# Promising practices in prevention, reduction and elimination of coercion across Europe

## Introduction

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 in line with the UN CRPD. Realising that this entails major challenges for most mental health systems across Europe, we have sought to learn more about the use of coercion in psychiatry and how to avoid it.

Our recent 'Mapping and Understanding Exclusion' report gathered information on the use of forced placement and treatment, seclusion and restraint in over 30 countries in Europe. To build on the findings of this report, Mental Health Europe has put together, with the help of our members and partners, this scoping report on successful and promising programmes and practices which help to prevent, reduce and eliminate coercion in mental health care, including restraint and seclusion. The report does not aim to be comprehensive but rather to highlight some positive examples across Europe and beyond. It is aimed to be a living document, open to future contributions.

**Coercion or coercive measures** refer to involuntary, forced or non-consensual practices used in mental health services against people with mental health problems.

**Involuntary, forced or non-consensual placement/commitment or treatment** can be defined as any treatment or placement in/commitment to hospital or other institution administered against someone's expressed wishes – expressed verbally or by any other means (body language, advance directive, etc.) Please note that the legal definitions of involuntary placement and treatment vary from country to country. It is also important to note that in many countries, laws and regulations applying to the health sector (covering involuntary psychiatric hospitalisation and related practices) do not cover the social sector (institutions for persons with disabilities or the elderly) where there is still little control or even awareness that these practices exist.

**Restraint:** there are different types of restraint used in mental health services including:

 - **Physical restraint:** manually holding a person to prevent or restrict the movement of their body or parts of the body.

 - **Mechanical restraint:** the use of devices (e.g. straps, belts, cage beds, etc.) to prevent or subdue the movement of one's body or parts of the body.

 - **Chemical or pharmacological restraint:** the use of medication to control or subdue behaviour (e.g. rapid tranquilisation).

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

# Mapping and Understanding Exclusion – some interesting findings

In our Mapping and Understanding Exclusion report we found that the regulation of involuntary placement and treatment varies greatly across Europe. Our report explains that any data on prevalence or trends in involuntary placement should be approached with extreme caution and interpreted in the local context. This is because not only do many countries not publish data on the use of coercion, but when published such data may be partial or unreliable. A number of countries where relatively reliable data on involuntary placement exist, reported an increase in the use of coercion, including England, Scotland, Ireland, Belgium, France and the Netherlands. Elsewhere, in Austria and Sweden, the rate of involuntary placement has been relatively stable since the early 2010s. Two countries - Finland and Germany - reported a decrease following legislative changes and targeted programmes to reduce the use of coercion in psychiatry.

Compulsory treatment in the community (community treatment order, "CTO") as a form of involuntary treatment exists in a number of countries across Europe, although in some jurisdictions it is only applicable to forensic patients. Community treatment orders compel persons to receive medical treatment in the community. This type of involuntary treatment is viewed as a way to keep people in the community and out of hospital. At the same time, a CTO may lay down other conditions (alcohol or drug tests, obligation to live in a certain place, etc.) in some countries. Where data exist, they suggest that this is a rapidly expanding form of involuntary treatment. In France, community treatment orders represented 40% of all people currently subject to a form of compulsory treatment in 2015, while in Scotland approximately 40% of existing compulsory treatment orders were community based in 2015-2016. In Malta, around one-third of the people receiving compulsory treatment were in the community. Unfortunately, far less is known about the use of seclusion and restraint in mental health services across Europe.

# Promising practices in prevention, reduction and elimination of coercion



We have collected information on the following practices with the help of our members. For each practice, we aimed to gather what was done to reduce coercion, if the practice had been evaluated, what were factors contributing to its success and what were the challenges.  It should be noted that not all practices presented go as far as the elimination of all coercion, as required by the UN CRPD. Indeed, across Europe there are no mental health systems that have yet switched to fully consensual practices.

# Hospital-based practices

### Denmark – Psychiatric Centre Ballerup

In 2014, the Danish Ministry of Health, in collaboration with regional authorities, decided that the use of mechanical restraint must be reduced by 50% by 2020. Courses in de-escalation techniques and conflict resolution were provided to staff members on psychiatric wards, more leisure activities were introduced for users, and architectural changes were introduced. As a result, in January 2017 the Psychiatric Centre in Ballerup (Copenhagen region) had been free from the use of mechanical restraint for at least 100 days, without having increased the use of medication.

