Alternatives to Coercion in Mental Health Settings: A Literature Review

Piers Gooding, Bernadette McSherry, Cath Roper, Flick Grey

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Commissioned by the United Nations Office at Geneva to inform the report of the United Nations Special Rapporteur on the Rights of Persons with Disabilities

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Cath Roper
Flick Grey

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Introduction

Informed consent to medical treatment is generally presumed to be central to the provision of good quality healthcare. Compulsory treatment challenges this presumption. Mental health laws in many countries set out legal criteria enabling the detention and treatment without consent of persons with mental health conditions or psychosocial disabilities in certain circumstances.

There are moves to reduce, end and prevent coercion, at the international, regional, national and local levels. A *Resolution on Mental Health and Human Rights* from the United Nations Human Rights Council calls upon States to 'abandon all practices that fail to respect the rights, will and preferences of all persons, on an equal basis' with others and to 'provide mental health services for persons with mental health conditions or psychosocial disabilities on the same basis as to those without disabilities, including on the basis of free and informed consent'.[1] This statement captures an international shift away from coercive practices in mental health settings.

This systematic literature review examines empirical research on efforts to reduce, end and prevent coercion in the mental health context, whether in hospitals in high-income countries, or in family homes and remote communities in rural parts of low- and middle-income countries. We will use the term, 'persons with mental health conditions or psychosocial disabilities', as adopted in the aforementioned Human Rights Council Resolution.

We have sought to undertake a comprehensive review of the scholarly research drawn from a range of different disciplinary backgrounds and experiences. However the review cannot claim to be exhaustive. For example, time and language limitations prevented a more expansive inquiry. Indeed, we recommend that a more expansive inquiry is required to uncover empirical research and exploratory reports of progressive efforts, particularly in non-English-speaking regions. Nevertheless, this review encompasses 169 studies from many parts of the world (including 48 reviews and notable grey literature reports), offering valuable insights into the state of research on finding alternatives to reduce, end and prevent coercion of people with mental health conditions and psychosocial disabilities.

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1 United Nations Human Rights Council, *Resolution on Mental Health and Human Rights*, UN Doc A/HRC/36/L.25 (2017) 4.

Defining 'Coercion'

It is important to define 'coercion' for the purposes of this review. A distinction can be made between 'coercion' and 'compulsion'. The Oxford English Dictionary defines coercion as 'the action or practice of persuading someone to do something by using force or threats'.[2] 'Compulsion' refers to 'the action or state of forcing or being forced to do something; constraint'.[3] Rather than using the term 'coercion and compulsion', the term 'coercion' alone will be used in this review to refer to both threats *and* compulsion or, in other words, the action or practice of persuading in a way that is characterised by the use of force and threats, or forcing someone to do something, in the context of mental health care provision.[4]

Coercion in mental health settings is commonly associated with powers of civil commitment; that is, compulsory treatment or psychiatric detention, often imposed under the terms of mental health legislation. Civil commitment practices may include compulsory admission, treatment, including medication without consent, involuntary electroconvulsive therapy, seclusion and mechanical/physical/chemical restraint. However, coercion can also occur in nominally 'voluntary' service provision. The MacArthur Coercion Study, for example, in a study involving over 1500 adult patients admitted to hospitals in three US jurisdictions over a 10-year period, reported that formal involuntary detention and treatment:

> is only a blunt index of whether a patient experienced coercion in being admitted to a mental hospital. A significant minority of legally 'voluntary' patients experience coercion, and a significant minority of legally 'involuntary' patients believe that they freely chose to be hospitalized.[5]

Similarly, Fennell discusses the 'shadow of compulsion' that voluntary patients may experience:

> Detention, forcible treatment without consent, seclusion and restraint are the ultimate mechanisms of clinical power. A person may consent

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2 See <https://en.oxforddictionaries.com/definition/coercion>

3 See <https://en.oxforddictionaries.com/definition/compulsion>

4 For a detailed discussion of terms surrounding 'coercion' and 'compulsion' in mental health services, see George Szmukler, 'Compulsion and "Coercion" in Mental Health Care' (2015) 14(3) *World Psychiatry* 259.

5 John Monahan et al, 'Coercion in the Provision of Mental Health Services: The MacArthur Studies' in Joseph P Morrissey and John Monahan (eds), *Research in Community and Mental Health*, Vol. 10: *Coercion in Mental Health Services – International Perspectives* (Emerald Group Publishing, 1999) 13-30, 27.

to treatment or to remain in hospital if they know that they will be compelled in the event of refusal. Compliance in the shadow of compulsion is an important feature of the psychiatric system.[6]

Coercion also takes place outside hospitals in community based mental health services, family homes and disability residential facilities. This may include formal compulsory outpatient psychiatric interventions, but also where individuals are threatened with civil commitment, eviction or refusal of other services if they do not comply with proposed interventions.[7]

In low- and middle-income countries, including those without mental health services *per se*, coercion may take the form of people being shackled, caged or detained in homes or communal areas, or in 'prayer camps' and other sites in which persons with disabilities are deprived of liberty.[8]

Finally, coercion may be understood as less visible and explicit than taking particular actions against a person, in the imposition of certain ways of understanding distress (for example, as a curse, or as a purely biomedical or socially constructed phenomenon). However, this report will not engage with these less visible forms of forceful persuasion, and instead concentrate on explicit actions constituting coercion, such as seclusion and restraint, threats, and treatment without consent.

What did the Review Find?

Most of the scholarly literature was quantitative and most of the studies were undertaken by psychiatrists. Most of the studies were discipline

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6 Philip Fennell, 'Institutionalising the Community: The Codification of Clinical Authority and the Limits of Rights-Based Approaches' in Bernadette McSherry and Penelope Weller (eds), *Rethinking Rights-Based Mental Health Laws* (Hart Publishing Ltd, 2010) 13.

7 See generally Tony Zigmond, 'Pressures to Adhere to Treatment: Observations on "leverage" in English Mental Healthcare' (2011) 199(2) *The British Journal of Psychiatry* 90.

8 See, eg, Luh Ketut Suryani, Cokorda Bagus Jaya Lesmana and Niko Tiliopoulos,'Treating the Untreated: Applying a Community-Based, Culturally Sensitive Psychiatric Intervention to Confined and Physically Restrained Mentally Ill Individuals in Bali, Indonesia' (2011) 261(2) *European Archives of Psychiatry and Clinical Neuroscience* S140; Laura Asher et al, '"I Cry Every Day and Night, I Have My Son Tied in Chains": Physical Restraint of People with Schizophrenia in Community Settings in Ethiopia' (2017) 13 *Globalization and Health* 47; Harry Minas and Hervita Diatri, 'Pasung: Physical Restraint and Confinement of the Mentally Ill in the Community' (2008) 2(1) *International Journal of Mental Health Systems* 8; Ibrahim Puteh, M Marthoenis and Harry Minas, 'Aceh Free Pasung: Releasing the Mentally Ill from Physical Restraint' (2011) 5 *International Journal of Mental Health Systems* 10.

specific – mostly within psychiatry, some within social work, law, psychology, and associated disciplines.

A small but significant amount of work was undertaken by persons who had experienced mental health conditions or psychosocial disabilities. Much of the work by this group occurred outside the scholarly literature.[9] Formal research typically did not involve persons with psychosocial disabilities as either active research participants – for example as interviewees, survey recipients, and so on – or as lead or co-researchers, though there were several notable exceptions to this general rule.

There are clear geographical gaps in the research. Relatively little research could be located from low- and middle-income countries, which is concerning. Overall, research locations are dominated by the United States, the United Kingdom (particularly England), the Netherlands and Northern Europe.

The body of literature had some over-arching themes, namely: the value of recovery-oriented and trauma-informed practices; laws to reduce coercive practices; 'peer-led' initiatives, family- or social network-directed initiatives; crisis resolution responses in hospitals, respite centres and home-based support; advance planning to improve crisis responses; the use of non-legal 'advocacy'; supported decision-making; low-medication or no-medication alternatives; and culturally appropriate mental health support.

Perhaps one of the most important emerging themes is that both top-down *and* local-level leadership is important in order to create and to maintain practices that reduce, prevent and end coercive practices.

Structure of this Literature Review

This review is divided into five sections and three appendices:

- **Section One** provides the background, terms of reference and methodology.

- **Section Two** provides the results of the review, including a thematic analysis, which is broadly organised around overarching themes, hospital-based and 'community'-based initiatives.

- **Section Three** sets out regional themes.

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9 See Appendix Three.

- **Section Four** discusses gaps in research and suggests future research directions.

- **Appendix One** provides a table of literature used for full review, which summarises the year, region, aim, methods and findings of each study.

- **Appendix Two** provides a table of literature reviews and other notable materials.

- **Appendix Three** provides a table of 'alternatives to coercion in practice', which are summarised.

It is important to emphasise that the Appendices are the core of this report. The tables in the Appendices are meant for use in future research and should be viewed as an iterative source of materials that can be updated with new materials or existing materials which were not uncovered in this literature review. Relevant research and practices are highly likely to be identified that were not captured in our research design. The list of 'alternatives to coercion in practice' in Appendix Three, for example, is not meant to be exhaustive, but instead offers a sample based on the practices identified in the literature search and those most familiar to the authors of this report.

Section One: Background and Methodology

Background to this Literature Review

There are several motivations for finding alternatives to coercive practices in mental health settings. Most notably, persons with mental health conditions or psychosocial disabilities themselves have consistently pointed out the human rights implications of involuntary detention and treatment and have advocated for alternatives.

The Convention on the Rights of Persons with Disabilities

The Convention on the Rights of Persons with Disabilities ('CRPD')[10] has challenged States Parties to improve access to voluntary mental health supports and to reduce, prevent and end involuntary or coercive interventions.

Article 12 of the CRPD deals with equal recognition before the law. Article 12(2) sets out that 'persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life'. The Committee on the Rights of Persons with Disabilities has described legal capacity as the 'ability to hold rights and duties (legal standing) and to exercise those rights and duties (legal agency)'.[11] Article 12(3) requires States Parties to 'take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity'. Such support may include support to make decisions about medical treatment and care.

Article 25 of the CRPD addresses health care and promotes the right of persons with disabilities to the highest attainable standard of health on an equal basis with others, without discrimination on the basis of disability. Article 25(d) requires health care professionals to provide care 'on the basis of free and informed consent'.

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10 *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, Doc.A/61/611 (entered into force 3 May 2008) ('CRPD').

11 Committee on the Rights of Persons with Disabilities*, General Comment No 1: Article 12: Equal Recognition Before the Law, 11th sess*, UN Doc CRPD/C/GC/1 (19 May 2014) and CRPD Committee, *Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities: The Right to Liberty and Security of Persons with Disabilities*, 14th sess (September 2015) para 13.

Articles 12 and 25 intersect in relation to medical treatment without consent.[12] They are supplemented by Articles 14, 15 and 17. Article 14, requires governments to 'ensure that persons with disabilities, on an equal basis with others… [a]re not deprived of their liberty unlawfully or arbitrarily… and that the existence of a disability shall in no case justify a deprivation of liberty'. Additionally, Article 15 provides that '[n]o one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment' and Article 17 provides that '[e]very person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others'.

United Nations Bodies

Several United Nations bodies have called for the prevention, reduction and ending of coercive practices in mental health settings.

The Committee on the Rights of Persons with Disabilities (the 'CRPD Committee') has stated that detention and forced treatment of persons with disabilities on health care grounds violate Article 12 of the CRPD in conjunction with Article 14.[13] The Committee produces 'concluding observations' that respond to the CRPD-compliance reports of governments and regions which have signed and ratified the CRPD. The Committee has consistently urged States Parties to repeal provisions that allow for compulsory admission and treatment of persons with disabilities in mental health institutions based on actual or perceived impairments.

This position is supported by the Special Rapporteur on the Rights of Persons with Disabilities, the United Nations Working Group on Arbitrary Detention, and the United Nations High Commissioner on Human Rights.

Some United Nations bodies have declared that certain types of coercive practices can, under some circumstances, help protect human rights and particularly the right to life (Article 10 of the CRPD) of persons with severe mental health conditions. These bodies include the Human Rights Committee[14] and the Subcommittee on Prevention of Torture and Other

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12 Bernadette McSherry and Lisa Waddington (2017) 'Treat with Care: The Right to Informed Consent for Medical Treatment of Persons with Mental Impairments in Australia' (2017) 23(1) *Australian Journal of Human Rights* 109, 111.

13 Committee on the Rights of Persons with Disabilities, *General Comment No 1: Article 12: Equal Recognition Before the Law*, 11th sess, UN Doc CRPD/C/GC/1 (19 May 2014) and CRPD Committee, *Guidelines on Article 14 of the Convention on the Rights ofPersons with Disabilities: The Right to Liberty and Security of Persons with Disabilities*, 14th sess (September 2015) <www.ohchr.org/Documents/HRBodies/CRPD/GC/GuidelinesArticle14.doc>.

14 United Nations Human Rights Committee, *General Comment No. 35 - Article 9: Liberty and Security of Person*, UN Doc CCPR/C/GC/35 (2014) 6 [19].

Cruel, Inhuman or Degrading Treatment or Punishment.[15] Other United Nations bodies are less explicit on the legitimacy of forced interventions.[16]

Irrespective of whether coercion is viewed as a 'necessary evil'[17] in some emergency situations, it is agreed that coercive psychiatric measures restrict human rights and that support should be framed around the 'rights, will and preferences' (Article 12(4) CRPD) of the individual. Thus, numerous United Nations bodies have articulated an urgent need to develop alternatives to coercive interventions.

Changing Policies and Practices

International trends in mental health policy and practice have also generated a push to find alternatives to coercive practices.

'Recovery-oriented' and 'trauma-informed' service delivery for example, have become prominent in recent years in many parts of the world. Recovery-orientated practice generally focuses on a person's ability to recover from mental health crises. This approach seeks to avoid what Fisher describes as interventions 'being done to' people.[18] High priority is placed on respect for self-determination. Support is personalised to the capabilities of each individual.[19] Similarly, 'trauma-informed' approaches seek to understand the impact of interpersonal violence and victimisation on an individual's life and development. In Elliott and colleagues' terms, trauma-informed services are designed to ensure that 'every interaction [within services] is consistent with the recovery process and reduces

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15 United Nations Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Approach of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment regarding the rights of persons institutionalized and treated medically without informed consent, UN Doc CAT/OP/27/2 (2016) 2 [8].

16 See, United Nations Human Rights Council, *Resolution on Mental Health and Human Rights*, UN Doc, A/HRC/36/L.25 (2017); D Pūras, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, UN Doc A/HRC/35/2 (2017); JE Méndez, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, UN Doc A/HRC/22/53 (2013).

17 Melbourne Social Equity Institute, *Seclusion and Restraint Project: Report* (University of Melbourne, 2014) 140.

18   Pamela Fisher, 'Questioning the Ethics of Vulnerability and Informed Consent in Qualitative Studies from a Citizenship and Human Rights Perspective' (2012) 6 *Ethics and Social Welfare* 2, 12.

19 See, Patricia Deegan, 'Recovery as a Journey of the Heart' (1996) 19(91) *Psychosocial Rehabilitation Journal* 91; David Pilgrim and Ann McCranie, *Recovery and Mental Health: A Critical Sociological Account* (Palgrave MacMillan, 2013); Mike Slade, *Personal Recovery and Mental Illness: A Guide for Mental Health Professionals* (Cambridge University Press, 2009).

the possibility of re-traumatization'.[20] Hence, trauma-informed services often promote 'no-force' forms of care and support.[21]

This is consistent with findings from other studies focused on the perspectives of people who have experienced coercion, contributing to a growing body of evidence that coercive practices, such as restraint and seclusion, are harmful.[22] Law and policy reforms can contribute to the goal of reducing and eliminating these practices, by regulating their use and improving accountability.[23]

In summary, efforts are underway at the international, regional, national and local levels to find alternatives to coercive practices. This report contributes to those efforts by reviewing the available research literature in the field.

Terms of Reference for the Literature Review

The authors signed a contract with United Nations Office at Geneva on 10 May 2018 to produce an academic literature review on existing evidence on intervention and strategies to end, reduce and/or prevent coercion in mental health care. The Office commissioned the literature review on non-coercive practices in the context of mental health care to inform the report of the Special Rapporteur on the Rights of Persons with Disabilities, pursuant to the Human Rights Council resolution 35/6.

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20 Denise E Elliott et al, 'Trauma-Informed or Trauma-Denied: Principles and Implementation of Trauma-Informed Services for Women' (2005) 33(4) *Journal of Community Psychology* 461, 462.

21 See, eg, Robert D Stolorow, *Trauma and Human Existence* (Routledge, 2007); Maxine Harris and Roger D Fallot, 'Envisioning a Trauma-Informed Service System: A Vital Paradigm Shift' (2001) 89 *New Directions for Mental Health Services* 3.

22 Bradley Foxlewin, *What is Happening at the Seclusion Review that Makes a Difference? A Consumer Led Research Study* (ACT Mental Health Consumer Network, 2012); Christina Katsakou et al, '"Psychiatric Patients" Views on Why their Involuntary Hospitalisation was Right or Wrong: A Qualitative Study' (2012) 47 *Social Psychiatry and Psychiatric Epidemiology* 1169; Caroline Larue et al, 'The Experience of Seclusion and Restraint in Psychiatric Settings: Perspectives of Patients' (2013) 34 *Issues in Mental Health Nursing* 317; Cynthia Robins et al, 'Special Section on Seclusion and Restraint: Consumers' Perceptions of Negative Experiences and "Sanctuary Harm" in Psychiatric Settings' (2005) 56 *Psychiatric Services* 1134.

23 See, eg, Australian Department of Health, National Standards for Mental Health Services (Commonwealth of Australia, 2010); Melbourne Social Equity Institute, above n 17, 146.

It was agreed that the review should include:

- An overview of practices within and beyond traditional mental health settings;

- A thematic analysis of the literature available across disciplines;

- An identification of survivor/user led interventions; and

- An analysis of gaps and weaknesses in the available literature.

It was also agreed that this literature review should include an analysis of any academic and 'grey' literature on interventions and strategies of this kind. 'Grey' literature is not formally published and therefore typically not subject to peer review (or external validation) of content. It can take the form of government reports, conference papers, policy documents and web materials. However, there are distinct reasons to include this material, as discussed in the Section on Methodology below.

Scope of the Review

This literature review is guided by the directive from the United Nations Office at Geneva to 'identify, select and critically evaluate relevant interventions and strategies with the purpose or effect of ending, reducing and/or preventing coercion in mental health care (compulsory admission, involuntary treatment, involuntary medication, seclusion, restraint, etc.).'

According to the Committee on the Rights of Persons with Disabilities '[f]orced treatment is a particular problem for persons with psychosocial, intellectual and other cognitive disabilities'.[24] This review focuses on these groups.

Effort was taken to consider practices, strategies, policy and laws from across low-, middle- and high-income countries. Care was taken to expand the scope of the literature beyond high-income Western countries, in response to concerns by several commentators that some research and commentary concerned with the CRPD casts Western-centric material in

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24 Committee on the Rights of Persons with Disabilities, *General Comment No 1: Article 12: Equal Recognition Before the Law,* 11th sess, UN Doc CRPD/C/GC/1 (19 May 2014) para 42.

universal terms.[25] However, due to time and language constraints, we excluded articles which were not available in English (unless the abstract contained sufficient useful information). In our recommendations for future research, we recommend that this type of systematic review expand to include non-English language resources.

Again, the scope of the review was also limited by time constraints. A more exhaustive study would also draw in material from the bibliographies of each study, would cast a view further back than 1990 and would undertake consultation and peer review from leading representatives in the field, including both academics as well as organisations representing persons with psychosocial disabilities.

Methodology

A literature review is aimed at collecting, analysing and presenting available research in a given field of interest. A range of methodologies can be used, some more systematic and organised than others.[26] Scoping reviews use strict, transparent methods for surveying the literature and evaluating the findings. They are particularly useful for surveying a potentially large field that has not yet been comprehensively reviewed and for which clarification of concepts is required. A scoping review is therefore well suited for the purposes of this review.[27] This review extends from peer-reviewed articles to 'grey literature' and international reports.

Two main questions guided the review:

What laws, policies and/or practices help to reduce and eliminate coercive practices in mental health settings?

What alternative strategies, laws, policies and/or practices exist which promote rights-based support in the mental health context?

For the academic and 'grey' literature, a rapid review method (streamlined literature review) was used. Numerous search strings in multiple

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25 See Bhargavi V Davar, 'Legal Capacity and Civil Political Rights for People with Psychosocial Disabilities' in Asha Hans (ed), *Disability, Gender and the Trajectories of Power* (Sage, 2015) 238; Inclusion International, 'Video: Preparing Feedback to the CRPD Committee on the Draft General Comment on Article 19' <http://inclusion-international.org/video-preparing-feedback-to-the-crpd-committee-on-the-draft-general-comment-on-article-19/>; Amita Dhanda, 'Conversations between the Proponents of the New Paradigm of Legal Capacity' (2017) 13(1) *International Journal of Law in Context* 87.

26 Hilary Arksey and Lisa O'Malley, 'Scoping Studies: Towards a Methodological Framework' (2005) 8(1) *International Journal of Social Research Methodology* 19.

27 Micah DJ Peters et al, 'Guidance for Conducting Systematic Scoping Reviews' (2015) 13(3) *International Journal of Evidence-Based Healthcare* 141, 141.

combinations of the following words were used in keyword fields, or abstract and title fields (where available in each database). The Help section of each database was checked for relevant wildcard operators (typically * or !):

'mental (health or ill* or disability or impair*)'; 'coerc* or forced or compulsory or involuntary*'; 'psychiatr*'; 'disab*'; 'disability law'; 'health care'; 'alternative*'; 'healthcare'; 'health*'; 'health services'; 'right to health'; 'alternative*'; 'advoca*': 'user'; 'survivor'; 'crisis respite'; 'trauma-informed'; 'recovery', etc.

Examples of the many individual search strings include:

- 'human rights' AND (mental AND (ill* OR health OR disab* OR impair*)) AND (coerci* OR force* OR civil commitment)

- (mental AND (ill* OR health OR disab* OR impair*)) AND (coerci* OR force* OR civil commitment)

- (mental AND (ill* OR disab* OR impair*)) AND (coerci* OR force*) AND (alternative* OR advoca*)

- (mental AND (ill* OR disab* OR impair*)) AND (coerci* OR force*) AND (law OR legislat*)

- (coerc* OR forced OR compulsory OR involuntary) AND (mental (health OR ill*)

- ('mental health' OR 'mental* ill' OR psychosocial) AND 'human rights'

- ('mental health' OR 'mental* ill') AND alternatives

- non-coercive* AND psychiatry

- (alternative* OR voluntary*) AND 'mental health'

- right* AND 'mental health'

- advoca* AND 'mental health'

- right* AND 'mental health'

- psychiatr* AND voluntary

- psychiatr* AND alternative*

- reduc* AND (seclusion OR restraint) AND (mental (health OR ill* OR disability))

For journal articles and similar sources, legal indexing/abstracting and full text databases were searched including: University of Melbourne Libraries Catalogue; TROVE – National Library of Australia Catalogue; and Worldcat.

The following research databases were used:

- INFORMIT (which includes AGIS, Health Collection, Health and Society Database);

- EBSCO (which includes Academic Search Complete, CINAHL Complete, MEDLINE, Index to Legal Periodicals);

- PROQUEST (which includes Health and Medical Collection and Psychology Database);

- Science Direct Journals;

- SSRN;

- Google Scholar; and

- LegalTrac.

A limit was placed on the date range for the search, from 1990 onwards and a language filter was applied to focus on English-language results.

The materials collected through the systematic review and consultation were analysed using thematic content analysis, as well as doctrinal legal analysis.[28] Doctrinal legal analysis emphasises identifying a problem of justice (namely, restrictions on rights following coercive intervention) and canvassing alternatives.[29] Attention was paid to materials authored by the CRPD Committee, the Human Rights Committee and other treaty bodies, as well as the Special Rapporteurs for the Rights of Persons with Disability, on the Right to Health, on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, and other human rights agencies.

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28 Terry Hutchinson and Nigel Duncan, 'Defining and Describing What We Do: Doctrinal Legal Research' (2012) 17(1) *Deakin Law Review* 84, 113.

29 Martha Minow, 'Archetypal Legal Scholarship – A Field Guide' (2013) 63(1) *Journal of Legal Education* 65.

Elevating the Perspectives of Persons with Disabilities

The CRPD explicitly directs that persons with disabilities 'should have the opportunity to be actively involved in decision-making processes about policies and programmes, including those directly concerning them',[30] which would reasonably extend to research informing policy and programmes. In addition, the terms of reference required this review to emphasise materials generated by persons with disabilities.

Two authors of this report have expertise with such materials, and themselves draw on their personal experience with mental health services. Ms Flick Grey is a survivor of childhood trauma and has an academic background in sociology, linguistics and mad studies. Ms Cath Roper's thinking and positioning is influenced by multiple experiences of being subject to mental health legislation involving compulsory treatment, detention and restrictive practices. The list of practices compiled by Ms Grey and Ms Roper – and supplemented by the literature review – are included in Appendix Three. These practices informed the research scope, as discussed shortly.

In addition to the rights-based claims, there are pragmatic reasons to emphasise materials produced by users of mental health services, or those who describe themselves as surviving coercive measures. Greenhalgh and colleagues have argued that 'evidence-based medicine' in general – not simply in the mental health context – carry potential biases that can 'inadvertently devalue the patient and carer agenda' due to:

> limited patient input to research design, low status given to experience in the hierarchy of evidence, a tendency to conflate patient-centred consulting with use of decision tools, insufficient attention to power imbalances that suppress the patient's voice, over-emphasis on the clinical consultation, and focus on people who seek and obtain care (rather than the hidden denominator of those that do not seek or cannot access care).[31]

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30 *CRPD* Preamble para (o), Art 33(3).

31 Trisha Greenhalgh et al, 'Six "Biases" Against Patients and Carers in Evidence-Based Medicine' (2015) 13(1) *BMC Medicine* 200, 200.

Greenhalgh and colleagues suggest several ways to reduce such 'biases',[32] which also have application to the growing body of literature aimed at improving the involvement of service users, former service users and persons with psychosocial disabilities in research.[33]

The devaluing of service user and family perspectives may be acute in mental health research. Beaupert argues that legal and institutional processes devalue the perspective of users and survivors to the extent of compromising their freedom of opinion and expression.[34] Russo and Beresford argue that professional researchers in the mental health fields have a 'longstanding academic habit of avoiding a dialogue with subjects of their interest' noting that academics tend to conceive of themselves as developing tools and philosophies to help 'those people' out there, rather than inviting in and incorporating 'mad people's knowledge'.[35] Nevertheless, for over two decades at least, service user and survivor researchers have created an evidence-base for change by challenging traditional research assumptions, theories and methods, developing ethical frameworks, and aligning their work to other social movements.[36] This has occurred independently of, and in collaboration with a wide range of fellow researchers, including clinical and legal academics, social workers and social scientists.

Emphasising the perspectives of persons with disabilities expanded the field of practices considered in this literature search. Russo has argued that there is a general absence of formal research on coercion that is led by people in the 'user/survivor movement':

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32 Ibid 8-9.

33 See, eg, Angela Sweeney et al, (eds) *This is Survivor Research* (PCCS Books Ltd, 2008); Alison Faulkner and Phil Thomas, 'User-Led Research and Evidence-Based Medicine' (2002) 180(1) *The British Journal of Psychiatry* 1; Jan Wallcraft, Beate Schrank and Michaela Amering, *Handbook of Service User Involvement in Mental Health Research* (John Wiley & Sons, 2009).

34 Fleur Beaupert, 'Freedom of Opinion and Expression: from the Perspective of Psychosocial Disability and Madness' (2018) 7 *Laws* 3.

35 Jasna Russo and Peter Beresford, 'Between Exclusion and Colonisation: Seeking a Place for Mad People's Knowledge in Academia' (2015) 30(1) *Disability & Society* 153, 154.

36 See Angela Sweeney et al, above n 33.

Coercion in psychiatry and the fight against forced treatment are two of the main topics in the mental health service user/ psychiatric survivor movement worldwide. At the same time, our own user-led or survivor-controlled research in this field is nonexistent.[37]

There are notable exceptions to this general observation, which we will discuss throughout this review,[38] but perhaps more importantly for this section of the review, it seems to be the case that most empirical research by persons with mental health conditions or psychosocial disabilities does not focus on coercion in a direct sense. Instead, it typically focuses on practices designed to address unmet need—which may, as a secondary effect, work to reduce coercive practices. 'Unmet need' here refers to the type of support that is desired but may not be available. The National User Survivor Network ('NUSN') in the United Kingdom, for example, states that its aim is to '[m]ake the policy of "getting the right support, at the right time, in the right place, from the right person" a reality'.[39] Better meeting people's support needs, as well as being valuable in and of itself, is likely to help prevent, reduce or end coercive interventions.

Again, this is not to suggest that research into coercion by persons with mental health conditions and psychosocial disabilities has not taken place. Indeed, NUSN has published several reports

37 Jasna Russo and Jan Wallcraft, 'Resisting Variables - Service User/Survivor Perspectives on Researching Coercion' in Thomas W. Kallert, Juan E. Mezzich and John Monahan (eds.), *Coercive Treatment in Psychiatry: Clinical, Legal and Ethical Aspects* (John Wiley & Sons, 2011) 213, 213.

38 For legal research and scholarship, see: Tina Minkowitz, 'The United Nations Convention on the Rights of Persons with Disabilities and the Right to be Free from Non-consensual Psychiatric Interventions' (2007) 34(2) *Syracuse Journal of International Law and Commerce* 405; Bhargavi Davar, 'Legal Frameworks for and against People with Psychosocial Disabilities' (2012) 47(52) *Economic and Political Weekly* 123; Elyn Saks, 'Mental Health Law and the Americans with Disabilities Act: One Consumer's Journey' (2016) 4(1) *Inclusion* 39. For phenomenological, sociological and first person-accounts, see: Erick Fabris and Katie Aubrecht, 'Chemical Constraint: Experiences of Psychiatric Coercion, Restraint, and Detention as Carceratory Techniques' in Liat Ben-Moshe, Chris Chapman and Alison C Carey (eds) *Disability Incarcerated* (New York: Palgrave Macmillan, 2014) 185–99; Erick Fabris, *Tranquil Prisons: Chemical Incarceration under Community Treatment Orders* (University of Toronto Press, 2011).

39 National Survivor User Network, *Manifesto 2017: Our Voice, Our Vision, Our Values* (2017) 3 <https://www.nsun.org.uk/our-manifesto>.

which explore experiences of coercion[40] and has committed to campaigning against 'abusive practices of forced medication, restraint and seclusion, and stripping'.[41] There is also a large international body of first-person accounts of traumatic coercive experiences,[42] which has added urgency to the search for alternatives. However, researchers who have used mental health services or been subject to coercive interventions tend not to have framed their research around the explicit question, 'does X practice reduce coercion?' Instead, researchers tended to ask questions such as the following: 'how do people experience current approaches? What alternative responses are preferred, and what are the benefits of these alternatives?' It is also the case that explicitly testing the impact of a certain practice on rates of coercion often requires considerable resources and professional authority within health systems, which may not be available to service user researchers and representative organisations. Prominent practices promoted by user organisations include talking therapies, individual advocacy, mutual aid programs (such as 'intentional peer support'), peer-run crisis respite houses and non-medication or low-medication approaches, all of which are discussed throughout this report. Again, rarely are these practices explicitly tested for their contribution to preventing or reducing coercive interventions—often they are evaluated in terms of the personal benefits to individuals (for example, through hospital diversion, short-term reduction in distress, and self-reported satisfaction). These trends present a challenge when undertaking a formal review of alternatives to coercion in mental healthcare that seeks to elevate the perspectives of persons with mental health conditions and psychosocial disabilities.

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40 See, eg, Dorothy Gould, *Service Users' Experiences of Recovery under the 2008 Care Programme Approach: A Research Study* (National User Survivor Network, 2012); Dorothy Gould, *The Healthy Lives Project Full Report* (National User Survivor Network, 2016), 24, 45, 58.

41 National Survivor User Network, above n 39, 11. Aim number 6 of the manifesto is to '[c]ampaign to radically reform the Mental Health Act (2007) to make the provisions of the UN Convention on the Rights of Persons with Disability (UNCRPD) a reality for people with lived experience of mental distress, as part of the wider disability community'.

42 See above n 38. See also <http://www.mindfreedom.org/personal-stories/personal-stories/>; <http://psychrights.org/horrors.htm>.

As such, Appendices Two and Three contain relevant literature and other materials generated by persons with mental health conditions and psychosocial disabilities that did not fall within the explicit aim to identify empirical studies on alternatives to coercive practices. Appendix Two contains materials that were either non peer reviewed or were peer reviewed but did not fit expressly within the scope. For example, a non peer reviewed report authored by the Users and Survivors of Psychiatry – Kenya examines the role of organised and informal peer support in 'exercising legal capacity in Kenya'.[43] There were also service user-led initiatives explicitly designed to reduce coercive practices, including Foxlewin's empirical study, commissioned by the Australian Capital Territory (ACT) Mental Health Consumer Network.[44] Foxlewin's project examined seclusion reduction interventions at a single Australian hospital, in which seclusion incident rates reportedly fell from 6.9% in 2008/9 to less than 1% in 2010/11. Although this project report is not formally peer reviewed, it is valuable for the added description of a service user-led strategy. It seemed important to acknowledge this type of work and to include relevant grey literature throughout this Review.

To further incorporate practices promoted by persons with mental health conditions and psychosocial disabilities and their representative groups, we included terms during the literature search that reflected these alternatives, such as the terms 'advocacy', 'medication discontinuation', 'crisis resolution' and 'crisis/respite houses'.[45] We will discuss the relevance of each of these categories to different types of coercion in mental healthcare as they arise. Again, Appendix Three contains a list of practices that are commonly presented by organisations representing persons with mental health conditions and psychosocial disabilities, a significant number of which have not been subject to either formal or informal evaluation.

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43 Users and Survivors of Psychiatry – Kenya, *The Role Of Peer Support In Exercising Legal Capacity in Kenya* (April 2018) <www.uspkenya.org>.

44 Bradley Foxlewin, *What Is Happening at the Seclusion Review That Makes a Difference?: A Consumer Led Research Study* (ACT Mental Health Consumer Network, 2012).

45 It should also be noted that this approach of undertaking additional searches on particular initiatives was taken to other initiatives, not necessarily service user-led, such as the 'Six Core Strategies', uncovering several studies which did not appear in the original search.

As a final comment on the importance of involving persons with disabilities in research affecting them, it is noteworthy that coercion in mental health interventions is also used on persons with intellectual and/or developmental disabilities and older persons. A more extensive study would seek to incorporate the views of these individuals and their representative organisations.

Section Two: Results of the Literature Review

After an extensive search, 500+ relevant peer-reviewed research studies were identified for review. From these, non-research articles (theoretical papers, reviews, overviews and commentaries), articles which were not available in English, duplicates and articles not available in full text (and where a detailed abstract was not available) were excluded. This resulted in a total of 121 empirical research papers included in the review.
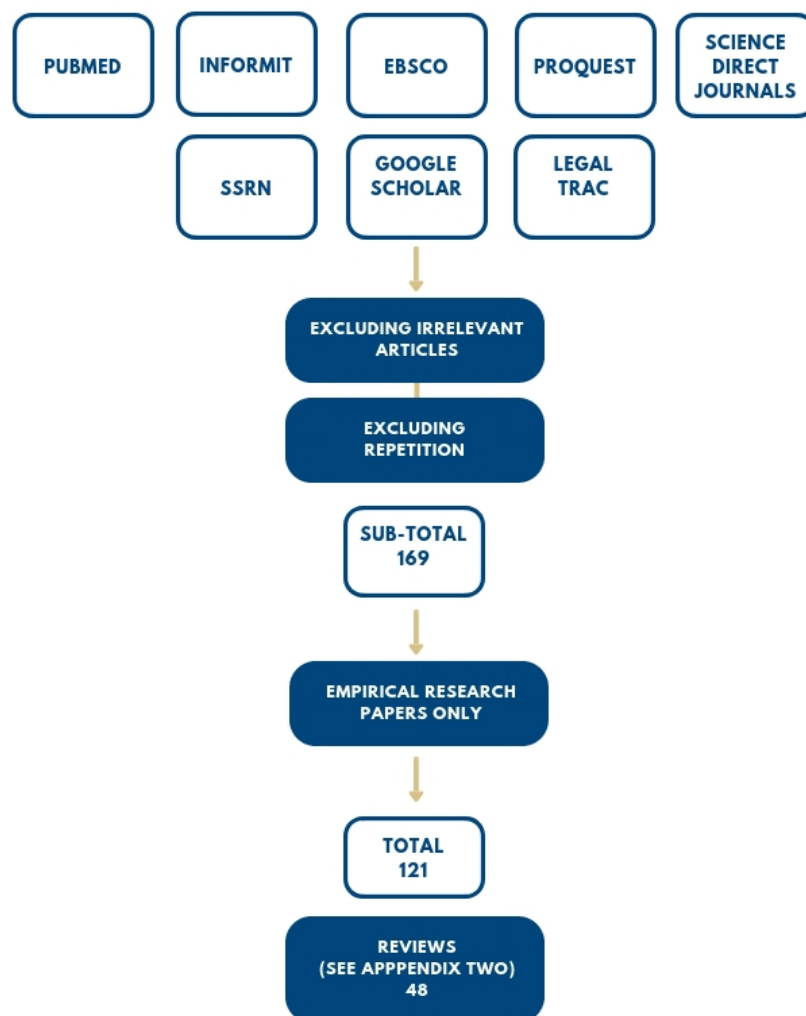
Figure 1: Flow chart showing inclusion process

Secondary to the research papers, we also identified 48 review papers and other notable materials relevant to this review. 'Notable materials' include grey literature, including research papers undertaken by service user organisations, government agencies, and so on. An overview and summary of all the identified review papers and notable materials can be found in Appendix Two. In general, the review papers and notable materials have not been included in the thematic analysis and reporting of results in this report, as they do not contain peer-reviewed primary data. However, we occasionally refer to relevant review papers to supplement observations about themes emerging from the empirical studies.

Methods Used in the Studies

The research methods used in the literature can be roughly distinguished between positivist or phenomenological research philosophies.

Positivistic methods are typically deductive, highly structured, include large samples, measurement, and typically adopt quantitative methods of analysis, which allow a range of data to be analysed.[46] Researchers in this tradition typically position themselves as detached, neutral and independent and endeavour to undertake value-free research from an objective stance.[47]

Phenomenological methods consider the way people experience a particular situation or phenomenon. Researchers would typically use qualitative methods, mostly in the form of in-depth conversations and interviews, or data collected through observation. Often, sample sizes are relatively small, often less than 25 participants.[48] Data is typically analysed inductively in an attempt to identify themes or make generalisations about a particular phenomenon, and how it is perceived or experienced. Researchers in this tradition typically position themselves as interacting with research

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46 See generally, Michael Polanyi, *Personal Knowledge: Towards a Post-Critical Philosophy* (University of Chicago Press, 1958).

47 Pamela Maykut and Richard Morehouse, *Beginning Qualitative Research: A Philosophical and Practical Guide* (The Falmer Press, 2002) 15.

48 Ibid 58.

subjects; for example, as a participant observer, interviewer, or a focus group facilitator, 'but also remove[…] him/herself from the situation to rethink the meanings of the experience'.[49]

The specific methods used in the empirical research papers we reviewed were:

- Case Study: 5

- Mixed Methods: 17

- Qualitative: 26

- Quantitative: 73

Thus, most papers used quantitative methodology, typically comprising service data and surveys. Overall, sample sizes tended to be small and used convenience sampling (that is, focused on specific services). There were a few national surveys that provide valuable generalisable data. Qualitative studies provided an insight into subjective experiences of participants, and detailed understandings of enablers and barriers to reducing coercive practices in a variety of settings. Often the samples in qualitative studies were small and non-generalisable.

The quantitative studies mostly analysed service data, such as reports of seclusion or restraint incidents, rates of restricted leave being imposed, rates of involuntary detention, and so on. Qualitative studies typically consisted of interviews. Many of these studies had limitations in terms of study design, length of trial periods and settings.

Research involved adults with mental health conditions and psychosocial disabilities, both men and women (with only several studies having a gender-focus),[50] prisoners or forensic mental

49 Ibid 23.
50 Clive G Long et al, 'Reducing the Use of Seclusion in a Secure Service for Women' (2015) 11(2) *Journal of Psychiatric Intensive Care* 84.

health patients,[51] children and adolescents,[52] older adults,[53] and ethnic minorities or migrant groups,[54] as well as professionals, typically in clinical settings.

Summarising and Reporting the Results

The thematic analysis is structured as follows. First, we discuss (1) themes and practices that are applicable across hospital and community settings, before focusing on (2) hospital-based and (3) non-hospital measures. We then discuss miscellaneous trends in the literature, including advance planning, supported decision-making and the need for culturally appropriate services.

1. Overarching Themes

This section will discuss overarching approaches to reducing coercion before discussing more specific studies based in hospitals and community-based services.

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51 Helen Olsson and Ulla-Karin Schön, 'Reducing Violence in Forensic Care - How Does It Resemble the Domains of a Recovery-Oriented Care?' (2016) 25(6) *Journal of Mental Health* 506; Tessa Maguire, R Young and Trish Martin, 'Seclusion Reduction in a Forensic Mental Health Setting' 19(2) Journal of *Psychiatric and Mental Health Nursing* 97.

52 Andrés Martin et al, 'Reduction of Restraint and Seclusion Through Collaborative Problem Solving: A Five-Year Prospective Inpatient Study' (2008) 59(12) *Psychiatric Services* 1406.

53 Patricia S Mann-Poll et al, 'Long-Term Impact of a Tailored Seclusion Reduction Program: Evidence for Change?' (2018) 89(3) *Psychiatric Quarterly* 733; Elisabeth Gjerberg et al, 'How to Avoid and Prevent Coercion in Nursing Homes: A Qualitative Study' (2013) 20(6) *Nursing Ethics* 632.

54 Marie Louise Norredam et al, 'Excess Use of Coercive Measures in Psychiatry among Migrants Compared with Native Danes.' (2010) 121(2) *Acta Psychiatrica Scandinavica* 143; Eric O Noorthoorn et al, 'Seclusion Reduction in Dutch Mental Health Care: Did Hospitals Meet Goals?' (2016) 67(12) *Psychiatric Services* 1321; Martin et al, above n 52.

Policies and Practices Promoting Human Rights, Recovery and Trauma-Informed Support

Three over-arching themes emerged, which were generally associated with a shift away from coercive practices. In Watson and colleagues' terms:

> Three frameworks currently used in mental health services – human rights, personal recovery, and trauma-informed – are consistent with a shift away from the use of force.[55]

These three terms are used in diverse ways to refer to a wide range of policies, practices and law reform efforts. As such, it is difficult to pin-point an evidentiary basis for the causative impact of 'rights-based', 'recovery-oriented' or 'trauma-informed' services, policies and laws on rates of coercion. Each of these categories refer to complex interventions that are often contested and which can be applied in a wide range of national contexts and settings, from low- to high-income countries, in hospitals, respite houses, in-home support services and in efforts to curb coercion in the family home. However, the review findings support Watson and colleagues' general observation that these overarching themes are typically linked to efforts to reduce and end coercive practices. For the purposes of this section we will briefly outline these policy/practice frameworks and highlight several indicative studies. (In-depth consideration of particular studies will occur later in the review in relation to particular practices; for example, respite houses, de-escalation strategies or open door policies).

The basis for **human rights** approaches to reducing coercion has been described in the Background Section of this report. 'Human rights' (and associated terms, such as 'fundamental' rights) were explicitly mentioned in the titles, abstracts or keywords of 12

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55 Sandy Watson et al, 'Care without Coercion – Mental Health Rights, Personal Recovery and Trauma-Informed Care' 49(4) *Australian Journal of Social Issues* 529.

studies.[56] This seems a rather low number, and it seems reasonable to suggest that the concept of human rights has not been explicitly used as a framing category in most empirical studies on reducing coercion in mental health settings, though human rights were referred to in the body of several more articles.[57] The studies that explicitly refer to human rights tended to do so in relation to: efforts to reduce coercion in low and middle income countries,[58] law reform endeavours following the CRPD coming into force (particularly supported decision-making measures in Argentina and the invalidation of some civil commitment powers in Germany),[59] and research on self-advocacy by persons with mental health conditions or psychosocial disabilities.[60] We will discuss these specific efforts later in the report.

