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Abolition of coercion in mental health services – A European survey of feasibility

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ABSTRACT

Background: In 2019, the Council of Europe agreed to urge member states to take steps toward total abolition of psychiatric coercive measures.
Aims: To test if this aspiration is perceived as realistic and what the alternative would be in the event of a total abolition, we surveyed members of the European FOSTREN network of mental health practitioners and researchers, which is specifically dedicated to exchanging knowledge on reducing psychiatric coercion to its minimum.
Methods: Web-based survey. Categorical responses were analyzed using frequencies, and free text responses were analyzed through thematic analysis.
Results: In total, out of 167 invitations to FOSTREN network members, 76 responded to the survey (Response Rate 45.5%). A minority (31%) of participating experts dedicated to the reduction of psychiatric coercive measures believed a total abolition to be an achievable goal. A commonly held belief was that total abolition is not achievable because mental health disorders are difficult to treat and may cause violence, necessitating coercion, and there is a need to protect the involved persons from harm. Those responding that complete abolition is achievable argued that the consequences of coercion outweigh any gains and indicated that use of advance directives are sufficient as alternatives to coercion.
Conclusion: Of a European group of experts specifically dedicated to the reduction of psychiatric coercion who participated in this questionnaire study, a minority believed a total abolition be an achievable goal. The study adds to the empirical evidence of the feasibility of the aspiration to totally abolish involuntary measures in the mental health services from the perspective of experts.

1. Introduction

Coercion in health care can be defined as *measures applied against the patient's will* (Chieze, Clavien, Kaiser, & Hurst, 2021). Arguably, coercion overrides some fundamental patient rights such as liberty of movement, and the use of coercion therefore always requires ethical (and legal) justification (Chieze et al., 2021; Norvoll, Hem, & Pedersen, 2017). It is widely agreed that psychiatric coercion can only be legitimate in exceptional circumstances when the infringement of a patient's right to self-determination is the only means to fulfill more important values and goals such as the safety of the patient themself or of others and only when the patient is judged to lack mental capacity. Recently, the Parliamentary Assembly of the European Council issued Resolution 2291 (2019), which "urges the member States to immediately start to transition to the abolition of coercive practices in mental health settings" (European Council, 2019). This approach to psychiatric coercive measures is remarkable.

According to Article 7 of the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (Oviedo convention), the necessity for

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occasionally using coercive measures on patients with mental illness is recognized (European Council, 1997). Nevertheless, the overall principle of the convention is respect for the individual's right to self-determination (Article 5). Similarly, a general principle of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) (Article 3) is "[r]espect for inherent dignity, individual autonomy including the freedom to make one's own choices," and in Article 14 it is stated that parties shall ensure that persons with disabilities "[e]njoy the right to liberty and security of person" on an equal basis with others (UN, 2006). In 2019, the WHO Quality Rights group released resources seeking to enable mental health practices to adhere to the principles of the CRPD (WHO, 2019). A major goal of the initiative is to reduce coercive practices. For example, the section "Freedom from coercion, violence and abuse" highlights the negative impact of coercive measures on individuals and makes suggestions for reducing (rather than abolishing) these practices. It also emphasizes the importance of better communication, training, and of paying attention to the alternatives to coercive measure use (Duffy & Kelly, 2020).

The wish to decrease coercion in mental health to the very lowest level possible would presumably be advocated for by most patients, patient organizations, mental health staff, and others (Herrman, Allan, Galderisi, Javed, & Rodrigues, 2022; Sashidharan, Mezzina, & Puras, 2019). As mentioned above, however, it is widely accepted in all European countries that coercion in some instances may be legitimate, at least to protect the patient's life or that of others. It is therefore desirable to examine the range of views held by experts on this topic to identify whether any consensus exists on what is or what is not possible to achieve.

