal coercion outside them (Molodynski et al, 2016). In other countries the issues may be very different, as evidenced by the recent Human Rights Watch report on *pasung* (Human Rights Watch, 2016), which cited Indonesian government data that approximately 19000 people are

PSYCHIATRY UNDER RESTRICTIVE CONDITIONS

The containment and coercion of people who have a mental illness has always been at the heart of mental healthcare, and the subject of fierce debate. Concerns initially focused on conditions and restrictions of liberty in the earliest facilities, the so-called 'mad houses'. In many high-income group (HIG) countries, care for the mentally ill moved into large asylums in the 19th century

subject to *pasung* at any one time. *Pasung* is literally translated as to 'tie' or 'bind'. In practice it is physical restraint by these or other means, such as chaining, locking in animal sheds or other highly restrictive measures. It can continue for anything from hours to decades and is typically prolonged. It occurs in hospitals, healing centres and within communities and families. There is evidence that these practices occur in other countries, albeit with varying frequency, level of state involvement and overtness (Raboch *et al*, 2010). The reasons for the use of force vary, as do the justifications for it and the levels of scrutiny applied (Molodynski *et al*, 2016). One striking feature of all these descriptions is the lack of evidence for improved outcome.

Physical restraint

The use of physical restraint within institutions is ubiquitous and debated. Some argue there should never be cause to use it, others that it should be used only for those who lack capacity and are at significant risk. Still others see it as a necessary part of mental healthcare that we must accept.

The nature of restraint varies. In the UK, restraint is 'person to person', whereas in much of North America and Europe straps, magnets or ties are used. Cage beds, with metal sides up to the ceiling, are still used in Czech psychiatry. Chaining and tying are common in institutions in Africa, Asia and elsewhere. It is an under-investigated area, although some have attempted to measure it internationally (Raboch *et al*, 2010) and one group even used a randomised design to assess its effects (Bergk *et al*, 2011). In many HIG countries there are clear moves to reduce or eliminate the use of certain types of restraint, such as the movement to eliminate 'face down' restraint in the UK and moves in the USA to reduce the use of strapping (Knox & Holloman, 2012). *Pasung* itself was banned in Indonesia in 1977, but continues to be widely practised. In most middle- and low-income countries there have been only limited attempts to reduce institutional coercion and the widespread use of tying, shackling or beating by alternative practitioners and families and communities.

Restriction of movement and association

Perhaps the most culturally bound coercive practice is that of restriction of association. There has been a recent move in UK psychiatry for all mental health wards to be locked, often with 'prison style' entrances, despite a lack of evidence of need (Huber *et al*, 2016). In theory, a voluntary patient can ask to leave but the context may not make this clear and in reality many would not be allowed to (Sjöström, 2006). Also in the UK, the increasingly common practice of admitting people many miles from home without choice is coercive. Many European countries, however, still have unlocked wards.

The majority of institutions internationally, regardless of resources, have facilities for the seclusion of those deemed to need it. There are significant variations in how seclusion is used and

reviewed, how long it goes on for, and under what conditions (Steinert *et al*, 2010).

In countries with a strong emphasis on individual rights, manifest restriction outside institutions appears to be relatively uncommon. This is not always the case in collectivist cultures that balance individual rights and responsibilities against those of the whole community. Domestic restriction, frequently associated with physical tethering, often appears to relate to the lack of availability of support and treatment. However, domestic cells are still seen in countries that have services available and have relatively low levels of poverty. In these cases it appears that family attitudes, shame and stigma are powerful driving forces.

Legal compulsion

Many countries have introduced or modernised legislation to allow and safeguard the care of those at risk. While this is welcome, there remain concerns on two main fronts.

First, mental health acts in many countries remain outdated and do not in reality contain safeguards due to lack of resources to enforce them. A recent report on mental healthcare in Uganda highlights these issues (Mental Disability Advocacy Centre, 2016), identifying an outdated mental health act with offensive terminology such as 'lunatic' that is in any case systematically ignored. Such issues are commonplace in other countries with limited resources and healthcare systems.