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56 Asher et al, above n 8; Francisco J Bariffi and Matthew S Smith, 'Same Old Game but with Some New Players – Assessing Argentina's National Mental Health Law in Light of the Rights to Liberty and Legal Capacity under the UN Convention on the Rights of the Persons with Disabilities' (2013) 31(3) *Nordic Journal of Human Rights* 325; Paul Cutler, Robert Hayward and Gabriela Tanasan, *Supporting User Led Advocacy in Mental Health* (Open Society Foundations, 2006); Lili Guan et al, 'Unlocking Patients with Mental Disorders Who Were in Restraints at Home: A National Follow-Up Study of China's New Public Mental Health Initiatives' (2015) 10(4) *PLoS ONE* e0121425; Jasna Russo and Diana Rose, '"But What If Nobody's Going to Sit down and Have a Real Conversation with You?" Service User/Survivor Perspectives on Human Rights' (2013) 12(4) *Journal of Public Mental Health* 184; Sharon Kleintjes, Crick Lund and Leslie Swartz, 'Organising for Self-Advocacy in Mental Health: Experiences from Seven African Countries' (2013) 16(3) *African Journal of Psychiatry* 187; Ragnfrid Eline Kogstad, 'Protecting Mental Health Clients' Dignity - The Importance of Legal Control.' (2009) 32(6) *International Journal Of Law and Psychiatry* 383; Ellen Meijer et al, 'Regaining Ownership and Restoring Belongingness: Impact of Family Group Conferences in Coercive Psychiatry' (2017) 73(8) *Journal Of Advanced Nursing* 1862; Watson et al, above n 55; Petr Winkler et al, 'A Blind Spot on the Global Mental Health Map: A Scoping Review of 25 Years' Development of Mental Health Care for People with Severe Mental Illnesses in Central and Eastern Europe' (2017) 4(8) *The Lancet. Psychiatry* 634; Martin Zinkler, 'Germany without Coercive Treatment in Psychiatry—A 15 Month Real World Experience' (2016) 5(1) *Laws* 15; Sophie Corlett, 'Policy Watch: A Steady Erosion of Rights.' (2013) 17(2) *Mental Health and Social Inclusion* 60.

57 See, eg, Chris Maylea, 'Minimising Coerciveness in Coercion: A Case Study of Social Work Powers under the Victorian Mental Health Act' (2017) 70(4) *Australian Social Work* 465; Diana Rose et al, 'Service User Perspectives on Coercion and Restraint in Mental Health' (2017) 14(3) *BJPsych International* 59; Laura S Shields et al, 'Unpacking the Psychiatric Advance Directive in Low-Resource Settings: An Exploratory Qualitative Study in Tamil Nadu, India' (2013) 7 *International Journal of Mental Health Systems* 29.

58 Guan et al, above n 56; Asher et al, above n 8; Winkler et al, above n 56.

59 Zinkler, above n 56; Bariffi and Smith, above n 56.

60 Kleintjes, Lund and Swartz, above n 56; Cutler, Hayward and Tanasan, above n 56.

Recovery-oriented support is prominent in the literature. The term 'recovery' appeared in the title, abstract or table of contents of 20 studies,[61] and was referred to in the text of several more.[62] Leamy and colleagues argue that there are five key themes in the literature on recovery:

- connectedness;

- hope and optimism about the future;

- rebuilding or redefining a positive identity;

61 Lori Ashcraft and William Anthony, 'Eliminating Seclusion and Restraint in Recovery-Oriented Crisis Services' (2008) 59(10) *Psychiatric Services (Washington, D.C.)* 1198; Lori Ashcraft, Michelle Bloss and William A Anthony, 'Best Practices: The Development and Implementation of "No Force First" as a Best Practice.' (2012) 63(5) *Psychiatric Services (Washington, D.C.)* 415; Mary Chambers et al, 'The Experiences of Detained Mental Health Service Users: Issues of Dignity in Care.' (2014) 15(1) *BMC Medical Ethics* 50; Corlett, above n 56; Bevin Croft and Nilüfer Isvan, 'Impact of the 2nd Story Peer Respite Program on Use of Inpatient and Emergency Services' (2015) 66(6) *Psychiatric Services* 632; Carolyn Doughty and Samson Tse, 'Can Consumer-Led Mental Health Services Be Equally Effective? An Integrative Review of CLMH Services in High-Income Countries' (2011) 47(3) *Community Mental Health Journal* 252; Robert E Drake and Patricia E Deegan, 'Are Assertive Community Treatment and Recovery Compatible? Commentary on "ACT and Recovery: Integrating Evidence-Based Practice and Recovery Orientation on Assertive Community Treatment Teams"' (2008) 44(1) *Community Mental Health Journal* 75; Claire Henderson et al, 'A Typology of Advance Statements in Mental Health Care' (2008) 59(1) *Psychiatric Services (Washington, D.C.)* 63; Matthias Jaeger et al, 'Patients' Subjective Perspective on Recovery Orientation on an Acute Psychiatric Unit.' (2015) 69(3) *Nordic Journal Of Psychiatry* 188; Kleintjes, Lund and Swartz, above n 56; Renata Kokanović et al, 'Supported Decision-Making from the Perspectives of Mental Health Service Users, Family Members Supporting Them and Mental Health Practitioners (2018) 52(9) *Australian & New Zealand Journal of Psychiatry* 826; Harriet P Lefley, 'Advocacy, Self-Help, and Consumer- Operated Services' in Alan Tasman et al (eds) *Psychiatry* (Wiley-Blackwell, 2008) 2083; Long et al, above n 50; Christina Lyons et al, 'Mental Health Crisis and Respite Services: Service User and Carer Aspirations' (2009) 16(5) *Journal of Psychiatric and Mental Health Nursing* 424; Olsson and Schön, above n 51; Sanaz Riahi et al, 'Implementation of the Six Core Strategies for Restraint Minimization in a Specialized Mental Health Organization' (2016) 54(10) *Journal of Psychosocial Nursing and Mental Health Services* 32; Shields et al, above n 57; Watson et al, above n 55; Jennifer P Wisdom et al, 'The New York State Office of Mental Health Positive Alternatives to Restraint and Seclusion (PARS) Project' (2015) 66(8) *Psychiatric Services* 851; Roberto Mezzina, 'Community Mental Health Care in Trieste and Beyond: An "Open Door–No Restraint" System of Care for Recovery and Citizenship' (2014) 202(6) *The Journal of Nervous and Mental Disease* 440.

62 See, eg, Guan et al, above n 56; Gert Schout et al, 'The Use of Family Group Conferences in Mental Health: Barriers for Implementation' (2017) 17(1) *Journal of Social Work* 52; Mike Slade et al, 'Alternatives to Standard Acute In-Patient Care in England: Short-Term Clinical Outcomes and Cost-Effectiveness' (2010) 197(Suppl 53) *The British Journal of Psychiatry* s14.

- pursuing a meaningful life; and

- empowerment through personal responsibility.[63]

Several practices aimed at reducing coercion drew explicitly from the concept of 'recovery'. Wisdom and colleagues, for example, reported that the 'Positive Alternatives to Restraint and Seclusion' project of the New York State Office of Mental Health was designed to 'eliminate the use of [seclusion and restraint] throughout the state's mental health system of care by creating coercion- and violence-free treatment environments governed by a philosophy of recovery, resiliency, and wellness'.[64] The project drew on the 'Six Core Strategies to Reduce the Use of Seclusion and Restraint' program, which we will discuss in greater detail shortly. The strategy reportedly resulted in 'significant decreases in restraint and seclusion episodes per 1,000 client-days' which included developing 'ways to facilitate open, respectful two-way communication between management and staff and between staff and youths and greater involvement of youths in program decision making'.[65] Riahi and colleagues examine the impact of a Six Core Strategies approach, referring to it explicitly as a 'recovery-oriented' initiative.[66]

A 'trauma-informed' approach, which again is prominent in the advocacy of organisations for people with psychosocial disabilities, was explicitly discussed in only three studies, in which it was positioned as a framing concept for specific efforts to reduce seclusion and restraint.[67] Several other studies referred to the traumatising impact of coercive practices.[68] 'Trauma-informed' approaches involve the recognition of the high prevalence of traumatic experiences in people with mental health issues and

63 Mary Leamy et al, 'Conceptual Framework for Personal Recovery in Mental Health: Systematic Review and Narrative Synthesis' (2011) 199(6) *The British Journal of Psychiatry* 445, 455.

64 Jennifer P Wisdom et al, 'The New York State Office of Mental Health Positive Alternatives to Restraint and Seclusion (PARS) Project' (2015) 66(8) *Psychiatric Services* 851, 851.

65 Ibid.

66 Riahi et al, above n 61.

67 Muhammad Waqar Azeem et al, 'Effectiveness of Six Core Strategies Based on Trauma Informed Care in Reducing Seclusions and Restraints at a Child and Adolescent Psychiatric Hospital' 24(1) *Journal of Child and Adolescent Psychiatric Nursing* 11.

68 See, eg, Cutler, Hayward and Tanasan, above n 56; Git-Marie Ejneborn Looi, Åsa Engström and Stefan Sävenstedt, 'A Self-Destructive Care: Self-Reports of People Who Experienced Coercive Measures and Their Suggestions for Alternatives' (2015) 36(2) *Issues in Mental Health Nursing* 96; Riahi et al, above n 61; Maylea, above n 57

the approach emphasises understanding and responding to the effects of all types of trauma as well as ensuring that practice does not result in re-traumatisation. Azeem and colleagues reported on an approach in which a state mental health plan had incorporated trauma-informed care into the Six Core Strategies to Reduce the Use of Seclusion and Restraint discussed below).[69] Borckhardt and colleagues also incorporated trauma-informed care into a particular intervention aimed at reducing the rate of seclusion and restraint in an inpatient psychiatric hospital.[70] Several crisis houses, particularly those that are peer-led, place a strong emphasis on addressing histories of trauma in the lives of residents.[71] According to the Mental Health Coordinating Council (Australia), there are eight foundational principles of trauma-informed care:

- understanding trauma and its impact;

- promoting safety;

- ensuring cultural competence;

- supporting service user control, choice and autonomy;

- sharing power and governance;

- integrating care;

- healing happening in relationships; and

- recovery being possible.[72]

Given the prominence elsewhere in the mental health-related literature on the importance of trauma-informed support, there appears to be a gap in research explicitly concerned with the impact of trauma-informed approaches to reducing, preventing and ending coercive practices.

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69 Azeem et al, above n 67, 11.

70 Jeffrey J Borckardt et al, 'Systematic Investigation of Initiatives to Reduce Seclusion and Restraint in a State Psychiatric Hospital' (2011) 62(5) *Psychiatric Services* 477, 477.

71 See, eg, Alyssum Residential Service, Rochester, Vermont <https://www.alyssum.org/program>.

72 Mental Health Coordinating Council, *Trauma Informed Care and Practice: Towards a Cultural Shift in Policy Reform Across Mental Health and Human Services in Australia: A National Strategic Direction*, Position Paper and Recommendations of the National Trauma-Informed Care and Practice Advisory Working Group (2013) <http://www.mhcc.org.au/media/32045/ticp_awg_position_paper__v_44_final___07_11_13.pdf>.

National Policies

Several studies undertook analyses of national practices and policies.[73] For example, Noorthoorn and colleagues studied the result of more than 100 reduction projects in 55 hospitals, following €35 million in funding from the Dutch government.[74] The average yearly nationwide reduction of secluded patients recorded by this study was about 9%.[75] Guan and colleagues studied the result of a national policy in China, referred to as the '686' Program, which was designed to reduce and eliminate incidents of community-based locking away of persons with psychosocial disabilities. Instead, there were concerted efforts made to extend community-based mental health treatment to such persons. The authors report a 92% success rate for those previously detained, as recorded in the year of the empirical research (2012) and suggested that the policy sets a useful precedent for low- and middle-income countries.[76]

Laws Designed to Reduce, End or Prevent Coercion

Six studies examined the impact of legal change on rates of coercion in mental health settings. In **Germany**, in 2011 and 2012, several landmark decisions by Germany's Constitutional Court and Federal Supreme Court restricted the imposition of involuntary psychiatric interventions.[77] The restriction narrowed the grounds for intervention to 'life-threatening emergencies' only.[78] The court restrictions were based on Germany's constitutional obligations as signatories to the CRPD. According to Zinkler, the legal provisions led to 'examples where clinicians put an even greater emphasis on consensual treatment and did not return to

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73 Christoffer Thomsen et al, 'Risk Factors of Coercion among Psychiatric Inpatients: A Nationwide Register-Based Cohort Study' (2017) 52(8) *Social Psychiatry and Psychiatric Epidemiology* 979; Eric O Noorthoorn et al, 'Seclusion Reduction in Dutch Mental Health Care: Did Hospitals Meet Goals?' (2016) 67(12) *Psychiatric Services* 1321; Christopher Toorgard Thomsen et al, 'Patient-controlled Hospital Admission for Patients with Severe Mental Disorders: A Nationwide Prospective Multicentre Study' (2018) 137(4) *Acta Psychiatrica Scandinavica* 355; Martin Zinkler, 'Germany without Coercive Treatment in Psychiatry—A 15 Month Real World Experience' (2016) 5(1) *Laws* 15; Fleur J Vruwink et al, 'The Effects of a Nationwide Program to Reduce Seclusion in the Netherlands' (2012) 12 *BMC Psychiatry* 231; PS van der Schaaf et al, 'Impact of the Physical Environment of Psychiatric Wards on the Use of Seclusion' (2013) 202 *The British Journal Of Psychiatry* 142.

74 Noorthoorn et al, above n 54.

75 Ibid.

76 Guan et al, above n 56.

77 Federal Constitutional Court (Germany), 'Press Office - Press Release No 28/2011 of 15 April 2011, Order of 23 March 2011', 2 BvR 882/09.

78 Ibid.

coercive treatment'.[79] Flammer and Steinart point to some evidence that the legal reform led to a reduction in the use of involuntary medication, although the study was small-scale.[80] Despite the overall reduction, they reported some adverse effects, including a possible increase in some services of 'violent incidents', which potentially increased the use of physical and mechanical restraint.[81]

Argentina's *National Mental Health Law 2010* ('NMHL')[82] was the subject of a small qualitative study. The NMHL contains a mechanism that requires any civil commitment measure to be based on interdisciplinary evaluations that seek to assess not just the person's mental health condition but the availability of support in his or her life and the harm caused by involuntary interventions.[83] Bariffi and Smith argue that 'the evolving practice arising from the interdisciplinary evaluation requirement, suggests that interdisciplinary teams aware of the CRPD may prove effective in promoting the replacement of restrictions with supported decision-making arrangements'.[84]

The teams consist of psychiatrists, psychologists, lawyers and social workers, who reportedly use the CRPD as a guide in communicating and reporting to judges, including highlighting a person's communication needs, considering whether past experiences of involuntary treatment have compromised the person's autonomy and personal development, and looking for gaps that could be remedied with services.[85] Aside from Bariffi and Smith's study, which reports on several cases under the NMHL, there does not appear to be any English-language research on how this

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79 Martin Zinkler, 'Germany without Coercive Treatment in Psychiatry—A 15 Month Real World Experience' (2016) 5(1) *Laws* 15.

80 Erich Flammer and Tilman Steinert, 'Involuntary Medication, Seclusion, and Restraint in German Psychiatric Hospitals after the Adoption of Legislation in 2013' (2015) 6 *Frontiers in Psychiatry* 153.

81 Ibid.

82 Law No 26657, 3 December 2010 [32041] BO 1; 'Mental Health Regime', House of Representatives Res D-276/07 (7 March 2007) art 1.

83 Francisco J Bariffi and Matthew S Smith, 'Same Old Game but with Some New Players – Assessing Argentina's National Mental Health Law in Light of the Rights to Liberty and Legal Capacity under the UN Convention on the Rights of the Persons with Disabilities' (2013) 31(03) *Nordic Journal of Human Rights* 325, 325.

84 Ibid 339.

85 Ibid 340.

measure is working in practice, including no indication that data on involuntary hospitalisation is being collected.[86]

Bruckner and colleagues undertook a study in **California,** the United States, to examine the impact of California's *Mental Health Services Act 2004* (MHSA) on quarterly rates of '72-hour holds' (N=593,751) and '14-day psychiatric hospitalizations' (N=202,554).[87] They examined 28 Californian counties, with over 22 million inhabitants, from 2000-07. They sought to test the hypothesis that the incidence of the two types of involuntary treatment, 72-hour holds and 14-day psychiatric civil commitments, declined as the service access and quality was improved by the $3.2 billion tax revenue investment associated with the MHSA in California. They reported that the petitions for involuntary 14-day hospitalisations, but not involuntary 72-hour holds, fell below expected values after disbursement of MHSA funds. In these counties, 3,073 fewer involuntary 14-day treatments – approximately 10% below expected levels – could be attributed to disbursement of MHSA funds. They concluded that fewer than expected involuntary 14-day holds for continued hospitalisation may indicate an important shift in service delivery, and argue that MHSA funds may have facilitated the discharge of clients from hospitals by providing enhanced resources and access to a range of less-restrictive community-based treatment alternatives.

Research conducted by the **Vermont** Department of Mental Health in the United States, is notable with regards to legislative change and a requirement placed on the Vermont government to report on developments aimed at ending and reducing coercive mental health practices. The Department is obliged under state law to report annually 'regarding the extent to which individuals with a mental health condition or psychiatric disability receive care in the most integrated and least restrictive setting available',[88] including reporting on the following:

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86 See, Bariffi and Smith, above n 83. See also, Ana Laura Aiello, 'Argentina' in Lisa Waddington and Anna Lawson, *The UN Convention on the Rights of Persons with Disabilities in Practice: A Comparative Analysis of the Role of Courts* (Oxford University Press, 2018) Ch 2.

87 Tim A Bruckner et al, 'Involuntary Civil Commitments After the Implementation of California's Mental Health Services Act' (2010) 61(10) *Psychiatric Services* 1006, 1006.

88 2017 Vermont Statutes, Title 18 – Health, Chapter 174 - Mental Health System of Care, § 7256 Reporting requirements.

(6) ways in which patient autonomy and self-determination are maximized within the context of involuntary treatment and medication;

(7) performance measures that demonstrate results and other data on individuals for whom petitions for involuntary medication are filed; and

(8) progress on alternative treatment options across the system of care for individuals seeking to avoid or reduce reliance on medications, including supported withdrawal from medications.[89]

It is not clear to what extent such reporting requirements impact upon rates of coercion in mental health services.

Eytan and colleagues examined the impact of a law introduced in **Switzerland** in 2006, in which only certified psychiatrists were authorised to require a compulsory admission, whereas previously, all physicians could do so, including 'residents'.[90] The study, which was based on a single hospital in Switzerland led to a significant reduction in compulsory admissions, with service users being less likely to be hospitalised on a compulsory basis after the change. The proportion of compulsory admissions increased from 55% in 2001 to 69% in 2005. After the law was introduced, this proportion decreased to 48% in 2007 and remained below 50% thereafter. According to the authors, the results 'strongly suggest that limiting the right to require compulsory admissions to fully certified psychiatrists can reduce the rate of compulsory versus voluntary admissions'.[91] This reform endeavour will not satisfy the high standard of the CRPD Committee, given its directive to repeal mental health legislation authorising involuntary interventions. However, this relatively modest study may provide a strategy to reduce rates of involuntary intervention within the general framework of existing law.

In **Italy**, Mezzina undertook a general review of the available literature on 'Law 180', a law which precipitated Italian deinstitutionalisation. Mezzina presents some evidence of the laws impact over 40 years, stating that '[m]echanical restraints have been abolished in health and social care, including nursing homes and

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89 Ibid (6)-(8).

90 Ariel Eytan et al, 'Impact of Psychiatrists' Qualifications on the Rate of Compulsory Admissions' (2013) 84(1) *Psychiatric Quarterly* 73, 73.

91 Ibid.

general hospitals'.[92] He points out that after the law was enacted in 1978, involuntary treatments 'dropped dramatically' and 'have sustained the lowest ratio in Europe (17/100,000 in 2015) and the shortest duration (10 days)'.[93] However, it is not clear to which data he is referring when making this claim. Mezzina further notes in relation to rates in the city of Trieste and also the Friuli-Venezia region that '[i]nvoluntary treatments show the lowest rate in Italy, and about 40% of them are managed in [Community Mental Health Centres] with open doors.'[94] We will discuss the Trieste model of mental healthcare in Section 2.2 of this report.

'Peer-Led' Initiatives and Research

One theme in the literature concerns the wide range of initiatives led by persons with mental health conditions or psychosocial disabilities. These initiatives include self-help organisations and community development groups,[95] state-supported service user organisations, independent activist groups, 'peer-workforces' in hospitals and other mental health services. These groups appear across low, middle-, and high-income countries. Because of this diversity, this specific section on user-led initiatives will refer to some of the prominent studies on such initiatives, but will discuss them in greater detail when referring to specific practices (such as 'peer-run crisis centres' and 'self-help groups').

Organisations or groups representing service users, former service users and others with psychosocial disabilities are inclined to advocate for stronger measures to reduce and end coercion and to aim for more ambitious change in practice, compared to other stakeholder groups, such as clinicians or clinician researchers who have led most of the published intervention studies. Often, such organisations stress the need for elimination of seclusion and restraint,[96] which has not been the explicit target of any largescale research published study to date. According to Rose and colleagues, in their report on a survey of 65 service

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92 Roberto Mezzina, 'Forty Years of the Law 180: The Aspirations of a Great Reform, Its Successes and Continuing Need' (2018) 27(4) *Epidemiology and Psychiatric Sciences* 336.

93 Ibid.

94 Mezzina, above n 92.

95 See, eg, 'TCI-Asia' and 'Club House' initiatives in Appendix Three.

96 See, eg, World Network of Users and Survivors of Psychiatry, *Human Rights Position Paper of the World Network of Users and Survivors of Psychiatry* <http://www.wnusp.net/index.php/human-rights-position-paper-of-the-world-network-of-users-and-survivors-of-psychiatry.html>; Balance Aotearoa, 'Disability Action Plan' <http://www.balance.org.nz/disability-action-plan>.

users in England, '[f]rom the perspective of service users, co-ercion and restraint are mostly harmful and must stop being le-gitimised'.[97] The material in this review shows little evidence of hospitals involving people with lived experience of mental health issues in planning, oversight or review of strategies to reduce and eliminate coercion in mental health practices, though there are exceptions.[98]

As noted, most empirical research by persons with psychosocial disabilities does not focus directly on coercion but rather practic-es designed to address unmet need. The Users and Survivors of Psychiatry – Kenya (USPK), for example, examined the role of or-ganised and informal peer support in 'exercising legal capacity in Kenya'.[99] The study focused on 10 peer-support meetings (com-prising users, carers, friends, USPK staff members) with eight additional interviews with service users. The researchers sought to identify concrete examples of decisions taken with the support of peers, which included informal advance directives, representa-tional supports and other practices that the formal literature indi-cates helps to reduce coercive interventions (as discussed later in the report). Other studies, such as Foxlewin's empirical study, commissioned by the Australian Capital Territory Mental Health Consumer Network, were explicitly aimed at seclusion reduction – again, he reports incidence rates falling from 6.9% in 2008/9 to less than 1% in 2010/11.[100]

Some empirical studies indicated that certain types of user-led initiatives were not associated with any impact on coercion. For example, Thomsen and colleagues produced evidence indicating that 'patient-controlled admission' did not reduce coercion.[101] On the other hand, Croft and Isvan compared 139 users of 'peer res-pite' with 139 non-users of respite with similar histories of behav-ioural health service use and clinical and demographic character-istics, finding that the odds of using any inpatient or emergency services after the programme start date were approximately 70%

97 Rose et al, above n 57.

98 See, eg, Foxlewin, above n 44.

99 See, eg, Users and Survivors of Psychiatry – Kenya, 'The Role Of Peer Support In Exercising Legal Capacity In Kenya' (April 2018) 1 <www.uspkenya.org>.

100 Foxlewin, above n 44.

101 Thomsen et al, 'Patient-controlled Hospital Admission for Patients with Severe Mental Disorders: A Nationwide Prospective Multicentre Study', above n 73, 355.

lower among respite users than non-respite users.[102] (However, the odds reportedly increased with each additional respite day and the association 'was one of diminishing returns, with negligible decreases predicted beyond 14 respite days').[103] The authors conclude that by reducing the need for inpatient and emergency services for some individuals, peer respites may increase meaningful choices for recovery and decrease 'reliance on costly, coercive, and less person-centered modes of service delivery'.[104] Other studies concerning user-led initiatives did not directly engage with the issue of coercive treatment, though discussed positive impacts of user-led initiatives that are likely to contribute to the reduction and ending of coercion. Tanenbaum, for example, undertook qualitative research and argued that user-led organisations helped address the community needs of formerly institutionalised populations, and provided a counter-argument to those who insist that 'deinstitutionalisation' and 'community care' have failed.[105]

Many studies sought to include the views of persons with psychosocial disabilities.[106] It is also true that many studies – both qualitative and quantitative – did not incorporate the views of service users, former service users or others with psychosocial disabilities.

It was not always possible to identify which studies were led by, co-authored by, or co-designed by persons with mental health conditions or psychosocial disabilities. Some people may not self-identify in this way. Others who do may not make a point of

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102 Bevin Croft and Nilüfer Isvan, 'Impact of the 2nd Story Peer Respite Program on Use of Inpatient and Emergency Services' (2015) 66(6) *Psychiatric Services* 632, 632.

103 Ibid, 632.

104 Ibid.

105 Sandra J Tanenbaum, 'Consumer-Operated Service Organizations: Organizational Characteristics, Community Relationships, and the Potential for Citizenship' (2012) 48(4) *Community Mental Health Journal* 397, 397.

106 See, eg, Kolja Heumann, Thomas Bock and Tania M Lincoln, 'Please Do Something - No Matter What! A Nationwide Online Survey of Mental Health Service Users About the Use of Alternatives to Coercive Measures' (2017) 44(2) *Psychiatrische Praxis* 85; Len Bowers et al, 'Locked Doors: A Survey of Patients, Staff and Visitors.' (2010) 17(10) *Journal of Psychiatric And Mental Health Nursing* 873; William A Fisher, 'Elements of Successful Restraint and Seclusion Reduction Programs and Their Application in a Large, Urban, State Psychiatric Hospital' (2003) 9(1) *Journal of Psychiatric Practice* 7; Marvin S Swartz, Jeffrey W Swanson and Michael J Hannon, 'Does Fear of Coercion Keep People Away from Mental Health Treatment? Evidence from a Survey of Persons with Schizophrenia and Mental Health Professionals.' (2003) 21(4) *Behavioral Sciences & The Law* 459.

it in the studies they conduct. Four studies, to our knowledge, were led by researchers who had experience using mental health services,[107] with several others involved as a co-author.[108] One notable initiative is the EURIKHA Project, which is a 'global user-controlled research project looking at the emergence of social movements which privilege the rights and perspectives of people who experience severe mental distress, variedly known around the world as users, survivors, consumers, clients, patients, persons with psychosocial disabilities, etc'.[109] This relatively new project may provide a useful resource for collating and fostering research on coercive practices that is led by persons with mental health conditions and psychosocial disabilities.

Providing Family-based Support when Responding to Crises and Support Needs

Several studies considered the role of support that was explicitly directed to a person within the context of their family and/or social network. This included both hospital and non-hospital-based crisis resolution.

The Finnish practice of **Open Dialogue** includes an emphasis on working with a person in their family and/or social network. The practice is presented as an alternative to hospital and is therefore associated with reduced likelihood of involuntary treatment. Seikkula and colleagues' small-scale comparative analysis of 45 adults who were given Open Dialogue support compared with 14 service users in typical acute services, indicates that the Open Dialogue approach, 'like other family therapy programs, seems to produce better outcomes than conventional treatment'.[110] We will discuss Open Dialogue later in the report, in relation to Community Crisis Resolution and Home Support, though we note

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107 Tanenbaum, above n 105; Foxlewin, above n 44; Russo and Rose, above n 56; Watson et al, above n 55.

108 Barbara Barrett et al, 'Randomised Controlled Trial of Joint Crisis Plans to Reduce Compulsory Treatment for People with Psychosis: Economic Outcomes' (2013) 8(11) *PLoS One* e74210; Helen Gilburt et al, 'The Importance of Relationships in Mental Health Care: A Qualitative Study of Service Users' Experiences of Psychiatric Hospital Admission in the UK' (2010) 197(Suppl 53) *The British Journal of Psychiatry* s26; Graham Thornicroft et al, 'Clinical Outcomes of Joint Crisis Plans to Reduce Compulsory Treatment for People with Psychosis: A Randomised Controlled Trial' (2013) 381(9878) *The Lancet* 1634.

109 The Eurikha Project <https://www.eurikha.org/about/>

110   Jaakko Seikkula et al, 'Open Dialogue Approach: Treatment Principles and Preliminary Results of a Two-Year Follow-Up on First Episode Schizophrenia' (2003) 5(3) *Ethical Human Sciences and Services* 163, 164.

here that there does not appear to be any empirical research on its impact on rates of coercion. Further, as with all family-based interventions, the benefits may be undermined where family relationships are a source of stress and trauma for an individual.

Family Group Conferencing (FGC) was discussed in five studies, all of them from the Netherlands.[111] Schout, Meijer and de Jong refer to FCG as a '"family-driven" decision-making model and social network strategy'.[112] De Jong and Schout describe FGC as follows:

> the traditional method of decision making in which the professional is in charge is abandoned; it is the family who determines the agenda. Families often find better solutions than care providers. Family Group Conferences (FGCs) enable families to cope with problems in a manner that is consistent with their own culture, lifestyle and history. Unlike traditional approaches that are often 'family-centred', a FGC is 'family-driven'. In other words, the approach is not aimed at the family, but achieves results through the family. Family Group Conferencing employs the resources within society—the natural resources of the family, friends and neighbours are mobilised.[113]

De Jong and Schout examined whether FGC is an effective tool to 'generate social support, to prevent coercion and to promote social integration', reporting on the 'steady growth in conferences' in the Netherlands in recent years.[114] They report that an amendment to the Dutch Civil Code designates FGC as 'good practice'.[115] Meijer and colleagues (including de Jong and Schout) followed this proposal with a study involving 41 family

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111 Gert Schout, Ellen Meijer and Gideon de Jong, 'Family Group Conferencing—Its Added Value in Mental Health Care' (2017) 38(6) *Issues in Mental Health Nursing* 480; Gert Schout et al, 'The Use of Family Group Conferences in Mental Health: Barriers for Implementation' (2017) 17(1) *Journal of Social Work* 52; Gideon de Jong and Gert Schout, 'Prevention of Coercion in Public Mental Health Care with Family Group Conferencing' (2010) 17(9) *Journal Of Psychiatric And Mental Health Nursing* 846; Gideon de Jong and Gert Schout, 'Researching the Applicability of Family Group Conferencing in Public Mental Health Care' (2013) 43(4) *British Journal of Social Work* 796; Ellen Meijer et al, 'Regaining Ownership and Restoring Belongingness: Impact of Family Group Conferences in Coercive Psychiatry' (2017) 73(8) *Journal Of Advanced Nursing* 1862.

112 Schout, Meijer and de Jong, above n 111, 480.

113 de Jong and Schout, 'Researching the Applicability of Family Group Conferencing in Public Mental Health Care', above n 111, 796, 797.

114 Ibid, 796.

115 Ibid.

group conferences in three regions.[116] Survey and observation data was used to identify the impact of the practice on coercive treatment in adult psychiatry.[117] They conclude that family group conferencing 'seems a promising intervention to reduce coercion in psychiatry' by helping to 'regain ownership and restore[] belongingness'.[118] They argue that '[i]f mental health professionals take a more active role in the pursuit of a [sic] family group conferences and reinforce the plans with their expertise, they can strengthen the impact even further'.[119] In the same year, Schout and colleagues examined 17 families/social networks engaged in FCG and sought to identify barriers to applying Family Group Conferences, including identifying when it is not appropriate. [120] They identified the following barriers:

1. (the acute danger in coercion situations, the limited time available, the fear of liability and the culture of control and risk aversion in mental health care;

2. the severity of the mental state of clients leading to difficulties in decision-making and communication;

3. considering a Family Group Conference and involving familial networks as an added value in crisis situation is not part of the thinking and acting of professionals in mental health care;

4. clients and their network (who) are not open to an [sic] Family Group Conference.[121]

Awareness of the barriers for Family Group Conferences, they argue, can 'help to keep an open mind for its capacity to strengthen the partnership between clients, familial networks and professionals' and 'can help to effectuate professional and ethical values of social workers in their quest for the least coercive care'.[122] Two other Dutch studies, by Boumans and colleagues, examines how the 'methodical work approach' could be utilised to reduce seclusion, which includes an explicit process of involving family

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116 Meijer et al, above n 111, 1862.

117 Ibid.

118 Ibid.

119 Ibid.

120 Schout et al, 'The Use of Family Group Conferences in Mental Health: Barriers for Implementation' above n 111, 52.

121 Ibid.

122 Ibid.

in responding to treatment in acute hospital settings.[123] We will discuss this approach in more detail in the Hospital-Based Strategies Section of this report.

In low- and middle-income countries, research suggested that family-based interventions were important to address the restraint of persons with mental health conditions and psychosocial disabilities in community-settings. Asher and colleagues' research with adults with schizophrenia, 'their caregivers, community leaders and primary and community health workers' in rural Ethiopia indicated that increasing access to treatment was the most effective way to reduce the incidence of restraint.[124] Guan and colleagues conducted a largescale project in China involving a nationwide two-stage follow-up study to measure the effectiveness and sustainability of the 'unlocking and treatment' intervention and its impact on the 'well-being of patients' families'.[125] The emphasis on family wellbeing rather than individual wellbeing is notable. The authors reported that over 92% of participants remained free of restraints in 2012 and they argued that '[p]ractice-based evidence from our study suggests an important model for protecting the human rights of people with mental disorders and keeping them free of restraints […][via] accessible, community based mental health services with continuity of care'.[126] The programme focused on 'promoting rehabilitation and recovery, *family education and support*, and making medications continuously available'.[127] (The 686 Programme is discussed below in the regional analysis concerning Asia). The studies noted here are just a handful of those framed around family intervention, or strong family involvement, though others will be discussed throughout.

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123 Christien E Boumans et al, 'Reduction in the Use of Seclusion by the Methodical Work Approach' (2014) 23(2) *International Journal of Mental Health Nursing* 161; Christien E Boumans et al, 'The Methodical Work Approach and the Reduction in the Use of Seclusion: How Did It Work?' (2015) 86(1) *Psychiatric Quarterly* 1.

124 Laura Asher et al, '"I Cry Every Day and Night, I Have My Son Tied in Chains": Physical Restraint of People with Schizophrenia in Community Settings in Ethiopia' (2017) 13 *Globalization and Health* 47, 47.

125 Guan et al, above n 56, e0121425.

126 Ibid.

127 Ibid (emphasis added).

2. Hospital-based Strategies for Reducing Coercion

The literature on hospital-based practices identifies a number of strategies for reducing coercion such as seclusion reduction/elimination (including 'Six Core Strategies' and 'Safewards' approaches), open door policies, improving ward culture and staff/patient ratios.

Perhaps one of the most important emerging themes is that both top-down *and* local-level leadership (that is at the ward level) is important in order to create and to maintain culture change. There is some indication that leadership should include peer involvement for ultimate effectiveness.

Reducing Seclusion and Restraint

Seclusion and restraint are interventions currently permitted for use in mental health services and other settings to control or manage a person's behaviour. Restraint is also used on individuals with mental health issues in prisons, remand centres, emergency departments and by police and emergency transport providers. Seclusion and restraint are generally defined in mental health legislation. The term 'restraint' may encompass physical, mechanical and/or chemical forms of restraint.

A recurring theme in the literature was differences in formal definitions of restraint and no uniform requirements for reporting, which makes it difficult to ascertain whether or not rates of seclusion and restraint are falling. However, it is clear that there have been attempts by governments and mental health organisations towards implementing multi-level strategies to reduce the use of seclusion and all forms of restraint. Several studies indicate that many of these practices are effective.

Fifty-one studies were concerned with reducing, preventing and ending 'seclusion' and/or 'restraint' in mental health settings.[128] Five of these, from studies in China, Indonesia and Ethiopia, related to restraint in family and communal settings, outside the hospital, which we will discuss later in the report. Many mental health practitioners, service users and family organisations have embraced the aim to prevent and reduce or end seclusion and restraint.

'Six Core Strategies to Reduce the Use of Seclusion and Restraint'

Six empirical studies examined the implementation and outcomes of the *Six Core Strategies to Reduce the Use of Seclusion and Restraint.*[129] Many of these endeavours reflect the strategies set out in a 2005 document entitled *Six Core Strategies to Reduce the Use of Seclusion and Restraint Planning Tool* which was released by the National Technical Assistance Center in the United States.[130] These strategies are:

1. 'Leadership towards organizational change' — articulating a philosophy of care that embraces seclusion and restraint reduction;

2. 'Using data to inform practice' — using data in an empirical, 'non-punitive' way to examine and monitor patterns of seclusion and restraint use;

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128 See, eg, Anu Putkonen et al, 'Cluster-Randomized Controlled Trial of Reducing Seclusion and Restraint in Secured Care of Men With Schizophrenia' (2013) 64(9) *Psychiatric Services* 850; Fleur J Vruwink et al, 'The Effects of a Nationwide Program to Reduce Seclusion in the Netherlands' (2012) 12(1) *BMC Psychiatry* 231; PS van der Schaaf et al, 'Impact of the Physical Environment of Psychiatric Wards on the Use of Seclusion' (2013) 202 *The British Journal of Psychiatry* 142; Lori Ashcraft and William Anthony, 'Eliminating Seclusion and Restraint in Recovery-Oriented Crisis Services' (2008) 59(10) *Psychiatric Services* 1198; Eric O Noorthoorn et al, 'Seclusion Reduction in Dutch Mental Health Care: Did Hospitals Meet Goals?' (2016) 67(12) *Psychiatric Services* 1321; Patricia S Mann-Poll et al, 'Long-Term Impact of a Tailored Seclusion Reduction Program: Evidence for Change?' (2018) 89(3) *Psychiatric Quarterly* 733.

129 Azeem et al, above n 67; Riahi et al, above n 61; Maguire, Young and Martin, above n 51; Wisdom et al, above n 61; Foxlewin, above n 44; Long et al, above n 50; Dow A Wieman et al, 'Multisite Study of an Evidence-Based Practice to Reduce Seclusion and Restraint in Psychiatric Inpatient Facilities' (2014) 65(3) *Psychiatric Services* 345.

130 National Technical Assistance Center, *Six Core Strategies to Reduce the Use of Seclusion and Restraint Planning Tool* (Alexandria, VA: National Association of State Mental Health Program Directors, 2005) <https://www.nasmhpd. org/content/six-core-strategies-reduce-seclusion-and-restraint-use>.

3. 'Workforce' — developing procedures, practices and training that are based on knowledge and principles of mental health recovery;

4. 'Use of seclusion and restraint reduction tools' — using assessments and resources to individualise aggression prevention;

5. 'Consumer roles in inpatient settings' — including consumers, carers and advocates in seclusion and restraint reduction initiatives; and

6. 'Debriefing techniques' — conducting an analysis of why seclusion and restraint occurred and evaluating the impacts of these practices on individuals with lived experience.[131]

These strategies have been used in services in the United States, Canada, Australia and New Zealand and there have been several studies, with the most tested strategy being that of leadership.[132] Much of the literature on this topic deals with the importance of top-down organisational leadership *in conjunction with* local level leadership (for example, at ward level) in order to create and maintain culture change. It may be that the emphasis on leadership as a strategy for change reflects the fact that a lot of the research in the field is management - rather than service user - driven. Many seclusion reduction projects feature the strategy of staff training and the use of new assessment, review and de-briefing tools. Very few reported projects incorporate consumer/service user roles, as recommended in the Six Core Strategies, with some notable exceptions.[133]

Six empirical studies in this review, and one notable grey litera-ture study, examined the use of the Six Core Strategies approach and all reported a significant decrease in the use of seclusion and restraint.[134] The studies focused upon services for children and young people,[135] adult inpatient wards[136] and forensic services.[137] Aside from the studies involving forensic services, it appears that

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131 Ibid, 1-3.

132 Melbourne Social Equity Institute, *Seclusion and Restraint Project: Report* (University of Melbourne, 2014).

133   Foxlewin, above n 44.

134 Azeem et al, above n 67; Maguire, Young and Martin, above n 51; Riahi et al, above n 61; Wieman et al, above n 129; Wisdom et al, above n 61.

135 Azeem et al, above n 67; Wisdom et al, above n 61.

136 Riahi et al, above n 61; Wieman et al, above n 129.

137 Maguire, Young and Martin, above n 51; Long et al, above n 50.

the testing of the Six Core Strategies approach occurred in services with a mixture of people who are voluntary service users and those subject to involuntary orders.

Two peer-reviewed studies examined **adult inpatient services** in North America. Riahi and colleagues studied the Six Core Strategies approach in a recovery-oriented, tertiary level mental health care facility in Ontario, Canada. Over a three year period they reported a 19.7% decrease in incidents of seclusion and restraint from 2011/12 to 2013/14, with a 38.9% decrease in the average length of a mechanical restraint or seclusion incident over the 36-month evaluation period.[138] Wieman and colleagues undertook a comparative study on the application of the Six Core Strategies across 43 inpatient psychiatric facilities in the United States, which had planned to introduce the strategies. They distinguished between five 'category types' among services: those that had 'stabilised' use of the strategies (N=28), those which continued seeking to implement them (N=7), services which decreased their use of the strategies (N=5), and those that discontinued the use of strategies (N=1), or never implemented them (N=2). They reported that the 'stabilized group' reduced the percentage secluded by 17% (p=.002), seclusion hours by 19% (p=.001), and proportion restrained by 30% (p=.03). The reduction in restraint hours was 55% but non-significant (p=.08). They concluded that the strategy was 'feasible to implement and effective in diverse facility types'.[139] Fidelity over time was non-linear and varied among facilities, and the researchers called on further research on relationships between facility characteristics, fidelity patterns, and outcomes.

Two studies examined the use of the Six Core Strategies in **services for children and young people**. Azeem and colleagues examined its application in services for young people (females 276/males 182).[140] Their three-year study reported a downward trend in seclusions/restraints among hospitalised youth after implementation of National Association of State Mental Health Program Directors' Six Core Strategies based on trauma-informed care.[141] Wisdom and colleagues evaluated the impact of the Six Core Strategies implemented in three participating residential treatment programmes for 'children with severe emotional

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138 Riahi et al, above n 61, 32.

139 Wieman et al, above n 129, 345.

140 Azeem et al, above n 67, 11.

141 Ibid.

disturbances' in New York, the United States.[142] The three participating mental health treatment facilities demonstrated significant decreases in restraint and seclusion episodes per 1,000 client-days. Each identified specific activities that contributed to success, including ways to facilitate open, respectful two-way communication between management and staff and between staff and youths and greater involvement of youths in programme decision making.

Two studies on the Six Core Strategies considered **forensic mental health services**.[143] (These were two of only three studies concerning forensic services identified in the review). Maguire, Young and Martin examined the application of the Six Core Strategies to a 116-bed forensic hospital in Australia. The researchers concluded that 'reducing seclusion in a forensic hospital is a complex undertaking as nurses must provide a safe environment while dealing with volatile patients and may have little alternative at present but to use seclusion after exhausting other interventions'.[144] In the second study focusing on forensic services, Long and colleagues sought to evaluate efforts, 'which reflect elements of the six core strategies', to minimise the use of seclusion 'in response to risk behaviours' among 38 women admitted to the medium secure unit of an independent charitable trust in England.[145] The intervention reportedly led to a significant reduction in the number of seclusions and risk behaviour post-change, which 'was complemented by improved staff ratings of institutional behaviour, increased treatment engagement and a reduction in time spent in medium security'.[146] Staff and patients rated the most effective strategies differently, with staff favouring ward training and use of de-escalation techniques as most effective, while patients favoured the 'Relational Security' item of 'increased individual engagement' and 'timetabled Behaviour Chain Analysis sessions'.[147] Long and colleagues argue that the findings confirm that 'seclusion can be successfully reduced without an increase in patient violence or alternative coercive strategies',[148] though as with Maguire and colleagues, the researchers stop short of arguing that seclusion can be eliminated.

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142 Wisdom et al, above n 61, 851.

143 Maguire, Young and Martin, above n 51; Long et al, above n 50.

144 Maguire, Young and Martin, above n 51, 97.

145 Long et al, above n 50, 85.

146 Ibid.

147 Ibid.

148 Ibid.

One noteworthy non-peer reviewed study was led by Foxlewin,[149] and is included in Appendix Two. Foxlewin led a **service user or 'consumer'-controlled** empirical study, overseen in Australia by the Australian Capital Territory Mental Health Consumer Network. The study was aimed at seclusion reduction intervention at the Canberra Hospital Psychiatric Services Unit beginning in 2009 using features of the Six Core Strategies. Foxlewin notes other features of the Six Core Strategies that were employed at Canberra Hospital from 2006- 2009, including the formation of a Seclusion and Restraint Working Group in line with the strategy of Organisational Leadership and the involvement of many key staff investigating reduction possibilities.[150] They combined the strategies with a strong emphasis on the involvement of consumer workers, or peer-workers, in the hospital. Overall, the programme contributed to a reduction in seclusion incidents from 6.9% in the year 2008/9 to less than 1% in 2010/11.[151] It appears that the study occurred in relation to those under compulsory treatment orders. Although this project report is not peer reviewed, it is valuable for the added description of a consumer-led strategy.

Studies suggest that the Six Core Strategies approach can serve to reframe seclusion and restraint as a service failure. (It is perhaps noteworthy that forensic services may be particularly challenging in this respect, given Maguire, Young and Martin's conclusion that staff 'may have little alternative at present but to use seclusion after exhausting other interventions', though even they report on the effectiveness of the Six Core Strategies in reducing overall restraint and seclusion incidents in their case study).[152] Although the pool of empirical research uncovered in this review is relatively small, the strategies appear to have diverse application, with success reported in adult, child and adolescent and forensic mental health services.

The empirical research studies and grey literature analysed by the research team also suggest the following interventions may reduce the use of seclusion and restraint, and broader hospital-level coercive practices:

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149 Foxlewin, above n 44.