FOSTREN (Fostering and Strengthening Approaches to Reducing Coercion in European Mental Health Services) is a multidisciplinary network of mental health care practitioners and researchers which has been established in order to specifically focus on improving knowledge about how to reduce coercion use in the mental health services (Whittington, Aluh, & Caldas-de-Almeida, 2023). The network has been funded from 2020 to 2024 by the European Cooperation on Science and Technology (COST) scheme. The FOSTREN network constitutes a valuable resource and consists of topic experts who are well qualified to test the question of whether or not the reduction of coercion is feasible/desirable from a professional perspective and feeds into the wider debate on this topic beyond FOSTREN. Therefore, in a collaborative survey across European countries, FOSTREN members were asked if the complete abolition of coercion is considered a reasonable objective. Furthermore, their views on the most important barriers to decreasing coercive measure use in current mental health care practice were explored.

2. Methods

2.1. Study design

This is a cross-sectional survey distributed among FOSTREN members in 30 participating countries via emails to members. The survey was distributed on November 3, 2023, reminders were sent out on November 17 (after 14 days), and the survey was closed for responses after 28 days.

2.2. Study measures

There was a combination of structured and free-text response options, and the precise wording of all questions can be found in Table 2 below. Firstly, participants were asked whether they thought the complete abolition of coercive practices in mental health settings is an achievable goal at some point in the future (please see wording in Table 2) and, if so, what would be reasonale alternatives and when it would be possible to abolish all coercion. In addition, participants were questioned about their views on the most important obstacles to decreasing the use of coercive measures in current mental health care services. Furthermore, information was obtained about participants' gender and age, experience with mental health care practice (years), research experience in mental health, and country of residence. The study instrument was piloted among the research team prior to distribution. Chi-square and Fisher's exact test were used to test associations between respondent characteristics and responses. A p-level of 0.05 was considered as statistically significant.

2.3. Study participants

All individuals registered as FOSTREN members at the time the survey was distributed were invited to participate through an email link to the electronic survey on a web-based platform (REDCap; Research Electronic Data Capture ©). The criteria for FOSTREN membership are very wide and designed to be as inclusive as possible to enable representation of all relevant stakeholders from professional, patient, and carer groups. All members of FOSTREN have an interest in the issue of coercion in mental health services or have some professional or personal expertise relevant to the topic. Completed responses were loaded into an Excel file, and using the qualitative survey questions the data were then condensed into a summative, coherent text under each survey question. Subsequently, the material was re-contextualized by testing it against the original text in order to avoid misinterpretations (Gildberg et al., 2015; Weber, 1990).

2.4. Ethical considerations

According to Danish legislation, survey studies using this design require no research ethics committee approval. However, the collection and management of survey data require compliance with the European General Data Regulation and Directive 679 (incl. Article 6) regarding the participant's right to confidentiality, and the survey was approved according to Directive 679 requirements.

3. Results

3.1. Quantitative analyses

Out of 167 invitations, 76 experts responded to the survey (Response Rate 45.5%).

Table 1
Participant characteristics*

	Characteristic	Percentage (number)
Gender	Female	51.6% (33)
	Male	48.4% (31)
Age	20–30	4.7% (3)
	31–40	21.9% (14)
	41–50	31.3% (20)
	51–60	26.6% (17)
	61-	15.6% (10)
What is your current role?	Clinician	42.2% (27)
	Researcher	81.3% (52)
	Other	17.2% (11)
What is your profession?	Nurse	45.3% (29)
	Nurse assistant	0.0% (0)
	Therapist	0.0% (0)
	Psychologist	12.5% (8)
	Medical doctor	23.4% (15)
	Other background	18.8% (8)
How many years have you worked in or experienced mental health services?	0–5 years	17.2% (11)
	6–10 years	9.4% (6)
	11–15 years	15.6% (10)
	16–20 years	17.2% (11)
	21–25 years	10.9% (7)
	>25 years	29.7% (19)

* 12 missing.

The characteristics of the participants are shown in Table 1.

It is clear from Table 1 that there were relatively few respondents aged under 30 years or >60 years. Importantly, nearly half of the respondents had a clinical role, which may or may not have been combined with a research role. There was a high representation of nurses and medical doctors, and the majority had 16 years of experience or more in mental health services. The participants' responses are summed up in Table 2.