Second, in line with the shift in focus to community settings, legislation in recent decades has seen the widespread introduction of community treatment orders (CTOs), measures that compel psychiatric treatment in community settings (Rugkåsa & Dawson, 2013). First introduced in the USA in the 1960s, CTOs have become common internationally, and have been introduced in most Commonwealth countries, as well as in Spain, Israel, Pakistan, France and Sweden. Compulsory community treatment is controversial ethically and in terms of evidence of effectiveness.

A feature of CTOs in the Australasian region is that their use has steadily increased since their introduction almost three decades ago. There is also a high level of variation within and across jurisdictions (O'Brien, 2014). Some level of increase might be expected where CTOs were part of deinstitutionalisation, as they may have facilitated the discharge of patients. However, in some regions, such as Victoria and New Zealand, increases have occurred well after reductions in hospital bed numbers. It appears CTOs have become a mainstay of community mental healthcare, although, as Light *et al* (2012) note, without any explicit policy commitments, and at the risk of marginalising people with mental illness.

One explanation for the widespread use of CTOs might be a perception that in systems with limited resources, a legal order may prioritise consumers for access to care and even allow for rapid assessment and admission in crisis. There is evidence from qualitative studies that this

perception is prevalent. In jurisdictions as diverse as New York, New Zealand and the UK, researchers have reported consumers' and family views that the CTO provides increased confidence in access to services (Pridham *et al.*, 2015). In New York there is some evidence that those subject to compulsory community treatment receive more services (Swartz *et al.*, 2010). This expectation of access is no doubt reinforced when compulsory treatment is court mandated, as it is in New York, as the order binds both the consumer to accept treatment and the service to provide it.

Guaranteeing access to services can be only a partial explanation for the use of compulsion. Some consumers identify a more overt purpose of surveillance, a perception in keeping with their rationale of establishing an obligation to accept treatment under threat of enforced hospitalisation. Also, more frequent use of CTOs with people with higher levels of social deprivation raises questions about whether poverty creates a context in which coercion is seen as a necessary price to pay for services that might otherwise not be available.

Medication and other treatments

Most people treated for mental health problems worldwide do not regard medication as coercive and welcome its effects. There are ways, though, in which medication administration can be coercive. Within institutions, medication can be given forcibly. This may or may not have a legal backing with scrutiny and rights of appeal. If medication is given against someone's will it is generally by injection and closely related to physical restraint. The coercive context described above can lead many to feel they must take medication even if it is not actually forced upon them, as they believe that if they do not, adverse consequences will follow. This has been described in closed environments, but also increasingly in the community, with the widespread existence of powers to compel. The covert administration of medication is undoubtedly coercive and reduces autonomy (Hung *et al.*, 2012). It is legally permitted in tightly controlled circumstances in countries such as England and the USA but it is well documented that it is much more frequently used 'off the record' by clinicians and families everywhere. There has been particular attention to the issue in India (Rao *et al.*, 2012) and other countries with a more collectivist outlook (Wong *et al.*, 2005). The ethical issues are complex and opinions vary significantly, but the practice remains widespread.

Conclusions

There will always be an imbalance in relationships between those receiving care and those delivering it. Progress has been made in 'levelling things out', at least in theory. However, coercive practices remain routine and widespread, and take a variety of forms. In HIG countries with well-funded services there is a move towards more coercive and 'inclusive' legislation alongside in-patient units that are increasingly secure and have very high rates

of detained patients. In countries with less well resourced and developed services, coercion more often occurs within families and communities out of necessity and practices such as *pasung* and covert medication are undoubtedly more common.

There is no evidence that coercion improves outcome. The distressing Human Rights Watch report serves to remind us of these widespread human rights abuses in Indonesia. At the same time we must be mindful that related practices occur worldwide in different guises, with or without external scrutiny.

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