150 Ibid.

151 Ibid.

152 Maguire, Young and Martin, above n 51, 97. For other seemingly effective interventions to reduce coercion in forensic services, see Olsson and Schön, above n 51; Long et al, above n 50.

- national oversight;

- organisational culture change through an emphasis on recovery, trauma-informed care and human rights; and

- independent advocacy directed at public opinion, politicians, policymakers and service providers. Future research should focus on mental health care policies targeted at empowering treatment approaches, respecting the patient's autonomy and promoting reductions of institutional coercion.

One further intervention that does not appear in the Six Core Strategies that shows promise relates to physical changes to the environment, which will be discussed shortly. Borckhardt and colleagues have observed that physical changes to the environment are some of the easiest changes to implement.[153]

Of the studies that looked at multiple interventions such as the Six Core Strategies, it is not possible to tell which particular factors led to a reduction in seclusion and/or restraint. In some of the literature, there was either no pre-testing or the data was not compared with data from settings that did not undertake interventions. Stewart and colleagues, in their review of methods to reduce seclusion and restraint, reported that the research did not address which programme components were most successful and called for more attention to understanding how interventions work, particularly from the perspective of nursing staff.[154]

Open Door Policies

Six studies examined locked/unlocked door policies in mental health wards. Again, this section of the report is referring specifically to hospital settings.

Huber and colleagues have argued that doors are locked in hospitals due to the belief that doing so will prevent absconding, suicide attempts, and death by suicide.[155] However, they argue that 'there is insufficient evidence that treatment on locked wards can effectively prevent these outcomes' and their own study indicates

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153 Borckardt et al, above n 70.

154 Duncan Stewart et al, 'A Review of Interventions to Reduce Mechanical Restraint and Seclusion among Adult Psychiatric Inpatients' (2010) 31(6) *Issues in Mental Health Nursing* 413.

155 Christian G Huber et al, 'Suicide Risk and Absconding in Psychiatric Hospitals with and without Open Door Policies: A 15 Year, Observational Study' (2016) 3(9) *The Lancet Psychiatry* 842, 842.

that 'locked doors might not be able to prevent suicide and absconding'.[156] On the contrary, their study even offered some evidence that open wards are associated with a 'decreased probability of suicide attempts (OR 0·658, 95% CI 0·504–0·864; p=0·003), absconding with return (0·629, 0·524–0·764; p<0·0001), and absconding without return (0·707, 0·546–0·925; p=0·01), but not completed suicide (0·823, 0·376–1·766; p=0·63)'.[157]

Bowers and colleagues have reported that locking doors in psychiatric wards in England has increased in recent years, but that this has received little attention by researchers.[158] Bowers and colleagues conducted a survey in England, receiving responses from a total of 1227 patients, staff and visitors on the practice of door locking in acute psychiatry wards. They identified five factors (adverse effects, staff benefits, patient safety benefits, patient comforts and cold milieu) associated with door locking.[159] The researchers did not consider the impact of open door policies on other forms of seclusion and restraint. Instead, they focused on service user, visitor and staff perceptions: service users held more negative views about door locking than staff, including reporting feeling anger, irritation and depression as a consequence of locked doors, while staff tended to associate locked wards more positively, as did the (relatively few) visitors who responded to the survey.

Another study, by Greenfield and colleagues in the United States, compared the effectiveness of an unlocked, mental health consumer-managed, crisis residential programme (CRP) to a locked, inpatient psychiatric facility (LIPF) for adults with severe mental health conditions.[160] This randomised trial, involved 393 adults who were subject to involuntary treatment orders. Participants in the CRP reportedly experienced significantly greater improvement based on 'interviewer-rated and self-reported psychopathology' than did participants in the LIPF condition.[161] Reported service satisfaction was 'dramatically higher' in the CRP condition, leading the researchers to conclude that 'CRP-style facilities

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156 Ibid.

157 Ibid.

158 Bowers et al, above n 106.

159 Ibid.

160 Thomas K Greenfield et al, 'A Randomized Trial of a Mental Health Consumer-Managed Alternative to Civil Commitment for Acute Psychiatric Crisis' (2008) 42(1–2) *American Journal of Community Psychology* 135, 135.

161 Ibid.

are a viable alternative to psychiatric hospitalization for many individuals facing civil commitment'.[162]

A group of German researchers undertook two largescale studies based on data for 349,574 admissions to 21 German psychiatric inpatient hospitals from 1998, to 2012.[163] They sought to compare hospitals without locked wards and hospitals with locked wards. They wished to test the hypothesis that locked wards reduced the rates of adverse incidents, like suicides, suicide attempts, and so on. However, Huber and colleagues' findings indicated that hospitals with an 'open door policy' did *not* have increased numbers of suicide, suicide attempts, and absconding with return, and without return.[164] In contrast, treatment on open wards was associated with a decreased probability of suicide attempts, absconding with return, and absconding without return, but not completed suicide.[165] In a second study using the same dataset, Schneeberger and colleagues measured the effects of 'open versus locked door policies' against rates of 'aggressive incidents' and restraint/seclusion.[166] The effect of open versus locked door policy was non-significant in all analyses of aggressive behaviour during treatment. However, '[r]estraint or seclusion during treatment was less likely in hospitals with an open door policy', as was aggressive behaviour.[167] Further, 'bodily harm' was more likely on open wards than on closed wards.[168] It is notable, however, that the study has been criticised on the grounds that the term 'open door policy' was classified arbitrarily.[169] Nevertheless, several studies support the view that locked doors might not be able to prevent suicide and absconding, and have several downsides, from a pragmatic and rights-based perspective.

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162 Greenfield et al, above n 160, 135.

163 Andres R Schneeberger et al, 'Aggression and Violence in Psychiatric Hospitals with and without Open Door Policies: A 15-Year Naturalistic Observational Study' (2017) 95 *Journal of Psychiatric Research* 189; Huber et al, above n 155.

164 Huber et al, above n 155.

165 Ibid.

166 Schneeberger et al, above n 163, 189.

167 Ibid.

168 Ibid.

169 Thomas Pollmächer and Tilman Steinert, 'Arbitrary Classification of Hospital Policy Regarding Open and Locked Doors' (2016) 3(12) *The Lancet Psychiatry* 1103. Cf. Christian G Huber et al, 'Arbitrary Classification of Hospital Policy Regarding Open and Locked Doors – Authors' Reply' (2016) 3(12) *The Lancet Psychiatry* 1103.

Mezzina reports on the outcomes of an '*open door*… no restraint system of care for recovery and citizenship' in the city of Trieste, Italy.[170] He writes:

> Trieste (a city of 236,000 inhabitants in the northeastern region Friuli Venezia Giulia) changed from a clinical model based on treating illness to a wider concept of mental health that looks at the whole person and the social background. The core of the organization is a network of Community Mental Health Centers active 24 hours a day, 7 days a week… with relatively few beds in each of them. The system coordinated by the [Department of Mental Health] also comprises one general hospital psychiatric unit, a network of supported housing facilities and several social enterprises.[171]

The 'Trieste Model' as it is known has been the subject of considerable research, though our review did not uncover a large amount of empirical research. This gap may be attributable, at least in part, to methodological challenges in identifying the direct effect of individual measures within complex, system-wide change. In a review paper, Mezzina writes that '[i]n Trieste, it has not been possible to evaluate the effectiveness of single interventions (i.e. psychoeducational, rehabilitative, psychotherapeutic) because these are interwoven in its ''whole system'' approach'.[172] Nevertheless, there have been several 'cohort studies on patients with psychosis, family burden studies, research on crisis intervention, user and family member satisfaction, and attitude toward community care', according to Mezzina, though most appear to be Italian-language studies.[173] Mezzina reports that '[f]ewer than 10 people per 100,000 of the population receive a [compulsory psychiatric treatment order], usually for approximately 7 to 10 days', which is 'approximately 1% of all episodes of residential care'.[174] Further, 'most of them are handled by the [Community Mental Health Centres], which have come to take over most [general hospital psychiatric unit] admissions'.[175] Mezzina summarises the largely Italian-language evidence base as follows:

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170   Mezzina, above n 61, 440.

171   Ibid.

172   Ibid.

173   Ibid.

174   Ibid, 442.

175   Ibid, 442.

Crisis management at [Community Mental Health Centers] also proved effective in preventing relapses and chronic courses. A national survey carried out in 13 centers showed that crisis care provided by 24/7 [Community Mental Health Centers] is more effective in crisis resolution and at 2-year follow-up, particularly when related to trusting therapeutic relationships, continuity and flexibility of care, and service comprehensiveness. A 50% reduction occurred in emergency presentation of general hospital casualty for approximately 20 years… Qualitative research particularly highlighted some major social factors connected to services and the connection between recovery, social inclusion, and participatory citizenship. Recent data suggest 75% compliance with antipsychotic medication (n = 587), a situation related to the quality of therapeutic relationship and social network enhancement. User satisfaction with services has been high right from the early years and, more recently, recorded 83% in two [Community Mental Health Centers]

Interestingly, even some forensic services 'are managed de facto with an open door policy',[176] though evidence on the outcomes and precise nature of such interventions remain limited.[177]

Creating 'Safewards', Changing the Physical Environment and Improving Service Culture

In England, the **Safewards** model[178] has identified aspects of working in psychiatric wards that are known to create potential 'flashpoints'. This model comprises ten interventions aimed at helping staff manage those flashpoints to reduce conflict. Bowers and colleagues proposed six domains of originating factors in the Safewards approach to reducing conflict, restraint and seclusion: the staff team, the physical environment, outside hospital, the patient community, patient characteristics and the regulatory framework. The Safewards approach places a strong emphasis on the culture of hospital settings – including staff interactions with patients and family/friends and the physical characteristics

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176 Ibid.

177 Roberto Mezzina and Daniela Vidoni, 'Beyond the Mental Hospital: Crisis Intervention and Continuity of Care in Trieste. A Four Year Follow-Up Study in a Community Mental Health Centre' (1995) 41(1) *International Journal of Social Psychiatry* 1.

178 Len Bowers et al, (2014) 'Safewards: The Empirical Basis of the Model and a Critical Appraisal', (2014) 21(4) *Journal of Psychiatric and Mental Health Nursing* 354.

of wards. Such service culture was a recurrent theme in several studies.[179]

The **Safewards** model was evaluated positively in 2015 with an estimated 15% decrease in conflict and 24% decrease in 'containment' across 31 wards in England.[180] However, the methodology used for this evaluation has been criticised.[181] An evaluation of a trial of Safewards in the Australian state of Victoria found a reduction in the use of seclusion across the wards that had implemented the approach.[182]

In a Dutch study, Boumans and colleagues presented four detailed case examples and a separate quantitative study to examine how the **'methodical work approach'** could work to reduce seclusion.[183] The 'methodical work approach' appears to have provided guidance for the multidisciplinary team, the patient and the family to work together in a systematic and goal-directed way to reduce seclusion. The methodical work approach has five phases: '(i) translation of problems into goals; (ii) search for means to realize the goals; (iii) formulation of an individualized plan; (iv) implementation of the plan; and (v) evaluation and readjustment'[184]. The quantitative study compared an experimental ward with 134 adults to a controlled ward with 544 adults, and reported a reduction in the use of seclusion in a ward with a high seclusion rate.[185] Compared to control wards within the same hospital, at the ward where the methodical work approach was

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179 Len Bowers et al, 'Correlation between Levels of Conflict and Containment on Acute Psychiatric Wards: The City-128 Study.' (2013) 64(5) *Psychiatric Services* 423; Fisher, above n 106; Alice Keski-Valkama et al, 'A 15-Year National Follow-up: Legislation Is Not Enough to Reduce the Use of Seclusion and Restraint.' (2007) 42(9) *Social Psychiatry And Psychiatric Epidemiology* 747; Schout et al, above n 62.

180 Len Bowers et al, **'**Reducing Conflict and Containment Rates on Acute Psychiatric Wards: The Safewards Cluster Randomised Controlled Trial' (2015) 52(9) *International Journal of Nursing Studies* 1412, 1422.

181 Feras Ali Mustafa, 'The Safewards Study Lacks Rigour Despite its Randomised Design'(2015) 52(12) *International Journal of Nursing Studies* 1906.

182 Justine Fletcher et al, 'Oucomes of the Victorian Safewards Trial in 13 Wards: Impact on Seclusion Rates and Fidelity Measurement' (2017) 26(5) *International Journal of Mental Health Nursing* 461.

183 Boumans et al, 'Reduction in the Use of Seclusion by the Methodical Work Approach', above n 123; Boumans et al, 'The Methodical Work Approach and the Reduction in the Use of Seclusion: How Did It Work?', above n 123.

184 Ibid.

185 Boumans et al, 'The Methodical Work Approach and the Reduction in the Use of Seclusion: How Did It Work?', above n 123, 1.

implemented, a more pronounced reduction was achieved in the number of incidents and in the total hours of seclusion.[186]

Emphasising 'Environmental Factors' Within Hospitals

Seven studies explicitly considered environmental factors conducive to reducing, eliminating and preventing coercive practices in clinical mental health settings, though many studies concerned with reducing seclusion and restraint, and other coercive practices, considered environmental factors in the broad sense of the term.

There is some indication that sensory-based approaches such as the use of sensory modulation rooms can help reduce levels of distress[187] thereby preventing the need to use seclusion or restraint. Sensory modulation tools can include the use of audio and video equipment, weighted blankets, soft materials and pleasant aromas. These sensory-based approaches are included in some studies of the Six Core Strategies.

Physical design features may play a similar role. Van der Schaaf and colleagues examined the effect of design features on the risk of being secluded, the number of seclusion incidents and the time in seclusion.[188] They referred to data on 77 Dutch psychiatric hospitals and also a benchmark study on the use of coercive measures in 16 Dutch psychiatric hospitals. Several design features were associated with rates of seclusion and restraint. The 'presence of an outdoor space', 'special safety measures' and a large 'number of patients in the building' increased the risk of being secluded, while design features such as more 'total private space per patient', a higher 'level of comfort' and greater 'visibility on the ward', decreased the risk of being secluded.[189] The authors called for a 'greater focus on the impact of the physical environment on patients' which they argue 'can reduce the need for seclusion and restraint'.[190]

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186 Ibid.

187 See generally, Angela Chalmers et al, 'Establishing Sensory-Based Approaches in Mental Health Inpatient Care: A Multidisciplinary Approach' (2012) 20(1) *Australasian Psychiatry: Bulletin of Royal Australian and New Zealand College of Psychiatrists* 35; Tina Champagne and Edward Sayer, *The Effects of the Use of the Sensory Room in Psychiatry*' <https://www.ot-innovations.com/wp-content/uploads/2014/09/qi_study_sensory_room.pdf> 13.

188 van der Schaaf et al, above n 73, 142.

189 Ibid.

190 Ibid.

Similarly, Borckhardt and colleagues have argued that physical changes to the environment are some of the easiest measures to implement in reducing seclusion and restraint.[191] They surveyed changes to the environment that helped reduce the use of seclusion and restraint by over 82.3% in a state run hospital in the south-eastern United States, which included 'repainting walls with warm colors, placement of decorative throw rugs and plants, and rearrangement of furniture... along with replacing worn-out furniture and continuing with environmental changes...'.[192]

Bowers and colleagues investigated wards with the counterintuitive combination of 'low containment and high conflict'. They use the term 'containment' to refer to 'coerced medication, seclusion, manual restraint and other types of containment'.[193] The researchers collected cross-sectional data from 136 acute psychiatric wards across England in 2004-2005. Among the variables significantly associated with the various ward characteristics, some, such as environmental quality, were changeable, and others – such as social deprivation of the area served – were fixed. High-conflict, low-containment wards had higher rates of male staff and 'lower-quality environments' than other wards[194] (which somewhat contradicts Van der Schaaf and colleagues' findings).[195] Low-conflict, high-containment wards had higher numbers of beds. High-conflict, high-containment wards utilised more temporary staff as well as more unqualified staff. No overall differences were associated with low-conflict, low-containment wards though the researchers conclude that '[w]ards can make positive changes to achieve a low-containment, nonpunitive culture, even when rates of patient conflict are high'.[196]

Bak and colleagues sought to test the hypothesis that 'factors of non-medical origin' may explain the differing number of mechanical restraint episodes between Denmark and Norway. An earlier study found that mechanical restraint was used twice as frequently in Denmark than Norway. They found that six preventive factors confounded the difference in mechanical restraint use between Denmark and Norway, including staff education (- 51%),

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191 Jeffrey J Borckardt et al,'Systematic Investigation of Initiatives to Reduce Seclusion and Restraint in a State Psychiatric Hospital' (2001) 62(5) *Psychiatric Services,* 47.

192 Ibid 479.

193 Bowers et al, above n 180, 423.

194 Ibid.

195 See above van der Schaaf et al, above n 73.

196 Bowers et al, above n 180, 423.

substitute staff (- 17%), acceptable work environment (- 15%), separation of acutely disturbed patients (13%), patient-staff ratio (- 11%), and the identification of the patient's crisis triggers (- 10%).[197] This research suggests these preventive factors might partially explain the difference in the frequency of mechanical restraint episodes observed in the two countries.[198]

Examining the Relationship Between Service User Characteristics and Coercion

In contrast to a focus on environmental factors, several studies examined the association between individual service user characteristics and coercive measures. These included socio-economic characteristics, 'the epidemiology of mental disorders', gender, migrant status, all of which – if they are positively associated with rates of coercion – could be taken into account in efforts to reduce, end and prevent coercive practices.

The findings were mixed, particularly regarding the causation and correlation attributable to service user characteristics. For example, Thomsen and colleagues used nationwide data from Denmark to identify risk factors associated with coercive measures, and reported that 'clinical characteristics were the foremost predictors of coercion and patients with organic mental disorder [attracting] the highest increased risk of being subjected to a coercive measure' (OR=5.56; 95% CI=5.04, 6.14).[199] These findings, they argue, can assist 'researchers in identifying patients at risk of coercion and thereby help targeting new coercion reduction programs'.[200] Similarly, Lay, Nordt and Rössler undertook a study suggesting that the kind and severity of mental illness are the most important risk factors for being subjected to any form of coercion, yet nevertheless found that variation in rates of coercion across the six psychiatric hospitals in their study was high, even after accounting for risk factors on the patient level, which suggested that centre effects are an important source of variability. However, they argued that 'effects of the hospital characteristics "size of the hospital", "length of inpatient stay", and "work load

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197 Jesper Bak et al, 'Comparing the Effect of Non-Medical Mechanical Restraint Preventive Factors between Psychiatric Units in Denmark and Norway' (2015) 69(6) *Nordic Journal Of Psychiatry* 433, 433.

198 Ibid.

199 Christoffer Thomsen et al, 'Risk Factors of Coercion among Psychiatric Inpatients: A Nationwide Register-Based Cohort Study' (2017) 52(8) *Social Psychiatry and Psychiatric Epidemiology* 979, 979.

200 Ibid.

of the nursing staff" were only weak ("bed occupancy rate" was not statistically significant)'.[201]

However, other studies seemed to point in the opposite direction. For example, Siponen and colleagues examined data for all adolescents aged 13–17 from two Finnish districts between the years 1996–2003, and reported that factors *other than the characteristics of the adolescents themselves* – such as 'divorces, single parent families, social exclusion' – are associated with use of compulsory interventions.[202] Indeed, most studies that considered service user characteristics, also examined socioeconomic status, and other 'external' factors. Even Thomsen and colleagues' study, noted previously, found evidence indicating that certain socioeconomic variables were associated with an increased risk of coercion, namely: 'male sex, unemployment, lower social class and immigrants from low and middle income countries (all p<0.001)'.[203] Similarly, Janssen and colleagues produced evidence suggesting that 'more admissions of severely ill patients are related to higher seclusion rates', and examined patient and background characteristics of 718 secluded patients over 5,097 admissions on 29 different admission wards over seven Dutch psychiatric hospitals.[204] Seclusion rates, they argued, depended on both patient *and* ward characteristics. Their evidence suggested that differences in seclusion hours between wards could partially be explained by ward size next to patient characteristics. They concluded that the 'largest deal of the difference between wards in seclusion rates could not be explained by characteristics measured in [their] study' and concluded that 'adequate staffing may, in particular on smaller wards, be key issues in reduction of seclusion'.[205] We will discuss the ratio of staff to service users, and the characteristics of staff, in the next section.

201 Barbara Lay, Carlos Nordt and Wulf Rössler, 'Variation in Use of Coercive Measures in Psychiatric Hospitals.' (2011) 26(4) *European Psychiatry: The Journal Of The Association Of European Psychiatrists* 244, 244.

202 Ulla Siponen et al, 'A Comparison of Two Hospital Districts With Low and High Figures in the Compulsory Care of Minors: An Ecological Study' (2011) 46(8) S*ocial Psychiatry and Psychiatric Epidemiology* 661.

203 Ibid.

204 Wim A Janssen et al, 'Differences in Seclusion Rates between Admission Wards: Does Patient Compilation Explain?' (2013) 84(1) *The Psychiatric Quarterly* 39, 39.

205 Ibid.

Several studies from the US and England identified higher rates of coercive practices used against minority ethnic groups,[206] suggesting that targeted efforts to reduce, prevent and end coercive practices among these groups should further examine these disproportionate impacts and their underlying causes, including discrimination, lack of culturally responsive services, socio-economic disadvantage, and so on.

It should be noted that in all studies that use ecological or observational study design cited in this section – that is, a study which uses register data on patient characteristics, services, and socio-economic status – cannot establish causality, even as they identify predictors of coercion. Further, as noted previously, rates of coercion vary greatly between – and even within – countries, suggesting that a focus on service user or patient characteristics is likely to be less important than socio-political factors extrinsic to the person. Salize and Dressing, for example, present evidence showing that rates of 'involuntary placements' in the European Union range from 6 per 100,000 in Portugal, to 218 per 100,000 in Finland.[207]

The Number/Ratio of Staff to Service Users, and Staff Characteristics

The Six Core Strategies and Safewards practices discussed previously include elements of staff training, which should be considered in addition to these specific studies concerning staff-to-service user ratios and staff characteristics.

Several studies considered the staff-to-service-user ratio and its impact on coercive practices. Bak and colleagues found that patient/staff ratio was significant in explaining why Danish hospital units had roughly twice the rates of mechanical restraint than

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206 See, eg, Gregory M Smith et al, 'Pennsylvania State Hospital System's Seclusion and Restraint Reduction Program' (2005) 56(9) *Psychiatric Services* 1115; Barbara Barrett et al, 'Randomised Controlled Trial of Joint Crisis Plans to Reduce Compulsory Treatment for People with Psychosis: Economic Outcomes' (2013) 8(11) *PLoS One* e74210; Andrés Martin et al, 'Reduction of Restraint and Seclusion Through Collaborative Problem Solving: A Five-Year Prospective Inpatient Study' (2008) 59(12) *Psychiatric Services* 1406, 1410.

207 Hans Joachim Salize and Harald Dressing,'Epidemiology of Involuntary Placement of Mentally Ill People Across the European Union' (2004) 184(2) *British Journal of Psychiatry* 163.

Norwegian hospitals.[208] They compared units in which the staff-to-patient ratio was higher than or equal to three-to-one on average with those units where this ratio was lower than three-to-one. According to the authors, the factor explains a large [Δ exp(B) 11%] portion of the difference in mechanical restraint episodes between the two countries.[209] The effects of the staff-to-patient ratio were partially supported by other research.[210] Most research in this regard finds it difficult to determine what portion of reduction in coercive practices is attributable to added staffing, because several factors often contribute to the effect. Janssen and colleagues reported that seclusion was used more commonly when the number of service users per staff was greater in long-term wards.[211] The idea, according to Bak and colleagues, is that staff are better able to interact and co-operate with service users, reduce workplace stress and learn skills in support and communication to create a more 'recovery oriented environment'.[212]

However, Bak and colleagues point to some research which indicated that the relative risk of violence increased with more nursing staff, and that increased levels of aggressive incidents were associated with increased staffing. Yet, as Bak and colleagues observe, these studies did not precisely target mechanical restraint or seclusion but instead targeted violence and aggression.[213] From this, relatively limited and regionally specific evidence (located largely in Scandinavia), staff-to-patient ratios of higher than or equal to three-to-one on average seem to be decisive in rates of seclusion and restraint, even if increased staff may raise other issues.

The composition of staff was considered in some studies. As noted, Janssen and colleagues, using the largescale Norwegian-Danish dataset, concluded that 'ward policy and adequate staffing may, in particular on smaller wards, be key issues in reduction of seclusion'.[214] In a previous study led by Janssen, researchers sought to conduct a retrospective analysis of staff characteristics

208 Jesper Bak et al, above n 197, 439; see also Jesper Bak et al, 'Mechanical Restraint – Which Interventions Prevent Episodes of Mechanical Restraint? – A Systematic Review' (2012) 48(2) *Perspectives in Psychiatric Care* 83.

209 Ibid.

210 See, eg, Smith et al, above n 206, 1115.

211 Janssen et al, 'Differences in Seclusion Rates between Admission Wards: Does Patient Compilation Explain?', above n 204, 39.

212 Bak et al, above n 197, 439.

213 Ibid, 440.

214 Janssen et al, 'Differences in Seclusion Rates between Admission Wards: Does Patient Compilation Explain?', above n 204, 39.

from ten wards in four mid-sized general psychiatric hospitals in the Netherlands. The data show that two variables were associated with seclusion rates: the male–female staff ratio and the variability in team's work experience. More female and less male nurses in a shift and less variability in team's work experience predicted an increase in seclusion rates.[215] No other studies considered male-female staff ratio, and this modest study remains non-generalisable.

Existence of Registries/Reporting

There was relatively little research on the existence of registries and reporting measures and their contribution to the reduction of coercive practices. As noted, the Six Core Strategies approach promotes the use of data to inform practice, including doing so in an empirical, 'non-punitive' way to examine and monitor patterns of seclusion and restraint use.[216] Janssen and colleagues have discussed important methodological issues in monitoring the use of coercive measures.[217] In order to monitor the effects of initiatives at a national and international level to reduce coercion, 'consensus on definitions of coercive measures, assessment methods and calculation procedures of these coercive measures are required',[218] to which their study involves a literature review and an illustrative case study, using data from a large multicentre study on seclusion patterns in the Netherlands. They argue that:

> Coercive measures can be reliably assessed in a standardized and comparable way under the condition of using clear joint definitions. Methodological consensus between researchers and mental health professionals on these definitions is necessary to allow comparisons of seclusion and restraint rates.[219]

Countries such as the Netherlands, Denmark and Norway, appear to have comprehensive coercion measure data sets. These exemplary monitoring mechanisms could be considered alongside the

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215 Wim A Janssen et al, 'The Influence of Staffing Levels on the Use of Seclusion' (2007) 30(2) International Journal of Law and Psychiatry 118, 118.

216 National Technical Assistance Center, above, n 130.

217 Wim A Janssen et al, 'Methodological Issues in Monitoring the Use of Coercive Measures' (2011) 34(6) *International Journal of Law and Psychiatry* 429, 429.

218 Ibid.

219 Ibid.

CRPD obligation under Article 31 (statistics and data collection), in which Subsection (1) directs States Parties to:

> …undertake to collect appropriate information, including statistical and research data, to enable them to formulate and implement policies to give effect to the present Convention. The process of collecting and maintaining this information shall:
>
> > a) Comply with legally established safeguards, including legislation on data protection, to ensure confidentiality and respect for the privacy of persons with disabilities;
> >
> > b) Comply with internationally accepted norms to protect human rights and fundamental freedoms and ethical principles in the collection and use of statistics.

De-Escalation Techniques

Twelve studies discussed de-escalation techniques in hospital settings, considering either their effectiveness, or the need for staff training in de-escalation techniques.[220] Long and colleagues found that staff reported positively on ward training and the use of de-escalation techniques, arguing that it was the most effective factor in their successful reduction of seclusion in a women's secure unit in England.[221] Staff attended weekly one hour training sessions using ward case examples of how to manage disturbed behaviour by 'non-invasive relational strategies'.[222] In India, a study involving 210 psychiatrists and 210 'caregivers' found that these groups perceived staff training in de-escalation techniques to be an urgent need in efforts to reduce coercion in psychiatric hospitals (in addition to 'early identification of aggressive behavior, interventions to reduce aggressiveness, empowering patients [and] improving hospital resources').[223] Gjerberg and colleagues

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220 Azeem et al, above n 67; Barbara Lay, Wolfram Kawohl and Wulf Rössler, 'Outcomes of a Psycho-Education and Monitoring Programme to Prevent Compulsory Admission to Psychiatric Inpatient Care: A Randomised Controlled Trial' (2018) 48(5) *Psychological Medicine* 849; Long et al, above n 50; Lyons et al, above n 61; Maguire, Young and Martin, above n 51; Martin et al, above n 52; BN Raveesh et al, 'Staff and Caregiver Attitude to Coercion in India.' (2016) 58(Suppl 2) *Indian Journal of Psychiatry* s221; Shields et al, above n 57; Vruwink et al, above n 73; Wieman et al, above n 129; Zinkler, above n 56; Bak et al, above n 197.

221 Long et al, above n 50.

222 Ibid.

223 Raveesh et al, above n 220, s221.

examined what conditions staff in Norwegian services for older persons (one of only two papers concerned with services for older adults) were considered as necessary to succeed in avoiding the use of coercion, and indicated that the nursing home staff usually spent a lot of time trying a wide range of approaches to avoid the use of coercion, including deflecting and persuasive strategies, limiting choices by conscious use of language, different kinds of flexibility and one-to-one care.[224] According to the staff, their opportunities to effectively use alternative strategies are greatly affected by the nursing home's resources, by the organization of care and by individual staff members' competence.[225]

A Cochrane review, which assessed research on the effects of de-escalation techniques for managing non-psychosis-induced aggression in adults in care settings, in both staff and service users, concluded that research quality in the field was 'very low due to high risk of bias and indirectness of the outcome measures'.[226] Arguably, a similar uncertainty remains around the effectiveness of de-escalation and the relative efficacy of different techniques in the mental health context. High-quality research on the effectiveness of this intervention is therefore needed.

3. 'Community' Based Alternatives to Coercion

This section provides an overview of studies concerning non-hospital acute and crisis mental health services. Prominent topics included crisis resolution, respite houses, and home-based support.

Residential Programmes for People in Acute Crisis as Alternatives to Hospitalisation

Community homes for the treatment of people with acute conditions or in extreme distress have been established in several places in the world as alternatives to inpatient hospitalisations. Several features are typical of these settings: fewer residents compared to hospital wards; a de-emphasis on medication; and greater contact with staff. The models differ with respect to emphasis on medication and composition of staff. Staff may be predominately those who have used services in the past, or may

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224 Gjerberg et al, above n 53.

225 Ibid.

226 Sally Spencer, Paula Johnson and Ian C Smith, 'De-escalation Techniques for Managing Non-psychosis Induced Aggression in Adults' in (2018) Issue 7 *Cochrane Database of Systemic Reviews* Art No: CD012034.

be typical mental health professionals, including psychiatrists, psychologists, and so on – or a mixture. The literature tends to indicate that for most people in acute crisis who are eligible for hospitalisation, residential support can be a viable alternative. Some research considers effectiveness, cost, coercive practices within residential programmes, and long-term outcomes.

Most crisis houses offer:

- overnight accommodation

- a small number of beds

- a home-like environment

- intensive treatment.

The different types of residential programmes identified in this review are:

Crisis or Respite Houses

Crisis homes offer a smaller scale residential alternative for people in crisis, sometimes designed for specific groups, including women,[227] and minority ethnic groups. Gilburt and colleagues, conducting research in England, proposed that little is known about the 'preferences and experiences of people with mental illness in relation to residential alternatives to hospital'.[228] Forty purposively selected 'patients in residential alternative services' were interviewed, who had previously experienced hospital in-patient stays. Interviewees reported an overall preference for residential alternatives, including 'being safer, having more freedom and decreased coercion, and having less paternalistic staff compared with traditional in-patient services'.[229] Interestingly, respondents identified no substantial difference between their relationships with staff overall and the care provided between the two types of services. The researchers concluded, that alternative residential services 'minimise coercion and maximise freedom, safety and opportunities for peer support'.[230]

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227 Alyssum Residential Service, Rochester, Vermont <https://www.alyssum. org/>.

228 Helen Gilburt et al, 'Service Users' Experiences of Residential Alternatives to Standard Acute Wards: Qualitative Study of Similarities and Differences' (2010) 197(Suppl 53) *The British Journal of Psychiatry* s26, s26.

229 Ibid.

230 Ibid.

Fenton and colleagues examined 119 adults who experienced an 'illness exacerbation', and who having accepted voluntary treatment were randomly assigned to the acute psychiatric ward of a general hospital or a community-based respite house.[231] Case mix data indicated that patients treated in the hospital (N=50) and the alternative (N=69) were comparably ill, and that treatment episode symptom reduction and patient satisfaction were comparable for the two settings.[232] Psychosocial functioning, satisfaction, and acute care use in the six months following admission were also comparable between the two settings. The authors conclude that for patients who do not require intensive general medical intervention and are willing to accept voluntary treatment, the alternative programme model studied provides outcomes comparable to those of hospital care.[233]

Osborn and colleagues compared the experiences of 314 'patients in four residential alternatives and four standard services', considering patient satisfaction, ward atmosphere and perceived coercion 'using validated measures'.[234] They reported that 'alternatives to traditional in-patient services' appear to be associated with a better experience of admission, greater service user satisfaction and less negative experiences.[235] They attributed some of these differences to the involuntary nature of admission.

Slade and colleagues examined 'short-term clinical outcomes and cost data' for six residential alternatives to acute in-patient care in England, comparing them with six standard in-patient care services.[236] All measures indicated improved outcomes for both types of service, with 'adjusted improvement' found to be greater for standard services according to most measures, but not 'Global Assessment of Functioning' symptoms.[237] Admissions to residential alternatives were 20.6 days shorter, and hence cheaper (UK£3832 v. £9850). Standard services cost an additional £2939 per unit 'Health of the Nation Outcome Scales' improvement, and the authors concluded that there was an 'absence of clear-cut

231 Wayne S Fenton et al, 'Randomized Trial of General Hospital and Residential Alternative Care for Patients with Severe and Persistent Mental Illness' (1998) 155(4) *American Journal of Psychiatry* 516, 516.

232 Ibid.

233 Ibid.

234 David PJ Osborn et al, 'Residential Alternatives to Acute In-Patient Care in England: Satisfaction, Ward Atmosphere and Service User Experiences' (2010) 197(Suppl 53) *The British Journal Of Psychiatry* s41, s41.

235 Ibid.

236 Slade et al, above n 62, s41.

237 Osborn et al, above n 234, s41.

advantage for either type of service', which highlights the importance of 'the subjective experience and longer-term costs'.[238]

Lawlor and colleagues' research suggests that respite houses may be more likely to be used by particular ethnic groups compared to others.[239] In their study of service data related to 287 women admitted to an acute psychiatric inpatient ward or a women's crisis house in four London boroughs, they found that all groups of 'black' patients and 'white other' patients were significantly more likely to have been compulsorily admitted than 'white British' patients, whereas white British patients were more likely than other groups to be admitted to a crisis house.[240] (Differences between groups in help-seeking behaviours in a crisis, they concluded, may explain some differences in rates of compulsory admission).[241]

Soteria is a 'Therapeutic Community Residence' for the prevention of hospitalisation.[242] Soteria facilities were founded in the United States and are small, residential settings for responding to people experiencing psychosis. Similar facilities exist in Switzerland, Germany, Sweden, Budapest and Denmark.[243] Much of the empirical research that exists on Soteria appears to have been undertaken prior to 1990 (and hence is outside the scope of this review).[244] The Soteria Vermont website indicates that it is designed for 'individuals experiencing a distressing extreme state, commonly referred to as psychosis'[245] which in the authors' terms, 'can be a temporary experience that one works through rather than a chronic mental illness that needs to be managed'.[246] According to the Vermont Agency of Human Services' Department of Mental Health, the Soteria House programme opened in 2015

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238 Slade et al, above n 62.

239 Caroline Lawlor et al, 'Ethnic Variations in Pathways to Acute Care and Compulsory Detention for Women Experiencing a Mental Health Crisis.' (2012) 58(1) *The International Journal Of Social Psychiatry* 3, 3.

240 Ibid.

241 Ibid.

242 Tim Calton et al, 'A Systematic Review of the Soteria Paradigm for the Treatment of People Diagnosed With Schizophrenia' (2008) 34(1) *Schizophrenia Bulletin* 181.

243 Ibid.

244 See generally, ibid.

245 Soteria Website <http://www.pathwaysvermont.org/what-we-do/our-programs/soteria/.

246 Ibid.

and 'includes care from a psychiatrist to support withdrawal from medications'.[247]

A similar service, Cedar House, was established in Boulder, Colorado. It is a 15-bed residence that runs as a therapeutic community giving responsibility to the 'guests' whose stay is no longer than 10-15 days. According to Warner, Cedar House has been running for 30 years in the public system.[248] Warner presents some evidence that these alternatives have shown similar or better outcomes for service users including improved satisfaction and involving demonstrating reduced admissions and re-admission rates. Warner writes:

> The county mental health system has found that the facility can accommodate at least half of the catchment area patients in need of acute in-patient care at any point in time, including many patients requiring compulsory treatment. Costing half as much as hospital care (which is purchased by the mental health system at the best price in the marketplace), there has never been any question as to its cost-effectiveness.[249]

Warner argues that size is an important variable determining the style of working and individualisation of treatment. He describes the variation in size of non-hospital residential alternatives in the United States:

> Progress Foundation in San Francisco, which accommodates public-sector patients, has been able to limit the size of each facility to 8–10 residents, but this is unusual and is due to its selection of people who are less severely ill. Cedar House, in Boulder, struck the balance at 15 beds. Venture, in Vancouver, British Columbia, is substantially larger at 20 beds and the operators concede that this leads to a less homelike quality of the environment. Private acute care facilities, such as Balsam House in Boulder, Colorado, and Crossing Place in Washington, DC, each with 8 beds, tend to be smaller, and the higher per capita cost is passed on to consumers and their

247 Department of Mental Health, Agency of Human Services, 'VERMONT2017 Reforming Vermont's Mental Health System Report to the Legislature on the Implementation of Act 79' January 15, 2017, 41 <https://legislature.vermont.gov/assets/Legislative-Reports/2017-ACT-79-Report.pdf>

248 Richard Warner, 'The Roots of Hospital Alternative Care' (2010) 197(Suppl 53) *British Journal of Psychiatry* s4, s4.

249 Ibid.

families. Private-sector residential alternatives in the United States that are geared more towards rehabilitation than acute treatment can function well with a larger group size.[250]

By their nature, respite houses tend to eschew standardisation, making research difficult to undertake.

There appears to be some terminological and conceptual ambiguity about the range of non-hospital acute and crisis residential services. While some 'crisis houses' are very much houses in the typical sense of having three or four bedrooms, of which a small number are available to people in crisis (as with Alyssum), other non-hospital 'residential alternatives' have a much greater number of beds. Slade's aforementioned study, for example, drew on six alternative-to-hospital residential services which varied from three bed facilities to facilities with 30 beds.[251] The English mental health charity, Mind, also points out that 'crisis houses' are often mistaken for 'sanctuary or safe havens', the latter which refers to crisis support services that do not provide residential support: 'Sanctuaries and safe havens might be open overnight as a supportive place for you to go for several hours during a crisis, but they don't usually provide somewhere for you to sleep or live in'.[252] Mind's comments here relate to English services, suggesting the terminological and conceptual variation is even greater at the international level, adding an extra layer of complexity to research into crisis resolution alternatives to acute hospitalisation.

'Peer-run' Crisis or Respite Houses

Crisis houses managed and run by service users, former service users and persons with psychosocial disabilities typically have a strong recovery and self-help ethos. Strategies used include: counselling, art, meditation, physical work, massage, skills training and meditation. Croft and Isvan undertook a propensity score matching to create matched pairs of '139 users of peer respite and 139 non-users of respite with similar histories of behavioral health service use and clinical and demographic characteristics'.[253] Their findings suggested that 'by reducing the need for

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250 Ibid s5.

251 Slade et al, above n 62. The makeup of the services are described in an article from the same dataset: Mary E Johnson, 'Violence and Restraint Reduction Efforts on Inpatient Psychiatric Units' (2010) 31(3) *Issues in Mental Health Nursing* 181.

252 See Mind, The Mental Health Charity <www.mind.org.uk>.

253 Croft and Isvan, above n 102, 632.

inpatient and emergency services for some individuals, peer respites may increase meaningful choices for recovery and decrease the behavioral health system's reliance on costly, coercive, and less person-centered modes of service delivery'.[254] As noted previously, Greenfield and colleagues, compared the effectiveness of an unlocked, mental health service user-managed, crisis residential programme (CRP) to a locked, inpatient psychiatric facility (LIPF) for adults with severe mental health conditions.[255] The trial CRP experienced significantly greater improvement based on 'interviewer-rated and self-reported psychopathology' than did participants in the LIPF condition. Reported service satisfaction was 'dramatically higher' in the CRP condition, leading the researchers to conclude that 'CRP-style facilities are a viable alternative to psychiatric hospitalization for many individuals facing civil commitment'.[256]

Ostrow, in her (non-peer reviewed) Master's thesis, examined the growth of peer-run crisis respites 'operated by trained mental health consumers (i.e. peers)' in seven of the US states.[257] She provides background to the growth of peer-run respites in the United States, a case study for a Massachusetts based-service and recommends effective strategies for their development.[258]

The Vermont Agency of Human Services' Department of Mental Health, reported on data collected between 2011-16 on a peer-run crisis house, called Alyssum. Alyssum's two bed home is a residential crisis respite and hospital diversion service funded by the Vermont Department of Mental Health. According to the Alyssum website: 'The mission of the corporation is to provide a peer-operated, peer staffed holistic approach to mental wellness, discovery and recovery for Vermonters who are experiencing a mental health crisis'.[259] The Vermont Department of Mental Health reported the following:

> Alyssum opened its doors in November 2011 and expanded its capacity through additional Act 79 funding. The program offers a peer-developed approach to crisis support for

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254 Ibid.

255 Greenfield et al, above n 160.

256 Ibid.

257 Laysha Ostrow, *A Case Study of the Peer-Run Crisis Respite Organizing Process in Massachusetts*, (Heller School of Social Policy and Management, 2010) 38.

258   Ibid.

259   Alyssum, above n 227.

individuals who are seeking an alternative to traditional [drug and alcohol] crisis programs. As one resident stated, 'Alyssum is a safe haven for me. It works so much better for me than a traditional hospital setting. Being able to talk to peers who have been in my shoes and giving me first hand advice that works for them and try it myself is amazing.' As of the end of November 2016, Alyssum has had a total of 375 admissions and served 252 individuals (unduplicated). Over this period, Alyssum has had an 86% occupancy rate and an average length of stay of 7 days. Demand for the program has been high—a total of 568 unique individuals have been denied a bed due to full occupancy. 80% of admissions have been for hospital diversion and 20% were for transition from a hospital (step-down). Out of a possible 100% satisfaction rate, guests report 90% satisfaction with the progress made on personal goals while at the program. Upon departure from Alyssum, 84% of guests self-report feeling better, 20% say they feel the same, while 6% say they feel worse. The staff turnover rate at Alyssum is less than 10% annually.[260]

Alyssum is one of several peer-run crisis centres in Vermont, which were funded after a natural disaster destroyed a psychiatric largescale hospital:

Since the evacuation of the Vermont State Hospital in Waterbury at the end of August 2011, after Tropical Storm Irene, the new community capacities for crisis services, hospital diversion and step-down, peer-supported alternatives such as Alyssum (already open) and Soteria House (scheduled to open early in 2015) … are the most important ways in which the redesign of public mental health here in Vermont has emphasized individual choice among a range of options for treatment and support.[261]

260 Department of Mental Health, Agency of Human Services, *VERMONT2017 Reforming Vermont's Mental Health System*, Report to the Legislature on the Implementation of Act 79; January 15, 2017, 38 <https://legislature.vermont.gov/assets/Legislative-Reports/2017-ACT-79-Report.pdf>

261 Department of Mental Health, Agency of Human Services, *VERMONT2015 Reforming Vermont's Mental Health System*, Report to the Legislature on the Implementation of Act 114: January 1-November 30, 2014, January 15, 2015, 25 <https://legislature.vermont.gov/assets/Documents/2016/WorkGroups/Senate%20Judiciary/Reports%20and%20Resources/W~Department%20of%20Mental%20Health~The%20Implementating%20of%20Act%20114~1-15-2015.pdf>.

A similar 'intensive residential program' in Vermont called Hilltop, which has been in operation since 2012, 'also provides treatment and support using the Soteria model'.[262]

Crisis Respite Services

'Crisis respite services' may refer to a combination of non-residential settings, including guest houses or supported accommodation managed and supported by community mental health centre staff,[263] visiting centres, as well as home-based services. These may be peer-run, as for example with the Leeds Survivor-Led Crisis Service (discussed shortly), or may have more typical, formal professional-aligned staff.