Associations between responses and the participant characteristics listed in Table 1 were estimated. No association could be established between responding that a total abolition of psychiatric coercion is achievable and the participant's gender (two-tailed chi square, $p > 0.40$). A younger age was statistically significantly associated with responding that a total abolition of psychiatric coercion is achievable (cut-off 51 Y, two-tailed chi square, $p < 0.02$), and, likewise, less experience with working in mental health services was statistically significantly associated with responding that a total abolition of psychiatric coercion is achievable (cut-off 16 Y, two-tailed chi square, $p < 0.02$). No association could be established between this response and the participant's role as a researcher versus clinician (two-tailed chi square, $p > 0.50$) or a professional background as a nurse versus a medical doctor (two-tailed chi square, $p > 0.50$). There was little consensus on feasible timescales (q2) among those respondents who believed abolition is achievable, but over half did not think it would occur in the current decade. Among all respondents, there was greater optimism about the potential for ending in-patient coercion (q4) than involuntary commitment (q3). Finally, when questioned about the top coercive measure that respondents found should be abolished, if complete abolition was not an option, mechanical restraint was mentioned first, followed by seclusion (q6).

Table 2
Participant responses.

Question	Response	Percentage (n)
1. Do you think the complete abolition of coercive practices in mental health settings is achievable in your country at some point in the future?	Yes	31.0% (22)
	No	69.0% (49)
(*q1*; 5 missing; Reasons given for answer in free text box: 22 missing, examples mentioned in text)		
2. If you think complete abolition is achievable, what date could it be achieved by?	2022–25	4.8% (1)
	2025–30	38.1% (8)
	2030–40	33.3% (7)
(*q2*; 55 missing; Reasons given for answer in free text box: 63 missing, examples mentioned in text)	Beyond 2040	23.8% (5)
3. To what degree do you agree or disagree with the statement "every involuntary admission could be avoided"?	'Agree' or 'Agree very much'	34.3% (23)
	Neither disagree or agree	16.4% (11)
(*q3*; 9 missing; Reasons given for answer in free text box: 36 missing, examples mentioned in text)	'Disagree very much' or 'disagree'	49.2% (33)
4. Would you agree or disagree with the statement "each coercive measure in hospital could be avoided"?	'Agree' or 'Agree very much'	41.7% (28)
	Neither disagree or agree	10.4% (7)
(*q4*; 9 missing; Reasons given for answer in free text box: 41 missing, examples mentioned in text)	'Disagree very much' or 'disagree'	47.7 (32)
5. In your opinion, in a health care system where psychiatric coercive measures have been totally abolished, what are the acceptable options for providing care for severely mentally ill people who pose an immediate danger to themselves or others and who do not want to receive health care (for whatever reason)?		
(*q5*; Reasons given for answer in free text box: 53 missing, examples mentioned in text)		
Is there anything else you want to add on this topic? (free text box: 72 missing)		
6. If complete abolition is not an option, which specific coercive measure used currently in European mental health services should be the first to be abolished?	Mechanical restraints	21
	Seclusion	11
	Physical restraint	5
	Net beds/cage beds	3
(*q6*; 22 missing)	Chemical restraint	1

3.2. Qualitative analyses

When prompted to provide reasons for why abolition might or might not be achievable (q1 free text), various explanations emerged in the qualitative thematic analysis. Seven main themes were identified: *resources, training and alternatives, mental health disorder, safety and harm, consequences and feasibility, society*, and *attitude*.