## Israel – National initiative to reduce restraint and seclusion

In 2016, the Department of Mental Health Services of the Israeli Government launched a national initiative to reduce the use of mechanical and physical restraints in acute wards of inpatient settings. Users, family organisations and human rights organisations were involved in the development of the programme and were the main drivers behind the initiative. The initiative consisted of:

● **training trainers to become experts in de-escalation techniques for them to train staff across the country aiming the reduction of coercion to be a sustainable change**

● **training hospital staff working in 60 acute wards**

● **preventing users from experiencing boredom by introducing more leisure activities**

● **focusing on strengths of users**

● **providing funding to renovate buildings and redesign wards**

● **introducing a new regulation for restraint and seclusion orders: the length of restriction orders are shortened, new orders require permission from senior officials, and reporting requirements areintensified**

● **monitoring restriction orders: every six months psychiatric wards need to report the number of restriction orders to the Mental Health Department of the Ministry of Health**

The main challenges encountered were to convince all stakeholders of the need for change, in addition to resources, as there is still a huge gap between funding available for mental health and public health in general. However, and despite the challenges, by the first half of 2018, the overall effect since 2016 has been a 76% documented reduction in the use of restraint and seclusion.

## Italy – Psychiatric units of general hospitals (no restraint SPDC)

SPDCs (Servizi Psichiatrici di Diagnosi e Cura) were established during the deinstitutionalisation process in Italy by the same law which ordered the closure of the psychiatric hospitals at national level (Law 180/1978). SPDCs are psychiatric units of general hospitals aimed at reducing and eliminating the use of restraint. Currently there are a total of 320 SPDCs across Italy. Due to a significant effort, there are SPDCs that are completely open and that have abandoned the use of restraint for many years ('no restraint SPDC'), while other SPDCs still aim to reduce or eliminate restraint.

SPDCs usually have no more than 15 beds and are part of the regional mental health service. 85-90% of users are admitted informally to SPDCs but there are still 10 to 15% of involuntary admissions. While this is still low compared to other European countries, more work can be done to further improve these figures.

SPDCs are based on a policy of open doors, and respect for the rights, freedom and dignity of persons, favouring interventions based on dialogue and stimulating people to take responsibility for their own recovery. Becoming a 'no restraint SPDC' is a long process, which requires education and new skills for mental health professionals but also new general attitudes towards persons with mental health problems. In addition, 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 the local services are organised and coordinated, the less hospitalisation is required.

## Netherlands - High & Intensive Care (HIC) Units

In 2006 in the Netherlands, many mental health care facilities started projects to reduce the use of seclusion with the support of the Dutch government. A national goal was set to reduce the number of placements in seclusion by 10% per year. Since the start of these projects, there has been an overall

reduction of the number of placements in seclusion, but seclusion is still being used as a practice. In addition, sixteen mental health facilities have signed a Manifesto, which states that seclusion should not be used any more by the year 2020.

One of the projects to achieve a reduction in the use of seclusion and reduce the number of beds devoted to mental health care, is the development of High and Intensive Care (HIC) Units. The Units were developed in 2013 by a multidisciplinary group of Dutch experts, including users and family representatives. The HIC Units are acute admission wards focusing on restoring and maintaining contact and crisis prevention.

The Units require a multidisciplinary team (psychiatrists, nurses, psychologists, users) of a sufficient size, who must be specifically trained in crisis management, handling aggression and suicidal behaviour. Apart from skilled and sufficient staff, a specific architectural environment is cultivated including one-person bedrooms, large and light living rooms and the availability of outdoor spaces. The approach includes methods such as a careful assessment of the risk of escalation and setting up an individual crisis plan in consultation with the person concerned and their relatives. This plan describes how escalation can be prevented. In case stress and anxiety arise, a person is never left alone - making and remaining in contact with the person is essential - and the Units offer a welcoming and healing environment. Collaboration between staff members, the outpatient team, users and relatives is central. In addition, frequent risk assessment enables staff members to act proactively and prevent escalation.