A report by the Social Policy Research Centre at the University of New South Wales in its evaluation of a crisis respite service in South Australia, reported that the service 'resulted in statistically significant reductions in: Psychological distress; Hospital admissions; Time in hospital; Emergency Department visits; A large proportion of the costs were offset by the reductions in hospitalisation and Emergency Department presentations'.[264] Rosen and O'Connell provide some evidence to suggest adults who were admitted to a mental health respite programme self-reported a significant improvement in symptom distress ($p < 0.05$), 'mental health confidence' ($p < 0.1$), and self-esteem ($p < 0.05$) from admission to discharge.[265]

In Trieste, Italy, Mezzina and Vidoni followed a sample group of 39 new patients with acute and severe crises at community mental health centers over a four-year period, and reported that 'voluntary and compulsory hospitalization were avoided in favor of short-term day and night support in the [community mental health centers]', and there were 'no suicides, no crimes, no dropouts' and '[s]ocial adjustment remained unchanged'.[266] They argue that 'mental health services in Trieste are able to cope with acute crises without psychiatric hospitalization'.[267]

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262 Department of Mental Health, Agency of Human Services, above n 260, 41.

263 International Collaboration Mental Health Network, *Acute and Crisis Mental Health Services* <https://imhcn.org/bibliography/transforming-services/acute-and-crisis-mental-health-services>.

264 Fredrick Zmudzki et al, *Evaluation of Crisis Respite Services: Final Report*, SPRC Report 06/16 (Social Policy Research Centre, UNSW Australia, 2016) 1.

265 Jonathan Rosen and Maria O'Connell, 'The Impact of a Mental Health Crisis Respite upon Clients' Symptom Distress' (2013) 49(4) *Community Mental Health Journal* 433.

266 Mezzina and Vidoni, above n 177.

267 Ibid.

Sledge and colleagues undertook two largescale studies investigating the 'clinical feasibility and the outcome for patients of a program designed as an alternative to acute hospitalization', in which a conventional inpatient programme for the 'urban, poor, severely ill voluntary patients who usually require hospitalization' was compared with an alternative experimental programme consisting of 'a day hospital linked to a crisis residence'. The authors report that the 'clinical, functional, social adjustment, quality of life, and satisfaction outcome measures were not statistically different for the patients in the two treatment conditions; however, there was a slightly more positive effect of the experimental program on measures of symptoms, overall functioning, and social functioning'.[268] This study does not make it clear whether this resulted in a reduction in participants who were treated and detained involuntarily.

Sledge and colleagues' second study compared 'service utilization and costs for acutely ill psychiatric patients treated in a day hospital/crisis respite program or in a hospital inpatient program', including following up on outcomes 10 months after discharge.[269] The day hospital/crisis respite programme cost less than inpatient hospitalisation (roughly 20% of the total direct costs), although the programmes had roughly equal direct service staff and capital costs.[270] The difference was largely due to operating costs (day hospital/crisis respite operating costs were 51% of inpatient hospital costs). Sledge and colleagues' study indicates that the experimental condition (a combined day hospital/crisis respite community residence) seems to have had the same treatment effectiveness as acute hospital care for urban, poor, acutely ill voluntary patients with severe mental illness.

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268 William H Sledge et al, 'Day Hospital/Crisis Respite Care versus Inpatient Care, Part I: Clinical Outcomes' (1996) 153(8) *The American Journal of Psychiatry* 1065, 1065.

269 William H Sledge et al, 'Day Hospital/Crisis Respite Care versus Inpatient Care, Part II: Service Utilization and Costs' (1996) 153(8) *The American Journal of Psychiatry* 1074.

270 Ibid.

Host Families

Some schemes provide a family support structure for individuals during crisis, or as a form of crisis prevention.[271] The Family Care Foundation in Sweden, for example, works with 'family home living, psychotherapy and family therapy'.[272] The staff at Family Care Foundation are psychotherapists, psychologists and social workers, and work with teams consisting of the client, his or her network, the family home, a supervisor and a therapist. No peer-reviewed empirical research on 'host family' arrangements appeared in the review.

Addressing Coercive Practices in Housing and Independent Living Services

One socio-legal study considered the use of coercive practices within housing and residential services. Allen analysed legal, policy and research materials and argued that mental health services in the United States appear to be using coercive practices or 'leveraging' in some housing services; that is, threatening discontinuation of housing services or eviction if psychiatric intervention is not accepted.[273] Allen argues that, within the United States, this practice appears to breach the Americans with Disabilities Act, and according to the author has multiple, negative flow-on effects. Hence, Allen sets out legal avenues for preventing 'leverage'.[274]

Richter and Hoffman reviewed randomised and non-randomised controlled trials examining outcomes for people living in 'independent settings' versus 'institutionalised accommodation'[275]— the latter in which more coercive practices seem likely to be used. The results of Richter and Allen's study indicated that 'Independent Housing and Support-settings' provide at least similar outcomes to 'residential care'[276] and the authors conclude

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271 International Collaboration Mental Health Network, *Acute and Crisis Mental Health Services* <https://imhcn.org/bibliography/transforming-services/acute-and-crisis-mental-health-services>.

272 The Family Care Foundation, Gothenburg, Sweden <www.familjevardsstiftelsen.se>.

273 Michael Allen, 'Waking Rip van Winkle: Why Developments in the Last 20 Years Should Teach the Mental Health System Not to Use Housing as a Tool of Coercion.' (2003) 21(4) *Behavioral Sciences & the Law* 503, 503.

274 Ibid.

275 Dirk Richter and Holga Hoffmann, 'Independent Housing and Support for People with Severe Mental Illness: Systematic Review' (2017) 136(3) *Acta Psychiatrica Scandinavica* 269, 269.

276 Ibid.

by arguing that housing should be based on clients' preferences rather than service providers sense of their 'best interests'.[277]

Some persons with mental health conditions and psychosocial disabilities may refuse any housing attached to mental health services, while others may embrace it. There are even reports of services in Ireland using civil commitment laws to detain homeless people who refuse shelter,[278] which may be occurring elsewhere. 'Housing First' policies and programmes are an example of how housing support might be provided in ways that respect a person's will and preference rather than being based on the coercive approach of refusing a person housing support if he or she does not comply with mental health treatment. Under some iterations of the Housing First scheme, persons with mental health conditions and psychosocial disabilities who are homeless are supported through intensive case management to move into regular housing, with no requirement that they adhere to treatment plans (even when such treatment is offered).[279] Such practices appear likely to reduce instances of coercion in housing services for persons with mental health conditions and psychosocial disabilities, though no research has explicitly examined whether this is indeed the case.

Community Crisis Resolution and Home Support

This section discusses non-hospital, non-residential crisis resolution and home support on the basis that such settings may reduce the likelihood of coercion. People typically end up in hospital settings or acute psychiatric facilities when they are in extreme crises, which might be exacerbated where there is an absence of 'step-down' or alternative, non-hospital crisis resolution services open to people who need various levels of support. Again, better meeting people's support needs, as well as being valuable in and of itself, is likely to help prevent, reduce or end coercive interventions. Several community-based crisis-intervention programmes and services in the review could be broadly categorised as alternatives to coercive practices. These include

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277 Ibid.

278   See, eg, Kitty Holland, 'Services 'Sectioning' Homeless People Who Refuse Shelter' *Irish Times* (3 March 2018).

279 See, eg, Micah Projects, *Housing First: a Foundation for Recovery: Breaking the Cycle of Brisbane's Housing, Homelessness and Mental Health Challenges* (2016) <www.micahprojects.org.au>

supports for intensive intervention to address crises and prevent hospital admission for adults[280] and children.[281]

Leeds Survivor Led Crisis Service (LSLCS) was set up in the English city of Leeds in 1999 by a group of service users, initially in partnership with the United Kingdom Government's Social Services. According to the LSCS website:

> The service was set up to be a place of sanctuary, which was an alternative to hospital admission and statutory services for people in acute mental health crisis. The service was established, and continues to be governed and managed, by people with direct experience of mental health problems. We have our own unique perspectives on what it feels like to be in crisis and what helps and does not help. We have developed our service based on this knowledge and experience, while responding to the needs articulated by our visitors and callers.[282]

Several reports have been authored by LSLCS, which provide some evidence to support its efficacy.[283]

Hackett and colleagues examine a crisis and home support programme for the black and minority ethnic community in Sheffield, England, which was aimed at addressing both an over representation of such groups in psychiatric wards and people avoiding mainstream services altogether.[284] The **Sheffield Crisis Resolution Home Treatment** (CRHT) Service created the Enhancing Pathways Into Care (EPIC) project, which initially focused on engagement with the Pakistani community – the largest black and minority ethnic (BME) group in Sheffield. The home treatment service joined with a local Pakistani Muslim Centre, which had existing links with the Pakistani community and provided a range

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280 See, eg, Christina Lyons et al, 'Mental Health Crisis and Respite Services: Service User and Carer Aspirations' (2009) 16(5) *Journal of Psychiatric and Mental Health Nursing* 424, 424.

281 Mary E Evans, Roger A Boothroyd and Mary I Armstrong, 'Development and Implementation of an Experimental Study of the Effectiveness of Intensive In-Home Crisis Services for Children and Their Families' (1997) 5(2) *Journal of Emotional and Behavioral Disorders* 93, 93.

282 See Leeds Survivor-Led Crisis Service <https://www.lslcs.org.uk/additional>

283 See Leeds Survivor-Led Crisis Service <https://www.lslcs.org.uk/additional-services/publications/>

284 Rashna Hackett et al, 'Enhancing Pathways Into Care (EPIC): Community Development Working with the Pakistani Community to Improve Patient Pathways within a Crisis Resolution and Home Treatment Service' (2009) 21(5) *International Review of Psychiatry* 465, 465.

of social, respite and occupational opportunities. The partnership created an innovative new role: the Pakistani link worker. While there is no direct evidence of a resulting reduction in coercion, the authors reported evidence of positive change including more referrals to the Centre from psychiatric services.[285]

Johnson and colleagues, again in England, provided some evidence that a 'crisis resolution team', who assisted 260 residents of the inner London Borough of Islington who were experiencing crises severe enough for hospital admission to be considered, were less likely to be admitted to hospital in the eight weeks after the crisis, though compulsory admission was not significantly reduced.[286] A difference of 1.6 points in the mean score on the client satisfaction questionnaire (CSQ-8) was not quite significant (P = 0.07), although it became so after adjustment for baseline characteristics (P = 0.002).[287] The authors concluded that crisis resolution teams can reduce hospital admissions in mental health crises and they may also increase satisfaction in patients, but this was an equivocal finding.

The **Open Dialogue** model is prominent in rights-based debates about crisis support and resolution in people's homes and communities.[288] Currently, research on Open Dialogue consists of small-scale studies based in Western Lapland, Finland, which focus on people with first-episode psychosis.[289] However, irrespective of its prominence in some human rights commentary, which positions Open Dialogue as a CRPD-aligned practice, the review did not find any empirical evidence that examines its direct impact on rates of coercion. (It is perhaps also noteworthy that Finland has some of the highest rates of formal involuntary psychiatric interventions in the European Union).[290] On the other hand, Open Dialogue was designed as a treatment alternative to

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285 Ibid.

286 Sonia Johnson et al, 'Randomised Controlled Trial of Acute Mental Health Care by a Crisis Resolution Team: The North Islington Crisis Study' (2005) 331(7517) *BMJ* 599.

287 Ibid.

288 Seikkula et al, above n 110.

289 Jaakko Seikkula et al, above n 110; Niels Buus et al, 'Adapting and Implementing Open Dialogue in the Scandinavian Countries: A Scoping Review' (2017) 38(5) *Issues in Mental Health Nursing* 391; Jukka Aaltonena, Jakko Seikkulaa and Klaus Lehtinen, 'The Comprehensive Open-Dialogue Approach in Western Lapland: I. The Incidence of Non-Affective Psychosis and Prodromal States' (2011) 3(3) *Psychosis* 179.

290 Salize and Dressing, above n 207.

hospitalisation.[291] In avoiding hospitalisation, there is less likelihood – or so it would seem – of formal coercion, including seclusion and restraint.

Research on Open Dialogues typically concerns its direct benefits to individuals and families. For example, preliminary results of a two-year follow-up found that a group of people with a first-instance diagnosis of schizophrenia who used the approach 'were hospitalized for fewer days, family meetings were organised more often and neuroleptic medication was used in fewer cases'.[292] Seikkula and colleagues reported that participants experienced 'fewer relapses and less residual psychotic symptoms and their employment status was better than in the (non-participating) Comparison group'.[293] Razzaque and Stockman describe 'peer-supported open dialogue' as a variant of the Finnish practice, which is being trialled in six National Health Service trusts in the United Kingdom commencing in 2016.[294] They describe how a 'core principle of the approach is the provision of care at the social network level, by staff who have been trained in family, systems and related approaches'.[295] Rigorous empirical analysis of Open Dialogue is yet to occur, and its application outside of Finland remains largely untested, although studies are beginning to emerge.[296]

Evans and colleagues examined demographic data from **in-home services for children**, highlighting the efficacy of various in-home services as alternatives to hospitalisation for children experiencing serious psychiatric crises.[297] However, they did not consider coercion against children and young people, and there is a general absence in literature on preventing coercive practices against children and young people.

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291 Seikkula et al, above n 110.

292 Ibid.

293 Ibid.

294 Russell Razzaque and Tom Stockmann, 'An Introduction to Peer-Supported Open Dialogue in Mental Healthcare' (2016) 22(5) *BJPsych Advances* 348, 348.

295 Ibid.

296 Mary Olson, Jaakko Seikkula and Douglas Ziedonis, *The Key Elements of Dialogic Practice in Open Dialogue* (The University of Massachusetts, 2014).

297 Evans, Boothroyd and Armstrong, above n 281.

4. Other Trends in the Literature

This section notes trends in the literature that cut across hospital and non-hospital settings, yet which are not as overarching as the themes set out in Section 2.1 of this review.

Advance Planning to Improve Crisis Responses

Ten studies explicitly engaged with advance planning.[298] Although there is undoubtedly a much larger literature concerning advance planning in mental health services, this review encompassed studies that were particularly aimed at assessing their impact on the use of coercive practices.

'Joint Crisis Plans' are a form of advance agreements from the United Kingdom, which are written by an individual in collaboration with his or her clinicians, and were considered in 5 studies.[299] Joint Crisis Plans were trialled in England and developed in consultation with national service user groups, including 'detailed development work with service users in south London'.[300] Each plan is formulated by the patient, 'care coordinator', psychiatrist, and a 'project worker' and contained contact information, details of mental and physical illnesses, treatments, indicators for relapse, and advance statements of preferences for care in the event of future relapse.

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298 Thornicroft et al, above n 108; Graham Thornicroft et al, 'Randomised Controlled Trial of Joint Crisis Plans to Reduce Compulsory Treatment for People with Psychosis: Clinical Outcomes and Implementation' Abstract 0-90, (2015) 5(Suppl 2) *BMJ Supportive & Palliative Care* A28; Jeffrey Swanson et al, 'Psychiatric Advance Directives and Reduction of Coercive Crisis Interventions.' (2008) 17(3) *Journal of Mental Health* 255; Alexia Papageorgiou et al, 'Advance Directives for Patients Compulsorily Admitted to Hospital with Serious Mental Illness. Randomised Controlled Trial' (2002) 181(6) *The British Journal of Psychiatry* 513; Barrett et al, above n 91, e74210; Bruce J Winick, 'Advance Directive Instruments for Those with Mental Illness.' (1996) 51(1) *University Of Miami Law Review* 57; Shields et al, above n 57; Claire Henderson et al, 'Effect of Joint Crisis Plans on Use of Compulsory Treatment in Psychiatry: Single Blind Randomised Controlled Trial' (2004) 329(7458) *BMJ* 136; Claire Henderson et al, 'Views of Service Users and Providers on Joint Crisis Plans' (2009) 44(5) *Social Psychiatry and Psychiatric Epidemiology* 369; Claire Henderson et al, 'Informed, Advance Refusals of Treatment by People with Severe Mental Illness in a Randomised Controlled Trial of Joint Crisis Plans: Demand, Content and Correlates' (2017) 17(1) *BMC Psychiatry* 376.

299 C Henderson, et al, 'Effect of Joint Crisis Plans on Use of Compulsory Treatment in Psychiatry: Single Blind Randomised Controlled Trial' above n 298, 136.

300 Ibid.

In a 2004 study, Henderson and colleagues found that use of compulsory admission or treatment under the Mental Health Act 1983 (England and Wales) was significantly reduced for the group who had Joint Crisis Plans.[301] 13% (10/80) of the group who had Joint Crisis Plans experienced compulsory admission or treatment compared with 27% (21/80) of the control group (risk ratio 0.48, 95% confidence interval 0.24 to 0.95, P = 0.028).[302] Henderson and colleagues' 2009 study, which consisted of surveys of Joint Crisis Plan recipients and case managers, suggested that participants felt more in control of their mental health problem and that the Plans 'empower their holders to obtain their preferred care and treatment in a crisis'.[303] However, the 2013 follow-up trial was unable to replicate the previous results, although the authors argued 'that patchy implementation and lack of real commitment are more likely culprits', and that 'one meeting between patients and professionals is unlikely to be sufficient to counteract a culture of professional dominance in decision making where this prevails'.[304]

Barrett and colleagues compared Joint Crisis Plans plus 'treatment as usual' (TAU) to TAU alone for 569 participants from four English mental health trusts, and found that the addition of Joint Crisis Plans to TAU had 'no significant effect on compulsory admission.[305] They also analysed fiscal cost, and found some evidence suggesting a higher probability (80%) of Joint Crisis Plans being the more cost-effective option, particularly amongst the 'Black ethnic group'.[306] Henderson and colleagues' 2017 trial, compared 221 Joint Crisis Plans with 424 'baseline routine care plans' and aimed to estimate the demand for treatment refusals in such plans, as authorised under the *Mental Capacity Act 2005* (England and Wales).[307] 45% of the Joint Crisis Plans contained a treatment refusal compared to 10 of 424 (2.4%) baseline routine care plans.[308] They demonstrated significant demand for written treatment refusals in line with the *Mental Capacity Act 2005*

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301 Ibid.

302 Ibid.

303 Henderson et al, 'Views of Service Users and Providers on Joint Crisis Plans', above n 298, 369.

304 Thornicroft et al, above n 108

305 Barrett et al, above n 81, e74210.

306 Ibid.

307 Henderson et al, 'Informed, Advance Refusals of Treatment by People with Severe Mental Illness in a Randomised Controlled Trial of Joint Crisis Plans: Demand, Content and Correlates.', above n 298, 376.

308 Ibid.

(England and Wales), which had not previously been elicited by the process of treatment planning. The authors argued that future treatment/crisis plans should incorporate the opportunity for service users to record a treatment refusal during the drafting of such plans.[309]

'Psychiatric **advance directives**' and **advance statements** are a form of statutory advance planning, in which a person makes decisions designed to bind oneself or direct others to action in the future, particularly during times of crisis. Swanson and colleagues studied whether the completion of 'facilitated' advance planning a 'Facilitated Psychiatric Advance Directive (F-PAD)' was associated with reduced frequency of coercive crisis interventions.[310] In their study of 130 adults, their quantitative analysis of randomised controlled trial data suggested that F-PAD completion was associated with lower odds of coercive interventions (adjusted OR = 0.50; 95% CI = 0.26-0.96; $p < 0.05$).[311] They concluded that 'PADs may be an effective tool for reducing coercive interventions around incapacitating mental health crises'.[312] Shields and colleagues sought 'client and carer' views on psychiatric advance directives in India (making it the only study on advance directives in a low- or middle-income country).[313] Most interviewees reported being unfamiliar with advance directives and although some clients felt it was important to have a say in treatment wishes, carers expressed 'concerns about service user capacity to make decisions'.[314] The authors conclude that advance directives 'could potentially mitigate the risks of coercive treatments to persons with severe mental illness'.[315] Winick, in his socio-legal analysis of law relevant to living wills and advance directives, particularly case law, argues that advance directive instruments can be a useful means of planning for mental illness and of avoiding disputes concerning hospitalisation and treatment.[316] However, one study found little observable impact of advance directives on coercion. Papageorgiou and colleagues in their study found users' advance instruction directives had little observable impact on compulsory readmission rates at 12 months.[317] In contrast, de Jong and

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309   Ibid.
310   Swanson et al, above n 298, 255.
311   Ibid.
312   Ibid.
313   Shields et al, above n 57, 29.
314   Ibid.
315   Ibid.
316   Winick, above n 298.
317   Papageorgiou et al, above n 298.

colleagues conducted a systematic literature review on advance statements, including a meta-analyses of all randomised control trials (RCTs), which they argue 'showed a statistically significant and clinically relevant 23% reduction in compulsory admissions in adult psychiatric patients, whereas the meta-analyses of the RCTs on community treatment orders, compliance enhancement, and integrated treatment showed no evidence of such a reduction'.[318]

Using Non-Legal Advocacy to Avoid Coercion

Some articles considered advocacy to avoid coercion. 'Advocacy' was referred to in the sense of non-legal advocacy including individual action, but also forms of group and peer advocacy, and systemic advocacy. Cutler, Hayward and Tanasan write:

> advocacy enables individuals to have a say in their life and the dimensions that affect their livelihood, whether that be their care, their family, their housing or their work. This is particularly important in mental health, as people experiencing crises may have many of their fundamental rights taken away when they are treated or compulsorily admitted to hospital.[319]

Interestingly, advocacy was solely discussed with regards to service user-run organisations, and self-help groups. Kleintjes, Lund and Swartz, in their qualitative study involving 11 members of leadership in mental health self-help organisations across Africa, concluded that self-help organisations provide 'advocacy to … promote the protection of user's rights'.[320] Tanenbaum, in her study of the directors of 15 consumer-operated service organisations (service user led organisations) in the United States observed they 'provide peer support and advocacy training'.[321] No empirical evidence in the review was able to indicate the effectiveness of non-legal advocacy in causing a reduction in coercive practices, except perhaps Winkler and colleagues' study of mental health policy in Central and Eastern Europe, in which the study respondents suggested that systemic advocacy had been crucial in progressive change away from coercive, institutional practices—change that reportedly occurred 'because of grassroots

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318 Mark H de Jong et al, 'Interventions to Reduce Compulsory Psychiatric Admissions: A Systematic Review and Meta-Analysis' (2016) 73(7) *JAMA Psychiatry* 657, 657.

319 Cutler, Hayward and Tanasan, above n 56, 1.

320 Kleintjes, Lund and Swartz, above n 56.

321 Tanenbaum, above n 105.

initiatives supported by international organisations, rather than by systematic implementation of government policies'.[322]

The general absence in the literature on individual advocacy seems significant, given the prominent position given to non-legal advocacy in many CRPD debates about coercion in mental health services. The Swedish *personligt ombud* (or PO) is important in this regard. In its *Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities*, the Office of the High Commissioner for Human Rights (OHCHR) recommends the 'PO Skåne' programme – an iteration of the PO scheme run by persons who had used mental health services – as a form of supported decision-making.[323] The Commissioner for Human Rights of the Council of Europe, Nils Muižnieks, writes that 'recourse to the Personal Ombudsmen system could be a way of limiting coercive practice in psychiatric institutions'.[324] According to the Swedish National Board of Health and Welfare, an important function of the PO is to 'make demands on the public authorities that are responsible for people with serious psychiatric disabilities, to ensure that they are receiving the help and service to which they are entitled'.[325] According to the report, this function reduces the number of mental health crises that a person experiences, and leads to savings of up to 17 times the cost of the service itself. Yet, there is an absence of academic research examining the empirical basis for claims about the PO system, which seems like a significant gap in the scholarly literature. Further, despite the PO scheme being presented as a rights-based approach to advocacy for persons with mental health conditions and psychosocial disabilities, it is worth noting that Sweden has among the highest rates of formal involuntary psychiatric interventions in the world.[326] No English-language materials that examine the

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322 Petr Winkler et al, above n 56, 634.

323 Office of the High Commissioner for Human Rights, 'Chapter Six: From Provisions to Practice: Implementing the Convention, Legal Capacity and Supported Decision-Making', *United Nations Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities* (United Nations, 2007) 89.

324 Swedish National Board of Health and Welfare, *A New Profession is Born – Personligt ombud, PO* (Västra Aros, Västerås, November 2008) 10 <www. personligtombud.se>.

325 Ibid.

326 Salize and Dressing, above n 207.

impacts of the scheme on rates of coercion within mental health settings were identified in the review.

Reducing Fear of Coercion

There is some evidence to suggest that fear of coercion may keep people away from mental health treatment, which may increase risk of coercion. Several studies considered the impact of dissatisfaction with services, or the result of 'negative' encounters with services.[327] Some studies identified dissatisfaction of service users with services they have used in the past, as an indicator of the likelihood of treatment refusal. Louk and colleagues provide some evidence indicating that more satisfaction with prior treatment seems to 'reduce the risk of civil detention remarkably'.[328] Swartz and colleagues provided some evidence to indicate that involuntary hospitalisation and 'recent warnings about treatment nonadherence' were found to be significantly associated with barriers that may inhibit future help seeking, and concluded that 'mandated treatment may serve as a barrier to treatment, but that ongoing informal pressures to adhere to treatment may also be important barriers to treatment'.[329] Informal pressures were examined by Valenti and colleagues in their international study involving 10 countries. They conducted focus groups with mental health professionals regarding their attitudes toward and experiences with the use of informal coercion. Despite the different sociocultural contexts, the researchers found that 'disapproval of informal coercion in theory is often overridden in practice', which tends to 'make professionals feel uneasy, and requires more debate and guidance'.[330]

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327 Louk FM van der Post et al, 'Patient Perspectives and the Risk of Compulsory Admission: The Amsterdam Study of Acute Psychiatry V' (2014) 60(2) *The International Journal of Social Psychiatry* 125; Brodie Paterson, Lindsay Bennet and Patrick Bradley, 'Positive and Proactive Care: Could New Guidance Lead to More Problems.' (2014) 23(17) *British Journal of Nursing* 939.

328 van der Post et al, above n 327.

329 Marvin S Swartz, Jeffrey W Swanson and Michael J Hannon, 'Does Fear of Coercion Keep People Away from Mental Health Treatment? Evidence from a Survey of Persons with Schizophrenia and Mental Health Professionals' (2003) 21(4) *Behavioural Sciences & The Law* 459.

330 Emanuele Valenti et al, 'Informal Coercion in Psychiatry: A Focus Group Study of Attitudes and Experiences of Mental Health Professionals in Ten Countries' (2015) 50(8) *Social Psychiatry and Psychiatric Epidemiology* 1297, 1297.

Culturally Appropriate Pathways Through Mental Health Services

Several studies in high-income Western countries, considered the distinct issues concerning mental health and coercion, or crisis resolution, facing persons with mental health conditions or psychosocial disabilities who are from minority ethnic communities. Lawlor and colleagues found that all groups of 'black' patients and 'white other' patients were significantly more likely to have been compulsorily admitted than 'white British' patients.[331] Differences between groups in help-seeking behaviours in a crisis may contribute to explaining differences in rates of compulsory admission. Smith and others reported in their study that '[p]atients from racial or ethnic minority groups had a higher rate and longer duration of seclusion than whites'.[332] Barrett and colleagues, in their study of Joint Crisis Plans, reported that 'the evidence does not support the cost-effectiveness of [Joint Crisis Plans] for White or Asian ethnic groups, there is at least a 90% probability of the JCP intervention being the more cost-effective option in the Black ethnic group'.[333] As noted above, Hackett and colleagues examined a crisis and home support programme for the black and minority ethnic community in Sheffield, England, which appeared to drive positive change including more referrals to the Sheffield Crisis Resolution Home Treatment Service from psychiatric services.[334] Several examples from grey literature appeared, which sought to address culturally-specific needs. The Leeds Survivor-Led Crisis Service, again in England, reports on its partnership with a service that supports people from black and minority ethnic (BME) groups, for which the partnership provides out-of-hours crisis services to people from BME groups in acute mental health crisis. The Manager, Senior Crisis Support Worker and three Crisis Support Workers are all from BME groups.[335]

Supported Decision-Making

'Supported decision-making' is advanced by United Nations bodies as the preferred response for people who are otherwise

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331 Lawlor et al, above n 239.

332 Smith et al, above n 206.

333 Barrett et al, above n 81, e74210.

334 Hackett et al, above n 284.

335 See Leeds Survivor-Led Crisis Service <https://www.lslcs.org.uk/additional>.

subject to forced psychiatric interventions.[336] The OHCHR refers to supported decision-making as simply 'the process whereby a person with a disability is enabled to make and communicate decisions with respect to personal or legal matters'.[337]

As noted previously, Bariffi and Smith describe the use of Argentina's *National Mental Health Law 2010* (NMHL) as a means of providing supported decision-making arrangements to people who may otherwise be subject to civil commitment and involuntary treatment.[338] Bariffi and Smith provide several case studies to show how the provision in the NMHL that authorises the provision of a supported decision-making packages, works in practice. One scholarly study conducted empirical research into the possible impact of 'supported decision-making' on coercive practices. Kokanović and colleagues conducted interviews with 90 mental health service users, family members supporting them and mental health practitioners.[339] The authors conclude that enabling supported decision-making in clinical practice and policy can be facilitated by (1) support for good communication skills and related attitudes and practices among mental health practitioners and removing barriers to their good practice in health and social services and (2) introducing legal supported decision-making mechanisms.[340]

Other studies could be broadly categorised as being concerned with supported decision-making and broader 'support to exercise legal capacity' in line with Article 12(3) of the CRPD. Consider the PO Skåne' program, for example, which the OHCHR described as a form of supported decision-making (as discussed in the

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336 See, eg, Committee on the Rights of Persons with Disabilities, *General Comment No 1: Article 12: Equal Recognition Before the Law*, 11th sess, UN Doc CRPD/C/GC/1 (19 May 2014) 6 [26].

337 UN Office of the High Commissioner for Human Rights, *Annual Report of the United Nations High Commissioner for Human Rights and Reports of the Office of the High Commissioner and the Secretary-General: Thematic Study by the Office of the United Nations High Commissioner for Human Rights on Enhancing Awareness and Understanding of the Convention on the Rights of Persons with Disabilities*, UN Doc A/HRC/10/48 (26 January 2009) [45].

338 Law No 26657, 3 December 2010 [32041] BO 1; 'Mental Health Regime', House of Representatives Res D-276/07 (7 March 2007) art 1.

339 Renata Kokanović et al, 'Supported Decision-Making from the Perspectives of Mental Health Service Users, Family Members Supporting Them and Mental Health Practitioners, Supported Decision-Making from the Perspectives of Mental Health Service Users, Family Members Supporting Them and Mental Health Practitioners' [2018] *Australian & New Zealand Journal of Psychiatry* 826.

340 Ibid.

previous section).[341] In another study, Robertson and Collinson sought to explore outreach workers' experiences of assisting clients with positive risk-taking,[342] which has overlap with the emphasis in supported decision-making on so-called 'dignity of risk'.[343] The authors found different understandings of positive risk-taking at different levels within organisations and a 'need for better informed, coherent organisational approaches to its practice'.[344] Conservative practices were associated with 'promoting coercion and disrupting therapeutic relationships, and so increasing risks over a longer time period', and the researchers called for more research on creating effective frameworks for assisting people with positive risk taking.[345]

Overall, however, despite the prominence of the concept of supported decision-making in human rights related activity, there were few empirical studies on its application in the mental health context.

Providing Low-medication and/or No-medication Approaches

Organisations representing persons with mental health conditions and psychosocial disabilities tend to characterise support with medication discontinuation, or low-medication approaches, as an unmet need. Although discontinuation may not seem at first glance to be an alternative to coercive practice, there is some evidence to suggest that many service users chose to keep discontinuation a secret from mental health professionals to avoid perceived negative consequences such as involuntary treatment.[346] Service providers may not wish to assist service users to reduce

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341 Office of the High Commissioner for Human Rights, above n 323, 89.

342 John P Robertson and Christine Collinson, 'Positive Risk Taking: Whose Risk Is It? An Exploration in Community Outreach Teams in Adult Mental Health and Learning Disability Services.' (2011) 13(2) *Health, Risk & Society* 147, 147.

343 Piers Gooding, 'Supported Decision-Making: A Rights-Based Disability Concept and Its Implications for Mental Health Law' (2013) 20(3) *Psychiatry, Psychology and Law* 431, 432 .

344 Robertson and Collinson, above n 342.

345 Ibid.

346 Carmela Salomon, Bridget Hamilton and Stephen Elsom, 'Experiencing Antipsychotic Discontinuation: Results from a Survey of Australian Consumers' (2014) 21(10) *Journal of Psychiatric and Mental Health Nursing* 917, 922.

or discontinue. A subtly coercive effect can therefore occur which narrows service users' options for healthcare decision-making.

Studies indicate that discontinuing psychiatric medication is often a complicated and difficult process.[347] Salomon, Hamilton and Elsom in their empirical research on 98 service users or former service users in Australia, argued that 'there may be a need to improve education, monitoring, and support strategies for some people during discontinuation' and that '[s]hifting toward a more collaborative, transparent, and service user-driven approach to discontinuation may help to mitigate some of the negative discontinuation impacts identified'.[348] (They also acknowledge that findings cannot be readily generalised because of sampling constraints). Ostrow and colleagues, in their sample of 250 service users in the US, argue that '[f]uture research should guide health care systems and providers to better support patient choice and self-determination regarding the use and discontinuation of psychiatric medication'.[349] It seems reasonable to assume that discontinuation practices, whether formally or informally, are occurring worldwide. Groot and van Os have proposed 'tapering strips' as a practical solution to help service users discontinue more safely.[350] They conducted an observational study on the use of 'antidepressant tapering strips to help people come off medication more safely' (n=1194) and concluded that '(t)apering strips represent a simple and effective method of achieving a gradual dosage reduction'.[351] An international initiative, The Tapering Project, is promoting the use of Tapering Strips as a way to improve the choice, control and safety of those who take them.[352]

Cullberg and colleagues, in their study of 253 adults with first episode psychosis in the Swedish Parachute project found some evidence that psychiatric in-patient care was lower as was

347 Ibid; Laysha Ostrow et al, 'Discontinuing Psychiatric Medications: A Survey of Long-Term Users' (2017) 68(12) *Psychiatric Services* 1232.

348 Ibid.

349 Ibid.

350 Peter C Groot and Jim van Os, 'Antidepressant Tapering Strips to Help People Come off Medication More Safely' (2018) 10(2) *Psychosis* 142.

351 Ibid.

352 The Tapering Project <http://www.taperingstrip.org/>. Research at Maastricht University is being undertaken into the use of Tapering Strips. See *Project Tapering*, Maastricht University <https://urc.mumc.maastrichtuniversity.nl/node/13125>.

prescription of neuroleptic medication in project participants.[353] Satisfaction with care was generally high in the Parachute group, with access to a small overnight crisis home associated with higher 'Global Assessment of Functioning' scores. The researchers argue that it is possible to successfully treat first episode patients with 'fewer in-patient days and less neuroleptic medication than is usually recommended, when combined with intensive psychosocial treatment and support'.[354] Morrison and colleagues, examined 74 individuals randomly assigned to receive either cognitive therapy plus treatment as usual (n=37), or treatment as usual alone (n=37) in order to examine the feasibility and effectiveness of using cognitive behavioural therapy (CBT) in people with schizophrenia who are not taking medication.[355] They provide some evidence indicating that 'cognitive therapy significantly reduced psychiatric symptoms and seems to be a safe and acceptable alternative for people with schizophrenia spectrum disorders who have chosen not to take antipsychotic drugs', though they call for a larger, definitive trial.[356] As previously discussed, the Open Dialogue approach 'emphasises using fewer neuroleptic medication', and Seikkula provides some evidence to indicate that the 'patients in the Open Dialogue in Acute Psychosis (ODAP) group had fewer relapses and less residual psychotic symptoms and their employment status was better than patients in the comparison group receiving 'typical' treatment.[357]

Several studies discussed possible correlations between rates of seclusion and physical or mechanical restraint on the one hand, and the use of psychotropics, neuroleptics and so on (forced or otherwise) on the other. Flammer and Steiner, in Germany, reported that '[r]estriction of involuntary medication [following the 2013 Constitutional Court rulings] was associated with a significant increase in use of mechanical coercive measures and violent incidents'.[358] Noorthoorn and colleagues similarly found that

353 Johan Cullberg et al, 'One-Year Outcome in First Episode Psychosis Patients in the Swedish Parachute Project' (2002) 106(4) *Acta Psychiatrica Scandinavica* 276.

354 Ibid. See also Johan Cullberg et al, 'Treatment Costs and Clinical Outcome for First Episode Schizophrenia Patients: A 3-Year Follow-up of the Swedish "Parachute Project" and Two Comparison Groups' (2006) 114(4) *Acta Psychiatrica Scandinavica* 274.

355 Anthony P Morrison et al, 'Cognitive Therapy for People with Schizophrenia Spectrum Disorders Not Taking Antipsychotic Drugs: A Single-Blind Randomised Controlled Trial' (2014) 383(9926) *The Lancet* 1395, 1395.

356 Ibid.

357 Seikkula et al, above n 110.

358 Erich Flammer and Tilman Steinert, 'Association Between Restriction of Involuntary Medication and Frequency of Coercive Measures and Violent Incidents.' (2016) 67(12) *Psychiatric Services* 1315.

'[i]n some hospitals where seclusion decreased, use of forced medication increased' and that in others '[s]eclusion decreased significantly, and forced medication increased'.[359] However, Højlund and colleagues found that '[a] decrease in coercive measures from 2013 to 2016 has not lead to significant increases in the use of antipsychotic medication or benzodiazepines'.[360] These mixed outcomes suggest that more research is needed to identify strategies to both reduce and eliminate coercive practices like physical and mechanical restraint, while also ensuring that low- or no-medication options are available to individuals in crisis.

359 Noorthoorn et al, above n 54.

360 Højlund Mikkel et al, 'Use of Antipsychotics and Benzodiazepines in Connection to Minimising Coercion and Mechanical Restraint in a General Psychiatric Ward' (2018) 64(3) *The International Journal of Social Psychiatry* 258.

Section Three: Regional Themes

As can be seen in the table and figure below, most of the reviewed research was conducted in North America and Western Europe. Overall, research locations are dominated by the United States, the United Kingdom (particularly England), the Netherlands and Northern Europe. The regions of Asia, Africa, the Middle East, Eastern and Southern Europe and Latin America remain significantly under-represented. There was one study that encompassed all South American countries.[361] Similarly, a single study encompassed seven African countries.[362] Hence, the representation in the table below does not necessarily convey the number of studies undertaken in each region.

Region	N*	Specific countries
Asia	6	India (2), Indonesia (3), China (1)
Eastern Europe	4	Bulgaria (1), Czech Republic (1), Lithuania (1), Poland (1),
Latin America	15	Argentina (2), Mexico (1), Chile (2); Bolivia (1), Brazil (1), Colombia (1), Ecuador (1), Guyana (1), Paraguay (1), Peru (1), Suriname (1), Uruguay (1), Venezuela (1)
Middle East	0	-
North America	28	United States (25), Canada (3)
Northern Africa	4	Kenya (1), Uganda (1), Ethiopia (1), Ghana (1)
Oceania	7	Australia (7)
Southern Africa	4	Rwanda (1), Tanzania (1), South Africa (1), Zambia (1)
Southern Europe	7	Croatia (1), Italy (3), Greece (1), Spain (2)
Western Europe	81	Denmark (10), Finland (5), Germany (7), Iceland (1), Netherlands (15), Norway (9), Sweden (8), Switzerland (6), England (20)

Table 1: Regions in which studies found in the literature review were conducted

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361 Christina Larrobla and Neury José Botega, 'Restructuring Mental Health: A South American Survey' (2001) 36(5) *Social Psychiatry and Psychiatric Epidemiology* 256.

362 Kleintjes, Lund and Swartz, above n 56, 187.
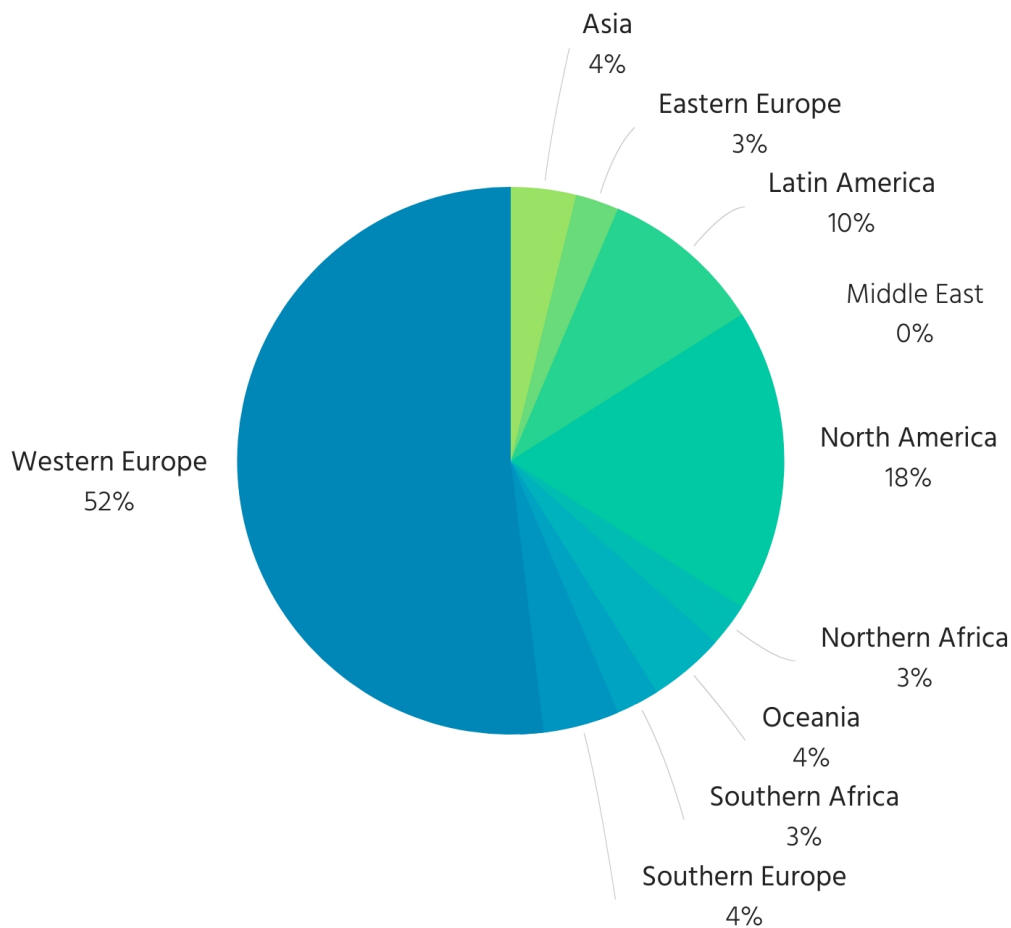
Figure 2: Regions in which the reviewed research has been conducted

The under-representation of research identified from low- and middle-income countries throughout the world is of concern. This may be partly explained by this review's bias toward English-language material which tends to direct attention to high-income countries with majority Anglophone populations (namely, Western Europe and Northern America). Publications in other languages and relevant publications that are not peer-reviewed are available online and elsewhere but were outside the scope of this review.

Africa

Elizabeth Kamundia points out that persons with disabilities in Africa, including those with psychosocial, intellectual and cognitive disabilities, typically live with their families against a cultural backdrop of mostly communal ways of life without individualised state-funded support services.[363] As such, strategies and practices for creating non-coercive practices differ considerably. The

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363 See generally, Elizabeth Kamundia, 'Choice, Support and Inclusion: Implementing Article 19 of the Convention on the Rights of Persons with Disabilities in Kenya' in *African Yearbook on Disability Rights* (Pretoria Law Press, 2013) 49.

cultural context of communalism with relatively strong social co-hesion, especially in rural areas, seems to be an important foun-dation when talking about 'alternatives' in Africa.

Peer support seems to be a key mode of support in Africa that might be broadly termed as a means to prevent coercion in the mental health context, whether through formal mental health services or community-based forms of coercion (for example in family homes or religious camps).[364] Kamundia has characterised peer support as culturally appropriate, recovery-focused and community-based.[365] Stefan Kleintjes and colleagues, in their qualitative study involving 11 members of leadership in mental health self-help organisations across Africa, concluded that:

Self-help organisations can provide crucial support to [mental health service] users' recovery in resource poor settings in Af-rica. Support of Ministries, NGOs, DPOs, development agencies and professionals can assist to build organisations' capacity for sustainable support to members' recovery.[366]

The review material – although limited, given the few studies available – suggests that these responses include tools to address coercion, such as informal advance directives and representation agreements, peer support groups to whom local communities and local police may turn to de-escalate crises, informal advoca-cy and information sharing.[367]

Lack of resources appears to be a pressing issue in low-income African countries, as with low-income countries worldwide. Ash-er and colleagues undertook qualitative research interviewing 35 adults with schizophrenia, 'their caregivers, community leaders and primary and community health workers' in rural **Ethiopia**, in order to better understand the experiences of, and reasons for, restraint of people with schizophrenia in community settings.[368] All types of participants cited increasing access to treatment as the most effective way to reduce the incidence of restraint. The

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364 Users and Survivors of Psychiatry – Kenya, "The Role Of Peer Support In Exercising Legal Capacity in Kenya (April 2018) <www.uspkenya.org>; Kleintjes, Lund and Swartz, above n 56.

365 Kamundia, above n 363.

366 Kleintjes, Lund and Swartz, above n 56, 187.

367 Users and Survivors of Psychiatry – Kenya, above n 364.

368 Asher et al, above n 8, 47.

authors conclude that a scale up of accessible and affordable mental health care may go some way to address the issue of restraint.