In the *resources* theme, arguments both for and against the feasibility of abolition were put forward, stating that abolition is impossible due to shortages in qualified staff but would be possible if the number of staff were increased and significant financial resources were put into community prevention and training. In addition, respondents thought it possible to abolish coercion if a strong community and primary mental health service could be established where people live, making it possible to treat people voluntarily in their homes with appropriate care, safety, and human contact. In contrast, other respondents argued that the lack of systematic training and education in alternatives and interventions such as de-escalation makes coercion impossible to abolish at this stage. However, some respondents proposed that *training and alternatives* to coercion could succeed making abolition possible. A core concern regarding abolition was presented in the theme *mental health disorder* in relation to the severity of the disorder with some respondents arguing that mental health disorder is difficult to treat and that this is the main reason for violence and subsequent coercion. Connected to this was the theme *safety and harm* under which respondents argued that coercion cannot be abolished because of the need to protect those involved (staff and/or others within the community) from harm or self-harm. Some respondents argued that abolition would lead to a prolonged lack of treatment and worse outcomes, but that this should be tolerated because of the negative consequences of coercion. They argued that it is unnecessary to treat mental health disorder with coercion and that it should be treated with care, safety, and human contact. Respondents arguing for an abolition also pointed to *consequences and feasibility*, stating that coercion should be abolished due to its negative consequences, such as trauma, retaliation, death, and injuries, which according to these respondents outweigh any gains from the use of coercion. Others argued that abolition could be achieved by using "psychiatric advance directives," which has been demonstrated to be possible, or that it simply is possible "out of positive belief." Within the theme *society*, respondents argued that abolition is not possible because society, culture, and history prohibit it. They argued that it would require too many changes to the health care system, policies, and legislation. Furthermore, it was held that coercive practices are closely linked to the currently predominant care model, which is highly focused on eliminating symptoms and not sufficiently focused on the person's recovery, support, and psychosocial well-being. As one respondent stated, "[t]here will always be situations where something needs to be done against the person's will." On the other hand, some respondents argued that society will not tolerate abolition and that coercion can be regulated by law, managed through effective policies, and minimized by involving and empowering user-organizations. This connects to the final theme *attitude*, with respondents stating that the main obstacles to complete abolition are negative attitudes among healthcare staff, underlining that it depends greatly on the basic attitude in the clinic and to a lesser extent on the patients' behavior and illnesses. The abolition of coercion therefore depends on a change in attitude when working with patients, based on training staff and using alternative techniques.

Among the participating FOSTREN members, expert opinions on the alternatives to psychiatric coercive measures in the event of a total abolition of psychiatric coercion were of particular interest (q5). The thematic analysis revealed that the alternatives proposed by experts were centered on the following themes: *Early detection and prevention*—several respondents asserted that an acceptable option is very

early detection of disorders and intervention, e.g., by mobile crisis teams; *Community mental health services*—several respondents reported on the need to have alternative services in the community, e.g., crisis centers, intensive home treatment, long-term community-based services with sufficient staff to provide a type of crisis prevention support service that the patient is able to use, experiences as safe, and wants to receive. In addition, these services should operate with a lower threshold of access, a recovery-oriented philosophy, and proactive, collaborative work with the formally and informally educated actors in the community where the patient is located. Furthermore, some informants stated the need for more timely and flexible resources and staff support in terms of both numbers and level of training. In a similar vein, some respondents wrote about the importance of *Relatives* in providing care under such circumstances, stating that family involvement and psychoeducation should be a part of routine mental health care and the individual's support plan. The need to create *Safe therapeutic environments* for the patient was put forward by other respondents, and some of them also pointed out the need for *Peer involvement* as a desirable option for providing care for patients with severe mental illness who pose an immediate danger. Several respondents put forward *Alternative techniques* as acceptable options for providing coercion-free care, pointing out a range of options from verbal techniques, safewards, de-escalation, environmental changes, advance care decision planning, pharmacological tools (administered voluntarily), negotiation, use of advance psychiatric directives, person-centered options, and dialogue network meetings to working with a pharmacist, explaining the rationale for medication choices, and approaches that respect people's rights. The final theme *Issues regarding legal definition* was characterized by one respondent stating that if people do not want to be identified as having mental illness, they should be taken care of outside of the mental health care system. Another respondent noted that when a person without mental capacity intends to harm somebody, the police and the criminal system, rather than mental health services, should be used. Finally, one respondent stated that people are not obliged to accept help, but professionals must be obliged to offer help, to be present, and to be persistent in offering it.