The Units show promising results in terms of the use of seclusion in inpatient wards. Moreover, the decrease of seclusion rates is not associated with an increase of forced medication. Finally, if coercion is used, it must be documented and this data is regularly discussed among staff members in order to further assess how to reduce coercion with the aim of eliminating this practice.

## Norway – Lovisenberg Diakonale hospital

The Norwegian hospital of Lovisenberg Diakonale started a project in 2013 aiming to reduce the use of restraint. A web-based digital course was designed for staff members with a change of culture being the objective through several interventions, such as working on attitudes of staff members, debriefing after incidents, assessment of violence, changes in the physical environment on the wards, as well as data collection on the use of restraint. Following the implementation of the project, the use of mechanical restraint was reported to have decreased by nearly 85 %.

## Spain – Mental Health Unit of the Regional Hospital of Málaga

In 2012, the Mental Health Unit of the Regional Hospital of Málaga started a programme aiming to prevent and reduce the use of mechanical restraints in an acute psychiatric ward through multidisciplinary interventions. The programme is based on the principles of the Six Core Strategies to reduce coercion. Six Cores Strategies is a practice developed in the United States which has been successfully implemented in hospital units across the United States, Canada, Finland, Australia and the United Kingdom. The underlying ethos is that a lot of use of seclusion and restraint can be prevented if issues like ward design, number of staff members, poor communication and negative behaviour by staff are addressed.

As the name implies, the programme consists of six strategies to reduce coercion:

● **Leadership: having a staff member take the lead on implementing a policy to reduce coercion and introduce the required organisational changes**

● **Training: train staff members in conflict resolution, de-escalation techniques, trauma-informed care, recovery, therapeutic relationships, etc.**

● **Monitoring of data**

- User involvement: meaningfully involve users (and relatives if relevant) in all levels of the programme to reduce coercion

- Post-incident analysis: analyse what happened immediately after an incident and then 48 hours later with all staff members, user and family members (if required)

In Málaga, following organisational changes, registration and monitoring of persons at risk, training of staff members, and involvement of users in treatment programmes, a 64 % reduction of restraint and seclusion (from 15.1 % of users to 9.7%) was obtained.

## Sweden – Human rights training and 'To Come to One's Own Right - empowerment based psychiatry' project

The Human Rights Committee of the region of Västra Götaland introduced a human rights-based approach in a psychiatric ward (of the Sahlgrenska Hospital) for people experiencing psychosis. The pilot project ran from 2012 to 2015 and involved the training of service users, as well as their representative organisations, staff members, hospital managers and human rights experts in the field of human rights.

Evaluation of the project demonstrated the following results:

- **huge decrease in the use of restraint**

- **fewer forced injections**

- **users showed more satisfaction with the service**

- **staff enjoyed their work more**

- **users felt empowered**

After the success of the pilot project, work continued by scaling up the project to be rolled out in other parts of the region. The rights holders in the project formed a project of their own entitled 'To Come to One's Own Rights – empowerment psychiatry'. The project is financed by the Swedish Inheritance Fund and it is a collaboration between Sahlgrenska University Hospital and the Swedish Partnership for Mental Health in Gothenburg (NSPHiG). To Come to One's Own Rights expanded the work into the community and now includes workshops, discussion forums and picnics. The aim is to completely eliminate the use of restraint beds, to implement person-centred and recovery-oriented care and to promote human rights compliant services in the community. In this regard, a 2017-2020 Action Plan on Human Rights was adopted by the Regional Council including 'a vision for zero coercion in psychiatric care' as a core objective.

## Switzerland – Psychiatric hospital in the canton of Ticino

In 2005, the Swiss Canton of Ticino set up a project aiming to reduce mechanical restraint by greater use of monitoring in the psychiatric hospital of Ticino.  This hospital has 140 beds for 'acute' cases. By monitoring the use of restraint over a period of four years, this practice had been reduced by 50% by the year 2009.

Following this success, the next step aimed to eliminate the use of mechanical restraint. In this regard, the number of available staff was increased, training for staff was provided, and crisis teams were set up to take into account not only the health records of users, but their social reality as well. Dialogue and relationships became the centre of the work aimed at understanding users without judging them, talking and exchanging with users without a necessity to provide immediate treatment, trusting users instead of focusing on incapacity, and putting the rights of users at the heart of daily work. Four years later, the use of mechanical restraint and seclusion was abolished, and the hospital now consists only of open psychiatric wards.