Human Rights Watch (in a non-peer reviewed research report) indicated that a Ghanaian coalition of non-governmental groups, including disabled peoples organisations, family groups and mental health professionals, called on the 'the government of Ghana [to] ensure adequate funding for mental health services in **Ghana**, as a crucial step to eliminating the widespread practice of shackling and other abuses against people with psychosocial disabilities'.[369] The Ghanaian Mental Health Act 2012 includes a provision that requires the Minister responsible for finance to create a levy to fund mental health services through parliament,[370] though Human Rights Watch report that the levy has yet to be established.[371]

However, it is also clear from this report that more mental health services per se will not lead to a reduction or the elimination of coercive practices. According to the United Nations Special Rapporteur for the Right to Health, Dainius Pūras:

> The scaling-up of care must not involve the scaling-up of inappropriate care. For care to comply with the right to health, it must embrace a broad package of integrated and coordinated services for promotion, prevention, treatment, rehabilitation, care and recovery and the rhetoric of "scaling up" must be replaced with mental health actions to "scale across". That includes mental health services integrated into primary and general health care, which support early identification and intervention, with services designed to support a diverse community.[372]

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369 Human Rights Watch, 'Ghana: Invest in Mental Health Services to End Shackling' (9 October 2017) <https://www.hrw.org/news/2017/10/09/ghana-invest-mental-health-services-end-shackling>

370 *Mental Health Act 2012* (Ghana) Act 846, s 88.

371 Human Rights Watch, above n 369.

372 Human Rights Council, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, UN Doc, 35th sess, A/HRC/35/21 (28 March 2017) [55].

More research is needed to identify and address the type of coercion facing persons with mental health conditions and psychosocial disabilities in Africa, including strategies that are responsive to social and economic conditions, and which go beyond a mere call for more resources for mental health services.

Asia

Studies from **India**, **Indonesia** and **China** appeared in the review but given the low number of studies, few generalisations can be made.

Of the two **Indian** studies, Shields and colleagues sought 'client and carer' views on psychiatric advance directives, as noted previously[373] while Raveesh and colleagues examined the attitudes of psychiatrists and caregivers to the use of coercive practices. Regarding the latter, participants recommended 'early identification of aggressive behaviour, interventions to reduce aggressiveness, empowering patients, improving hospital resources [and] staff training in verbal de-escalation techniques' to prevent coercion.[374] They call for 'standardized operating procedure[s] in the use of coercive measures'; this recommendation is not an alternative to coercion per se, though the authors argue that clear regulation would reduce coercion overall.[375]

Three peer-reviewed studies were undertaken in **Indonesia**, all concerning the practice of 'pasung', that is, the shackling or restraint of persons with psychosocial disabilities in family homes and communities. All researchers are clinicians and most of the research was action-based, with researchers charting the impact of interventions that aimed to prevent, reduce and end pasung. Minas and Diatri, in their observational study on Samosir Island, argued that the 'provision of basic community mental health services, where there were none before, enabled the majority of the people who had been restrained to receive psychiatric treatment and to be released from pasung'.[376] Puteh and colleagues similarly concluded that the 'development of a community mental health system and the introduction of a health insurance system in Aceh (together with the national health insurance scheme for the poor) has enabled access to free hospital treatment for people

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373 Shields et al, above n 57.
374 Raveesh et al, above n 220, s221.
375 Ibid.
376 Minas and Diatri, above n 8.

with severe mental disorders, including those who have been in pasung'.[377] They argue that it can inform 'other low and middle-income countries where restraint and confinement of the mentally ill is receiving insufficient attention'.[378] Suryani and colleagues take a slightly different approach in applying a programme to address pasung; they sought to integrate more culturally-specific forms of support, which they describe as a 'community-based, culturally sensitive … mental health model' that assisted all 23 people subject to pasung to show 'a remarkable recovery within 19 months of treatment'.[379]

In **China**, as noted previously, a study by Guan and colleagues was a largescale, national project, involving a nationwide two-stage follow-up study to measure the effectiveness and sustainability of the 'unlocking and treatment' intervention and its impact on the 'well-being of patients' families'.[380] (The emphasis on family wellbeing rather than individual wellbeing is notable). Similar to the Indonesian studies, the unlocking process referred to an intervention to free people from deprivations of liberty in family homes or communal spaces (such as villages). 96% of participants were diagnosed with schizophrenia. Prior to unlocking, their total time locked ranged from two weeks to 28 years, with 32% having been locked multiple times. The authors reported that over 92% of participants remained free of restraints in 2012 and they argued that '[p]ractice-based evidence from our study suggests an important model for protecting the human rights of people with mental disorders and keeping them free of restraints […][via] accessible, community based mental health services with continuity of care'.[381] China's '686' Programme may be useful, therefore, for informing efforts in low-resource settings where community locking of persons with psychosocial disabilities is practiced.

Appendix 3 includes reference to 'Transforming Communities for Inclusion-Asia' (**TCI-Asia**), an India-based NGO that describes

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377 Ibrahim Puteh, M Marthoenis and Harry Minas, 'Aceh Free Pasung: Releasing the Mentally Ill from Physical Restraint' (2011) 5 *International Journal of Mental Health Systems* 10, 10.

378 Ibid.

379 Luh Ketut Suryani, Cokorda Bagus Jaya Lesmana and Niko Tiliopoulos, 'Treating the Untreated: Applying a Community-Based, Culturally Sensitive Psychiatric Intervention to Confined and Physically Restrained Mentally Ill Individuals in Bali, Indonesia' (2011) 261(Suppl 2) *European Archives of Psychiatry and Clinical Neurosciences* 140, s143.

380 Guan et al, above n 56.

381 Ibid.

itself as 'an Asian Alliance of people with psychosocial disabilities, and cross disability supporters, focusing on the monitoring and implementation of all human rights for persons with mental health problems and psychosocial disabilities'.[382] TCI-Asia has contributed to debate about the implications of the CRPD for low- and middle-income countries. They recently reported a growth of psychiatric institutions in Asia, and laws which authorise non-consensual psychiatric interventions.[383] TCI-Asia notes that 'even though mental health legislations do not exist in many [Asian] countries, and some have [only] recently adopted new coercive mental health laws, mental institutions are coming up quite fast, resulting in the escalation of barriers to inclusion'.[384]

Clearly, more research is needed regarding both community-based deprivations of liberty and other coercive practices, as well as research concerning more formal, state-based coercive practices, policies and law.

Europe

Europe contains major economic, cultural and political differences. A spectrum appears to exist between low- and middle-income countries with largescale, standalone institutions and minimal welfare services, as well as high-income countries that are 'deinstitutionalised' and have comprehensive welfare systems. These differences have major implications for the nature of mental health services, the types of coercion people experience, and the remedies for addressing them.[385]

English-language studies identified in the review within Europe were mostly conducted in high-income Western countries such as **the United Kingdom** (particularly **England**), **the Netherlands** and **Scandinavia** (particularly **Denmark**). This region had a diverse array of research projects, from quantitative to qualitative, national studies, comparative international studies, case studies and so on. The region has seen concerted efforts to reduce, end and prevent coercive practices in mental health settings.

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382 See Transforming Communities for Inclusion – Asia<http://www.internationaldisabilityalliance.org/tci-membership>.

383 Transforming Communities for Inclusion – *Asia, Submission to the UNCRPD Monitoring Committee, Day of General Discussion, Article 19* <www.ohchr.org>; see also <www.madinasia.com>.

384 Ibid.

385 Lucie Kalisova et al, 'Do Patient and Ward-Related Characteristics Influence the Use of Coercive Measures? Results from the EUNOMIA International Study' (2014) 49(10) *Social Psychiatry and Psychiatric Epidemiology* 1619.

However, it is also noteworthy that the rate of compulsory admissions is tending to rise in some parts of Western Europe. In de Jong and colleagues' terms:

> Although recent numbers for most countries are not available, rates in several European countries are tending to rise, albeit for reasons that are largely unknown. In England—where, as in many other countries, many patients have been moved from large institutions into the community—the reduction in the number of mental illness beds has been accompanied by a rise in compulsory admissions. In Western societies, tolerance of deviant behavior by psychiatric patients in the community seems to be decreasing, parallel to an increasing emphasis on autonomy and rights of patients and to strictly defined and regulated coercive measures.[386]

The **Netherlands** had a strong representation of research that considered family-directed interventions – particularly Family Group Conferencing, as noted. Scandinavian countries, particularly **Norway and Denmark** tended to include studies which reported on robust national data on rates and patterns of coercive practices in mental health settings.

There was only one study identified in the review that focused on **Eastern European** mental health services, and even that was a European wide study.[387] It included ten countries, including **Bulgaria**, **Czech Republic**, **Lithuania** and **Poland**. In the study, Kalisova and colleagues considered service data for 2,027 involuntarily admitted patients, who were divided into two groups, the first (N = 770) subject to at least one 'coercive measure', the other (N = 1,257) had not received a 'coercive measure' during hospitalisation. (Again, highlighting terminological issues in this field, the authors of this study distinguish 'coercion' from 'involuntary admission', where other studies include involuntary admission in the definition of coercion). This study sought to identify whether selected patient and ward-related factors are associated with the

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386 Mark H de Jong et al, 'Interventions to Reduce Compulsory Psychiatric Admissions: A Systematic Review and Meta-Analysis' (2016) 73(7) *JAMA Psychiatry* 657, 658. See, also Alessia de Stefano, Giuseppie Ducci, 'Involuntary Admission and Compulsory Treatment in Europe: An Overview' (2008) 37(3) *International Journal of Mental Health* 10; Stefan Priebe et al, 'Reinstitutionalisation in Mental Health Care: Comparison of Data on Service Provision from Six European Countries' (2005) 330(7483) *BMJ* 123; Katrien Schoevaerts et al, 'An Increase of Compulsory Admissions in Belgium and the Netherlands: An Epidemiological Exploration' [in Dutch] (2013) 55(1) *Tijdschrift Voor Psychiatrie* 45.

387 Kalisova et al, above n 385.

use of coercive measures. The authors found significant variance of coercive measures in the participating countries. Clinical factors, such as 'high levels of psychotic symptoms and high levels of perceived coercion at admission were associated with the use of coercive measures', when controlling for countries' effect.[388] The authors recommend attention to these factors in programmes aimed at reducing the use of coercive measures in psychiatric wards. Activity is clearly underway to reduce coercive practices in Eastern European mental health settings, with 'grey' literature materials available in English and regional languages.[389] Winkler and colleagues undertook a review of the 'development of mental health-care practice for people with severe mental illnesses' in Central and Eastern Europe over the past 25 years, drawing on an expert survey in 24 countries. They concluded as follows:

> National policies often exist but reforms remain mostly in the realm of aspiration. Services are predominantly based in psychiatric hospitals. Decision making on resource allocation is not transparent, and full economic evaluations of complex interventions and rigorous epidemiological studies are lacking. Stigma seems to be higher than in other European countries, but consideration of human rights and user involvement are increasing. The region has seen respectable development, which happened because of grassroots initiatives supported by international organisations, rather than by systematic implementation of government policies.[390]

Similarly, there were just two English-language studies concerning **Southern Europe** identified in the review (one of which was the same study that captured the Eastern European countries).[391] Again, it is apparent that endeavours are underway to reduce, end and prevent coercive practices in this region.[392]

Clearly, there is scope for further research in these regions, including a comprehensive survey of non-English language research, to identify effective measures that reduce coercion in mental health settings.

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388 Ibid.

389 See, eg, The EU PERSON Partnership <www.eu-person.com/>; Mental Disability Rights Initiative of Serbia <www.mdri-s.org/>; Resource Center for People with Mental Disability<www.zelda.org.lv/en/zelda/pilot-project-of-supported-decision-making>.

390 Winkler et al, above n 56, 634.

391 Kalisova et al, above n 385; Valenti et al, above n 330.

392 See, eg, the 'Trieste Model' summarised in Appendix Three.

Latin America

There was relatively little English-language research uncovered in the literature review from Latin America. Latin America has undoubtedly produced research relevant to this review in languages other than English. There are practices in this region aimed at reducing, ending and preventing coercion in mental health settings. How this is working in practice, however, is not clear – and there may or may not be research examining outcomes. The work of Barriffi and Smith, for example, describes the possibility of Article 42 of the **Argentinian** *National Mental Health Law* being used to promote supported decision-making arrangements as an alternative to civil commitment, but it is essentially a speculative piece of sociolegal research, insofar as it charts a possible legal and policy pathway without evidence of how the law is being applied.[393] Evidence of its application is probably now available, though it is not clear if research on the outcomes is underway.

Larrobla and Botega undertook a comparative study, via postal survey to all countries in **South America**, through 'health ministries, national psychiatric associations and key informants'.[394] This 2001 study sought to gather information available on the changes in mental health services in South American countries following the 'social and political upheavals of recent decades', which included a particular focus on the success or otherwise of deinstitutionalisation.[395] The survey results indicate that 'most' mental health programmes were implemented during the 1980s and 1990s and aimed at incorporating psychiatric care into primary health care, as well as relocating provision from large hospitals to decentralised services (which is likely to be associated with less coercive environments). However, the authors expressed concern about 'the availability of adequate human and material resources', concluding that the transition away from large mental institutions is 'on the way in South American countries'.[396]

Latin America countries are clearly taking some steps to move toward the 'will, preference and rights' approach. **Peru**, for example, has abolished substituted decision-making from its mental-health law following recommendations from the Committee

393 Bariffi and Smith, above n 56.
394 Larrobla and Botega, above n 361, 256.
395 Ibid.
396 Ibid.

on the Rights of Persons with Disabilities in 2012.[397] (There remain several caveats, including that the new legislation on mental health, which is part of the general health legislation, established an exception for 'drug addicts' and 'emergency situations'). Again, English-language scholarly research on many of these developments is not currently available.

Middle East

No materials were found on alternatives to coercion in mental health settings in the Middle East, indicating an urgent need for further research, including a comprehensive review of non-English research.

North America

The Six Core Strategies approach to reducing seclusion and restraint is prominent in North America, which is perhaps unsurprising given its origins in the **United States**.[398] The United States was also the source of several noteworthy, largescale studies, involving high participant numbers. For example, Ashcraft and colleagues conducted two studies, one involving service data on 14,500 adults per year for a four-year period, and another involving 12,346 adults.[399] Greenfield and colleagues' study is novel insofar as it involved quantitative methods and a randomised trial comparing the effectiveness of an unlocked, mental health consumer-managed, crisis residential programme to a locked, inpatient psychiatric facility for adults with severe mental health conditions.[400] In contrast, the vast majority of research concerning user/peer/consumer-led support services is qualitative – which is perhaps unsurprising, given the basis of phenomenological research in human experience. The Vermont Governments quantitative data on peer-run crisis centres, which was identified for inclusion in Appendix Three, is also unique in this respect (see previous discussion of respite houses). Research on crisis respite

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397   International Disability Alliance, *IDA Report on First Follow up Mission to Peru: Monitoring Implementation of the CRPD Committee's Recommendations* <www.internationaldisabilityalliance.org/ida-follow-up-peru-oct2015>.

398   See, eg, Azeem et al, above n 67; Riahi et al, above n 61; Wisdom et al, above n 61; Janice L LeBel et al, 'Multinational Experiences in Reducing and Preventing the Use of Restraint and Seclusion' (2014) 52(11) *Journal of Psychosocial Nursing and Mental Health Services* 22.

399   Ashcraft and Anthony, above n 61; Ashcraft, Bloss and Anthony, above n 61.

400   Greenfield et al, above n 160.

houses, including those that are 'peer-run', appear to be more prominent in research emanating from the United States.[401]

Only three studies were identified that examined **Canadian** mental health care, which seems a relatively small number, though there are likely to be a range of non-English resources in **Francophone Canada** relevant to this review, and much grey literature produced by civil society and federal, provincial and state governments across both Canada and the US. The Canadian studies that were identified were mostly case studies involving individual services that were able to trial seclusion and restraint reduction strategies.

Oceania

Oceania is a geographic region comprising Melanesia, Micronesia, Polynesia and Australasia. All studies uncovered for this literature review came from **Australia** – five in total – suggesting a need for further research in this region.

Australia was the source of several novel studies, including the only study concerning sensory-based approaches within the environment of a psychiatric inpatient unit, which provided some evidence for a 'significant reduction in patient distress levels, as per consumer and clinician ratings'.[402] Australia was also home to one of two studies identified in this review concerning 'supported decision-making', with Kokanović and colleagues providing some evidence to suggest that supported decision-making in mental health settings could better 'facilitate the participation of mental health service users and their family supporters' in healthcare decisions, though no empirical evidence was provided to show impact on rates of coercion.[403] Australia was also the location of the only study explicitly concerned with the role of social workers in imposing coercive practices on persons with mental health conditions or psychosocial disabilities. Maylea's case study considers the legislative powers granted to social workers in the mental health context, and argues that there may be ways for social workers to use these powers in a potentially less coercive approach than that taken by police or paramedics who are also empowered under mental health legislation.[404] Another novel

401 Croft and Isvan, above n 61; Rosen and O'Connell, above n 265; Sledge et al, above n 268; Sledge et al, above n 269; Fenton et al, above n 231.

402 Chalmers et al, above n 187, 35.

403 Renata Kokanović et al, above n 339.

404 Maylea, above n 57.

study was led by self-identifying mental health service users, or 'consumer' researchers, who examined the text of the *National Standards for Mental Health Services 2010* as well as the public text of speakers' notes regarding lived experience from the *Care Without Coercion Conference 2010*.[405] They used three different frameworks currently utilised in mental health services (human rights, personal recovery, and trauma-informed) and 'identified the use of force in many aspects of policy', suggesting instead 'pathways to apply the frameworks in national policy [to][…] bring about freedom from violence; support for decision making; access and choice about community and inpatient options; safety and risk management; and greater understanding of current policy frameworks through engagement with people with lived experience about the options and impact of support processes that exclude the use of force'.[406]

There is evidence that measures to address coercion in the mental health context are occurring in **Pacific Island countries**[407] and **New Zealand**.[408] The Pacific Disability Forum Sustainable Development Goals/CRPD Monitoring Report 2018, for example, notes that '[s]ome resources are still used to fund services in education and mental health that are not aimed at inclusion and participation and should be reallocated towards inclusive programs' yet highlights positive measures, such as the Kingdom of Tonga's first National Disability Inclusive Health Plan 2016-2020. This is designed to strengthen access to health care, rehabilitation and mental health services for people with disabilities in Tonga.[409] More research is needed to identify positive actions being taken in Pacific Island countries and New Zealand (and indeed, Australia) to reduce, prevent and end coercive practices in the mental health context, including among Indigenous communities. On this latter point, it is noteworthy that the Family Group Conference approach discussed earlier in the report, was developed from Māori approaches to family law disputes, and that several

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405 Watson et al, above n 55, 529.

406 Ibid.

407 See, eg, Pacific Disability Forum, *Pacific Disability Forum SDG-CRPD Monitoring Report 2018*, 15 <http://www.pacificdisability.org/What-We-Do/Research/FINAL_SDG-Report_Exec-Summary_2018.aspx>; Bhargavi Davar, 'From 'User Survivor' to 'Person with Psychosocial Disability': Why We Are 'TCI Asia'' (blog) <https://madinasia.org/2018/07/from-user-survivor-to-person-with-psychosocial-disability-why-we-are-tci-asia>

408 See, eg, Te Pou, *Reducing Seclusion and Restraint* <www.tepou.co.nz/initiatives/reducing-seclusion-and-restraint/102>; Kāhui Tū Kaha (<www.kahuitukaha.co.nz>

409 Pacific Disability Forum, above n 407.

crisis respite services in New Zealand draw from Māori cultural traditions.[410] Yet, empirical, scholarly research was not readily available, at least within the scope of this review.

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410 See Renee Thørnblad et al, 'Family Group Conferences: From Maori Culture to Decision-Making Model in Work with Late Modern Families in Norway' (2016) 19(6) *European Journal of Social Work* 992; see also 'Crisis Respite House' in Appendix Three.

Section Four: Knowledge Gaps and Future Research Directions

There are several gaps and limitations in the literature reviewed. This section sets out some of the major gaps and limitations that need to be acknowledged and addressed through future research.

More Research Led by or Actively Involving Persons with Psychosocial Disabilities

Most research in this area is conducted by academic psychiatrists, typically in the form of quantitative research based on service data. Governments and research institutions could take steps to ensure persons with mental health conditions or psychosocial disabilities are able to contribute to research in this field. Standards could be set to measure the extent to which service user organisations can influence national mental health research agendas. National research funds could require service user involvement and ethical research guidelines on mental health research could better promote the importance of research conducted with the active input or coproduced with persons with mental health conditions and disabilities themselves. Thomas and Cahill have argued in relation to compulsion and psychiatry that action research is likely to be the most suitable method:

> The participatory nature of action research engages research subjects actively in the research processes of deciding the research questions, design, and implementation. It is more 'democratic' than positivistic research and thus capable of taking different interests into account.[411]

More Mixed Methods Research that Incorporates Both Natural and Social Sciences

Although there are clear benefits to quantitative research, particularly in undertaking largescale research such as national surveys, it is also important to gain the benefits of phenomenological

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411 Philip Thomas and Anne B Cahill, 'Compulsion and Psychiatry—the Role of Advance Statements' (2004) 329(7458) *BMJ* 122, 123.

research, given that many of the practices for preventing, ending or reducing coercive practices are complex social interventions. The complexity of these interventions can have an impact upon the effectiveness of quantitative methods, including randomised control trials, in which variable confounding factors can make replication difficult.[412] The outcomes of such studies depend on multiple contextual factors relating to the intervention itself, but also on how it is researched and by whom.[413] Advance planning, peer support, respite services, trauma-informed approaches, family and social network responsiveness, are complex social interventions. Each occurs in a complex web of formal and informal relationships. Multiple contested ideas and values are at play. It is perhaps noteworthy that 'organisational culture' was identified as an important site for addressing the use of coercion in several studies in this review,[414] particularly regarding the *Safewards* strategy for reducing coercive practices in clinical mental health settings.[415] Yet, social science disciplines that tend to focus on organisational culture and human behaviour, such as sociology, anthropology and behavioural psychology, were almost entirely absent among the studies.

Regarding psychiatric research, Kleinman has called for a 'rebalancing of academic psychiatry', arguing that academic psychiatrists should pursue social, clinical and community studies within a humanistic frame.[416] (Kleinman takes particular issue with the over-investment in academic psychiatry into the 'narrowest of biological research').[417] He argues that ties between psychiatry, public health and social sciences need to be strengthened, to which might be added – as per the previous recommendation – the active contribution of service users and former service users in research aimed at preventing, ending and reducing coercion in mental health services. This is not to suggest that exemplary studies did not appear. Some studies both adopted mixed methods and included service user researchers and participatory

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412 See, eg, Thornicroft et al, above n 108.

413 See, eg, Diana Rose et al, 'Patients' Perspectives on Electroconvulsive Therapy: Systematic Review' (2003) 326(7403) *BMJ* 1363.

414 Bowers et al, above n 179; Fisher, above n 106; Keski-Valkama et al, above n 179; Schout et al, above n 111.

415 See Len Bowers, 'Safewards: A New Model of Conflict and Containment on Psychiatric Wards' (2014) 21(6) *Journal of Psychiatric and Mental Health Nursing* 499.

416 Arthur Kleinman, 'Rebalancing Academic Psychiatry: Why It Needs to Happen – and Soon' (2012) 201(6) *The British Journal of Psychiatry* 421, 421.

417 Ibid.

practices.[418] Nor is it to suggest that purely quantitative or qualitative research, or studies undertaken in a single discipline, are necessarily inappropriate. The point here is that mixed methods were used in a minority of studies, despite the apparent value of interdisciplinary research in examining the complex causes of and ways to address coercive practices.

Research Explicitly Premised on the Aim to Reduce, End and Prevent Coercion

Within the literature examined in this review, relatively few studies were explicitly designed with the aim of reducing, ending and preventing coercion. Expanding the scope beyond the review, it was notable that there was a relatively vast literature on 'perceptions of coercion', which did not seek alternatives or to undertake action research designed to reduce or end coercion. Although some studies concerning service user perceptions could be used to identify the most egregious forms of coercion, or hidden forms of coercion, which could become a focal point for efforts to ameliorate harm, most did not appear to have such an instrumental purpose. A more defined research field may be needed that is unambiguously premised on the need to prevent, reduce and end coercive interventions in mental health settings. Presupposing that coercion is undesirable – even if some view it as necessary – helps to refine the focus to effective steps toward prevention, reduction and elimination.

More Research Examining the Impact of Trauma-Informed Support on Reducing and Eliminating Coercion

Given the importance given to trauma-informed support elsewhere in the mental health-related literature on human rights and mental health, there appears to be a gap in research explicitly concerned with the impact of trauma-informed approaches on reducing, preventing and ending coercive practices. The promising research concerning the Six Core Strategies for Restraint Minimisation,[419] provides a strong starting point for further research along these lines.

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418 Greenfield et al, above n 160; Henderson et al, 'Informed, Advance Refusals of Treatment by People with Severe Mental Illness in a Randomised Controlled Trial of Joint Crisis Plans: Demand, Content and Correlates', above n 298.

419 Azeem et al, above n 67.

Greater Alliances between Academics and Service User Organisations, Policymakers and Service Providers

Internationally, there are examples of service providers, professionals, policymakers, as well as persons with psychosocial disabilities and their representative organisations putting 'alternatives to coercion' into action. Many of these practices are likely, even if indirectly, to help prevent, reduce or end coercive interventions. Yet, many of them have not been subject to academic research. Hence, many of the practices that appear in Appendix Three have not been subject to peer-reviewed research despite having been in operation, in some cases, for many years. There are pragmatic benefits for scholarly researchers to engage with existing programmes, including the relatively low cost of undertaking research into existing good practices (compared to creating and trialling new practices, for example through costly randomised control trials). There are examples of governments, United Nations bodies and other non-academic bodies, examining the efficacy of various programmes; as is the case, for example, with the Commissioner for Human Rights of the Council of Europe's information gathering on the Swedish Welfare *Personligt ombud* scheme, or the research into Soteria House by Vermont's Department of Mental Health.[420] In both instances, fruitful collaboration could have occurred with academic researchers to improve the quality and validation of reported efficacy.

A Comprehensive Review of Non-English Materials

Future research is needed outside the English-speaking world. Dhanda has argued that literature surveys 'need to expand their materials to search across languages and economic status, along with privileging survivor narratives'.[421] As noted, this review did not uncover English-language academic research concerning the Middle East, the Pacific, many parts of Asia, much of Africa, Central America, and so on. Efforts are undoubtedly underway in these places to reduce, prevent or end coercion, and there may be researchers seeking to pursue and record them. An exhaustive global review would seek to capture these efforts, particularly by expanding the scope to non-English resources and databases that may not be commonly available. Some high-income

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420 See Appendix Three.

421 Amita Dhanda, 'Conversations between the Proponents of the New Paradigm of Legal Capacity' (2017) 13(1) *International Journal of Law in Context* 87, 89.

countries outside the English-speaking world warrant attention, even as the gap in research in low- and middle-income countries is more pressing. Legal and policy developments in Germany, for example, warrant in-depth consideration.[422]

More Focus on Reducing and Eliminating Coercion for Older Persons and Other Marginalised Groups in the Mental Health Context

Coercion is likely to be occurring in homes for older persons, worldwide. This is likely to include coercive mental health practices. This review did not explicitly focus on strategies to reduce or eliminate coercive practices in these settings, even as some of the strategies cited throughout may work to this end. Gjerberg and colleagues, who did focus explicitly on reducing coercion in nursing homes, have argued that '[i]n many Western countries, studies have demonstrated extensive use of coercion in nursing homes, especially towards patients suffering from dementia'.[423] Although this may sit outside a strict definition of mental health settings, there are clear intersections. First, some strategies concerning staffing, training, resourcing and so on may be applicable across elder care and mental health settings. Second, the distinction between older persons and persons with mental health conditions or psychosocial disabilities is not always neat. Many older persons also have mental health conditions, and many persons with psychosocial disabilities become older persons and receive care services. More research is needed to examine alternatives to coercive practices in support settings specifically designed for older persons, including a systematic review of existing material.

People with intellectual and/or developmental disabilities also experience coercion in mental health settings, perhaps even at higher rates than others. Yet, there was no research uncovered in this review that directly concerned these groups. More research is needed to examine instances of coercion experienced by these individuals in mental health settings, and measures that can reduce, prevent and end the use of coercion against them.

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422 See above, Section 'Laws Designed to Reduce, End or Prevent Coercion', fn 77.

423 Elisabeth Gjerberg et al, 'How to Avoid and Prevent Coercion in Nursing Homes: A Qualitative Study' (2013) 20(6) *Nursing Ethics* 632, 632.

More Research on Organisational Cultural Change

Organisational cultural change was an important component of efforts to reduce coercive practices in hospital settings. There is some literature assessing the organisational social context[424] and organisational factors in burnout and work attitudes in mental health services,[425] but there is relatively little research on effective ways to change ward culture, or management culture. Social psychological theories of group processes and intergroup behaviour could shine a light on how best to change organisational culture. Organisational climate generally refers to shared attitudes and perceptions of the work environment.[426] Stressful climates characterised by high workloads may lead to coercive practices, but research measuring this and on how this could be changed would be of benefit. There was also relatively little research on the type of informal coercion people may experience in 'community-based' services; for example, housing services that use coercion, but this could logically extend to the work of social workers, occupational therapists, and other professionals.

More Research on Reducing Deprivations of Liberty in Communal and Family Settings in Low- and Middle-Income Countries

It seems reasonable to infer that coercion is occurring in low- and middle-income countries against persons with mental health conditions and psychosocial disabilities quite outside of any formal mental health services. According to Davar, non-Western, low- and middle-income countries such as India, tend to be more concerned with developing inclusive and community-based mental health support in more communal social contexts, which provide access or freedom to resources needed for good mental health (that is, promoting social and economic rights) rather than

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424 Charles Glisson et al, 'Assessing the Organizational Social Context (OSC) of Mental Health Services: Implications for Research and Practice' (2008) 35(1-2) *Administration and Policy in Mental Health and Mental Health Services Research* 98; Gregory A Aarons and Angelina C Sawitzky, 'Organizational Culture and Climate and Mental Health Provider Attitudes Toward Evidence-Based Practice' (2006) 3(1) *Psychological Services* 61.

425 Gregory A Aarons and Angelina C Sawitzky, 'Organizational Climate Partially Mediates the Effect of Culture on Work Attitudes and Staff Turnover in Mental Health Services' (2006) 33(3) *Administration and Policy in Mental Health and Mental Health Services Research* 289; Amy E Green et al, 'The Roles of Individual and Organizational Factors in Burnout Among Community-Based Mental Health Service Proviers' (2014) 11(1) *Psychological Services* 41.

426 Amy E Green, above n 425, 42.

resisting State intrusion (that is, civil and political rights).[427] Davar writes of the socio-economic minority of people in India taking part in and affected by debates about mental health law reform and institutionalisation in recent years:

> even these intense debates… are relevant only to the middle and upper classes in urban areas, especially non-resident Indians looking for the ideal mental institutions for ageing parents, sisters or other siblings and dependents. This may constitute around 7% of the Indian population. For the remaining 93% of the population in rural areas, inner city slums, mountainous terrains, and other far-flung regions of the country, where the social fabric is still intact, and where there is no doctor or asylum, this will have no relevance.[428]

It is striking therefore that there was only a handful of studies aimed at preventing, reducing, and ending coercive practices against persons with mental health conditions and psychosocial disabilities in these parts of the world. More research is needed, therefore, on reducing coercive practices in communal and family settings in low- and middle-income countries.

Establishing a Framework for Gathering Empirical Evidence

A final comment is that any examination of how existing laws and policies are working requires consideration of available empirical evidence. Irrespective of the ideological issues at stake in debates about coercion, evidence is crucial to assessing the efficacy of steps to reduce and end coercive practices.

Some conceptual clarity may also be needed to generate reliable and valid data. Shared understandings and definitions may be needed. The term 'coercion' is not necessarily used uniformly in research in this field. Some studies, for example, distinguished between 'compulsion', 'leverage', 'treatment pressures', 'conflict' and 'containment'. The field could benefit from establishing an agreed upon vocabulary, or a global agenda for research.

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427 Bhargavi Davar, 'Legal Capacity and Civil Political Rights for People with Psychosocial Disabilities' in A Hans (ed), *Disability, Gender and the Trajectories of Power* (Sage, 2015) ch 11.

428 Bhargavi Davar, 'Legal Frameworks for and against People with Psychosocial Disabilities' (2012) 47(52) *Economic and Political Weekly* 123, 130.

While there is a significant body of literature on the types of coercion that exist, and measures for their reduction and elimination, Szmukler has argued that 'substantial work is still needed to develop a useful vocabulary of "coercion" and related concepts'.[429]

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429 Szmukler, above n 4, 259.

Conclusion

To summarise, this systematic scoping review uncovered a complex and heterogenous body of literature. While we acknowledge time and language limitations, this review has identified themes and clarified concepts relating to alternatives to coercion in mental health settings. More importantly, the findings are generally positive. Efforts to reduce, prevent and end coercion appear effective in most studies, notwithstanding limitations in the research. A broad suite of practices, policies and interventions exist, which can be implemented at local, national and regional levels. A policy 'charter' or 'framework' could collate these findings, outlining the broad package of alternatives that have been introduced and tested elsewhere, or which warrant further investigation. No single country or national region has implemented the broad range of measures outlined in this review. This invites consideration of what might happen if countries or regions did so.

Another important theme in the research is that both top-down *and* local-level leadership are important in order to create and maintain culture change toward reducing, ending and preventing coercion. There is some indication that leadership should include peer involvement for ultimate effectiveness, for which a human rights imperative also exists.[430]

Another important theme is the need for new community-based crisis services, hospital diversion and step-down supports. Traditionally, mental health policy has been organised in many parts of the world into two categories of support: hospital- or community-based care. The hospital is typically presented as a site for acute treatment while the 'community' is presented as a site for non-urgent support and prevention. However, the findings of this review suggest that a more constructive and accurate distinction might be between 'crisis resolution' and 'general support'.

'Crisis resolution' could – and should – include hospital-based support, but could also include crisis respite houses, intensive home-based support, and residential programmes. 'General support' could include the range of non-urgent community-based services that currently exist to help prevent emergencies and assist people to live full lives; for example, by using independent

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430   CRPD, Article 4(3).

advocacy, housing support and personal assistance. In other words, 'getting the right support, at the right time, in the right place, from the right person'[431] is likely to have the one of the greatest impacts in reducing all forms of coercion in the context of mental health care. An effective suite of options for crisis resolution and general support will also require resources.

The empirical research studies and grey literature analysed by the research team also suggest the following interventions are likely to reduce coercion:

- national oversight (for example, national policies aimed at reducing and eliminating seclusion and restraint, legislation that restricts the use of involuntary treatment, mandates upon governments to collect data, including reporting on 'progress on alternative treatment options');[432]

- organisational culture change through an emphasis on recovery, trauma-informed care, individual- and family-led supports, and human rights; and

- independent advocacy directed at public opinion, politicians, policymakers and service providers.

Future research should focus on mental health care policies targeted at support and treatment that respect people's dignity and autonomy as well as promoting reductions of institutional coercion.

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431 National Survivor User Network, *Manifesto 2017: Our Voice, Our Vision, Our Values* <https://www.nsun.org.uk/our-manifesto>.

432 2017 Vermont Statutes, Title 18 – Health, Chapter 174 - Mental Health System of Care, § 7256 Reporting requirements (8).

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Appendix One - Literature Selected for Full Review

AUTHOR	YEAR	REGION/COUNTRY	POPULATION SAMPLE	AIM	TYPE OF STUDY	MAIN FINDINGS
Aagaard, J; Tuszewski, B; Kølbæk, P	2017	Denmark	240 men and women starting as recipients of Assertive Community Treatment during a five-year period.	To see whether Assertive Community Treatment (ACT) may have the quality to reduce the use of several types of coercion including compulsory admissions.	Quantitative - analysis of service data from the Danish National Case Register at three psychiatric hospitals.	An assertive approach appears to reduce hospitalisation including some involuntary admissions. ACT is preferable from both team and patient perspectives. The researchers recommend revision of the criterion of 'severe mental illness' to facilitate ACT to be offered to a larger group of patients. In addition, the researchers recommend that the introduction of Crisis Intervention Teams should be considered and allocated to psychiatric emergency rooms.
Allen, M	2003	United States	N/A	To summarise the reasons why housing for people with psychiatric diagnosis should be provided free of the use of coercion.	Qualitative - analysis of legal, policy documents and research reports.	Mental health services appear to be using coercive practices or 'leveraging' with housing. That is, threatening discontinuation of housing services or eviction if psychiatric intervention is not accepted. This practice appears to breach the *Americans with Disabilities Act*, and according to the author has multiple, negative flow-on effects.
Andersen, K; Nielsen, B	2016	Denmark	235 men and women admitted to a closed ward during 2011-2013 were randomly selected.	To identify possible external (extramural) factors that may increase the risk of coercion during admission to a closed psychiatric ward.	Quantitative - retrospective analysis of case report data.	66 people (28% of the sample) were subject to coercion. The time of forced procedures was predominately during the first hours after admission. The risk of forced measures being applied was sig-nificantly higher if patients were involuntarily admitted (OR = 6.4 (3.4- 11.9)), or were acutely intoxicated by substances at the time of admission (OR = 3.7 (1.7-8.2)). The researchers recommend that extramural factors should be considered when seeking to reduce coercion, and suggest better integrated efforts between mental health and substance abuse services as a way to reduce coercion.

Author	Year	Country	Sample	Aim	Method	Findings
Ashcraft, L; Anthony, W	2008	United States	Service data on 14,500 adults per year for a four-year period (incl. 4,600 brought to service involuntarily)	To evaluate a policy to eliminate physical and mechanical restraint and evaluate the success of the programme at two crisis centres in the United States.	Quantitative - analysis of case report data.	Existing records indicated that over a 58-month follow-up period (January 2000 to October 2004), the larger crisis centre took ten months until a month registered zero seclusions and 31 months until a month recorded zero restraints. The smaller crisis centre achieved these same goals in two months and 15 months, respectively.
Ashcraft, L; Bloss, M; Anthony, WA	2012	United States	12,346 adults who used a mental health crisis centre over a two year period.	To evaluate the success of the 'No Force First' approach developed by Recovery Inno-vations and evaluate the success of the prog-ramme in reducing chemical restraint at a crisis centre in the United States.	Quantitative - analysis of case report data (before and after introduction of 'No Force First').	At the crisis centre, chemical restraint was used for 56 of 12,346 people served over the two-year period (0.45%). The percentage of service recipients who received chemical restraint in any month ranged from 0% to 1.27 %. For rough comparative purposes, data were obtained from state records on the use of restraints by comparable programs: chemical restraints were used for 3.9% of individuals served statewide.
Asher, L; et al	2017	Ethiopia	35 adults with schizophrenia, 'their caregivers, community leaders and primary and community health workers' in rural Ethiopia.	To understand the experiences of, and reasons for, restraint of people with schizophrenia in community settings in rural Ethiopia in order to develop constructive and scalable interventions.	Qualitative -in-depth interviews and 5 focus group discussions with thematic analysis.	Most of the participants with schizophrenia and their caregivers had personal experience of the practice of restraint. The main explanations given for restraint were to protect the individual or the community, and to facilitate transportation to health facilities. These reasons were underpinned by a lack of care options, and the consequent heavy family responsibility and a sense of powerlessness amongst caregivers. All types of participants cited increasing access to treatment as the most effective way to reduce the incidence of restraint. The authors conclude that a scale up of accessible and affordable mental health care may go some way to address the issue of restraint.

Author	Year	Country	Sample	Aim	Methodology	Findings
Azeem, M; et al	2011	United States	458 youth (females 276/ males 182)	To determine the effectiveness of six core strategies based on trauma-informed care in reducing the use of seclusion and restraint with hospitalised youth between July 2004 and March 2007.	Quantitative – analysis of case report data and demographics, including age, gender, ethnicity, number of admissions, type of admissions, length of stay, psychiatric diagnosis, number of seclusions, and restraints	Seventy-nine patients or 17.2% (females 44/males 35) 'required' 278 seclusions/restraints (159 seclusions/119 restraints), with average number of episodes 3.5/patient (range 1–28). Thirty-seven children and adolescents placed in seclusion and/or restraints had three or more episodes. In the first six months of study, the number of seclusions/restraints episodes were 93 (73 seclusions/20 restraints), involving 22 children and adolescents (females 11/males 11). Comparatively, in the final six months of the study following the training program, there were 31 episodes (6 seclusions/25 restraints) involving 11 children and adolescents (7 females/4 males). The major diagnoses of the youth placed in seclusion and/or restraint were disruptive behaviour disorders (61%) and mood disorders (52%). This study shows a downward trend in seclusions/restraints among hospitalised youth after implementation of National Association of State Mental Health Program Directors' Six Core Strategies based on trauma-informed care.
Bak, J; Zoffmann, V; Sestoft, DM; Almvik, R; Brandt-Christensen, M	2014	Denmark, Norway	Survey data from all psy-chiatric hos-pital units in Denmark (87) and Norway (96) that treated adult inpatients.	To examine how potential mechanical restraint preventive factors in hospitals are associated with the frequency of mechanical restraint episodes.	Quantitative - cross-sectional survey of psychiatric units.	Three mechanical restraint preventive factors were significantly associated with low rates of mechanical restraint use: 'mandatory review' (exp[B]=.36, p < .01), 'patient involvement' (exp[B]=.42, p < .01), and 'no crowding' (exp[B]=.54, p < .01). None of the three restraint preventive factors presented any adverse effects. Authors recommend implementing the measures.
Bak, J; Zoffmann, V; Sestoft, DM; Almvik, R; Siersma, VD; Brandt-Christensen, M	2015	Denmark, Norway	Survey data from all psychiatric hospital units in Denmark (87) and Norway (96) that treated adult inpatients.	To test the hypothesis that 'factors of non-medical origin' may explain the differing number of mechanical restraint (MR) epi-sodes between Den-mark and Norway. An earlier study found MR was used twice as frequently in Denmark than Norway.	Quantitative – cross-sectional survey of psychiatric units.	Six MR preventive factors confounded [Δexp(B)> 10%] the difference in MR use between Denmark and Norway, including staff education (- 51%), substitute staff (- 17%), acceptable work environment (- 15%), separation of acutely disturbed patients (13%), patient-staff ratio (- 11%), and the identification of the patient's crisis triggers (- 10%). Researchers suggest these preventive factors might partially explain the difference in the frequency of MR episodes observed in the two countries. None of the six MR preventive factors presents any adverse effects.

Author	Year	Country	Sample	Aim	Methodology	Findings
Bariffi, FJ; Smith, MS	2013	Argentina	N/A	To analyse legal and policy materials concerning Argentina's *National Mental Health Law* (NMHL), and determine whether its 'supported decision-making' measures may improve compliance with the *Convention on the Rights of Persons with Disabilities* (CRPD) and reduce involuntary interventions.	Qualitative - analysis of case law, policy documents and research reports.	The NMHL establishes thresholds for depriving persons with disabilities of their liberty and for restricting their exercise of legal capacity that are inconsistent with the CRPD. However, despite the NMHL's significant shortcomings, it has the potential to contribute both to increased autonomy for users of the mental health system and also to less restrictive legal capacity restrictions. The authors conclude that while the NMHL is inconsistent with the CRPD, it may still help promote a shift away from involuntary commitments and legal capacity restrictions if its implementation results in the dissemination of 'better' practices that have emerged thus far.
Barrett, B; Waheed, W; Farrelly, S; Birchwood, M; Dunn, G; Flach, C; Henderson, C; Leese, M; Helen L; Marshall, M; Rose, D; Kim S; Szmukler, G; Thornicroft, G; Byford, S	2013	England	569 participants were chosen from four English mental health trusts.	To test the effectiveness of 'Joint Crisis Plans' (JCP), a form of (non-statutory) advance planning, in reducing rates of compulsory treatment. They compared JCP plus treatment as usual (TAU) to TAU alone for patients aged over 16, with at least one psychiatric hospital admission in the previous two years.	Quantitative – economic evaluation within a multi-centre randomised control trial.	The addition of JCPs to TAU had no significant effect on compulsory admissions or total societal cost per participant over 18-months follow-up. From the service cost perspective, however, evidence suggests a higher probability (80%) of JCPs being the more cost-effective option. Exploration by ethnic group highlights distinct patterns of costs and effects. Whilst the evidence does not support the cost-effectiveness of JCPs for White or Asian ethnic groups, there is at least a 90% probability of the JCP intervention being the more cost-effective option in the Black ethnic group. The researchers argue that the results by ethnic group are sufficiently striking to warrant further investigation into the potential for patient gain from JCPs among Black patient groups.