4. Discussion

4.1. Main findings

This survey attempted to identify any consensus among professional experts on the aspiration to move toward the abolition of coercion in European mental health services. Among members of the European FOSTREN network of coercion reduction experts, we found that around one third agreed that the objective to totally abolish psychiatric coercive measure use was achievable. A commonly held perception as to why a total abolition is not achievable was that mental health disorder is difficult to treat and may cause violence, necessitating coercion, and there is a need to protect the involved persons, staff and/or others within the community from harm or self-harm. In contrast, those responding that a complete abolition is achievable put forward the argument that the consequences of coercion, such as trauma, retaliation, death, and injuries, outweigh any gains, and some responded that the use of advance directives and better training and education in alternatives and interventions such as de-escalation might constitute alternatives to coercion. A younger age and less experience with working in the mental health services was associated with responding that a total abolition of psychiatric coercion is achievable, but there was no association between this view and gender or professional background.

4.2. Comparison with previous studies

The specific background of the present study is the Council of Europe Resolution 2291 from 2019 urging member states to take steps toward total abolition of coercive measures in mental health care (European Council, 2019). Among the reasons for advocating the abolition of all coercive practices in psychiatry, it is argued in resolution 2291 that such measures constitute arbitrary deprivations of liberty and that there is a lack of empirical evidence regarding both violence and the effectiveness of coercion. On the face of it, Resolution 2291 may appear to conflict with the more moderate position expressed in the Oviedo Convention (European Council, 1997; Gooding, McSherry, & Roper, 2020). Critics of the new Council of Europe initiatives may, for example, express worries as to how reasonable mental healthcare for the most seriously ill people can be ensured in mental health services with no power to temporarily make decisions on behalf of the mentally incapacitated and how to avoid the development of informal ("under the radar") coercion practices with little or no patient rights guarantees. Questions such as the latter currently seem to lack a clear answer.

While the ultimate objective to totally abolish psychiatric coercive measure use generates passionate debate both for and against, there is widespread agreement that its use should be reduced as much as possible (Herrman et al., 2022; Molodynski, Khazaal, & Callard, 2016; Sashidharan et al., 2019). In a recent narrative review of the literature of ethical arguments justifying or rejecting the use of coercive measures limiting freedom of movement, a minority of authors was found to argue in favor of an absolute ban on the use of medical coercion (Chieze et al., 2021). This minority argued that coercion violates fundamental principles, including the autonomy principle (Chieze et al., 2021). The majority of studies in the review stipulated, on the other hand, that coercion can be used in certain circumstances: for example, to protect other patients from violence and thereby promote the patient's well-being (Chieze et al., 2021). Other major bioethical principles such as non-maleficence (avoiding harm to patient or others) may counterbalance the infringement of autonomy (Chieze et al., 2021).

Outside the scientific forum as well, it is a common viewpoint that coercion in some instances may be legitimate to protect the life of a patient or others. Similarly, even if very few patients want to be coerced, patients might want other patients to be coerced to ensure their own safety. Thus, the common assumption that there is a single patient perspective is probably oversimplistic. Focus has therefore been on minimizing the use of coercive measure while safeguarding patients' legal rights and their right to reasonable treatment, rather than on simply abolishing all coercion. This is also mirrored in one of the most significant documents in the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (Oviedo convention) (European Council, 1997). According to Article 7, "a person who has a mental disorder of a serious nature may be subjected, without his or her consent, to an intervention aimed at treating his or her mental disorder only where, without such treatment, serious harm is likely to result to his or her health" (European Council, 1997). Notably, despite being a widely held argument for legitimizing coercion (Chieze et al., 2021), the safety of others is not a criterion in the Oviedo Convention (European Council, 1997).

It could be claimed that one of the benefits of the "abolitionist" objective is that it is a clear and measurable goal (instead of a "reduction"), and it is "good" to communicate the ultimate intention. On the other hand, it implies that staff applying coercive practices are violating human rights and acting immorally (and consequently well-educated professionals will be reluctant to work in acute psychiatric services). The apparent significant age effect found in the present study is noteworthy, as this may lead to change over the long term as the new generation achieves positions of authority in mental health service management. Alternatively, a shift away from abolitionism may be a feature of greater age and experience, in which case the opinions of the next generation of mental health service leaders may not differ from those expressed here.