## United Kingdom (UK) – No Force First

The 'No Force First' initiative aims to change ward cultures from containment to recovery and ultimately create coercion-free environments. This approach, which comes from 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 in order 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 staff sick leave (which led to financial savings as a result of less sickness-related absence). The Trust now has a strong culture of collaborative empowerment where staff and service users work together to reduce conflict and promote safety and recovery. Looking to the future, members of staff are encouraged to openly share learning from events that do not go as planned, and develop creative solutions. The focus is not around blaming individuals, but instead looking at the system and how it contributed to the event and could be improved.

## United Kingdom – Providing person-centred care

In 2013, the Cambridgeshire and Peterborough NHS Foundation Trust integrated fundamental aspects of an initiative called PROMISE (Proactive Management of Integrated Services and Environments) to reduce the use of restraint. This is an initiative that is working towards eliminating reliance on force in mental health services through person-centred care. It was sparked by a conversation between an expert by experience and a professional. People with lived experience of physical restraint were actively involved in shaping the qualitative research and an advisory group composed of users provided advice in connection with the project.

Initially emphasis was placed on incident reporting and evaluating data on restrictive interventions. Following interviews with service users and staff members who had direct experience or witnessed restraint, four key themes for change were identified: improving communication and relationships between staff and service users; making staff-related changes (such as having more skilled and experienced staff); improving ward environments and spaces; and having more activities and opportunities for service users on the wards.

Integrating fundamental aspects of the initiative into day-to-day activities has made a huge contribution to reducing the use of physical restraint at the trust. This reduction has been sustained over a period of nearly three years, and any use is usually only associated with a particularly unwell person for whom no other solution has been found.

# Community-based practices

## Finland - Open Dialogue Model

The Open Dialogue Approach to Acute Psychosis is a practice 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.

## Germany – 'Care-Foster-Live' Community-based services of the Pfalzklinikum

The 'Care-Foster-Live' department consists of community-based services founded at the end of the 1990s in Palatinate communities (Southwestern Germany). In 2007, services were increasingly moved into the communities and Care-Foster-Live has now become an integral part of mental health services in eleven communities. The initiative provides care services, residential services, day centres, as well as services for integration into the workforce. The different offerings were developed following intense collaboration between staff members, managers and users, leading to a change in professional self-understanding.

The main challenges encountered relate to the location of implementation, which is mainly in rural structures which show great differences in their infrastructure and prosperity, financial resources and demographic development. In addition, most regions had neither a wide range of service providers, nor community mental health groups available.

Throughout the years, 'Care-Foster-Live' has increasingly focused on persons with challenging behaviour patterns who are confronted with the limits of the welfare system when aiming to reintegrate the community. Therefore, specialised, time-limited, intermediate outpatient facilities have been developed, aimed to provide appropriate support when needed. No data is available yet on the direct impact of the 'Care-Foster-Live' services on coercion.

## Greece – Mental Health Mobile Units

In Greece, Mental Health Mobile Units have contributed to the reduction of involuntary hospital admissions. From the foundation of the first Unit in 1981 to the inclusion of Mobile Units in Greek law, more than 25 units have been founded and are still operational all over Greece.

Mobile Units are now used as a basis for the provision of mental health services and the protection of the rights of mental health users, particularly in small and remote prefectures. The main objective is not to cut the user off from the community through, for example, hospitalisation. The local community, other health services as well as key individuals (local authorities, police department, prosecutors) do not merely assist, but actively participate in the work of the Mobile Units, securing the person's right to remain an active member of the community. By allowing persons to stay in their communities and offering services as close to the user's home as possible, the Mobile Units ensure stability and continuity of care.

Factors for success are prevention, information of local inhabitants, timely interventions, therapeutic treatment and maintaining contact with both the family of the user as well as the community. The Mobile Units treat individuals as a bio-psycho-social whole, meaning that they deal with social or work-related issues whilst taking the necessary steps for users to access appropriate treatment if they choose. Comparisons of data with prefectures where no Mobile Units are in place show that the percentage of involuntary hospitalisations is much lower.