Author	Year	Country	Sample	Aim	Method	Findings
Borckardt, J; et al	2011	United States	Participants were patients and staff in an inpatient psychiatric hospital, for a total of 89,783 patient-days over a 3.5-year period from January 2005 through June 2008.	To use an experimental design to examine the effect of systematic implementation of behavioural interventions on the rate of seclusion and restraint in an inpatient psychiatric hospital.	Quantitative – a variant of the multiple baseline design. Each of five inpatient units was randomly assigned to implement the intervention components in a different order, and each unit served as its own control.	A significant reduction of 82.3% (p=.008) in the rate of seclusion and restraint was observed between the baseline phase (January 2005 through February 2006) and the follow-up, postintervention phase (April 2008 through June 2008). After control for illness severity and nonspecific effects associated with an observation-only phase, changes to the physical environment were uniquely associated with a significant reduction in rate of seclusion and restraint during the intervention rollout period. These data suggest that substantial reductions in use of seclusion and restraint are possible in inpatient psychiatric settings and that changes to the physical characteristics of the therapeutic environment may have a significant effect on the use of seclusion and restraint.
Boumans, CE; Walvoort, SJ; Egger, JIj; Hutschemaekers, GJ	2015	Netherlands	4 detailed case examples, involving 4 adults in the South East of the Netherlands.	To examine how the 'methodical work approach' worked to reduce seclusion, by providing a detailed case study. The study complemented a quantitative study on the approach (see below), which reportedly led to a reduction in the use of seclusion in a ward with a high seclusion rate.	Case Study - the team of this ward implemented the methodical work approach.	The 'methodical work approach', which has been adopted largely in Dutch and Flemish settings, appears to have provided guidance for the multidisciplinary team, the patient and the family to work together in a systematic and goal-directed way to reduce seclusion. Positive changes were reported in the team process: increased interdisciplinary collaboration, team cohesion, and 'professionalization'. It is argued that the implicit or non-specific effects of an intervention to prevent seclusion may constitute a major contribution to the results and therefore merit further research. This study follows from a study to test whether reductions in rates of seclusion occur (see below).

Authors	Year	Country	Sample	Aim	Method	Findings
Boumans, CE; Walvoort, SJ; Egger, JI; Sourren, P; Hutschemaekers, GJ	2014	Netherlands	134 adults admitted to an experimental ward and 544 adults in control wards for the intensive treatment of adults with psychosis and substance use disorders in the South-East of the Netherlands.	To test effectiveness of an intervention, the 'methodical work approach', designed to reduce seclusion. This is a 'systematic, transparent and goal-directed way' of working, characterised by 'an emphasis on cyclic evaluation and readjustment of the working process'.	Quantitative – analysis of case report data (before and after introduction of the methodical work approach).	The methodical work approach has five phases: (i) translation of problems into goals; (ii) search for means to realise the goals; (iii) formulation of an individualised plan; (iv) implementation of the plan; and (v) evaluation and readjustment. Compared to control wards within the same hospital, at the ward where the methodical work approach was implemented, a more pronounced reduction was achieved in the number of incidents and in the total hours of seclusion. The authors conclude that the methodical work approach can contribute to a reduction in the use of seclusion.
Bowers, L; Haglund, K; Muir-Cochrane, E; Nijman, H; Simpson, A; Van Der Merwe, M	2010	England	A total of 1227 responses were obtained, with the highest number coming from staff, and the smallest from visitors.	To survey the beliefs and attitudes of patients, staff and visitors to the practice of door locking in acute psychiatry. Locking doors in psychiatric wards has increased in the UK in recent years, but has received little attention by researchers.	Quantitative – cross-sectional questionnaire of staff, patients and visitors at psychiatric units.	Analysis identified five factors (adverse effects, staff benefits, patient safety benefits, patient comforts and cold milieu). Patients were more negative about door locking than the staff, and more likely to express such negative judgments if they were residing in a locked ward. For staff, being on a locked ward was associated with more positive judgments about the practice. There were significant age, gender and ethnicity effects for staff only. Patients registered more anger, irritation and depression as a consequence of locked doors than staff or visitors thought they experienced.

Author	Year	Country	Description	Methodology	Findings
Bowers, L; Stewart, D; Papadopoulos, C; lennaco, JD	2013	England	Secondary analysis of cross-sectional data collected from 136 acute psychiatric wards across England in 2004-2005.	This study investigated wards with the counterintuitive combination of 'low containment and high conflict' or 'high containment and low conflict'. Quantitative – secondary analysis of cross-sectional service data collected from 136 psychiatric wards.	Safe, calm inpatient psychiatric wards that are conducive to positive therapeutic care have thought to have lower rates of coerced medication, seclusion, manual restraint and other types of containment, and, usually, rates of conflict - for example, aggression, substance use, and absconding - are also low. Sometimes, however, wards maintain low rates of containment even when conflict rates are high. This study wanted to understand these anomalies. The researchers created a typology of different ward characteristics (e.g. high/low conflict, high/low containment, socio-economic disadvantage in the area). Among the variables significantly associated with the various typologies, some, such as environmental quality, were changeable, and others - such as social deprivation of the area served - were fixed. High-conflict, low-containment wards had higher rates of male staff and lower-quality environments than other wards. Low-conflict, high-containment wards had higher numbers of beds. High-conflict, high-containment wards utilised more temporary staff as well as more unqualified staff. No overall differences were associated with low-conflict, low-containment wards. Wards can make positive changes to achieve a low-containment, nonpunitive culture, even when rates of patient conflict are high.
Bowers, L; et al	2015	England	Staff and patients in 31 randomly chosen wards at 15 randomly chosen hospitals.	To test the efficacy of the Safewards model in reducing the frequency of 'conflict' and 'containment'. A pragmatic cluster ran-domised controlled trial with psychiatric hospitals and wards as the units of randomisation. The main outcomes were rates of conflict and containment.	The Safewards model enabled the identification of ten interventions to reduce the frequency of both. For shifts with conflict or containment incidents, the experimental condition reduced the rate of conflict events by 15% (95% CI 5.6–23.7%) relative to the control intervention. The rate of containment events for the experimental intervention was reduced by 26.4% (95% CI 9.9–34.3%). Simple interventions aiming to improve staff relationships with patients can reduce the frequency of conflict and containment.

Author	Year	Country	Sample/Setting	Aim	Method	Findings
Bruckner, TA; Yoon, J; Brown, TT; Adams, N	2010	United States	Quarterly counts of involuntary 72-hour holds (N=593,751) and 14-day psychiatric hospital-isations (N=202,554) for 28 Californian counties, with over 22 million inhabitants, from 2000-07.	To test the hypothesis that the incidence of two types of involuntary treatment, 72-hour holds and 14-day psychiatric civil commitments, declines as the service access and quality is improved by the $3.2 billion tax revenue investment associated with the *Mental Health Services Act* (MHSA) in California.	Quantitative - analysis of case report data (before and after introduction of the Act). A fixed-effects regression approach adjusted for temporal patterns in treatment.	The petitions for involuntary 14-day hospitalisations, but not involuntary 72-hour holds, fell below expected values after disbursement of MHSA funds. In these counties, 3,073 fewer involuntary 14-day treatments--approximately 10% below expected levels--could be attributed to disbursement of MHSA funds. Results remained robust to alternative regression specifications. The researchers conclude that fewer than expected involuntary 14-day holds for continued hospitalisation may indicate an important shift in service delivery. MHSA funds may have facilitated the discharge of clients from the hospital by providing enhanced resources and access to a range of less-restrictive community-based treatment alternatives.
Chalmers, A; Harrison, S; Mollison, K; Molloy, N; Gray, K	2012	Australia	Case study: implementation of practice in a 29-bed acute adult psychiatric inpatient unit in Victoria, Australia.	To reflect upon the implementation of sensory-based approaches within the environment of a psychiatric inpatient unit. A variety of sensory-based principles were planned, developed and implemented over a 3-year period.	Case Study – Analysis of case report data and descriptive statistics.	Preliminary data regarding sensory room use and acute arousal ratings within the high-dependency area were analysed. It showed a significant reduction in patient distress levels, as per consumer and clinician ratings. The majority of sensory room sessions were conducted by nursing staff. A significant reduction was also found for 'acute arousal ratings', 'pre to post', for the 'HDU engagement program'. Several issues were uncovered throughout implementation of the sensory-based strategies. Findings indicate the importance of cultural change, compared with simply an environmental change, giving all staff and consumers the confidence to utilise a variety of sensory-based methods during times of need. Further Australian research is required to explore the positive contribution sensory modulation can potentially make across the spectrum of psychiatric settings.

Author	Year	Country	Sample	Aims	Methodology	Findings
Chambers, M; Gallagher, A; Borschmann, R; Gillard, S; Turner, K; Kantaris, X	2014	England	19 adult service users detained under mental health legislation.	This paper reports on the experiences of 19 adults detained under mental health legislation. These service users had experienced coercive interventions and they gave their account of how they considered their dignity to be protected (or not), and their sense of self being respected (or not).	Qualitative – in-depth interviews with thematic analysis.	The service users considered their dignity and respect compromised by 1) not being 'heard' by staff members, 2) a lack of involvement in decision-making regarding their care, 3) a lack of information about their treatment plans particularly medication, 4) lack of access to more talking therapies and therapeutic engagement, and 5) the physical setting/environment and lack of daily activities to alleviate their boredom. Dignity and respect are important values in recovery and practitioners need time to engage with service user narratives and to reflect on the ethics of their practice. Respecting the dignity of others is a key element of the code of conduct for health professionals. Often from the service user perspective this is ignored.
Corlett, S	2013	England	N/A	This paper aims to review recent trends in detention under the *Mental Health Act 1983* in England and the relationship to trends in access to mental health services.	Qualitative – policy research review based on Care Quality Commission, which monitors the *Mental Health Act* and regulates health and social care.	The paper suggests that a steady increase in coercion is related to tightening access to mental health care and that these form a toxic relationship that undermines people's mental health, recovery and rights. These trends might be reversed by a combination of rights-based measures, shared decision-making and commissioning a better level and mix of mental health services. The paper updates and discusses knowledge on trends and cites recent evidence from the Care Quality Commission and from Mind.

Author	Year	Country	Sample	Aim	Methodology	Findings
Croft, B; Isvan, N	2015	United States	278 adult service users. This analysis used propensity score matching to create matched pairs of 139 users of peer respite and 139 non-users of respite with similar histories of behavioural health service use and clinical and demographic characteristics.	This study examined the relationship between peer respite and use of inpatient and emergency services among adults receiving publicly funded behavioural health services. By providing a safe and supportive space for individuals experiencing or at risk of experiencing a mental health crisis, a peer respite may reduce the need for traditional crisis interventions.	Quantitative - analysis of case report data. A two-stage regression model first predicted the likelihood of inpatient or emergency service use after the peer respite start date and then predicted hours of inpatient and emergency service use among 89 individuals who used any inpatient or emergency services.	After the authors controlled for relevant covariates, the odds of using any inpatient or emergency services after the programme start date were approximately 70% lower among respite users than nonrespite users, although the odds increased with each additional respite day. Among individuals who used any inpatient or emergency services, a longer stay in respite was associated with fewer hours of inpatient and emergency service use. However, the association was one of diminishing returns, with negligible decreases predicted beyond 14 respite days. By reducing the need for inpatient and emergency services for some individuals, peer respites may increase meaningful choices for recovery and decrease the behavioural health system's reliance on costly, coercive, and less person-centreed modes of service delivery.
Cullberg, J; Levander, S; Holmqvist, R; Mattsson, M; Wieselgren, I-M	2002	Sweden	253 adults with first episode psychosis (FEP) from a catchment with a population of 1.5 million.	To evaluate one-year outcomes in first episode psychosis patients in the Swedish Parachute project. Research participants were asked to participate in this 5-year project.	Quantitative - analysis of case report data, using historical (control (n=71)) and prospective (experimental (n=64)) populations.	A total of 175 patients (69%) were followed up through the first year of treatment. Global Assessment of Functioning (GAF) values were significantly higher than in the historical comparison group but similar to the prospective group. Psychiatric in-patient care was lower as was prescription of neuroleptic medication. Satisfaction with care was generally high in the Parachute group. Access to a small overnight crisis home was associated with higher GAF. The researchers argued that it is possible to successfully treat FEP patients with fewer in-patient days and less neuroleptic medication than is usually recommended, when combined with intensive psychosocial treatment and support.

Authors	Year	Country	Sample	Aim	Methods	Findings
Cullberg, J; Mattsson, M; Levander, S; Holmqvist, R; Tomsmark, L; Elingfors, C; Wieselgren, I-M	2006	Sweden	61 consecutive first episode schizophrenia patients were followed over 3 years, and compared to 66 service users from 'treatment as usual' and high quality service groups.	To undertake a three-year follow-up of the Swedish 'Parachute Project', which uses 'need-specific treatments', considering treatment costs and clinical outcomes for first episode schizophrenia patients.	Quantitative – analysis of case report data comparing Parachute Project group with 'treatment as usual' (n=41) and prospective group from a high quality psychiatric centre (n = 25).	Symptomatic and functional outcome was significantly better compared with the Historical group and equal with the Prospective group. During the first year, the direct costs for in- and out-patient care per patient in the Parachute project were less than half of those in the Prospective group. The researchers conclude that the evidence supports the feasibility, clinically and economically, of a largescale application of 'need-specific treatments' for first episode psychotic patients.
De Jong, G; Schout, GG	2013	Netherlands	N/A	The aim of the study is to answer the question of whether Family Group Conferencing (FGC) is an effective tool to generate social support, to prevent coercion and to promote social integration in public mental health care (PMHC).	Qualitative – policy analysis, and study design.	The paper merely sets out the proposed study, which is reported upon in the 2017 paper by the same authors, led by Schout (see below). The paper sketches the context for using FGC in the Netherlands, in which there has been a steady growth in conferences being organised each year. An amendment in the Dutch Civil Code designates FGC as good practice. Clients in PMHC often have a limited network. The authors proposed that they will research the applicability of FGCs in PMHC over the following two years by evaluating forty case studies.
Evans, M; Boothroyd, R; Armstrong, M	1997	United States	Demographic data are reported on the 238 children and families who received the full course of in-home services during the 26-month study period.	This article describes a 3-year research demonstration project. This project, which was conducted in the Bronx, New York, examined the efficacy of 3 models of intensive in-home services as alternatives to hospitalisation for children experiencing serious psychiatric crises.	Mixed Methods – Analysis of case report data and descriptive statistics.	The three models were characterised as 'alternatives to hospitalization'. The first, Home-Based Crisis Intervention (HBCI), was modelled on the Homebuilders model of family preservation; the second, Enhanced HBCI (HBCI+), added respite care, flexible service money, parent advocate and support services, and additional staff training in cultural competence and violence management. Crisis Case Management, the third model, used case managers to assess child and family needs and link them to services, as well as respite care and flexible money. The apparent benefits and limitations of each model is presented along with supporting evidence.

Author	Year	Country				
Eytan, A; Chatton, A; Safran, E; Khazaal, Y	2013	Switzer-land	This search retrieved data on a total of 2,227 hospital-isations for 1,584 patients in a single hospital in Geneva, Switzerland.	From October 2006, only certified psychiatrists were authorised to require a compulsory admission to this facility, while before all physicians were, including residents. This study sought to assess the impact of this change of procedure on the proportion of compulsory admissions.	Quantitative - analysis of case report data (before/after new requirement). All medical records of patients admitted respectively 4 months before and 4 month after the implementation of the procedure were retrospectively analysed.	The overall proportions of compulsory and voluntary admissions were 63.9 % and 36.1 % respectively. The average length of stay was 32 days (SD ± 64.4). During the study period, 25% of patients experienced two hospitalisations or more. Compared with the period before October 2006, patients hospitalised from October 2006 up were less likely to be hospitalised on a compulsory basis (OR = 0.745, 95 % CI: 0.596-0.930). Factors associated with involuntary admission were young age (20 years or less), female gender, a diagnosis of psychotic disorder and being hospitalised for the first time. The authors argue that their results 'strongly suggest that limiting the right to require compulsory admissions to fully certified psychiatrists can reduce the rate of compulsory versus voluntary admissions'.
Fenton, WS; Mosher, LR; Herrell, JM; Blyler, CR	1998	United States	185 adults who experienced an 'illness exacerbation' and were willing to accept voluntary treatment were randomly assigned to the acute psychiatric ward of a general hospital or a community residential alternative.	The authors report a prospective randomised trial to test the clinical effectiveness of a model of acute residential alternative treatment for patients with persistent mental illness requiring hospital-level care.	Quantitative – economic evaluation within a dual-centre randomised control trial.	The authors report that of 185 patients, 119 (64%) were successfully placed at their assigned treatment site. Case mix data indicated that patients treated in the hospital (N=50) and the alternative (N=69) were comparably ill. Treatment episode symptom reduction and patient satisfaction were comparable for the two settings. Nine (13%) of 69 patients randomly assigned to the alternative required transfer to a hospital unit; two (4%) of 50 patients randomly assigned to the hospital could not be stabilised and required transfer to another facility. Psychosocial functioning, satisfaction, and acute care use in the 6 months following admission were comparable for patients treated in the two settings and did not differ significantly from functioning before the acute episode. Hospitalisation is a frequent and high-cost consequence of severe mental illness. The authors conclude that for patients who do not require intensive general medical intervention and are willing to accept voluntary treatment, the alternative programme model studied provides outcomes comparable to those of hospital care.

Author	Year	Country	Sample	Description	Methods	Findings
Fisher, WA	2003	United States	N=260 adults overall. 148 adult service users, 54% of whom had been restrained or secluded; 112 staff (about 15% of the inpatient clinical staff at the time), 47% of whom were para-professionals.	This article describes elements associated in the literature with successful reduction of seclusion and restraint, and looks at their application in a successful restraint reduction programme at Creedmoor Psychiatric Center, a large, urban, state-operated psychiatric hospital.	Mixed Methods – data included rates of restraint and seclusion but also surveys gathering staff knowledge, evaluation of training programmes, and information about staff and recipient attitudes and actions.	The essential elements of such programmes are high level administrative endorsement, participation by recipients of mental health services, culture change, training, data analysis, and individualised treatment. These elements were applied successfully to a restraint reduction programme at Creedmoor Psychiatric Center, a large, urban, state-operated psychiatric hospital that reduced its combined restraint and seclusion rate by 67% over a period of 2 years.
Flammer, E; Steinert, T	2016	Germany	2,071 adults diagnosed with psychotic disorders and at least one admission during at least one of the three time periods were included, for a total of 3,482 admissions.	In one German state, 'involuntary medication of psychiatric inpatients was illegal during eight months from July 2012 until February 2013'. The authors examined whether the number and duration of mechanical coercive measures (seclusion and restraint) and the number and severity of violent incidents changed in this period.	Quantitative – A cross-sectional analysis was conducted of admission-related routine data collected in seven psychiatric hospitals.	Data was collected in three time periods (period 1, July 2011-February 2012; period 2, July 2012-February 2013; and period 3, July 2013-February 2014). The mean number of mechanical coercive measures and violent incidents per admission increased significantly during period 2, when involuntary medication was not possible, and decreased significantly during period 3. They also differed significantly between periods 1 and 3. The percentage of admissions involving seclusion increased during period 2 significantly and was significantly different during period 1 compared with period 3. The severity of illness and the length of hospitalizsation did not change over the three periods. The authors note that '[r]estriction of involuntary medication was associated with a significant increase in use of mechanical coercive measures and violent incidents'.

Author	Year	Country	Sample	Aim	Method	Findings
Fletcher, J; Spittal, M; Brophy, L; et al	2017	Australia	13 wards opted into a 12-week trial to implement Safewards and 1-year follow up. The comparison group was all other wards (*n* = 31) with seclusion facilities in the jurisdiction.	To assess the impact of implementing Safewards on seclusion in Victorian inpatient mental health services in Australia.	Quantitative - before-and-after design, with a comparison group matched for service type, using mandatorily reported service data.	Seclusion rates were reduced by 36% in Safewards trial wards by the 12-month follow-up period (incidence rate ratios (IRR) = 0.64,) but in the comparison wards seclusion rates did not differ from baseline to post-trial (IRR = 1.17) or to follow-up period (IRR = 1.35). Fidelity analysis revealed a trajectory of increased use of Safewards interventions after the trial phase to follow up. The findings suggest that Safewards is appropriate for practice change in Victorian inpatient mental health services more broadly than adult acute wards, and is effective in reducing the use of seclusion.
Gilburt, H; Slade, M; Rose, D; Lloyd-Evans, B; Johnson, S; Osborn, David P J	2010	England	40 adults living in residential alternative services who had previously experienced hospital in-patient stays.	To explore patients' subjective experiences of traditional hospital services and residential alternatives to hospital. To address gap in research on the 'preferences and experiences of people with mental illness in relation to residential alternatives to hospital'.	Qualitative – purposive sampling, thematic analysis of interview data.	Patients reported an overall preference for residential alternatives. These were identified as treating patients with lower levels of disturbance, being safer, having more freedom and decreased coercion, and having less paternalistic staff compared with traditional in-patient services. However, patients identified no substantial difference between their relationships with staff overall and the care provided between the two types of services. The authors conclude that 'for patients who have acute mental illness but lower levels of disturbance, residential alternatives offer a preferable environment to traditional hospital services: they minimise coercion and maximise freedom, safety and opportunities for peer support'.
Goulet, MH; Larue, C; Ashley, JL	2018	Canada	Acute adult psychiatric care unit specialised in first-episode psychoses with 27 beds.	To develop and evaluate a 'post-seclusion and/or restraint review' (PSRR) intervention implemented in an acute psychiatric care unit.	Case study design, qualitative in nature, with an added quantitative component.	Nurses reported that they were able to explore the patient's feelings during the PSRR intervention with patients, which led to restoration of the therapeutic relationship. PSRR with the treatment team was perceived as a learning opportunity, which allowed the therapeutic intervention to improve. Both the use of seclusion and the time spent in seclusion were significantly reduced 6 months after the implementation of PSRR intervention. Results suggest the efficacy of PSRR in overcoming the discomfort perceived by both staff and patient and, in the meantime, in reducing the need for coercive procedures. Systematic PSRR could permit to improve the quality of care and the safety of aggressiveness management.

Author	Year	Country	Sample	Aim	Method	Findings
Gjerberg, E; Hem, MH; Førde, R; Pedersen, R	2013	Norway	11 inter-disciplinary focus group interviews consisting of nurses, auxiliary nurses and some members of staff without formal qualifications, (N = 60).	This article examines what kinds of strategies or alternative interventions nursing staff in Norway used when patients resist care and treatment and what conditions the staff considered as necessary to succeed in avoiding the use of coercion.	Qualitative – inter-disciplinary focus group interviews with nursing home staff.	In many Western countries, studies have demonstrated extensive use of coercion in nursing homes, especially towards patients suffering from dementia. The study indicated that the nursing home staff usually spent a lot of time trying a wide range of approaches to avoid the use of coercion. The most common strategies were deflecting and persuasive strategies, limiting choices by conscious use of language, different kinds of flexibility and one-to-one care. According to the staff, their opportunities to use alternative strategies effectively are greatly affected by the nursing home's resources, by the organisation of care and by the staff's competence.
Greenfield, TK; Stoneking, BC; Humphreys, K; Sundby, E; Bond, J	2008	United States	393 adults, 'civilly committed'.	This experiment compared the effectiveness of an unlocked, mental health consumer-managed, crisis residential programme (CRP) to a locked, inpatient psychiatric facility (LIPF) for adults civilly committed for severe psychiatric problems.	Mixed methods – randomised control trial with economic evaluation and interviews with thematic analysis.	Following screening and informed consent, participants were randomised to the CRP or the LIPF and interviewed at baseline and at 30-day, 6-month, and 1-year post admission. Outcomes were costs, level of functioning, psychiatric symptoms, self-esteem, enrichment, and service satisfaction. Treatment outcomes were compared using hierarchical linear models. Participants in the CRP experienced significantly greater improvement on interviewer-rated and self-reported psychopathology than did participants in the LIPF condition; service satisfaction was dramatically higher in the CRP condition. CRP-style facilities are a viable alternative to psychiatric hospitalisation for many individuals facing civil commitment.
Groot, P; van Os J	2018	Netherlands	1194 adult users of tapering strips	To observe the use of 'tapering strips', which allow gradual dosage reduction and minimise the potential for withdrawal effects. A tapering strip consists of antidepressant medication, packaged in a roll of small daily pouches, each with the same or slightly lower dose than the one before it.	Quantitative – observational and survey study of 1194 users.	Of 1194 users of tapering strips, 895 (75%) wished to discontinue their antidepressant medication. In these 895, median length of antidepressant use was 2–5 years (IQR: 1–2 years– > 10 years). Nearly two-thirds (62%) had unsuccessfully attempted withdrawal before (median = 2 times before, IQR 1–3). Almost all of these (97%) had experienced some degree of withdrawal, with 49% experiencing severe withdrawal (7 on a scale of 1–7, IQR 6–7). Tapering strips represent a simple and effective method of achieving a gradual dosage reduction.

Author	Year	Country	Sample	Aim	Methods	Main Findings
Guan, L; et al	2015	China	266 patients found in restraints in their family homes from 2005 across China were recruited in Stage One of the study in 2009. In 2012, 230 of the 266 cases were re-interviewed (the Stage Two study).	To implement a nationwide two-stage follow-up study to measure the effectiveness and sustainability of the 'unlocking and treatment' intervention and its impact on the well-being of patients' families. Outcome measures included the patient medication adherence and social functioning, family burden ratings, and relocking rate.	Mixed methods – two-stage follow-up study, interviews pre-post intervention, outcome tests	96% of patients were diagnosed with schizophrenia. Prior to unlocking, their total time locked ranged from two weeks to 28 years, with 32% having been locked multiple times. The number of persons regularly taking medicines increased from one person at the time of unlocking to 74% in 2009 and 76% in 2012. Pre-post tests showed sustained improvement in patient social functioning and significant reductions in family burden. Over 92% of patients remained free of restraints in 2012. The authors report that 'Practice-based evidence from our study suggests an important model for protecting the human rights of people with mental disorders and keeping them free of restraints can be achieved by providing accessible, community based mental health services with continuity of care. China's "686" Programme can inform similar efforts in low-resource settings where community locking of patients is practiced.'
Hackett, R; Nicholson, J; Mullins, S; Farrington, T; Ward, S; Pritchard, G; Miller, E; Mahmood, N	2009	England	Access data was analysed for 200-300 adults.	The project aimed to empower the Pakistani community to seek mental health support earlier within their own community, build up trust in mainstream services and enhance the clinical pathways within services to provide more culturally appropriate care.	Mixed methods – qualitative report from 'link worker' (see Main Findings) and quantitative service data on access rates.	Black and Minority Ethnic (BME) communities receive different pathways into mental health care with BME service users often presenting in crisis. The Sheffield Crisis Resolution Home Treatment joined with the local Pakistani Muslim Centre (PMC) to work in partnership. The PMC had existing links with the Pakistani community and provided a range of social, respite and occupational opportunities. The partnership created an innovative new role: the Pakistani link worker. The EPIC partnership strengthened the PMC's influence and raised awareness of mental health issues in the community. Through integration of the link worker within the everyday practice of clinicians, pathways of care showed evidence of positive change including more referrals to the PMC from psychiatric services. The EPIC project piloted a model of partnership working that is effective and transferable.

Author	Year	Country	Sample/Population	Aim	Method	Findings
Haycock, J; Finkelman, D; Presskreischer, H	1993	United States	N/A – sociolegal analysis of law and alternative legal pathways	To review the statutes, regulations and case law governing civil commitment in Massachusetts, review the practice of civil commitment in this US state and consider whether the process of mediation could provide an alternative to civil commitment.	Qualitative – analysis of existing laws, and exploration of alternative legal pathways to civil commitment.	The authors argue that the process of mediation might better fit the therapeutic objectives that underlie clinical participation in the civil commitment process. They argue that 'No amount of tinkering from a rights-based agenda with commitment criteria is likely to correct the failures of our current system'. They note: 'how mediated agreements between clinicians and patients would work cannot be exhaustively described in advance of experimenting with such an alternative. Some of that experimentation need not wait on the full implementation of a mediation model. Even without instituting a full-blown mediation process, some of our suggestions could be incorporated into current civil commitment procedures.'
Henderson, C; Farrelly, S; Flach, C; Borschmann, R; Birchwood, M; Thornicroft, G; Waheed, W; Szmukler, G	2017	England and Wales	221 Joint Crisis Plans, which are plans formulated by service users and their clinical team with involvement from an external facilitator, compared to 424 'baseline routine care plans'.	The authors aimed to estimate the demand for an informed advance treatment refusal under the *Mental Capacity Act 2005* (England and Wales) within a sample of service users who had had a recent hospital admission, and to examine the relationship between refusals and service user characteristics.	Mixed methods – content analysis of Joint Crisis Plans, and routine care plans in sub-samples from a multi-centre randomised controlled trial of Joint Crisis Plans (plus routine mental health care) versus routine care alone (CRIMSON) in England.	99 of 221 (45%) of the Joint Crisis Plans contained a treatment refusal compared to 10 of 424 (2.4%) baseline routine care plans. No Joint Crisis Plans recorded disagreement with refusals on the part of clinicians. Among those with completed Joint Crisis Plans, adjusted analyses indicated a significant association between treatment refusals and perceived coercion at baseline (odds ratio = 1.21, 95% CI 1.02–1.43), but not with baseline working alliance or a past history of involuntary admission. They demonstrated significant demand for written treatment refusals in line with the *Mental Capacity Act 2005*, which had not previously been elicited by the process of treatment planning. Future treatment/crisis plans should incorporate the opportunity for service users to record a treatment refusal during the drafting of such plans

Author	Year	Country	Sample	Aim	Method	Findings
Henderson, C; et al	2004	England	160 people with an operational diagnosis of psychotic illness or non-psychotic bipolar disorder who had experienced a hospital admission within the previous two years.	To investigate whether a form of advance agreement for people with severe mental illness can reduce the use of inpatient services and compulsory admission or treatment.	Quantitative: Single blind randomised controlled trial, with randomisation of individual patients. The investigator was blind to allocation.	Use of the *Mental Health Act* was significantly reduced for the intervention group, 13% (10/80) of whom experienced compulsory admission or treatment compared with 27% (21/80) of the control group (risk ratio 0.48, 95% confidence interval 0.24 to 0.95, P = 0.028). The authors concluded that the use of Joint Crisis Plans reduced compulsory admissions and treatment in patients with severe mental illness. The reduction in overall admission was less. According to the authors '[t]his is the first structured clinical intervention that seems to reduce compulsory admission and treatment in mental health services.'
Henderson, C; Flood, C; Leese, M; Thornicroft, G; Sutherby, K; Szmukler, G	2009	England	62 adults who received a Joint Crisis Plan.	To report participants' and case managers' use of and views on the value of Joint Crisis Plans (JCPs), shown to reduce compulsory hospitalisation and violence.	Mixed methods – qualitative research in the form of questionnaires.	Intervention group participants were interviewed on receipt of the JCP, on hospitalisation, and at 15-month follow-ups; case managers were interviewed at 15 months. 46-96% of JCP holders (N = 44) responded positively to questions concerning the value of the JCP at immediate follow up. At 15 months the proportions of positive responses to the different questions was 14-82% (N = 50). Thirty-nine to eighty-five per cent of case managers (N = 28) responded positively at 15 months. Comparing the total scores of participants who had completed both the initial and follow up questionnaires showed a shift in responses, from positive to no change, from the immediate follow up to 15 months (means 6.1 vs. 8.3, difference 2.2, 95% CI 0.8, 3.7, P = 0.003), where a higher score indicates less positive views. The two items that received highest endorsement also showed least shift over time, i.e. whether the participant would recommend the JCP to others (90% initial vs. 82% at 15 months) and whether they felt more in control of their mental health problem as a result (71% at initial vs. 56% at 15 months). Case managers at 15 months were more positive than service users, with total score means of 5 vs. 7.8 (difference -2.8, 95% CI -4.5, -1.2, P = 0.002).

Author	Year	Country	Sample	Aim	Methodology	Findings
Heumann, K; Bock, T; Lincoln, TM	2017	Germany	83 service users	In recent years the legal basis in Germany for the use of coercive measures in psychiatry has changed, yet there is no regulation of the type or amount of 'milder measures', which must now be used. The authors investigated which and how many 'milder measures' were experienced by service users before coercion was used and which measures they value as potentially helpful to avoid it.	Quantitative – online survey of 83 service users. Their experience with 21 milder measures and their evaluation of whether the measures were helpful were assessed by self-reporting.	On average, participants reported 5.4 experienced milder measures. The most frequent reason provided for why measures failed were structural factors, followed by staff behaviour, and reasons caused by the participants themselves. The only milder measure rated by less than 50% as potentially helpful in avoiding coercive measures was being persuaded to take medication. Although many milder measures are perceived as potentially helpful, only few seem to be made use of in routine clinical practice. The authors conclude that in order to prevent coercion staff members should apply a wider range of milder measures.
Højlund M; Høgh L; Bojesen, A; Munk-Jørgensen P; Stenager E	2018	Denmark	Data from 101 admissions after implementation of interventions were compared with data from 85 admissions in a historical reference cohort.	To quantify and compare the use of antipsychotic and anxiolytic medications in connection with the implementation of a programme to reduce coercion and restraint.	Mixed methods – quantitative analysis of service data combined with observational study in a general psychiatric ward.	Mean defined daily doses of antipsychotics, benzodiazepines or the total amount of both showed no difference before and after implementation of the programme. The data showed that neither total dose of antipsychotics (adjusted ⍰: .05, 95% confidence interval (CI): −0.20 to 0.31), total dose of benzodiazepines (adjusted ⍰: −.13, 95%CI: −.42 to 0.16) nor total amount of both drugs (adjusted ⍰: .00, 95%CI: −.26 to 0.21) increased after implementation. A decrease in coercive measures from 2013 to 2016 has not lead to significant increases in the use of antipsychotic medication or benzodiazepines. The interventions are useful in establishing restraint-free wards, and careful monitoring of the psychopharmacological treatment is important for patient safety.

Authors	Year	Country	Sample	Aim	Methods	Findings
Høyer, G; Kjellin, L; Engberg, M; Kaltiala-Heino, R; Nilstun, T; Sigurjónsdóttir, M; Syse, A	2002	Denmark, Finland, Iceland, Norway, and Sweden (Northern Europe)	Not stated	Study called 'Paternalism and Autonomy—A Nordic Study on the Use of Coercion in the Mental Health Care System,' is a joint study involving all the five Nordic countries (Denmark, Finland, Iceland, Norway, and Sweden).	Mixed methods - textual analysis and interviews with ethicists, lawyers, and physicians, 'core interview' with service users, data from medical records and related documents	Preliminary data from all Nordic countries suggest that perceived coercion tends to be a 'dichotomized phenomenon', measured both by the 'MPCS' and the 'Coercion Ladder', and this dichotomized pattern remains even when formally voluntarily and involuntarily admitted patients are studied separately. The authors report being 'unable to produce a good explanation for the bimodal distribution of perceived coercion' and raise 'questions about flaws in the instruments used to measure perceived coercion' and "if perceived coercion really is a dichotomized phenomenon and, in this way, more resembles the concept of "integrity.""
Huber, CG; Schneeberger, AR; Kowalinski, E; Fröhlich, D; Felten, S von; Walter, M; Zinkler, M; Beine, K; Heinz, A; Borgwardt, S; Lang, UE	2016	Germany	349 574 admissions to 21 German psychiatric inpatient hospitals from Jan 1, 1998, to Dec 31, 2012.	To compare hospitals without locked wards and hospitals with locked wards and to establish whether hospital type has an effect on these outcomes.	Quantitative – naturalistic observational study with linear mixed-effects models to analyse the data.	Patients at risk are often admitted to locked wards in psychiatric hospitals to prevent absconding, suicide attempts, and death by suicide. However, there is insufficient evidence that treatment on locked wards can effectively prevent these outcomes. In the 145 738 propensity score-matched cases, suicide (OR 1·326, 95% CI 0·803–2·113; p=0·24), suicide attempts (1·057, 0·787–1·412; p=0·71), and absconding with return (1·288, 0·874–1·929; p=0·21) and without return (1·090, 0·722–1·659; p=0·69) were not increased in hospitals with an open door policy. Compared with treatment on locked wards, treatment on open wards was associated with a decreased probability of suicide attempts (OR 0·658, 95% CI 0·504–0·864; p=0·003), absconding with return (0·629, 0·524–0·764; p<0·0001), and absconding without return (0·707, 0·546–0·925; p=0·01), but not completed suicide (0·823, 0·376–1·766; p=0·63). Lock-ed doors might not be able to prevent suicide and absconding.

Authors	Year	Country	Sample	Aim	Method	Findings
Hustoft, K; Larsen, TK; Brønnick, K; Joa, I; Johannessen, JO; Ruud, T	2018	Norway	3338 patients referred for admission in 20 Norwegian acute psychiatric units across 3 months in 2005–06 (about 75% of national acute units).	The aim of this study was to investigate the extent to which Involuntarily Hospitalised (IH) patients were converted to a Voluntary Hospitalisation (VH), and to identify predictive factors leading to this conversion.	Quantitative – analysis of service data using generalized linear mixed modelling.	The incident of conversion from involuntarily hospitalisation (IH) to voluntary hospitalisation (VH) was analysed. Out of 3338 patients referred for admission, 1468 were IH (44%) and 1870 were VH. After re-evaluation, 1148 (78.2%) remained on involuntary hos-pitalisation, while 320 patients (21.8%) were converted to voluntary hospitalisation. The pre-dictors of conversion from involuntary to voluntary hospitalisation after re-evaluation of a specialist included patients wanting admission, better scores on Global Assessment of Symptom scale, fewer hallucinations and delusions and higher alcohol intake. The 24h re-evaluation period for patients referred for involuntary hospitalisation, as stipulated by the Norwegian *Mental Health Care Act*, appeared to give adequate opportunity to reduce unnecessary involuntary hospitalisation, while safeguarding the patient's right to VH.
Husum, TL; Bjørngaard, JH; Finset, A; Ruud, T	2010	Norway	The study includes data from 32 acute psychiatric wards and 1214 involuntarily admitted persons.	This study investigates to what extent use of seclusion, restraint and involuntary medication for involuntary admitted patients in Norwegian acute psychiatric wards is associated with patient, staff and ward characteristics.	Quantitative – multilevel logistic regression using Stata was applied with service data from patients that were linked to data about wards.	The total number of involuntary admitted patients was 1214 (35% of total sample). The percentage of patients who were exposed to coercive measures ranged from 0-88% across wards. Of the involuntary admitted patients, 424 (35%) had been secluded, 117 (10%) had been restrained and 113 (9%) had received involuntary depot medication at discharge. Data from 1016 patients could be linked in the multilevel analysis. The authors conclude that the substantial between-ward variance, even when adjusting for patients' individual psychopathology, indicates that ward factors influence the use of seclusion, restraint and involuntary medication and that some wards have the potential for quality improvement. They conclude that interventions to reduce the use of seclusion, restraint and involuntary medication should take into account organisational and environmental factors.

Authors	Year	Country	Sample	Study aim	Methods	Findings
Jaeger, M; Ketteler, D; Rabenschlag, F; Theodoridou, A	2014	Switzerland	39 mental health professionals.	This pilot study aimed at investigating how mental health professionals on acute psychiatric wards recognise different levels of formal and informal coercions and treatment pressures as well as their attitude towards these interventions.	Mixed methods – cross-sectional survey using a questionnaire that consisted of 15 vignettes describing typical clinical situations on five different stages of the continuum of coercion.	Low levels of coercion are recognised adequately while higher levels are grossly underestimated. The degree of coercion inherent to interventions comprising persuasion and leverage was underestimated by professionals with a positive attitude and overestimated by those with a negative attitude towards the respective interventions. No associations of the ability to recognise different levels of coercion with ward or staff related variables were found. Higher knowledge on ambiguous variations of coercive interventions seems to foster more balanced reflections about their ethical implications. The authors conclude that '(a)dvanced understanding of influencing factors of professionals' attitudes towards coercion could lead to improved training of professionals in utilizing interventions to enhance treatment adherence in an informed and ethical way'.
Jaeger, M; Konrad, A; Rueegg, S; Rabenschlag, F	2015	Switzerland	63 service users of an acute psychiatric unit in Switzerland.	This naturalistic observational study seeks to evaluate the subjective perspective and functional outcome of inpatients before and after structural alterations. The changes made were the introduction of treatment conferences and conjoint treatment planning, reduction of the total time spent on reports about patients (in their absence), and recovery-oriented staff training on an acute psychiatric unit.	Mixed methods – interview and surveying. During 1 year (2011/2012) eligible patients on the study unit were interviewed on a voluntary basis using established instruments to assess several recovery-relevant aspects.	Two different samples (before and after the project; n = 34 and n = 29) were compared with regard to subjective parameters (e.g. patients' attitudes toward recovery, quality of life, perceived coercion, treatment satisfaction, and hope), clinical and socio-demographic basic data, as well as the functional outcome according to the Health of the Nation Outcome Scales (HoNOS). Some patient attitudes towards recovery and their self-assessment of the recovery process improved during the study. Other subjective parameters remained stable between samples. Functional outcome was better in subjects who were treated after the implementation of the new concept. The length of stay remained unchanged. The implementation of recovery-oriented structures and providing the necessary theoretical underpinning on an acute psychiatric unit is feasible and can have an impact on attitudes and knowledge of personal recovery.

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Authors	Year	Country	Sample	Aim	Methods	Findings
Janssen, WA; Noorthoorn, EO; Nijman, HLI; Bowers, L; Hoogendoorn, AW; Smit, A; Widdershoven, GAM	2013	Netherlands	718 persons who had been secluded over 5,097 admissions on 29 different admission wards over seven Dutch psychiatric hospitals.	To test the hypothesis that difference in seclusion figures between wards may predominantly be explained by differences in patient characteristics, as these are expected to have a large impact on these seclusion rates. Nurses and ward managers tend to hold this view, assuming more admissions of severely ill patients are related to higher seclusion rates.	Mixed methods – descriptive analysis of service data, exploring relationship between patient and ward characteristics and the wards' number of seclusion hours per 1,000 admission hours.	The extreme group analysis showed that seclusion rates depended on both patient and ward characteristics. A multivariate and multilevel analyses revealed that differences in seclusion hours between wards could partially be explained by ward size next to patient characteristics. However, the largest deal of the difference between wards in seclusion rates could not be explained by characteristics measured in this study. The authors concluded ward policy and adequate staffing may, particularly on smaller wards, be key issues in reduction of seclusion.
Janssen, WA; van de Sande, R; Noorthoorn, EO; Nijman, HLI; Bowers, L; Mulder, CL; Smit, A; Widdershoven, GAM; Steinert, T	2011	Netherlands	Seclusion and restraint data from 31,594 admissions for 20,934 patients. 12 Dutch mental health institutes, comprising 37 hospitals and 227 wards containing 6812 beds.	The aim of this article is to identify problems in defining and recording coercive measures. The study contributes to the development of consistent comparable measurements definitions and provides recommendations for meaningful data-analyses illustrating the relevance of the proposed framework.	Mixed methods – literature was reviewed to identify various definitions and calculation modalities used to measure coercive measures in psychiatric inpatient care.	Considerable variation in ward and patient charact-eristics was identified in this study. The chance to be exposed to seclusion per capita inhabitants of the institute's catchment areas varied between 0.31 and 1.6 per 100.000. The number of seclusion incidents per 1000 admissions varied between 79 up to 745. The authors conclude that coercive measures can be reliably assessed in a standardised and comparable way under the condition of using clear joint definitions. Methodological consensus between researchers and mental health professionals on these definitions is ne-cessary to allow comparisons of seclusion and restraint rates. The study contributes to the development of international standards on gathering coercion related data and the consistent calculation of relevant outcome parameters.

Author	Year	Country	Population	Aim	Method	Findings
Johnson, S; Nolan, F; Pilling, S; Sandor, A; Hoult, J; McKenzie, N; White, IR; Thompson, M; Bebbington, P	2005	England	260 residents of the inner London Borough of Islington who were experiencing crises severe enough for hospital admission to be considered.	To evaluate the effectiveness of a crisis resolution team.	Quantitative – randomised control trial, examining service users' satisfaction.	Patients in the experimental group were less likely to be admitted to hospital in the eight weeks after the crisis (odds ratio 0.19, 95% confidence interval 0.11 to 0.32), though compulsory admission was not significantly reduced. A difference of 1.6 points in the mean score on the client satisfaction questionnaire (CSQ-8) was not quite significant (P = 0.07), although it became so after adjustment for baseline characteristics (P = 0.002). Crisis resolution teams can reduce hospital admissions in mental health crises. They may also increase satisfaction in patients, but this was an equivocal finding.
Kalisova, L; et al	2014	Bulgaria, Czech Republic, Germany, Greece, Italy, Lithuania, Poland, Spain, Sweden and England.	Involuntarily admitted patients (N = 2,027) divided into two groups, the first (N = 770) subject to at least one coercive measure, the other (N = 1,257) had not received a coercive measure during hospitalisation.	This study aims to identify whether selected patient and ward-related factors are associated with the use of coercive measures.	Mixed methods – descriptive data, including patients' socio-demographic and clinical characteristics and centre-related characteristics. Tested in a multivariate logistic regression model, controlled for countries' effect.	The frequency of coercive measures varied significantly across countries, being higher in Poland, Italy and Greece. Those who received coercive measures were more often male and diagnosed with psychotic disorder (F20-F29). According to the regression model, patients with higher levels of psychotic and hostility symptoms, and of perceived coercion had a higher risk to be coerced at admission. Controlling for countries' effect, the risk of being coerced was higher in Poland. Patients' sociodemographic characteristics and ward-related factors were not identifying as possible predictors because they did not enter the model. The use of coercive measures varied significantly in the participating countries. Clinical factors, such as high levels of psychotic symptoms and high levels of perceived coercion at admission were associated with the use of coercive measures, when controlling for countries' effect. These factors should be taken into consideration by programmes aimed at reducing the use of coercive measures in psychiatric wards.

