Coffey, M., Cohen, R., Faulkner, A., et al (2017) Ordinary risks and accepted fictions: how contrasting and competing priorities work in risk assessment and mental health care planning. *Health Expectations*, 20, 471–483.

Cusack, P., McAndrews, S. & Warne, T. (2016) Restraining good practice: reviewing evidence of the effects of restraint from the perspective of service users and mental health professionals in the United Kingdom (UK). *International Journal of Law and Psychiatry*, 46, 20–26.

Davor, B. (2013) From mental illness to disability: choices for women users/survivors of psychiatry in self and identity constructions. In Disability Studies in India: Global Discourses, Local Realities (ed. R. Addlakha), pp. 333–360. Routledge.

Dawson, J. & Smukler, G. (2006) Fusion of mental health and incapacity legislation. *British Journal of Psychiatry*, 188, 504–509.

Department of Health (2014) Positive and Proactive Care: Reducing the Need for Restrictive Interventions. Department of Health. Available at https://www.gov.uk/government/uploads/system/ uploads/attachment_data/file/300293/3RA_DoH_Guidance_on_RESTRICTIVE_PAPER_UNDER.jpg (accessed 6 June 2017).

Freeman, M. C., Kolappa, K. de Almeida, J. M. C., et al (2015) Reversing hard won victories in the name of human rights: a critique of the General Comment on Article 12 of the UN Convention on the Rights of Persons with Disabilities. *Lancet Psychiatry*, 2, 844–850.

Gallop, R., McCoy, E., Guha, M., et al (1999) The experience of hospitalization and restraint of women who have a history of childhood sexual abuse. *Health Care for Women International*, 20, 401–416.

Kleintjes, S., Lund, C. & Swartz, L. (2013) Organising for self-advocacy in mental health: experiences from seven African countries. *African Journal of Psychiatry*, 16, 187–195.

Mental Health Today (2016) Investigation launched after pregnant mental health patient ‘pinned to floor’. Available at https://www.mentalhealthtoday.co.uk/investigation-launched-after-pregnant-mental-health-patient-pinned-to-floor.aspx (accessed 25 August 2016).

Minas, H., Puthe, I. & Matthoens, M. (2011) Ache Free Pasung: releasing the mentally ill from physical restraint. *International Journal of Mental Health Systems*, 5, 10.

Newbigin, K., Ridley, J., McKeown, M., et al (2015) ‘When you haven’t got much of a voice’: an evaluation of the quality of Independent Mental Health Advocate (IMHA) services in England. *Health and Social Care in the Community*, 23, 313–324.

Papageorgiou, A., King, M., Jammahamed, A., et al (2002) Advance directives for patients compulsorily admitted to hospital with serious mental illness. *British Journal of Psychiatry*, 181, 513–519.

Rose, D., Evans, J., Laker, C., et al (2015) Life in acute mental health settings: experiences and perceptions of service users and nurses. *Epidemiology and Psychiatric Sciences*, 24, 90–96.

Spandler, H., Anderson, J. & Sapers, B. (2015) Madness, Distress and the Politics of Disablement. Policy Press.

Strout, T. (2010) Perceptions of the experience of being physically restrained: an integrative review of the qualitative literature. *International Journal of Mental Health Nursing*, 19, 416–427.

Wilson, C., Rouse, L., Rae, S., et al (2015) Promise: an exploration of staff and patient experience of physical intervention on mental health wards and their suggestions for reducing its use. Available at http://www.promise.global/tpc_1_5_cw.html (accessed 2 September 2016).

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’.

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 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...
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 overtress (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 passing 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.

References

Bergk, J., Einsiedler, B., Flammer, E., et al (2011) A randomized controlled comparison of seclusion and mechanical restraint in inpatient settings. Psychiatric Services, 62, 1310–1317.

Huber, C. G., Schneebberger, A. R., Kowalinski, E., et al (2016) Suicide risk and absconding in psychiatric hospitals with and without open door policies: a 15-year naturalistic observational study. Lancet Psychiatry, 3, 842–849.

Human Rights Watch (2016) Living in Hell. Abuses Against People with Psychosocial Disabilities in Indonesia. Available at https://www.hrw.org/report/2016/03/21/living-hell/abuses-against-people-psychosocialdisabilities-indonesia (accessed June 2017).

Hung, E. K., McIntiel, D. E. & Binder, R. L. (2012) Covert medication in psychiatric emergencies: is it ever ethically permissible? Journal of the American Academy of Psychiatry and the Law, 40, 239–245.

Knox, D. K. & Holloman, G. H. (2012) Use and avoidance of seclusion and restraint: consensus statement of the American Association for Emergency Psychiatry Project BETA Seclusion and Restraint Workgroup. Western Journal of Emergency Medicine, 13, 35–40.

Light, E. M., Kerridge, I. H., Ryan, C. J., et al (2012) Out of sight, out of mind: making involuntary community treatment visible in the mental health system. Medical Journal of Australia, 196, 591–593.

Mental Disability Advocacy Centre (2016) Mental Health and Human Rights in Uganda. Available at http://www.mdac.info/en/en/uganda (accessed 22 July 2016).

Moholyński, A., Rugkasa, J. & Burns, T. (eds) (2016) Coercion in Community Mental Health Care: International Perspectives. Oxford University Press.

O’Brien, A. J. (2014) Community treatment orders in New Zealand: regional variability and international comparisons. Australasian Psychiatry, 22, 352–356.

Pridham, K. M. F., Berntson, A., Simpson, A. I., et al (2015) Perceptions of coercion among patients with a psychiatric community treatment order: a literature review. Psychiatric Services, 67, 16–28.

Raboch, J., Kalisová, L., Nawka, A., et al (2010) Use of coercive measures during involuntary hospitalization: findings from ten European countries. Psychiatric Services, 61, 1012–1017.

Rao, T. S., Kalilivayali, R. A. & Andrade, C. (2012) Covert medication: do means justify the ends? Indian Journal of Psychiatry, 54, 203–205.

Rugkasa, J. & Dawson, J. (2013) Community treatment orders: current evidence and the implications. British Journal of Psychiatry, 203, 406–408.

Sjöström, S. (2006) Invocation of coercive context in compliance communication – power dynamics in psychiatric care. International Journal of Law and Psychiatry, 28, 36–47.

Steinert, T., Lepping, P., Bernhardsgütter, R., et al (2010) Incidence of seclusion and restraint in psychiatric hospitals: a literature review and survey of international trends. Social Psychiatry and Psychiatric Epidemiology, 45, 889–897.

Smukler, G. B. & Appelbaum, P. S. (2008) Treatment pressures, leverage, coercion, and compulsion in mental health care. Journal of Mental Health, 17, 233–244.

Swartz, M. S., Wider, C. M., Swanson, J. W., et al (2010) Assessing outcomes for consumers in New York’s assisted outpatient treatment program. Psychiatric Services, 61, 976–981.

Wong, J. G., Poon, Y. & Hui, E. C. (2005) I can put the medicine in his soup, doctor! Journal of Medical Ethics, 31, 262–265.