## Italy - 24/7 Community Mental Health Services

Community mental health services in Italy, which are available 24/7, report low rates of hospitalisation, and low compulsory treatment rates. The community centres are run by interdisciplinary teams operating around-the-clock and have four to eight beds for overnight stays. They are located in non-hospital residential facilities to which people have easy access.

Treatment plans at the centres are based on informal agreements among users, the team, and caregivers. Users are not considered as "inpatients" but as "guests," and they can receive visits without restrictions. Users are also encouraged to keep up their ordinary life activities and their connections to their environment, including outdoor activities. Social network interventions are key factors of success. Community mental health services ensure continuity of care, with little or no bureaucracy, and also reduce the stigma connected to hospitalisation. These services have thus contributed to reducing rates of compulsory hospitalisation and treatment.

## Poland – Warsaw Fountain House (Clubhouse International)

Warsaw Fountain House was accredited by Clubhouse International in 2014, which is an umbrella organisation for community-based membership in 'Clubhouses' or 'Fountain Houses' designed to support communities of and for people with mental health problems. Clubhouse International, as well as Clubhouse Europe, promote recovery, well-being and social inclusion of people living with mental ill health by advocating for the establishment and use of evidence-based Clubhouses, which facilitate psychosocial rehabilitation. Their development started in New York in 1948 and has expanded to Europe with currently around 80 Clubhouses working in 22 countries in Europe.

Clubhouses focus on members' strengths and abilities. Members, who are running Clubhouses with the help of staff members, are empowered and more aware of their rights. Clubhouses encourage people to contribute to the day-to-day operation of the Clubhouse through the Work-ordered Day and to gain new independent living skills through ICT courses, language groups, supported education, etc. As with others, the Warsaw Fountain House promotes the rights of persons with mental health problems and improves how society sees them, through active participation in a variety of programmes and initiatives, such as the organisation of study visits for medical students. Clubhouses are considered as places opposing coercion and claim to have a positive impact on attitudes and practices that lead to the use of coercion, both in its direct and indirect forms.

## (Peer-run) Respite houses (country of origin: United States)

The term 'respite house' typically refers to community-based, small, residential settings where people can go for short periods of time when they are experiencing a mental health crisis. Respite houses have been founded in the United States, but have been established in Switzerland, Germany, Sweden, Hungary, Denmark, the Netherlands and France. There are respite houses run by peers and respite houses that are not peer-run but with a director and staff who are peers, and which may be attached to clinical mental health services.

Respite houses are characterized by non-medical staff, peer support, empowerment of residents and 'being with' residents in times of crisis, social networking, and mutual responsibility. They tend to involve a minimal use of psychotropic medication based on personal choices of each resident and mental health services are usually dispensed outside of the respite house.

Respite houses aim to increase meaningful choices for recovery and decrease the health system's reliance on costly, coercive and less person-centred modes of mental health services. Currently, respite houses in several European countries rely on financing from budgets devoted to homeless shelters only and are not always open to any users who feel unwell and need a break from their home environment which could prevent involuntary hospitalisation.

# Other initiatives towards reduction of coercion

## Advance Planning

Advance planning through advanced directives or advance statements, means that a person makes decisions designed to bind him/herself or direct others, particularly during times of crisis. Advance planning may concern treatment preferences and other information, such as who to contact or not to contact. It can help respect the will and preferences of a person during a crisis.

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, 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, and attention is paid to the needs of service users. 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 enforceable advance planning measures.

## Austria – Crisis Helplines

In Austria, some provinces have put in place crisis helplines, which offer a wide range of services such as emergency support, telephone support, online support, crisis houses and day services. The overall goal is for users to get fast and uncomplicated help in crisis situations. The 'first aid' professionals and users work together on a strategy to cope with crises in general. The users gain self-confidence, capacity to act and to decide, as well as a better understanding of how to deal with crisis situations.

The crisis helpline helps to avoid self-endangering behaviour and to reduce forced or involuntary placement or hospitalisation and treatment. It is now necessary to gather statistical evidence of the impact these helplines have had on coercion.

## 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?" the question is "What happened?"

Intentional Peer Support provides a powerful framework for creating relationships where both people learn and grow together. It thus offers the opportunity to find and create new meaning through relationships and conversations that lead 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 as a good practice on 'Supported decision-making and Alternatives to Coercion'.