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Authors	Year	Country	Sample	Aim	Method	Findings
Keski-Valkama, A; Sailas, E; Eronen, M; Koivisto, A-M; Lönnqvist, J; Kaltiala-Heino, R	2007	Finland	National survey of psychiatric hospitals	To evaluate the nationwide trends in the use of seclusion and restraint were investigated in Finland over a 15-year span which was characterised by legislative changes aiming to clarify and restrict the use of these measures.	Quantitative – structured postal survey of Finnish psychiatric hospitals, using data from the National Hospital Discharge Register.	The total number of the secluded and restrained patients declined as did the number of all inpatients during the study weeks, but the risk of being secluded or restrained remained the same over time when compared to the first study year. The duration of the restraint incidents did not change, but the duration of seclusion increased. The authors conclude that legislative changes solely cannot reduce the use of seclusion and restraint or change the prevailing treatment cultures connected with these measures, and argue that the use of seclusion and restraint should be vigilantly monitored and ethical questions should be under continuous scrutiny.
Kleintjes, S; Lund, C; Swartz, L	2013	Ghana, Kenya, Rwanda, South Africa, Tanzania, Uganda and Zambia	11 members of leadership in mental health self-help organisations (including carers).	This paper reports on overarching strategies which supported the establishment and sustainability of nine mental health self-help organisations in seven African countries.	Qualitative – interviews with thematic analysis.	The interviews suggest that self-help organisations can provide crucial support to users' recovery in resource-poor settings in Africa. Support of ministries, NGOs, DPOs, development agencies and professionals can assist to build organisations' capacity for sustainable support to members' recovery. Organisations' work include advocacy to destigmatise mental disorders and promote the protection of user's rights, activities to improve access to health care and to income generation and social support, participation in legislative and policy reform, and capacity building of members.
Kogstad, RE	2009	Norway	335 adult service users	To investigate violations of dignity considered from the clients' points of view, and to suggest actions that may ensure that practice is brought in line with human rights values.	Qualitative – interviews with thematic content analysis.	The authors conclude that '[m]ental health clients experience infringements that cannot be explained without reference to their status as clients in a system which, based on judgments from medical experts, has a legitimate right to ignore clients' voices as well as their fundamental human rights'. They argue that 'recommendations and practices should be harmonized with the new UN Convention on the Rights of Persons with Disabilities (2006)'.

Author	Year	Country	Participants	Aim	Methodology	Findings
Kontio, R; Välimäki, M; Putkonen, H; Kuosmanen, L; Scott, A; Joffe, G	2010	Finland	22 nurses and 5 physicians	To explore nurses' and physicians' perceptions of what actually happens when an aggressive behaviour episode occurs on the ward and what alternatives to seclusion and restraint are actually in use as normal standard practice in acute psychiatric care.	Qualitative – focus group interview with thematic content analysis.	The participants believed that the decision-making process for managing patients' aggressive behaviour contains some in-built ethical dilemmas. They thought that patients' subjective perspective received little attention. Nevertheless, the staff proposed and appeared to use a number of alternatives to minimise or replace the use of seclusion and restraint. The authors conclude that '[m]edical and nursing staff need to be encouraged and taught to: (1) tune in more deeply to reasons for patients' aggressive behaviour; and (2) use alternatives to seclusion and restraint in order to humanize patient care to a greater extent.'
Kokanović, R; et al	2018	Australia	90 mental health service users who reported diagnoses of schizophrenia, psychosis, bipolar disorder and severe depression; family members supporting them and mental health practitioners.	The study aims to explore from several perspectives the barriers and facilitators to supported decision-making in an Australian context. Supported decision-making was considered in terms of interpersonal experiences and legal supported decision-making mechanisms.	Qualitative – interview data was analysed thematically across all participants.	Negative interpersonal experiences in the mental health care system undermined involvement in decision-making for people with psychiatric diagnoses and family carers. Mental health practitioners noted their own disempowerment in service systems as barriers to good supported decision-making practices. All groups noted the influence of prevailing attitudes towards mental health service users and the associated stigma and discrimination that exist in services and the broader community. They reported that legal supported decision-making mechanisms facilitate the participation of mental health service users and their family supporters in supported decision-making. The authors conclude that enabling supported decision-making in clinical practice and policy can be facilitated by (1) support for good communication skills and related attitudes and practices among mental health practitioners and removing barriers to their good practice in health and social services and (2) introducing legal supported decision-making mechanisms.

Author	Year	Country	Sample	Aims	Methodology	Findings
Larrobla, C; Botega, NJ	2001	South America: Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Guyana, Paraguay, Peru, Suriname, Uruguay, and Venezuela	A postal survey was conducted of all South American countries (health ministries, national psychiatric associations and key informants).	This study aims to gather information available on the changes in mental health services in South American countries following the 'social and political upheavals of recent decades'.	Quantitative – postal survey to assess the development of mental health programmes and the organisation of alternative psychiatric care centres such as the psychiatric units in general hospitals (PUGH).	The survey results indicate that most of the mental health programmes were implemented during the 1980s and 1990s, and aimed at incorporating psychiatric care into primary health care, as well as relocating provision from large hospitals to decentralised services (which is likely to be strongly associated with less coercive responses). Most of the countries surveyed have less than 0.5 psychiatric beds per 1000 inhabitants. This change reflects a tendency to reduce the total number of psychiatric beds and increase the number of PUGH. Over the last 10 years this increase was significant in some countries (50-75 %), but was not reflected in the availability of adequate human and material resources. A transition from a system based on large mental hospitals to alternative service provision is on the way in South American countries. Intensive efforts have to be made to collect and disseminate information, as well as to monitor the development and outcome of the mental health programmes in these countries.
Lawlor, C; Johnson, S; Cole, L; Howard, LM	2012	England	287 women admitted to an acute psychiatric inpatient ward or a women's crisis house in four London boroughs during a 12-week period were included.	To explore ethnic variations in compulsory detentions of women, and to explore the potential role of immediate pathways to admission and clinician-rated reasons for admission as mediators of these differences.	Quantitative – descriptive data drawn from health services.	287 women from White British, White Other, Back Caribbean, Black African and black other groups were included. Adjusting for social and clinical characteristics, all groups of Black patients and White other patients were significantly more likely to have been compulsorily admitted than White British patients; White British patients were more likely than other groups to be admitted to a crisis house and more likely than all the Black groups to be admitted because of perceived suicide risk. Immediate pathways to care differed: White Other, Black African and Black Other groups were less likely to have referred themselves in a crisis and more likely to have been in contact with the police. When adjustment was made for differences in pathways to care, the ethnic differences in compulsory admission were considerably reduced. There are marked ethnic inequities not only between White British and Black women, but also between White British and White Other women in experiences of acute admission. Differences between groups in help-seeking behaviours in a crisis may contribute to explaining differences in rates of compulsory admission.

Author	Year	Country	Sample	Aim	Methodology	Findings
Lay, B; Nordt, C; Rössler, W	2011	Switzerland	9689 inpatients from the year 2007 aged 18-70.	This study addresses three coercive measures and the role of predictive factors at both patient and institutional levels.	Quantitative – used 'generalized estimating equation' models to analyse variation in rates between psychiatric hospitals.	The authors report quotas of 24.8% involuntary admissions, 6.4% seclusion/restraint and 4.2% coerced medication. Results suggest that the kind and severity of mental illness are the most important risk factors for being subjected to any form of coercion. Variation across the six psychiatric hospitals was high, even after accounting for risk factors on the patient level suggesting that centre effects are an important source of variability. However, effects of the hospital characteristics 'size of the hospital', 'length of inpatient stay', and 'work load of the nursing staff' were only weak ('bed occupancy rate' was not statistically significant).
Lay, B; Blank, C; Lengler, S; Drack, T; Bleiker, M; Rössler, W	2015	Switzerland	238 inpatients who had at least one compulsory admission during the past 24 months.	The aim of this study was to evaluate an intervention programme for people with severe mental illness that targets the reduction in compulsory psychiatric admissions. In the current study, the researchers examine the feasibility of retaining patients in this programme and compare outcomes over the first 12 months to those after treatment as usual (TAU).	Quantitative – randomised controlled intervention study conducted currently at four psychiatric hospitals in the Canton of Zurich.	Participants were assigned at random to the intervention or to the TAU group. The intervention programme consists of individualised psycho-education focusing on behaviours prior to illness-related crisis, crisis cards and, after discharge from the psychiatric hospital, a 24-month preventive monitoring. In total, 238 (of 756 approached) inpatients were included in the trial. After 12 months, 80 (67.2 %) in the intervention group and 102 (85.7 %) in the TAU group were still participating in the trial. Of these, 22.5 % in the intervention group (35.3 % TAU) had been compulsorily readmitted to psychiatry; results suggest a significantly lower number of compulsory readmissions per patient (0.3 intervention; 0.7 TAU). This interim analysis suggests beneficial effects of this intervention for targeted psychiatric patients.

Author	Year	Country	Sample	Aim	Methodology	Findings
Lay, B; Kawohl, W; Rössler, W	2018	Switzerland	238 inpatients who had at least one compulsory admission during the past 24 months.	The aim of this study was to evaluate an intervention programme for people with severe mental illness that targets the reduction in compulsory psychiatric admissions. In the current study, the researchers examine the feasibility of retaining patients in this programme and compare outcomes over the 24 months to those after treatment as usual (TAU).	Quantitative – randomised controlled intervention study conducted currently at four psychiatric hospitals in the Canton of Zurich.	Fewer participants who completed the 24-month programme were compulsorily readmitted to psychiatry (28%), compared with those receiving TAU (43%). Likewise, the number of compulsory readmissions per patient was significantly lower (0.6 v. 1.0) and involuntary episodes were shorter (15 v. 31 days), compared with TAU. A negative binomial regression model showed a significant intervention effect (RR 0.6; 95% confidence interval 0.3–0.9); further factors linked to the risk of compulsory readmission were the number of compulsory admissions in the patient's history (RR 2.8), the diagnosis of a personality disorder (RR 2.8), or a psychotic disorder (RR 1.9). Dropouts (37% intervention group; 22% TAU) were characterised by a high number of compulsory admissions prior to the trial, younger age and foreign nationality. This study suggests that this intervention is a feasible and valuable option to prevent compulsory re-hospitalisation in a 'high-risk group of people with severe mental health problems, social disabilities, and a history of hospitalisations'.
Lewis, M; Taylor, K; Parks, J	2009	United States	A 900-bed tertiary care academic medical centre located in an urban, socio-economically distressed area.	A group of direct care psychiatric nurses in a large urban teaching hospital created an evidenced-based performance improvement programme that resulted in a decrease in the use of seclusion and restraint.	Quantitative – service data (before/after intervention).	No additional funds were required to develop this program. The public health prevention model was the framework utilised. Early results show a 75% reduction in the use of seclusion and restraint with no increase in patient or staff injuries since its implementation.
Lindgren, I; Falk Hagstedt, M; Cullberg, J	2006	Sweden	24 first-episode psychosis patients diagnosed between 1990-92 and 32 between 1993-96.	The aim of the present study was to follow the patients in the two groups for 5 years, comparing the outcome.	Quantitative analysis using Soteria Nacka recovery scale.	The results showed that easily accessible need-adapted treatment with integrated overnight care might be advantageous for first-episode psychotic patients. The duration of untreated psychosis was shorter and the outcome better

Author	Year	Country	Sample	Aims	Method	Findings
Long, CG; West, R; Afford, M; Collins, L; Dolley, O	2015	England	38 women admitted to the medium secure unit of an independent charitable trust.	Aims of the study are to assess the effectiveness of interventions designed to minimise the use of seclusion in response to risk behaviours by comparing matched patients before and after change.	Quantitative analysis of study interventions to reduce the use of seclusion.	A significant decline in both the number of seclusions and risk behaviour post-change was complemented by improved staff ratings of institutional behaviour, increased treatment engagement and a reduction in time spent in medium security. Staff and patients differed in terms of their ratings of the most effective strategies introduced. Patients favoured the Relational Security item of increased individual engagement and timetabled Behaviour Chain Analysis sessions. Staff viewed on ward training and use of de-escalation techniques as most effective. Findings confirm results from mixed gender forensic mental health samples that seclusion can be successfully reduced without an increase in patient violence or alternative coercive strategies.
Looi, G-M E; Engström, Å; Sävenstedt, S	2015	Sweden	Total of 19 self-reports	The aim of this study was to describe how people who self-harm perceive alternatives to coercive measures in relation to actual experiences of psychiatric care.	Qualitative -content analysis of self-reports.	The researchers came up with three themes from the literature: 'a wish for understanding instead of neglect; a wish for mutual relation instead of distrust; a wish for professionalism instead of a counterproductive care'. They argue that if the caregivers can understand and collaborate with the patient, there is seldom any need for coercive measures. [Only abstract available]
Lyons, C; Hopley, P; Burton, CR; Horrocks, J	2009	England	Postal questionnaires and 24 group meetings with service users and carers	To gain an understanding of how users and carers define a crisis and what range of crisis services, resources and interventions service users and carers thought would help avoid unnecessary hospital admission.	Quantitative analysis of questionnaires and group meetings.	There is emerging evidence that crisis resolution services can provide alternatives to hospital admission, reducing demand on inpatient beds. The authors conclude that expressed preferences of service users and carers for pre-emptive services that are delivered flexibly will present a challenge for service commissioners and providers, particularly where stringent access criteria are used. Home-based pre-emptive services that reduce the need for unnecessary hospital treatment may avoid progression to social exclusion of service users.

Authors	Year	Country	Setting/Sample	Aim	Methodology	Findings
Maguire, T; Young, R; Martin, T	2011	Australia	Forensic hospital with 116 beds, providing acute, rehabilitation and continuing care programmes for men and women.	To present a project that was undertaken at an Australian forensic mental health hospital to reduce seclusion. These initiatives are based on the Six Core Strategies that have been successfully used in North America to reduce seclusion.	Quantitative – service data following intervention.	The frequency and duration of seclusion events were reduced but there was less reduction in the number of patients that were secluded. At this time, seclusion may be necessary for the general safety of the unit. It is possible that the strategies were successfully supported by the identified opportunities to reduce the frequency and duration of seclusion but the challenges were significantly powerful in the early period of admission to prompt the need for seclusion. Reducing seclusion in a forensic hospital is a complex undertaking as nurses must provide a safe environment while dealing with volatile patients and may have little alternative at present but to use seclusion after exhausting other interventions.
Mann-Poll, PS; Smit, A; Noorthoorn, EO; Janssen, WA; Koekkoek, B; Hutschemaekers, GJM	2018	Netherlands	Five inpatient wards participated: three admission wards for adults, one admission ward for elderly and one ward providing long-stay resident care to adult patients.	The purpose of this study was to examine the impact of a seclusion reduction programme over a long time frame, from 2004 until 2013.	Quantitative analysis of government data.	This study shows a significant reduction in number and duration of seclusion incidents over a long time frame. Organisational leadership and a tailored package of interventions to reduce seclusion were used as key elements. However, reducing the use of seclusion remains challenging and requires time, grounding in the organisation and continuous organisational and professional awareness.

Author	Year	Country	Sample	Aim	Method	Findings
Martin, A; et al	2008	United States	The inpatient service had a bed capacity of 15; during the five-year interval of the study, the unit had an average of 198 admissions per year, a bed occupancy of 92%, and a length of stay of 29 days.	To describe changes in use of restraint and seclusion in a child psychiatric inpatient setting after the implementation of the collaborative problem-solving (CPS) model of care.	Quantitative – service data seclusion and restraint incidents, service user demographics.	During this five-year period, and after the complete implementation of the CPS model by early 2006, there was a marked reduction in the use of restraints (from 263 to seven events per year, representing a 37.6-fold reduction, slope B =-.696) and seclusion (from 432 to 133 events per year, representing a 3.2-fold reduction, B =-.423). The mean duration of restraints decreased from 41±8 to 18±20 minutes per episode, yielding cumulative unitwide restraint use that dropped from 16±10 to .3±.5 hours per month (a 45.5-fold reduction, B =-.674). The mean duration of seclusion decreased from 27±5 to 21±5 minutes per episode, yielding cumulative unitwide seclusion use that dropped from 15±6 to 7±6 hours per month, a 2.2-fold reduction (p for trend <.01 or better for all slopes). Strong racial differences emerged. Black children were more than four times as likely to be restrained or secluded as their white peers; Hispanic children were 50% more likely than whites to be restrained or secluded, although the difference was statistically significant only for seclusion.
Maylea, C	2017	Australia	N/A (Case study)	This paper considers a case study of the powers given to social workers by the Victorian *Mental Health Act 2014*	Case study – qualitative in nature, doctrinal legal analysis.	This paper outlines the coercive powers available to social workers under the *Mental Health Act 2014* (Vic), arguing that using these powers may be less restrictive than not using them. The use of coercion is problematic in social work practice, but the exercise of these powers by social workers, rather than by police or paramedics, has the potential to be a less coercive approach. The author argues that if social workers are uncomfortable with exercising these powers themselves, this might raise the question of whether they should be exercised at all.
Meijer, E; Schout, G; de Jong, G; Abma, T	2017	Netherlands	41 family group conferences were studied in three regions.	This study examined the impact of family group conferences on coercive treatment in adult psychiatry.	Mixed methods – survey and observational data, used to evaluate outcomes of family group conferences.	Family group conferences seems a promising intervention to reduce coercion in psychiatry. It helps to regain ownership and restores belongingness. If mental health professionals take a more active role in the pursuit of family group conferences and reinforce the plans with their expertise, they can strengthen the impact even further.

Author	Year	Country	Sample / Setting	Aim	Method	Findings
Mezzina, R; Vidoni, D	1995	Italy	39 new patients with 'acute and severe crises' in a 4-year follow-up study at the community mental health center in Trieste (CMHC).	To assess the impact of the Trieste model of mental health service delivery; particularly 'multi-disciplinary interventions employing a wide range of responses to the existential and social needs arising during a crisis'.	Mixed methods – service data analysis.	According to the authors, the evaluation indicates: '1) a generally good outcome of the initial crisis; 2) a low relapse rate; 3) a tendency towards favourable long-term outcomes'. Further: 'In terms of practice, voluntary and compulsory hospitalization were avoided in favor of short-term day and night support in the CMHC. There were no suicides, no crimes, no drop-outs. Social adjustment remained unchanged. The study demonstrates that the mental health services in Trieste are able to cope with acute crises without psychiatric hospitalization.'
Minas, H; Diatri, H	2008	Indonesia	Cross-sectional observational research in a natural setting, carried out during a six-month period of working as the only psychiatrist in a remote district	To investigate the nature of 'Pasung' – restraint and confinement by families – the clinical characteristics of people restrained, and the reasons given by families and communities for applying such restraint.	Qualitative analysis of observational data	Physical restraint and confinement ('pasung') by families of people with mental illness is known to occur in many parts of the world but has attracted limited investigation. This preliminary observational study was carried out on Samosir Island in Sumatra, Indonesia. The provision of basic community mental health services, where there were none before, enabled the majority of the people who had been restrained to receive psychiatric treatment and to be released from 'pasung'.
Morrison, AP; et al	2014	United Kingdom (country not specified)	74 individuals were randomly assigned to receive either cognitive therapy plus treatment as usual (n=37), or treatment as usual alone (n=37).	To examine the feasibility and effectiveness of using cognitive behavioural therapy (CBT) in people with schizophrenia who are not taking medication.	Quantitative - a single-blind randomised controlled trial at two UK centres between Feb 15, 2010, and May 30, 2013.	Mean PANSS total scores were consistently lower in the cognitive therapy group than in the treatment as usual group, with an estimated between-group effect size of -6.52 (95% CI -10.79 to -2.25; p=0.003). Cognitive therapy significantly reduced psychiatric symptoms and seems to be a safe and acceptable alternative for people with schizophrenia spectrum disorders who have chosen not to take antipsychotic drugs. Evidence-based treatments should be available to these individuals. A larger, definitive trial is needed.

Authors	Year	Country	Sample	Aim	Method	Findings
Noorthoorn, EO; Voskes, Y; Janssen, WA; Mulder, CL; van de Sande, R; Nijman, HLI; Smit, A; Hoogendoorn, AW; Bousardt, A; Widdershoven, GAM	2016	Netherlands	Data (2008 to 2013) were from a national register	In 2006, a goal of reducing seclusion in Dutch hospitals by at least 10% each year was set. More than 100 reduction projects in 55 hospitals have been conducted, with €35 million in funding. This study evaluated the results.	Quantitative analysis of government data	Hospital participation in the register ranged from eight in 2008 to 66 in 2013, and admissions ranged from 11,300 to 113,290. The average yearly nationwide reduction of secluded patients was about 9%. Reduction was achieved in half of the hospitals. Some hospitals saw increased rates. In some hospitals where seclusion decreased, use of forced medication increased. Higher seclusion rates were associated with psychotic and bipolar disorders, male gender, and several ward types. Seclusion decreased significantly, and forced medication increased. Rates varied widely between hospitals. For many hospitals, more efforts to reduce seclusion are needed.
Norredam, M; Garcia-Lopez, A; Keiding, N; Krasnik, A	2010	Denmark	Sample of 6476 individuals with psychiatric in-patient contact from a total cohort of 312, 300 persons	To investigate differences in risk of compulsory admission and other coercive measures in psychiatric emergencies among refugees and immigrants compared with that among native Danes.	Quantitative analysis of government data	Coercive measures in psychiatry are more likely to be experienced by migrants than by native Danes.
Norvoll, R; Hem, MH; Pedersen, R	2017	Norway	Seven semi-structured telephone interviews with key informants in charge of 'central development projects and quality-assurance work in mental health services in Norway'.	This article aims to increase understanding of how ethics can contribute to reducing coercive practices and improving their quality through a qualitative study of key informants from development projects and facilities in Norway that use little coercion.	Qualitative analysis of semi-structured telephone interviews	This study indicates that ethics can contribute significantly to development projects and quality assurance about coercion by offering more systematic ways of dealing with moral concerns. The interrelatedness of organisational environments, professional aspects and moral issues underlines the need for integrated and process oriented ethics. Further studies are needed to investigate how systematic use of various kinds of clinical ethics support could contribute to development work on coercion.

Author	Year	Country	Sample	Aim	Method	Findings
Olsson, H; Schön, U-K	2016	Sweden	13 'key care workers' at a maximum-security forensic psychiatric hospital.	To determine what resources forensic staff use to avoid or prevent violent situations, and to explore how these practices resemble the domains of recovery-oriented care.	Qualitative analysis of in-depth interview texts with thematic analysis.	Staff prevent violent situations using tacit knowledge and experience, and through a shared collegial responsibility. Staff safeguard patients, encourage patient participation, and provide staff consistency. The results have implications for forensic care as well as psychiatry regarding the process of making recovery a reality for patients in the forensic care setting.
Osborn, D; Lloyd-Evans, B; Johnson, S; Gilburt, H; Byford, S; Leese, M; Slade, M	2010	England	Experience of 314 patients in four residential alternatives and four standard services were compared.	To compare patient satisfaction, ward atmosphere and perceived coercion in the two types of service, using validated measures.	Quantitative analysis of data collected using: the Client Satisfaction Questionnaire, the Service Satisfaction Scale - Residential form, etc.	'Alternatives to traditional in-patient services' appear to be associated with a better experience of admission. Community alternatives were associated with greater service user satisfaction and less negative experiences. Some but not all of these differences were explained by differences in the two populations, particularly in involuntary admission.
Ostrow, L	2010	United States	N/A	To present a case study of Groundhogs' (a group of consumers in Massachusetts) organising strategies, intended to inform consumer groups in other states and counties that are interested in peer-run crisis respites (PRCRs).	Case study – qualitative in nature.	This brief reports the organising strategies of the Massachusetts group, Groundhogs, that has organised for peer-run crisis respites (PRCR). The analysis and options imparted here can be useful for consumers in other states and counties embarking on a similar mission. The authors write: 'If we are to be successful as a movement in bringing about recovery-oriented, consumer-driven systems, we need to be effective organizers of policy change and service innovation. The experience of Groundhogs in Massachusetts is informative for models of community and consumer organizing.' [Not peer reviewed]

Author	Year	Country	Sample	Aim	Method	Findings
Papageorgiou, A; King, M; Janmohamed, A; Davidson, O; Dawson, J	2002	England	156 in-patients about to be discharged from compulsory treatment under the *Mental Health Act* participated.	To evaluate whether use of advance directives by patients with mental illness leads to lower rates of compulsory readmission to hospital.	Quantitative analysis of in-patients' usual psychiatric care with usual care plus the completion of an advance directive.	Fifteen patients (19%) in the intervention group and 16 (21%) in the control group were readmitted compulsorily within 1 year of discharge. There was no difference in the numbers of compulsory readmissions, numbers of patients readmitted voluntarily, days spent in hospital or satisfaction with psychiatric services. There was no difference in the numbers of compulsory readmissions, numbers of patients readmitted voluntarily, days spent in hospital or satisfaction with psychiatric services. Users' advance instruction directives had little observable impact on the outcome of care at 12 months.
Paterson, B; Bennet, L; Bradley, P	2014	Netherlands	Random sample of 252 from the 2,682 patients consecutively coming into contact with two psychiatric emergency teams in Amsterdam.	Aim is to study the links between opinions about prior psychiatric treatment, insight, service engagement and the risk of (new) civil detentions.	Quantitative analysis of patient socio-demographic and clinical characteristics, and information about prior involuntary admissions.	More satisfaction with prior treatment seems to reduce the risk of civil detention remarkably. Low levels of satisfaction seem to be mainly dependent on a history of previous involuntary admission. These findings seem to open up a new perspective for diminishing the risk of (new) civil detention by trying to enhance satisfaction with treatment, especially for patients under detention.
Poulsen, HD	2002	Denmark	472 admissions to all psychiatric wards at one hospital were selected randomly by selecting every fifth admission.	To investigate the prevalence of 'extra-legal deprivation of liberty' – restrictions in leaving a psychiatric ward other than a formal involuntary commitment of detention – in a hospital population.	Quantitative – survey of large sample of psychiatric admission data (staff must record imposition of restricted leave).	Extra-legal deprivation of liberty seems to be a common phenomenon at the psychiatric ward also among patients admitted voluntarily. Reasons for using this type of coercion are probably complex, but it seems to be most common among severely ill patients.

Authors	Year	Country	Sample/Setting	Objective	Method	Findings
Putkonen, A; Kuivalainen, S; Louheranta, O; Repo-Tiihonen, E; Ryynänen, O-P; Kautiainen, H; Tiihonen, J	2013	Finland	13 wards of a secured national psychiatric hospital in Finland.	To study whether seclusion and restraint could be prevented in the psychiatric care of persons with schizophrenia without an increase of violence.	Quantitative – randomised controlled trial, comparing monthly incidence rate ratios (IRRs) of coercion and violence.	The proportion of patient-days with seclusion, restraint, or room observation declined from 30% to 15% for intervention wards (IRR=.88, 95% confidence interval [CI]=.86-.90, p<.001) versus from 25% to 19% for control wards (IRR=.97, CI=.93-1.01, p=.056). Seclusion-restraint time decreased from 110 to 56 hours per 100 patient-days for intervention wards (IRR=.85, CI=.78-.92, p<.001) but increased from 133 to 150 hours for control wards (IRR=1.09, CI=.94-1.25, p=.24). Seclusion and restraint were prevented without an increase of violence in wards for men with schizophrenia and violent behaviour. A similar reduction may also be feasible under less extreme circumstances.
Puteh, I; Marthoenis, M; Minas, H	2011	Indonesia	59 'former ex-pasung patients were examined'. The majority (88.1%) were men, aged 18 to 68 years.	To report the findings of a preliminary investigation of the demographic and clinical characteristics of patients who have been admitted to the Banda Aceh Mental Hospital as part of the *Aceh Free Pasung* program.	Qualitative – cross-sectional descriptive study conducted at the Banda Aceh Mental Hospital.	Physical restraint and confinement of the mentally ill (called '*pasung*' in Indonesia) is common in Aceh. The authors report that 'development of a community mental health system and the introduction of a health insurance system in Aceh (together with the national health insurance scheme for the poor) has enabled access to free hospital treatment for people with severe mental disorders, including those who have been in *pasung*.' Further, 'The demographic and clinical characteristics of this group of ex-pasung patients are broadly similar to those reported in previous studies. The *Aceh Free Pasung* programme is an important mental health and human rights initiative that can serve to inform similar efforts in other parts of Indonesia and other low and middle-income countries where restraint and confinement of the mentally ill is receiving insufficient attention'.
Raveesh, BN; Pathare, S; Noorthoorn, EO; Gowda, GS; Lepping, P; Bunders-Aelen, JGF	2016	India	A total of 210 psychiatrists and 210 caregivers participated in the study.	The objective of this study was to assess attitudes of Indian psychiatrists and caregivers toward coercion.	Quantitative analysis of a 15-item questionnaire	Caregivers and psychiatrists felt that the lack of resources is one of the reasons for coercion. Furthermore, they felt that the need on early identification of aggressive behaviour, interventions to reduce aggressiveness, empowering patients, improving hospital resources, staff training in verbal de-escalation techniques is essential. There is an urgent need in the standardised operating procedure in the use of coercive measures in Indian mental health settings.

Riahi, S; et al	2016	Canada	326-bed, tertiary level, specialised mental health care facility in Ontario, Canada.	To evaluate the Six Core Strategies for Restraint Minimisation at a recovery-oriented, tertiary level mental health care facility and its effect on mechanical restraint and seclusion incidents.	Quantitative – service data, retrospective review examines restraint practices.	Strategies were implemented in a staged manner across 3 years. The total number of mechanical restraint and seclusion incidents decreased by 19.7% from 2011/12 to 2013/14. Concurrently, the average length of a mechanical restraint or seclusion incident decreased 38.9% over the 36-month evaluation period. Implementation of the Six Core Strategies for Restraint Minimisation effectively decreased the number and length of mechanical restraint and seclusion incidents in a specialised mental health care facility.
Robertson, JP; Collinson, C	2011	England	Two groups of staff working in local community outreach teams in adult mental health and learning disability services in a midlands city.	To undertake an exploration into outreach workers' experiences of assisting clients with positive risk-taking (PRT), including dimensions of risk staff face, and factors influencing their risk approaches.	Qualitative analysis of interview transcripts.	The study highlighted different understandings of positive risk-taking PRT at different levels within organisations and a need for better informed, coherent organisational approaches to its practice. Interpersonal trust relies upon such organisational coherence; without it some staff may see themselves as gambling when undertaking PRT, whereas others may retreat into conservative interventions. Such conservative practices were perceived as potentially dangerous, promoting coercion and disrupting therapeutic relationships, and so increasing risks over a longer time period. Research is needed into the use of systems failure analysis and risk assessment tools to highlight how PRT can generate successful outcomes.
Rosen, J; O'connell, M	2013	United States	14 adults admitted to a mental health respite program.	To examine clients who were admitted to a mental health respite programme in the first 3 months of 2011 in order to identify the ability of the programme to reduce symptom distress and to explore related psychosocial factors.	Quantitative analysis of entry and exit questionnaires.	Measures of symptom distress, mental health confidence, and self-esteem all improved significantly over time spent in the respite program. However, the immediate impact of the respite programme on external indicators of functioning were not observed. A common definition for purpose and implementation of respite is lacking, and a better understanding of these details could improve current programmes as well as define a structure for newly created ones.

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Author	Year	Country	Sample	Purpose	Method	Findings
Russo, J; Rose, D	2013	Europe	Study involved one focus group in each of 15 European countries and extended to a total of 116 participants.	The purpose of this paper is to discuss human rights assessment and monitoring in psychiatric institutions from the perspectives of those whose rights are at stake.	Qualitative analysis of focus group data.	Paper highlights human rights issues which are not readily visible and therefore less likely to be captured in institutional monitoring visits. Key issues include the lack of interaction and general humanity of staff, receipt of unhelpful treatment, widespread reliance on psychotropic drugs as the sole treatment and the overall impact of psychiatric experience on a person's biography.
Salomon, C Hamilton, B; Elsom, S	2014	Australia	98 Australian consumers involved with participating organisations completed an anonymous survey detailing past antipsychotic discontinuation attempts.	To gain an understanding of consumer experiences of antipsychotic discontinuation. This study was designed to increase understanding of antipsychotic discontinuation from consumer perspectives.	Quantitative – survey.	Of the 88 participants who reported at least one discontinuation attempt, over half (n = 47, 54.7%) reported stopping without clinician knowledge or support. This group was 35% (confidence interval 15.4–54.6%) more likely to stop abruptly than those (n = 41, 45.3%) stopping with clinician support (P = 0.002). Only 10 participants (23.3%) recalled being given information about discontinuation symptoms other than relapse; however, 68 participants (78.2%) reported experiencing a range of discontinuation symptoms including physical, cognitive, emotional, psychotic or sleep-related disturbances. Findings cannot be readily generalised because of sampling constraints. However, the significant number of participants who reported discontinuation symptoms, in addition to psychosis, is consistent with previous research. This study provides new insight into consumer motivations for discontinuation and possible problems in clinical communication that may contribute to frequent non-collaborative discontinuation attempts. Mental health nurses, who play a pivotal role in medication communication events, may benefit from increased awareness of consumer perspectives on this topic.

Author	Year	Country	Sample	Aim	Methodology	Findings
Schneeberger, AR; Kowalinski, E; Fröhlich, D; Schröder, K; von Felten, S; Zinkler, M; Beine, KH; Heinz, Andreas; Borgwardt, S; Lang, UE; Bux, DA; Huber, CG	2017	Germany	Seclusion or restraint data in 21 German hospitals.	To examine the effects of open vs. locked door policies on aggressive incidents which remain unclear.	Quantitative analysis of hospital data. Naturalistic observational design and analysis of the occurrence of aggressive behaviour.	Restraint or seclusion during treatment was less likely in hospitals with an open door policy. On open wards, any aggressive behavior and restraint or seclusion were less likely, whereas bodily harm was more likely than on closed wards. Hospitals with open door policies did not differ from hospitals with locked wards regarding different forms of aggression. Other restrictive interventions used to control aggression were significantly reduced in open settings. Open wards seem to have a positive effect on reducing aggression. Future research should focus on mental health care policies targeted at empowering treatment approaches, respecting the patient's autonomy and promoting reductions of institutional coercion.
Schout, G; van Dijk, M; Meijer, E; Landeweer, E; de Jong, G	2017	Netherlands	Two case examples of families/social networks.	To address the question what Family Group Conferencing (FCG) adds to the existing methods to reduce coercion in mental health care and promote inclusion.	Qualitative analysis of evaluation study data	Research indicates that there are grounds for a wider application of FGC in mental health, even outside the framework of coercive care. Study observed that clients and/or their social network were not always able to participate in a conference, let alone to bring in enough self-direction; so that during the private time a plan could be established.

Author	Year	Country	Sample	Aim	Method	Findings
Schout, G; et al	2017	Netherlands	17 families/ social networks engaged in family group conferencing.	To identify barriers to applying Family Group Conferences. 'An answer to this question provides insights regarding situations in which Family Group Conferences may (not) be useful'.	Qualitative – 17 case studies	The following barriers emerged: '(1) the acute danger in coercion situations, the limited time available, the fear of liability and the culture of control and risk aversion in mental health care; (2) the severity of the mental state of clients leading to difficulties in decision-making and communication; (3) considering a Family Group Conference and involving familial networks as an added value in crisis situation is not part of the thinking and acting of professionals in mental health care; (4) clients and their network (who) are not open to an Family Group Conference.' Awareness of the barriers for Family Group Conferences can 'help to keep an open mind for its capacity to strengthen the partnership between clients, familial networks and professionals' and 'can help to effectuate professional and ethical values of social workers in their quest for the least coercive care'.
Seikkula, J	2003	Finland	Data from 69 service users, of whom 45 who were given Open Dialogue support were compared with 14 service users in typical acute services.	To evaluate the Open Dialogue (OD) approach that aims to treat psychotic patients in their home.	Quantitative analysis of government patient data	As part of the Need-Adapted Finnish model, the Open Dialogue (OD) approach aims to treat psychotic patients in their home. Treatment involves the patient's social network, starts within 24 hours of initial contact, and responsibility for the entire treatment rests with the same team in inpatient and outpatient settings. Patients in the Open Dialogue in Acute Psychosis (ODAP) group had fewer relapses and less residual psychotic symptoms and their employment status was better than patients in the comparison group. The OD approach, like other family therapy programmes, seems to produce better outcomes than conventional treatment. OD emphasises using fewer neuroleptic medication.

Author	Year	Country	Sample / Data	Aim	Method	Findings
Shields, LS; et al	2013	India	N =51. Clients (n =39) and carers (n =12) seeking mental health treatment at outpatient clinics in urban and rural settings.	To explore the feasibility and utility of psychiatric advance directives (PADs) in India, with a focus on the need for individual control over decision making and barriers to implementation, by exploring views of its central stakeholders, service users and carers.	Qualitative – interviews with thematic analysis.	Clients engaged in a number of forms of decision-making (passive, active, and collaborative) depending on the situation and decision at hand, and had high levels of self-efficacy. Most clients and carers were unfamiliar with PADs, and while some clients felt it is important to have a say in treatment wishes, carers expressed concerns about service user capacity to make decisions. After completing PADs, clients reported an increase in self-efficacy and an increased desire to make decisions. The authors conclude that 'PADs could potentially mitigate the risks of coercive treatments to persons with severe mental illness.'
Siponen, U; Välimäki, M; Kaivosoja, M; Marttunen, M; Kaltiala-Heino, R	2011	Finland	Data for all adolescents aged 13–17 from two Finnish districts between years 1996–2003.	The aim of the study was to explore features associated with compulsory intervention of adolescents at the regional level by comparing two hospital districts clearly differing in this regard.	Quantitative analysis of government hospital discharge data.	Factors other than the characteristics of the adolescents themselves – such as 'divorces, single parent families, social exclusion' – are associated with use of compulsory care, although an ecological study design cannot establish causality.
Slade, M; et al	2010	England	Admission cost data were collected for six alternative services and six standard services.	To explore short-term outcomes and costs of admission to alternative and standard services, and address the gap in research on outcomes following admission to residential alternatives to standard in-patient mental health services which are underresearched.	Quantitative - Health of the Nation Outcome Scales (HoNOS), Threshold Assessment Grid (TAG), Global Assessment of Functioning (GAF).	All outcomes improved during admission for both types of service (n = 433). Adjusted improvement was greater for standard services in scores on HoNOS (difference 1.99, 95% CI 1.12–2.86), TAG (difference 1.40, 95% CI 0.39–2.51) and GAF functioning (difference 4.15, 95% CI 1.08–7.22) but not GAF symptoms. Admissions to alternatives were 20.6 days shorter, and hence cheaper (UK£3832 v. £9850). Standard services cost an additional £2939 per unit HoNOS improvement. The absence of clear-cut advantage for either type of service highlights the importance of the subjective experience and longer-term costs.

Author	Year	Country	Sample	Aim	Method	Findings
Sledge, WH; Tebes, J; Rakfeldt, J; Davidson, L; et al	1996	United States	197 patients were enrolled in the 2-year research programme and followed for 10 months.	To investigate the clinical feasibility and the outcome for patients of a programme designed as an alternative to acute hospitalisation.	Quantitative analysis of random-design study data.	The clinical, functional, social adjustment, quality of life, and satisfaction outcome measures were not statistically different for the patients in the two treatment conditions; however, there was a slightly more positive effect of the experimental programme on measures of symptoms, overall functioning, and social functioning. The experimental condition, a combined day hospital/crisis respite community residence, seems to have had the same treatment effectiveness as acute hospital care for urban, poor, acutely ill voluntary patients with severe mental illness.
Sledge, WH; Tebes, J; Wolff, N; Helminiak, TW	1996	United States	197 patients were enrolled in the 2-year research programme and followed for 10 months.	To compare service use and costs for acutely ill psychiatric patients treated in a day hospital/crisis respite programme or in a hospital inpatient program.	Quantitative analysis of data collected for developing service use profiles and estimates of per-unit costs.	On average, the day hospital/crisis respite programme cost less than inpatient hospitalisation. The average saving per patient was +7,100, or roughly 20% of the total direct costs. There were no significant differences between programmes in service utilisation or costs during the follow-up phase. The programmes were equally effective, but day hospital/crisis respite treatment was less expensive for some patients. Potential cost savings are higher for nonpsychotic patients. Cost differences between the programmes are driven by the hospital's relatively higher overhead costs. The roughly equal expenditures for direct service staff costs in the two programmes may be an important clue for understanding why these programmes provided equally effective acute care.
Smith, G; et al	2005	United States	Records of patients older than 18 years who were civilly committed to one of the nine state hospitals in Pennsylvania were included in the analyses.	To examine the use of seclusion and mechanical restraint from 1990 to 2000 and the rate of staff injuries from patient assaults from 1998 to 2000 in a state hospital system, during a period of intervention to reduce rates.	Quantitative analysis of data collected pre/post intervention.	The rate and duration of seclusion and mechanical restraint decreased dramatically during this period; from 4.2 to 0.3 episodes per 1,000 patient-days. The average duration of seclusion decreased from 10.8 to 1.3 hours. The rate of restraint decreased from 3.5 to 1.2 episodes per 1,000 patient-days. The average duration of restraint decreased from 11.9 to 1.9 hours. Patients from racial or ethnic minority groups had a higher rate and longer duration of seclusion than whites. Many factors contributed to the success of this effort, including advocacy efforts, state policy change, improved patient-staff ratios, response teams, and second-generation antipsychotics.

Author	Year	Country	Sample	Study description	Method	Findings
Suryani, L; et al	2011	Indonesia	404,591 people clinically interviewed, of which 895 persons with mental health conditions were identified. 23 experienced physical restraint/ confinement.	This study identified, mapped and treated the clinical features of mentally ill people, who had been isolated and restrained by family and community members as a result of a functional failure of the traditional medical, hospital-based mental health model currently practiced in Indonesia.	Quantitative – 10-month epidemiological population survey carried out in Karangasem regency of Bali, Indonesia.	Duration of restraint ranged from 3 months to 30 years (mean = 8.1 years, SD = 8.3 years). According to the authors, 'Through the application of a holistic intervention model, all patients exhibited a remarkable recovery within 19 months of treatment.' They conclude that 'the development of a community-based, culturally sensitive and respectful mental health model can serve as an optimum promoter of positive mental health outcomes'.
Swanson, J; Swartz, M; Elbogen, E; Richard Van Dorn; Wagner, R; Moser LA; Wilder C; Gilbert AR	2008	United States	A total of 239 patients were assigned to be offered 'facilitated' advance planning; about 60% completed planning.	This study examined whether completion of a Facilitated Psychiatric Advance Directive (F-PAD) was associated with reduced frequency of coercive crisis interventions.	Quantitative analysis of randomised controlled trial data.	F-PAD completion was associated with lower odds of coercive interventions (adjusted OR = 0.50; 95% CI = 0.26-0.96; p < 0.05). PADs may be an effective tool for reducing coercive interventions around incapacitating mental health crises. Less coercion should lead to greater autonomy and self-determination for people with severe mental illness.

Author	Year	Country	Sample	Aim	Method	Findings
Swartz, MS; Swanson, JW; Hannon, MJ	2003	United States	Surveyed 85 mental health professionals, and 104 individuals with schizophrenia spectrum conditions.	To examine what extent do experiences with different forms of coercion and pressures to adhere to treatment create barriers that may inhibit future help seeking for mental health problems.	Quantitative analysis of survey data.	Of the clinicians, 78% reported that overall they thought legal pressures made their patients with schizophrenia more likely to stay in treatment. Regarding involuntary outpatient commitment, 81% of clinicians disagreed with the premise that mandated community treatment deters persons with schizophrenia from seeking voluntary treatment in the future. Of the consumer sample, 63% reported a lifetime history of involuntary hospitalisation, while 36% reported fear of coerced treatment as a barrier to seeking help for a mental health problem-termed here 'mandated treatment-related barriers to care.' In multivariable analyses, only involuntary hospitalisation and recent warnings about treatment nonadherence were found to be significantly associated with barriers that may inhibit future help seeking. These results suggest that mandated treatment may serve as a barrier to treatment, but that ongoing informal pressures to adhere to treatment may also be important barriers to treatment.
Tanenbaum, SJ	2012	United States	Survey of directors of 15 consumer-operated service organisations (service user led organisation) and follow up interview with 6 directors.	This study examines the operation of consumer-operated service organisations in one US state, and argues these organisations, which are new following 'deinstitutionalisation', are overlooked by proponents of bringing back largescale psychiatric hospitals.	Mixed methods – quantitative analysis of mail survey, with follow up quantitative telephone interviews.	Consumer-operated service organisations (COSOs) emerge as more self-governing and community-based than required by certification requirements and as developing internally and externally in tandem. COSOs are not only adjunct or alternative service providers, but also civic associations and loci for the expression of citizenship by mentally ill people. The authors argue that 'COSO membership consists of seriously mentally ill people (in various stages of recovery), and COSO services and linkages with other community groups provide the elements of hospital care that community-based clinical providers cannot: food, shelter, recreation, and socializa-tion.' Furthermore because COSOs are not content to replace the hospital but also participate in the recovery movement, they provide peer support and advocacy training and, perhaps most importantly, insist on self-governance and other forms of citizenship.