It is rather interesting that the use of mechanical restraint was the top coercive measure that respondents found should be abolished if complete abolition was not an option, followed by seclusion (q6). This may mirror a real belief among respondents that mechanical restraint is

particularly intrusive, degrading, or the like, and therefore should be abolished. However, participant responses could also reflect a hierarchy of the most well-known and publicly discussed coercive measure types in each country while neglecting other measures which might, a priori, be considered even more degrading but are so rare that they do not feature in people's awareness.

In parallel, advanced directives have shown promising results (Nicaise, Lorant, & Dubois, 2013; Swanson et al., 2008), and complex intervention programs to avoid coercive measures incorporating two or more interventions such as staff training, risk assessment, and advance directives may perhaps be even more effective (Hirsch & Steinert, 2019). Nevertheless, there still remains a lack of research-based evidence to support the notion that advance directives, de-escalation, or other measures mentioned by the respondents in our study can make the total abolition of coercive measure use a reality (Hirsch & Steinert, 2019; Nicaise et al., 2013).

4.3. Strengths and limitations

This study is unique as the first attempt to assess the degree of support for the abolitionist ideal in European mental health services. Previous studies have examined the degree of approval for specific types of coercion but none have previously gone beyond this step to test the idea of total abolition (Whittington, Bowers, Nolan, Simpson, & Neil, 2009). The expert collective in this study is a robust sample on which to base conclusions about the current consensus on a topic under passionate debate within psychiatry. Furthermore, the response rate is relatively high for a survey among health professionals. Nevertheless, the study has limitations which restrict the basis for drawing any strong conclusions. There are around 100,000 psychiatrists working in Europe with many more in other mental health professions, and the sample here is very small and self-selected (Michas, 2022). Therefore, it cannot be claimed that the responses represent all professional views. Self-selection could operate in either direction: those with a strong view either for or against coercion may be more motivated to engage with a group such as FOSTREN and thus skew the sample proportions on the question of abolition in either way. In addition, we received responses from less than half of FOSTREN's members, and we do not know if these respondents are representative of FOSTREN members overall, although this is likely to be the case for gender (54% of FOSTREN members are female and 52% of respondents in this survey were female).

Even more importantly, there are no respondents in this study who identified themselves as former or current patients. This is therefore a purely professional perspective, and the views of those who have been subjected to forced treatment may be very different to those who are engaged in implementing it. Furthermore, we could establish no association between participants' professional background and their view on a total abolition of coercion. It would be interesting to examine any differences between groups to indicate any special subgroups with a pro-abolitionist perspective. If there are countries where the objective is more highly regarded, perhaps the mental health system in that country can act as an exemplar for other countries in terms of what is achievable when aspirations are kept high.

5. Conclusions

Knowledge about the perceptions of a European network of mental health practitioners and researchers established to exchange knowledge on how to limit coercive measure use in psychiatry is important to inform further European-level policy debates about whether coercive measures should be illegal in mental health care in the future. This knowledge also highlights some of the possible hindrances to a total abolition of coercive measure use. In this survey among members of the European FOSTREN network of coercion reduction researchers and clinicians, we found that around one third of experts believe the objective to totally abolish psychiatric coercive measure use is achievable. A younger age was associated with responses stating that a total abolition of psychiatric coercion is achievable. The study points to the necessity for research evidence confirming the power of advance directives, de-escalation, and other measures to completely prevent the need for coercion in patients who pose a danger to themselves or others.

Ethics approval and consent to participate

According to Danish research ethics regulation, research ethics approval of questionnaire studies is only required, if the project involves human biological material (please see Act on Research Ethics Review of Health Research Projects dated 1338 af 01/09/2020, section 14(2)). Likewise, this study was conducted in accordance with EU General Data Protection Regulation 2016/679 and Directive 95/46/EC. We obtained informed consent from all study participants.

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CRediT authorship contribution statement

Søren Birkeland: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Project administration, Resources, Software, Validation, Visualization, Writing – original draft, Writing – review & editing. **Tilman Steinert:** Conceptualization, Methodology, Writing – review & editing. **Richard Whittington:** Conceptualization, Funding acquisition, Methodology, Writing – review & editing. **Frederik Alkier Gildberg:** Conceptualization, Formal analysis, Methodology, Validation, Writing – review & editing.

Declaration of competing interest

None declared.

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