## Spain – Andalusian strategy on reducing restraint

The Spanish region of Andalusia adopted a strategy to reduce restraint with a view to its complete elimination. The values underpinning this initiative are the rights of persons with mental health problems and the promotion of their autonomy. The strategy includes the implementation of anticipated treatment plans (advance directives), the need to register data on the use of mechanical restraint, and the provision of training in de-escalation techniques to prevent the use of restraint. In addition, a Protocol on the use of physical and /or mechanical restraint has been developed, aiming to reduce the use of restraint by addressing its legal aspects and using preventive measures and process. Other regional authorities (Comunidades Autónomas) have adopted similar Protocols. Currently, results are not yet available on their impact on the use of restraint.

## Sweden – Personal Ombudsman

The Swedish Personal Ombudsman Programme ('Personligt Ombud Skane' or 'PO') is a programme started in 1995 by persons with psychosocial disabilities, as a 'User-controlled Service with Personal Agents' which facilitates decision-making and demands they make of 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 users 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, as the Ombudsman enables persons to make and communicate decisions with respect to 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 profitable in socioeconomic terms since individuals with PO support require less care 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.

## United Kingdom – The British Institute of Human Rights

The British Institute of Human Rights completed two projects implementing human rights in mental health. The first project involved mental health services and staff members. The Institute worked with several NHS Trusts to raise awareness on the need to reduce the use of physical restraint and seclusion, as well as consent to medication and Community Treatment Orders (CTOs). As a result of the project, one of the partners reported that "Using a human rights approach has revolutionised decision-making. Staff are thinking differently and making decisions differently. It needs to be rights based, not just risk based."

In the second project, the Institute worked with advocates, to support them to help their clients challenge restrictive interventions, including restraint, seclusion and/or coercion. Booklets on human rights of service users were co-produced. As the use of restraint often happens when violence occurs, incidents of physical and/or verbal aggression were reported and tracked more closely. In addition, greater cooperation with the police and talking with residents and neighbours is aimed to create a safe environment for well-being and recovery. As a result, violent incidents have been reduced by 50% and evictions of service users from their homes are also down.

## World Health Organization (WHO) - QualityRights initiative

The WHO QualityRights Initiative is working to improve the quality of services and supports and promote human rights, empowerment, inclusion and participation of people with intellectual, psychosocial and cognitive disabilities in countries around the world.  In addition to an e-training platform, which provides a course in mental health, human rights and recovery, a comprehensive package of guidance and training modules has been published to help align services and practices with the obligations and requirements of the UN CRPD.

This training and guidance module addresses the use of coercive and violent practices in mental health and related services with a particular focus on seclusion and restraint. It aims to promote a greater understanding of why these practices are used and build practical skills to help end these practices. While the module itself focuses on ending these practices in the health care setting, much of the content can also be applied in other settings where seclusion and restraint occur, for example in the home, in social care institutions, homes for the elderly and the wider community.

# Conclusion

The initiatives highlighted above show that there is no one-size-fits-all approach to prevent, reduce and eliminate coercion. Many examples, however, do share some common aspects such as:

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

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

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

• **improving physical environments**

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

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

A holistic mental health system is crucial to truly eliminating coercion. It is not about changing individual practices but about implementing a new culture. A lack of integration of mental health in primary care services, and insufficient availability and continuity of care leads to forced hospitalisation. Prevention of crisis situations is key to avoiding coercion. From these examples, it appears that the best answer to prevent hospitalisation and coercion is effective work at the territorial level with good quality outpatient and community services. When any real strategy towards the reduction of coercion is lacking, evaluating national trends is challenging. A combination of both territorial work and overarching strategies seems the best way forward to end coercion and fully implement a human rights approach to mental health.

The above examples deserve greater financing, promotion and mainstreaming. Further identification of such good practices and research on the impact current programmes have in eliminating the use of coercion is absolutely necessary and very timely. This can lead to guidance for States when implementing the UN CRPD.

Although the aim of reducing coercion, designing prescriptions and "best practices" and gathering statistics on the use of seclusion and restraint may be one step forward, it is not the same as setting out to eliminate these practices. It is only the latter which will ensure systemic change leading to a human-rights based mental health system.

# Acknowledgements

# Further reading

### General

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