Author	Year	Country	Sample/Data	Aim	Method	Findings
Thomsen, CT; Benros, ME; Maltesen, T; Hastrup, LH; Andersen, PK; Giacco, D; Nordentoft, M	2018	Denmark	Clinical data obtained from recipients of patient-controlled admission in all the five regions in Denmark where patient-controlled admission is available.	To assess whether implementing patient-controlled admission (PCA) can reduce coercion and improve other clinical outcomes for psychiatric in-patients.	Quantitative analysis of patient-controlled admission data.	Implementing patient-controlled admission (PCA) did not reduce coercion, service use or self-harm behaviour when compared with treatment as usual (TAU). In a paired design, the outcomes of PCA patients during the year after signing a contract were compared with the year before. The PCA group had more in-patient bed days (mean difference = 28.4; 95% CI: 21.3; 35.5) and more medication use (P < 0.0001) than the TAU group. Before and after analyses showed reduction in coercion (P = 0.0001) and in-patient bed days (P = 0.0003). Beneficial effects of PCA were observed only in the before and after PCA comparisons. Further research should investigate whether PCA affects other outcomes to better establish its clinical value.
Thomsen, C; Starkopf, L; Hastrup, LH; Andersen, PK; Nordentoft, M; Benros, ME	2017	Denmark	Study population included all individuals aged 18–63 years with a psychiatric inpatient admission during January 1, 1999– December 31, 2014	To identify risk factors associated with coercive measures, to better identifying possible causes of (and hence remedies to) coercion.	Quantitative analysis of psychiatric inpatient admission data.	Clinical characteristics were the foremost predictors of coercion and patients with organic mental disorder had the highest increased risk of being subjected to a coercive measure (OR=5.56; 95% CI=5.04, 6.14). The risk of coercion was the highest in the first admission and decreased with the number of admissions (all p<0.001). The following socioeconomic variables were associated with an increased risk of coercion: male sex, unemployment, lower social class and immigrants from low and middle income countries (all p<0.001). Early retirement and social relations, such as being married and having children, reduced the risk of being subjected to coercive measure (all p<0.05). These findings can assist researchers in identifying patients at risk of coercion and thereby help targeting new coercion reduction programmes.

Author	Year	Country	Sample	Aim	Analysis	Findings
Thornicroft, G; et al	2013	England	569 participants were randomly assigned (285 to the intervention group and 284 to the control group)	To assess whether the additional use of Joint Crisis Plans improved patient outcomes compared with treatment as usual for people with severe mental illness.	Quantitative analysis of CRIMSON (Crisis Impact: Subjective and Objective coercion and eNgagement) randomised controlled trial data.	The findings are inconsistent with two earlier Joint Crisis Plans (JCP) studies, and show that the JCP is not significantly more effective than treatment as usual. There is evidence to suggest the JCPs were not fully implemented in all study sites, and were combined with routine clinical review meetings which did not actively incorporate patients' preferences. The study therefore raises important questions about implementing new interventions in routine clinical practice.
Valenti, E; et al	2015	International: Canada, Chile, Croatia, Germany, Italy, Mexico, Norway, Spain, Sweden, United Kingdom.	Focus groups with mental health professionals were conducted in ten countries.	This paper aims to identify the attitudes and experiences of mental health professionals towards the use of informal coercion across countries with differing sociocultural contexts.	Qualitative analysis of focus group interviews in ten countries with different sociocultural contexts.	A disapproval of informal coercion in theory is often overridden in practice. This dissonance occurs across different sociocultural contexts, tends to make professionals feel uneasy, and requires more debate and guidance.
van der Post, Louk FM; Peen, J; Visch, I; Mulder, CL; Beekman, ATF; Dekker, JJM	2014	Netherlands	Random sample of 252 from the 2,682 patients consecutively coming into contact with two psychiatric emergency teams in Amsterdam.	Aim is to study the links between opinions about prior psychiatric treatment, insight, service engagement and the risk of (new) civil detentions.	Quantitative analysis of socio-demographic and clinical characteristics and information about prior involuntary admissions.	More satisfaction with prior treatment seems to reduce the risk of civil detention remarkably. Low levels of satisfaction seem to be mainly dependent on a history of previous involuntary admission. These findings seem to open up a new perspective for diminishing the risk of (new) civil detention by trying to enhance satisfaction with treatment, especially for patients under detention.

Authors	Year	Country	Sample	Aim	Method	Findings
van der Schaaf, PS; Dusseldorp, E; Keuning, FM; Janssen, WA; Noorthoorn, EO	2013	Netherlands	Service data on 77 Dutch psychiatric hospitals and also a benchmark study on the use of coercive measures in 16 Dutch psychiatric hospitals.	To explore the effect of design features on the risk of being secluded, the number of seclusion incidents and the time in seclusion, for patients admitted to locked wards for intensive psychiatric care.	Quantitative analysis by combining data of building quality and safety with data on frequency and type of coercive measures.	A number of design features had an effect on the use of seclusion and restraint. The study highlighted the need for a greater focus on the impact of the physical environment on patients, as, along with other interventions, this can reduce the need for seclusion and restraint.
Vruwink, FJ; Mulder, CL; Noorthoorn, EO; Uitenbroek, D; Nijman, HLI	2012	Netherlands	Dutch hospitals that received a government grant program, which in 2006 (start of program) numbered 34 and by 2009 (end of program) numbered 42.	To establish whether the numbers of both seclusion and involuntary medication changed significantly after the start of this national programme designed to reduce seclusion in Dutch hospitals.	Quantitative analysis (using Poisson regression to estimate difference in logit slopes) of Dutch Health Care Inspectorate data for seclusion and involuntary medication.	After the start of the nationwide programme the number of seclusions fell, and although significantly changing, the reduction was modest and failed to meet the objective of a 10% annual decrease. The number of involuntary medications did not change; instead, after correction for the number of involuntary hospitalisations, it increased.

Author	Year	Country	Sample	Aim	Method	Findings
Wanchek, TN; Bonnie, RJ	2012	United States	500 Medicaid recipients who had a mental health diagnosis and at least one temporary detention order (TDO).	This study examined whether lengthening the holding period for an individual experiencing a mental health crisis under a temporary detention order (TDO) can reduce the number and length of post-TDO involuntary hospital commitments.	Quantitative analysis of data from Virginia Court System and Virginia Medicare claims database.	Longer TDO periods were correlated with an increased probability of a dismissal of the commitment petition rather than hospitalisation after a TDO. Among individuals who were hospitalised, longer TDO periods were correlated with an increased likelihood of voluntary hospitalisation, rather than involuntary commitment, and shorter hospitalisations, although the net care time (TDO period plus post-TDO hospitalisation) increased for individuals whose TDO length was greater than 24 hours.
Watson, S; Thorburn, K; Everett, M; Fisher, KR	2014	Australia	N/A	To apply three different frameworks currently used in mental health services (human rights, personal recovery, and trauma-informed) to the text of the *National Standards for Mental Health Services 2010* as well as the public text of speakers' notes regarding lived experience from the Care Without Coercion Conference 2010	Qualitative analysis of both a key national policy document as well as public text from speakers of a national conference.	The analysis sought to analyse the degree to which national policy documents reflect a shift signalled in the three frameworks. The authors identified the use of force in many aspects of policy. The authors suggest pathways to apply the frameworks in national policy, which they argue would bring about freedom from violence; support for decision making; access and choice about community and inpatient options; safety and risk management; and greater understanding of current policy frameworks through engagement with people with lived experience about the options and impact of support processes that exclude the use of force.

Author	Year	Country	Aim	Data source	Method	Findings
Wieman, D; et al	2014	United States	To examine implementation and outcomes of the Six Core Strategies for Reduction of Seclusion and Restraint (6CS) in 43 inpatient psychiatric facilities. Facilities were classified into five implementation types: stabilised (N=28), continued (N=7), decreased (N=5), discontinued (N=1), or never implemented (N=2).	Service data for 43 inpatient psychiatric facilities	Quantitative – a prototype Inventory of Seclusion and Restraint Reduction Interventions (ISRRI) 'tracked fidelity' over time.	Overall, the stabilised group reduced the percentage secluded by 17% (p=.002), seclusion hours by 19% (p=.001), and proportion restrained by 30% (p=.03). The reduction in restraint hours was 55% but nonsignificant (p=.08). Individual facility effect sizes varied; some rates increased for some facilities. The dose-effect hypothesis was supported for two outcomes, seclusion hours and percentage restrained. The order of implementation group effects in relation to each outcome varied unpredictably. The 6CS was feasible to implement and effective in diverse facility types. Fidelity over time was nonlinear and varied among facilities. Further research on relationships between facility characteristics, fidelity patterns, and outcomes is needed.
Winick, BJ	1996	United States	Article analyses how living wills and other advance directive instruments may be used in mental health contexts.	N/A	Qualitative analysis of law relevant to living wills and advance directives, particularly case law.	Advance directive instruments can be a useful means of planning for mental illness and of avoiding disputes concerning hospitalisation and treatment. The avoidance of hearings, either judicial or administrative, to resolve these controversies would produce considerable fiscal and administrative savings. It also could prevent diversion of scarce clinical resources from treatment to dispute resolution. In addition, it would avoid the patient dissatisfaction that results when patients lose such hearings and that sometimes produces a psychological reactance that undermines the chances for successful treatment.

Author	Year	Country	Sample	Aim	Method	Findings
Wisdom, JP; Wenger, D; Robertson, D; Van Bramer, J; Sederer, LI	2015	United States	Three participating mental health treatment centres that adopted the Six Core Strategies program.	To evaluate the Positive Alternatives to Restraint and Seclusion project of the New York State Office of Mental Health (OMH).	Quantitative – service data from state-operated and licensed inpatient and residential treatment programmes for 'children with severe emotional disturbances'.	The three participating mental health treatment facilities demonstrated significant decreases in restraint and seclusion episodes per 1,000 client-days. Each identified specific activities that contributed to success, including ways to facilitate open, respectful two-way communication between management and staff and between staff and youths and greater involvement of youths in programme decision making.
Zinkler, M	2016	Germany	Service data on a network of Bavarian hospitals	To review data on the use of coercion, against data on the use of coercive treatment in a group of Bavarian hospitals since 2014. Additionally, detailed data from one institution with an uncommon approach to violence and coercion is presented.	Quantitative data analysis of use of coercion in network of psychiatric hospitals	In a 15-month period starting in 2014, Germany's Constitutional Court and Federal Supreme Court restricted involuntary treatment 'in all but life-threatening emergencies' in response to the CRPD. National and local data suggests that giving up coercive medication is not straightforward and problems arise when one form of coercive treatment (coercive medication) is stopped but other forms of coercion (restraint) and violence in psychiatric institutions increase. The author writes that '[d]ata from a … local mental health service suggest that the use of coercive medication could be made obsolete.'

Appendix Two – Reviews and Other Notable Materials

AUTHOR	YEAR	TITLE	SUMMARY
Bak, J; Brandt-Christensen, M; Sestoft, DM; Zoffmann, V	2012	Mechanical restraint--which interventions prevent episodes of mechanical restraint? - a systematic review	This review identifies interventions preventing mechanical restraints, encompassing international research papers dealing with mechanical restraint. The review combines qualitative and quantitative research in a new way, describing the quality of evidence and the effect of intervention. The authors suggest 'cognitive milieu therapy', 'combined interventions', and 'patient-centered care' were the three interventions most likely to reduce the number of mechanical restraints, yet rue the lack of high-quality and effective intervention studies.
Bola, JR; Lehtinen, K; Cullberg, J; Ciompi, L	2009	Psychosocial treatment, antipsychotic postponement, and low-dose medication strategies in first-episode psychosis: a review of the literature	This review investigates the effects of acute psychosocial treatments using medication postponement protocols for early episode schizophrenia. Five studies were included in the review (n=261 patients); one was a randomised controlled trial (RCT), three were quasi-experimental studies and one was a case-control study. Follow-up ranged from two to five years (where reported). Twen27% to 43% of psycho-socially treated patients were not receiving antipsychotics at two or three-year follow-up.: Initial psychosocial treatment combined with time-limited postponement of antipsychotic medications may facilitate a reduction in long-term medication dependence and the discrimination of similar (but 'pathophysiologically different') diagnostic entities for patients with first-episode psychosis.
Bowers, L	2014	Safewards: a new model of conflict and containment on psychiatric wards	In England, the Safewards model has been developed which identifies aspects of working in psychiatric wards that are known to create potential 'flashpoints'. The model involves ten interventions aimed at helping staff manage those flashpoints to reduce conflict.
Burns, T; et al	2001	Home treatment for mental health problems: a systematic review	This review investigates the effectiveness of 'home treatment' for mental health problems in terms of hospitalisation and cost-effectiveness. The authors find that the evidence base for home treatment compared with other community-based services is not strong, although it does show that home treatment reduces days spent in hospital compared with inpatient treatment.
Buus, N; et al	2017	Adapting and Implementing Open Dialogue in the Scandinavian Countries: A Scoping Review	This scoping review 1) identified the range and nature of literature on the adoption of Open Dialogue in Scandinavia in places other than the original sites in Finland (33 publications), and 2) summarises this literature. Most studies in this scoping review were published as 'grey' literature and most grappled with how to implement Open Dialogue faithfully. In the Scandinavian research context, Open Dialogue was mainly described as a promising and favourable approach to mental health care.

Author	Year	Title	Summary
Calton, T; Ferriter, M; Huband, N; Spandler, H	2008	A Systematic Review of the Soteria Paradigm for the Treatment of People Diagnosed With Schizophrenia	Summarises the findings from all controlled trials that have assessed the efficacy of the Soteria paradigm for the treatment of people diagnosed with schizophrenia spectrum disorders. The studies included in this review suggest that the Soteria paradigm yields equal, and in certain specific areas, better results in the treatment of people diagnosed with first- or second-episode schizophrenia spectrum disorders (achieving this with considerably lower use of medication) when compared with conventional, medication-based approaches. Further research is urgently required to evaluate this approach more rigorously because it may offer an alternative treatment for people diagnosed with schizophrenia spectrum disorders.
Champagne, T; Sayer, E	2004	The Effects of the Use of the Sensory Room in Psychiatry	This is not a peer reviewed article. According to the authors, 47 service users ranging in age from 17 to 93 years participated in this study in a single 24 bed locked psychiatric unit. The aim was to evaluate the results of the use of multi-sensory rooms, modeled after existing sources. Surveys of clients and case report data was analysed. The researchers report that 'this client-centered quality improvement study' indicated that the use of the 'multi-sensory room' on an in-patient psychiatric unit, with adolescent and adult clients, had 'positive effects' on 98% of those who participated. The researchers conclude that the 'appropriate use of the multi-sensory environment provides experiential and alternative opportunities for de-escalation empowerment, choice, increasing awareness, and skill development'. [Not peer reviewed][1]
Champagne, T; Stromberg, N	2004	Sensory Approaches in Inpatient Psychiatric Settings: Innovative Alternatives to Seclusion & Restraint	This article explores the 'importance and efficacy of trauma-informed approaches that are sensory supportive, address the individual needs of the person, and strengthen the therapeutic relationship'. It discusses a United States-wide initiative to decrease the use of seclusion and restraint in psychiatric inpatient settings, which they argue requires innovative methods to facilitate the processes of consumer self-organisation, self-care, and positive change. The authors argue that sensory-based approaches and multisensory rooms are valuable resources as cultures of care shift to become more responsive and collaborative.
Danzer, G; Rieger, S	2016	Improving medication adherence for severely mentally ill adults by decreasing coercion and increasing cooperation	This literature review suggests best practice strategies for 'helping involuntary mentally ill patients grow into voluntary consumers of medication'. 'Best practice' strategies included decreasing usage of coercive tactics, helping patients cope with medication side effects, and emphasising the necessity of family involvement. The authors conclude with a review of the limitations of arguing for involuntary hospitalisation and treatment as restoring patient autonomy, along with implications for future practice focusing on increasing the medication adherence of severely mentally ill populations.
Department of Mental Health, Agency of Human Services Vermont	2018	2018 Reforming Vermont's Mental Health System Report to the Legislature on the Implementation of Act 79	Under Vermont law, the Department of Mental Health must report annually on or before January 15 to the state's Senate Committee on Health and Welfare and the House Committee on Human Services regarding the extent to which individuals with a mental health condition or psychiatric disability receive care in the most integrated and least restrictive setting available.

Author	Year	Title	Description
Doughty, C; Tse, S	2011	Can Consumer-Led Mental Health Services Be Equally Effective? An Integrative Review of CLMH Services in High-Income Countries	This study examined the evidence from controlled studies for the effectiveness of consumer-led mental health services. Following an extensive search of material published in English from 1980, predefined inclusion criteria were systematically applied to research articles that compared a consumer-led mental health service to a traditional mental health service. A total of 29 eligible studies were appraised; all of them were conducted in high-income countries. Overall consumer-led services reported equally positive outcomes for their clients as traditional services, particularly for practical outcomes such as employment or living arrangements, and in reducing hospitalisations and thus the cost of services. Despite growing evidence of effectiveness, barriers such as underfunding continue to limit the use and evaluation of consumer-led services.
Evans, E; et al	2012	Service Development for Intellectual Disability Mental Health: A Human Rights Approach	People with intellectual disability (ID) experience higher rates of major mental disorders than their non-ID peers, but in many countries have difficulty accessing appropriate mental health services. This paper reviews the current state of mental health services for people with ID using Australia as a case example, and critically appraises whether such services currently meet the standards set by the *Convention on the Rights of Persons with Disabilities*. The review highlighted a number of issues to be addressed to meet the mental health needs of people with ID to ensure that their human rights are upheld like those of all other citizens.
Ford, S; et al	2015	The experience of compulsory treatment: the implications for recovery-orientated practice?	This paper provides a literature review exploring patients' experiences of compulsory detention, and is presented here alongside a lived-experience commentary. This leads into a discussion of the implications for practice. There are three key themes identified: people's views on the justification of their compulsory detention; the power imbalance between patients and staff; and the lack of information or choice. The lived-experience commentary adds weight to these findings by citing personal examples and making suggestions for improving services. The discussion centres on the potential of co-production between people who access services, their supporters, and professionals to improve treatment for people who may need compulsory detention. The paper also raises questions on whether current legislation and service provision can effectively deliver recovery-orientated practice.
Foxlewin, B	2012	What is Happening at the Seclusion Review that Makes a Difference? A Consumer Led Research Study	This empirical study, undertaken by the ACT Mental Health Consumer Network, was aimed at seclusion reduction intervention at the Canberra Hospital Psychiatric Services Unit beginning in 2009. Features of the Six Core Strategies were employed at the hospital. The report states that 'the lived experience of both consumers and clinicians [was] the central driver for cultural change in relation to seclusion reduction'. The project report identifies that use of seclusion was declining prior to the review (from 8.5% of patients admitted in 2007/8 to 6.9% in 2008/9), but that these meetings drove seclusion to be classified as a rare event (to less than 1% in 2010/11). Seclusion came to be viewed by the organisation as a service failure. Although this project report is not peer reviewed, it is valuable for the added description of a consumer-led strategy. [Not peer reviewed]

Author	Year	Title	Description
Gaskin, C; Elsom S; Happell, B	2007	Interventions for Reducing the Use of Seclusion in Psychiatric Facilities: Review of the Literature	The authors seek empirically supported interventions that allow reduction in the use of seclusion in psychiatric facilities, by reviewing English-language, peer-reviewed literature on interventions that allow reduction in the use of seclusion. Interventions identified include state policy and regulation changes, leadership, examinations of the practice contexts, staff integration, treatment plan improvement, increased staff to patient ratios, monitoring seclusion episodes, psychiatric emergency response teams, staff education, monitoring of patients, pharmacological interventions, treating patients as active participants in seclusion reduction interventions, changing the therapeutic environment, changing the facility environment, adopting a facility focus, and improving staff safety and welfare. The authors recommend implementing several interventions at any one time.
Hem, MH; et al	2018	Ethical challenges when using coercion in mental healthcare: A systematic literature review	A systematic review of scientific literature concerning ethics and coercion in mental health settings. A total of 22 studies were included. The researchers found a lack of literature explicitly addressing ethical challenges related to the use of coercion in mental healthcare and argue that a more refined and rich language describing ethical challenge could improve clinicians ability to prevent coercion and the accompanying 'moral distress'.
Henderson, C; Swanson, JW; Szmukler, G; Thornicroft, G; Zinkler, M	2008	A typology of advance statements in mental health care	This article reviews the literature in English and German to develop a comparative typology of advance statements: joint crisis plans, crisis cards, treatment plans, wellness recovery action plans, and psychiatric advance directives (with and without formal facilitation). The features that distinguish them are the extent to which they are legally binding, whether health care providers are involved in their production, and whether an independent facilitator assists in their production.
Human Rights Watch	2017	Ghana: Invest in Mental Health Services to End Shackling	A report by a coalition calling on the government of Ghana to ensure adequate funding for mental health services in Ghana, as a crucial step to eliminating the widespread practice of shackling and other abuses against people with psychosocial disabilities. The coalition of non-governmental groups includes MindFreedom Ghana, Mental Health Society of Ghana, BasicNeeds Ghana, Law and Development Associates, Human Rights Advocacy Center, Christian Health Association of Ghana, Human Rights Watch, CBM, Disability Rights Advocacy Fund, Anti-Torture Initiative, and former United Nations Special Rapporteur on Torture Juan Mendez.
Janssen, WA; et al	2011	Methodological Issues in Monitoring the Use of Coercive Measures	This paper reviews relevant literature to identify various definitions of coercion, and calculation modalities used to measure coercive measures in psychiatric inpatient care. The authors calculate figures on the coercive measures in a standardised way. To illustrate how research in clinical practice on coercive measures can be conducted, data from a large multicenter study on seclusion patterns in the Netherlands were used. They conclude that coercive measures can be reliably assessed in a standardised and comparable way under the condition of using clear joint definitions. Methodological consensus between researchers and mental health professionals on these definitions is necessary to allow comparisons of seclusion and restraint rates.

Author	Year	Title	Description
Johnson, M	2010	Violence and Restraint Reduction Efforts on Inpatient Psychiatric Units	This paper presents an integrative review of research and quality improvement projects that aimed to reduce aggression/violence or restraint/seclusion through the use of an educational program. Forty-six papers are included in this review. This paper presents summaries and comparisons of the research designs, the content and length of programmes, and the outcomes of these programmes. From these summaries, trends in relation to design, content, and outcomes are identified, and recommendations for clinicians and researchers are given.
de Jong, G; Schout, G	2010	Prevention of coercion in public mental health care with family group conferencing	This editorial summarises research in a review of evidence for the use of Family Group Conferencing in public mental health services. The authors report little in the way of empirical evidence. The same authors report their own empirical findings on the practice in 2013 (see Appendix One).
de Jong, MH; et al	2016	Interventions to Reduce Compulsory Psychiatric Admissions: A Systematic Review and Meta-Analysis	The meta-analysis of the randomised controlled trials (RCTs) on advance statements showed a statistically significant and clinically relevant 23% reduction in compulsory admissions in adult psychiatric patients, whereas the meta-analyses of the RCTs on community treatment orders, compliance enhancement, and integrated treatment showed no evidence of such a reduction. In other words, advance statements appear to reduce the occurrence of compulsory admissions by approximately one-quarter, while community treatment orders, medication compliance enhancement, and integrated treatment measures were ineffective in reducing compulsory admissions. To date, only 13 RCTs have used compulsory admissions as their primary or secondary outcome measure. This demonstrates the need for more research in this field.
Kallert, TW	2008	Coercion in psychiatry	The author gathers reviews on 'involuntary hospital admission' and distinguishes several areas of concern, including 'coercion and the law', the 'patient's perspective', 'family burden of coercion' 'outpatient commitment', 'coercion in special (healthcare) settings and patient subgroups' and argues for further clinical and research initiatives in these areas.
Khazaal, Y; et al	2014	Psychiatric Advance Directives, a Possible Way to Overcome Coercion and Promote Empowerment	This review considers studies completed to assess the impact of advance directives on service use and coercion. Their results give a mixed picture but directives nevertheless have the potential to support the empowerment process, minimise experienced coercion, and improve coping strategies. Further studies on the different processes of facilitation involved and on different populations are needed.
Kisely, S; Campbell L	2014	Compulsory community and involuntary outpatient treatment for people with severe mental disorders	The authors reviewed all relevant randomised controlled clinical trials (RCTs) of compulsory community treatment compared with standard care for people with serious mental illness (mainly schizophrenia and schizophrenia-like disorders, bipolar disorder, or depression with psychotic features). They conclude that CCT results in no significant difference in service use, social functioning or quality of life compared with standard voluntary care.
Klag, S; O'Callaghan, F; Creed, P	2005	The Use of Legal Coercion in the Treatment of Substance Abusers: An Overview and Critical Analysis of Thirty Years of Research	Surveys three decades of research into the effectiveness of compulsory treatment for people affected by substance abuse, concluding that the literature yields a mixed, inconsistent, and inconclusive pattern of results, calling into question the evidence-based claims made by numerous researchers that compulsory treatment is effective in the rehabilitation of substance users. The present paper provides an overview of the key issues concerning the use and efficacy of legal coercion in the rehabilitation of substance users, including a critique of the research base and recommendations for future research.

Author	Year	Title	Description
LeBel, JL; et al	2014	Multinational Experiences in Reducing and Preventing the Use of Restraint and Seclusion	This paper reviews preliminary findings of some of the international efforts to reduce seclusion and restraint in mental health settings, Including the Six Core Strategies to Prevent Conflict, Violence and the Use of Seclusion and Restraint, and so on, including as implemented in U.S. states and countries including Finland, Australia, and the United Kingdom.
Mead, S; Filson, B	2017	Mutuality and Shared Power as an Alternative to Coercion and Force	The purpose of this paper is to demonstrate how mutuality and shared power in relationship can avoid coercion and force in mental health treatment. The authors note that '[t]his is not a research design. It is rather an opinion piece with extensive examples of the approach. The authors have found that using these processes can enable connection; the key to relationship building.'
Mezzina, R	2018	Forty years of the Law 180: the aspirations of a great reform, its successes and continuing need	This study seeks to evaluate the impact – the 'main achievements and challenges' – of 'Law 180' on Italian mental health services, including in efforts to reduce coercive practices, in Italy. Mezzina argues that 'even if the great principles of the Italian reform law were anticipatory (e.g., the UN Convention on Rights of Persons with Disabilities – CRPD), the law application has been poorly provided with resources and did not follow those avant-garde experiences as models.' Further '[l]imitations are evident today especially at the organisational levels, such as services capable to take up the challenge and transforming the field, left free from the imprint of total institutions'. Finally, '[t]he rights-based approach opened by the Law 180 should now take into consideration the new legal situation caused by the CRPD worldwide in the area of individuals' human rights, especially about the issue of legal capacity and related involuntary care' (336).
Mezzina, R	2014	Community Mental Health Care in Trieste and Beyond - An "Open Door—No Restraint" System of Care for Recovery and Citizenship	This study provides an overview of several Italian-language studies and combines them with service data for the mental health services of Trieste, Italy. The Trieste Model is defined as the 'whole system, whole community, recovery-oriented' approach. Mezzina reports 'low rates of hospitalization, low compulsory treatment rates, effective job placement, a low number of forensic patients, and a decreasing (30%) suicide rate during the last 15 years' (p.440). Further, 'Fewer than 10 people per 100,000 of the population receive a CPTO, usually for approximately 7 to 10 days' (p.442).
Möhler, R; et al	2011	Interventions for Preventing and Reducing the Use of Physical Restraints in Long-Term Geriatric Care	This review aims to evaluate the effectiveness of interventions to prevent and reduce the use of physical restraints in older people who require long-term nursing care (either in community nursing care or in residential care facilities). They conclude that there is insufficient evidence supporting the effectiveness of educational interventions targeting nursing staff for preventing or reducing the use of physical restraints in geriatric long-term care.
Olfson, M	2009	Review: Limited Evidence to Support Specialist Mental Health Services as Alternatives to Inpatient Care for Young People with Severe Mental Health Disorders	Inclusion criteria involved randomised controlled trials, well designed controlled before-after studies and interrupted time series comparing inpatient care for young people with one or more alternative specialist mental health services (beyond normal outpatient provision); only studies in young people aged 5-18 years with a serious mental health problem requiring more than generic outpatient services. There is limited evidence to support specialist mental health services as alternatives to inpatient care for young people with severe mental health disorders.

Authors	Year	Title	Description
Richter, D; Hoffmann, H	2017	Independent Housing and Support for People with Severe Mental Illness: Systematic Review'	Systematic review of Randomised and Non-Randomised Controlled Trials of publications that analyse the outcomes of living in independent settings versus institutionalised accommodation. The results indicate that Independent Housing and Support-settings provide at least similar outcomes than residential care. The authors propose that clients' preferences should determine the choice of housing setting.
Rosen A; Mueser KT; Teesson M	2007	Assertive community treatment -- issues from scientific and clinical literature with implications for practice	This review describes Assertive Community Treatment (ACT), an integral component of the care of persons with severe mental illness. Drawing on research from North America, Australasia, and Britain, we summarise the current evidence base for ACT and examine the trends and issues that may affect practice. Strong evidence supports the fidelity standardisation, efficacy, effectiveness, and cost-effectiveness of ACT models in psychiatry. Yet, significant methodological problems and issues affect implementation. The evidence indicates that the ACT model is one of the most effective systematic models for organising clinical and functional interventions in psychiatry. Effective systems based on the ACT model meet more ACT fidelity criteria; are often noncoercive; do not rely on compulsory orders; may rely on a wider range of interventions than just medication adherence, including vocational and substance abuse rehabilitation; contain other evidence-based interventions and more mobile in vivo interventions; involve individual and team case management; may involve consumers as direct service providers; and have an interdisciplinary workforce and support structure within the team, providing some protection from work-related stress or burnout.
Stastsny, P; Lehmann, P (eds)	2007	Alternatives Beyond Psychiatry	A collection of articles submitted by 61 authors from various backgrounds, including social work, clinical psychology, psychiatry, psychotherapy, law and teaching. The authors evaluate global mental health practices and seek ways to move 'beyond' psychiatry to new 'possibilities of self-help for individuals experiencing madness, and strategies toward implementing humane treatment'. [Not peer reviewed]
Van Dorn RA; Scheyett A; Swanson JW; Swartz MS	2010	Psychiatric advance directives and social workers: an integrative review.	This article reviews research in the social work tradition on the clinical and legal history of psychiatric advance directives and empirical evidence for their implementation and effectiveness. Despite what should be an inherent interest in advance directives and the fact that laws authorising psychiatric advance directives have proliferated in the past decade, there is little theoretical or empirical research on them in the social work literature.
Stewart, D; Van der Merwe, MV; Bowers, L; Simpson, A; Jones, J	2010	A Review of Interventions to Reduce Mechanical Restraint and Seclusion among Adult Psychiatric Inpatients	This review examines the nature and effectiveness of interventions to reduce the use of mechanical restraint and seclusion among adult psychiatric inpatients. Thirty-six post-1960 empirical studies were identified. Most studies reported reduced levels of mechanical restraint and/or seclusion, but the standard of evidence was poor. The research did not address which programme components were most successful. The authors argue that more attention should be paid to understanding how interventions work, particularly from the perspective of nursing staff, an issue that is largely overlooked.

Author	Year	Title	Description
Scanlan, JN	2010	Interventions to reduce the use of seclusion and restraint in inpatient psychiatric settings: what we know so far a review of the literature	This paper analyses evidence available from evaluations of single seclusion and/or restraint reduction programmes. A total of 29 papers were included in the review. Seven key strategy types that emerged from the analysis are outlined: (i) policy change/leadership; (ii) external review/debriefing; (iii) data use; (iv) training; (v) consumer/family involvement; (vi) increase in staff ratio/crisis response teams; and (vii) programme elements/changes. The researchers recommend further systematic research to more fully understand which elements of successful programmes are the most powerful in reducing incidents of seclusion and restraint.
Swedish National Board of Health and Welfare	2008	A New Profession is Born – Personligt ombud, PO	This report by the Swedish National Board of Health and Welfare examines the Personligt ombud scheme, offering some preliminary service data on the practice, including fiscal analysis and case studies to illustrate how the scheme is working in practice.
Users and Survivors of Psychiatry – Kenya (USPKA)	2018	The Role of Peer Support In Exercising Legal Capacity In Kenya	This study concerned 10 peer-support meetings. Participants at the meetings include users, carers, friends, USPK staff members. Eight additional interviews were conducted with service users. The study aimed to examine the roleof peer support among users and survivors in 'exercising legal capacity' in Kenya. The kinds of decisions addressed through peer support are tracked with concrete examples of decisions taken with the support of peers, and include informal advance directives, representational supports and other practices that the formal literature indicates helps to reduce coercive interventions. [Not peer reviewed]
Winkler, P; et al	2017	A Blind Spot on the Global Mental Health Map: A Scoping Review of 25 Years' Development of Mental Health Care for People with Severe Mental Illnesses in Central and Eastern Europe	This paper analyses the development of mental health-care practice for people with severe mental illnesses in this region. A scoping review was complemented by an expert survey in 24 countries. Mental health-care practice in the region differs greatly across as well as within individual countries. National policies often exist but reforms remain mostly in the realm of aspiration. Services are predominantly based in psychiatric hospitals. Decision making on resource allocation is not transparent, and full economic evaluations of complex interventions and rigorous epidemiological studies are lacking. Stigma seems to be higher than in other European countries, but consideration of human rights and user involvement are increasing. The region has seen respectable development, which happened because of grassroots initiatives supported by international organisations, rather than by systematic implementation of government policies.
Zmudzki, F; Griffiths, A; Bates, S; Katz, I; Kayess, R	2016	Evaluation of Crisis Respite Services: Final Report (SPRC Report 06/16)	This is the final report of the evaluation of the Crisis Respite Services (CRS). The programme is funded and managed by SA Health and delivered in partnership with Neami National. The evaluation team from the Social Policy Research Centre (SPRC) at UNSW Australia (the University of New South Wales) conducted the evaluation in collaboration with Époque Consulting. The overall aim of this research is to build a strong evidence base for the provision of best practice and improved policy in the delivery of recovery-oriented sub-acute crisis respite services in South Australia.

Appendix Three – Practice, Policy and Legal Measures to Help End, Reduce and Prevent Coercion

The following is a brief list of practices, strategies, policies, legislative changes and so on, which were cited in the formal and grey literature. Rather than evaluating evidence for or against their efficacy in reducing coercion, this list summarises prominent measures and approaches.

NAME	REGION	SUMMARY
Advance Planning	International	Advance planning can help respect the will and preference of a person during crises, and can minimise changes of coercive intervention. They allow for freely made decisions designed to bind oneself or direct others to action in the future, particularly during times of crisis. Decisions may concern treatment preferences or other information (for example, instructions for who to contact or not to contact or who to appoint as a formal supporter). Advance planning could take statutory form (as for example with the Canadian province of British Columbia's *Representation Agreement Act 1996*, India's *Mental Healthcare Act 2017*, and in many other countries) but can also take non-statutory forms, in the form of crisis planning for individuals with informal supporters and mental health professionals (such as Joint Crisis Planning), or informal arrangements between family and peers.
Berliner Krisendienst	Germany	Berlin krisendienst 'Crisis House' provides assistance for issues including 'psychosocial crises and acute mental and psychiatric emergencies' free of charge available year round.[2] People in need of assistance can be helped personally, by phone, and in extreme situations on site at nine Berlin locations without an appointment. The consultation can also be carried out anonymously upon request. The service promotes the use of 'trialogue' between staff, clients and families.
Crisis Cards	England	A form of advance planning, the crisis-card is the size of a credit card which details what should happen in the event that a person has a psychiatric crisis. It was conceived as an advocacy tool to ensure a person maintained control over their potential future treatment thus promoting autonomous choice and with the intent of reducing compulsory interventions.[3] A review of crisis cards found no information on their effects during mental health emergencies.[4]
Club House	Internationally	Clubhouse International helps start and grow Clubhouses globally. In contrast to traditional day-treatment and other day programme models, Clubhouse participants are called 'members' (as opposed to 'patients' or 'clients') and there is a focus on members strengths and abilities, not their illness. It is not a clinical program, meaning there are no therapists or psychiatrists on staff. All participation in a clubhouse is strictly on a voluntary basis. Five Clubhouses in Mainland China are registered as members of Clubhouse International, with five more reportedly undergoing accreditation.[5]
Family Group Conferencing	Netherlands, Australia	Family Group Conferencing is a voluntary consultation process, adapted from a Maori-led process for resolving family court disputes, in which an independent co-ordinator facilitates a series of discussions between an individual and her or his key social network. The individual selects friends and/or family, or professionals, to discuss issues of concern and seek solutions, including composing a plan which sets out the steps to be taken. The role of the co-ordinator is to think 'with' the group, and help remove barriers to participation and seek consensus. Clinicians may have a background support role, or could have roles in facilitating any outcomes of decisions that involve clinical care.[6]

Name	Location	Description
Hearing Voices Networks	International	Hearing Voices Groups (HVG) are based on the idea that members can share successful strategies with each other in a mutually safe space. HVG are an international phenomenon. A review evaluated the evidence for Hearing Voices Groups (HVG) and the mechanisms of change for successful interventions. CBT was the only approach with evidence from well-controlled studies. However, several evidence-based treatments share 'key ingredients' which evidence suggests help reduce distress. Successful groups supply a safe context for participants to share experiences, and enable dissemination of strategies for coping with voices as well as considering alternative beliefs about voices.[7]
Informal Safeguarding and Citizen Volunteering	Australia	The Western Australian Mental Health Commission (WAMHC) has undertaken systemic reform efforts to implement a 'self-directed approach' to mental health service provision, which includes efforts to foster 'informal or natural, intentional safeguard arrangements'.[8] Informal safeguards might include longstay inpatients being paired with citizen volunteers who agree to assist a person in a transition to independent living. Similar informal safeguarding approaches are likely to appear worldwide. (See, for example, Jenner's Admission Preventing Strategy below).
Informal Peer Support in Hospitals and Services	International	Much has been written on the role of informal peer support, including among inpatients. Quirk and colleagues argue that patients routinely take an active role in making a safe environment for themselves in part because they cannot rely on staff to do this for them, and recommend that mental health professionals consider how to build upon what patients are already doing to maximise ward safety.[9]
Intentional Peer Support	United States, Japan, New Zealand, Australia, England	'Intentional Peer Support' (IPS) was developed by Shery Mead as an alternative to traditional peer support practices within mental health services. IPS offers the opportunity to find and create new meaning through relationships and conversations that lead to new ways of understanding crisis. It provides a lens through which to address these issues by talking very overtly about power, who has it, who does not and to negotiate how it can be shared. Such relationships are more proactive, building mutuality, and shared meaning making. Mutuality and shared power are put forward as alternatives to coercion and force.[10] IPS has been advanced by the Centre for the Human Rights of Users and Survivors of Psychiatry as a form of support in line with the CRPD.[11] There is currently no peer-reviewed empirical research into Intentional Peer Support; however, this practice may be useful in operationalising elements of rights-based CRPD which help prevent coercive interventions.[12]
Jenner's Admission Preventing Strategy	Netherlands	A Dutch psychiatrist Jacobus Adrianus Jenner developed an approach where he worked closely together with the people who would be involved directly with the person in crisis.[13] Admission Preventing Strategies ('Opname Voorkomende Strategieën') involved family members and significant others being seen as auxiliary forces, as resources in overcoming a crisis. He regarded them as resources who could assist the person to get through a psychiatric crisis without being compulsorily admitted, calling them 'guardian angels' or 'bodyguards'. An underpinning idea of this approach was that crisis was viewed as an opportunity for growth. These practices would go on to inform Dutch efforts with Family Group Conferencing.[14]
Carina Hakansson, Family Care Foundation	Sweden	Carina Håkansson is the co-founder of the Family Care Foundation in Sweden. The Foundation is located in Gothenburg, and works with 'family home living, psychotherapy and family therapy in the absence of psychiatric diagnoses and manual'.[15] People who are experiencing mental health crises are essentially placed in a family home, often in the countryside, where they are given work roles and offered ongoing support in what the website describes as a 'family home living in a therapeutic context'. The staff at Family Care Foundation are psychotherapists, psychologists and social workers. The workers work together in teams consisting of the client, his or her network, the family home, a supervisor and a therapist.

	Location	Description
Leeds, 'Leeds Survivor-Led Crisis Service'	England	The Leeds Survivor-Led Crisis Service (LSLCS) is a mental health charity based in Leeds. They provide out-of-hours support to people in acute mental health crisis with the aim of reducing hospital admissions, A&E visits, and use of statutory crisis services. LSLCS was founded in 1999 by a group of campaigning mental health service users, who wanted a non-medical, non-diagnostic approach to people in crisis outside of a clinical environment. LSLCS has also partnered with Touchstone Support Centre in Harehills, which has experience of supporting people from Black and minority ethnic (BME) groups. The service provides out-of-hours crisis services to people from BME groups in acute mental health crisis and is staffed by a Manager, Senior Crisis Support Worker and three Crisis Support Workers who are all from BME groups.
Local Area Co-Ordination	England, Australia and New Zealand	'Local Area Co-ordination' involves supporting isolated people with a range of needs, including mental health support needs, to avoid relying solely on health and social care services for social contact. This practice involves community workers based in particular neighbourhoods whose role is to build relationships, identify problems, and help connect people to community associations, existing services, businesses and community organisations (rather than congregated, disability-specific services). There does not appear to be evidence suggesting Local Area Co-ordination reduces the likelihood of coercion, though it is generally agreed to constitute a preventative measure.
Medication Discontinuation	International	Service user organisations tend to present support with medication discontinuation as an unmet need. Of the few studies on the topic that do exist, several indicate that discontinuing psychiatric medication is often a complicated and difficult process.[16] It seems reasonable to assume that discontinuation practices, whether formally or informally, are occurring worldwide. Peter Groot and Jim van Os have proposed 'tapering strips' as a practical solution to help service users discontinue more safely. They conducted an observational study on the use of 'antidepressant tapering strips to help people come off medication more safely' (n=1194), and concluded that '(t)apering strips represent a simple and effective method of achieving a gradual dosage reduction.'[17] An international initiative, The Tapering Project, is promoting the use of Tapering Strips as a way to improve the choice, control and safety of those who take them.[18]
Open Dialogue	Sweden, England	The 'Open Dialogue Approach to Acute Psychosis' is a practice developed in Finland in which care decisions are made in the presence of the individual and his or her wider networks. Psychotherapeutic approaches are taken with the aim of developing dialogue between the person and their support system as a therapeutic intervention. Service providers aim to facilitate regular 'network meetings' between the person and his/her immediate network of friends, carers and family, and several consistently attending members of the clinical team. A strong emphasis is placed on equal hearing of all voices and perspectives as both a means and an objective of treatment in itself.[19]
Parachute Program	United States	Established in early 2013 by the New York Department of Health and Mental Hygiene (DHMH), the Parachute programme uses the Open Dialogue and Intentional Peer Support approaches, again to respond to crises and avoid hospitalisation. A team of therapists, social workers and peer workers work with service users and their families, encouraging them to define and work towards recovery. Reportedly, the approach 'rejects hierarchy, encouraging equal and open dialogue between everyone in the group'. It is less about getting 'better' and more about learning to dwell alongside and manage acute distress.

Peer Support	International	'Peer support', in which persons with psychosocial disabilities provide support to one another can take many forms. As noted previously, it can be informal (on wards, in institutions or in the community), or formal (where service user consultants assist in hospitals, or respite houses are run by people who experienced mental health crises). Regarding the latter, Julie Repper and Tim Carter undertook a meta-analysis of studies on peer support workers more generally, and reported that they 'can lead to a reduction in admissions among those with whom they work', and that 'associated improvements have been reported on numerous issues that can impact on the lives of people with mental health problems'. With sufficient training, supervision and management, they argue, this cohort has the 'potential to drive through recovery-focused changes in services'.[20] There is also much written on the benefit of peer support in low- and middle-income countries, including in the absence of formal mental health services.
Personligt ombud (or PO) Scheme, Sweden	Sweden	The *personligt ombud* (or PO) system emerged after advocates felt that existing legal capacity systems did not meet the needs of many people with psychosocial disabilities. A PO holds an independent position in a municipality's social services. The 'assistants' or 'advocates' are statutorily appointed to assist a person to make legal decisions in a facilitative rather than coercive fashion.[21] Municipalities may run the PO service or sub-contract them to non-governmental organisations. The Commissioner for Human Rights of the Council of Europe, Nils Muižnieks, reported that in 2013 a new regulation established permanent funding for the PO system in the regular welfare system.[22] As of 2014, according to Muižnieks, 310 POs provided support to more than 6,000 individuals and 245 municipalities (84 % of all municipalities in Sweden) included POs in their social service system.[23] In its *Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities*, the OHCHR recommend the 'PO Skåne' programme – an iteration of the PO programme run by persons with psychosocial disabilities – as an appropriate supported decision-making statutory mechanism.[24] Muižnieks writes that 'recourse to the Personal Ombudsmen system could be a way of limiting coercive practice in psychiatric institutions', although such empirical evidence does not appear to exist at present.
Recovery Camp and Working for Recovery	England, Scotland, Australia	Ron Coleman and Karen Taylor are service user advocates who run a series of practices and events directed toward Recovery. The Recovery Camp is a residential summer camp that is held in Scotland and England, and has been running since 2015.[25]
Recovery Models	International (mostly English-speaking high-income countries)	'Recovery'-oriented mental health policy and practice aims to enhance the agency of a person and to avoid what Pamela Fisher describes as interventions 'being done to' people.[26] It is the subject of an extensive literature, is understood in diverse ways, and has influenced mental health services internationally. Recovery is government policy in English-speaking countries such as Australia, Canada, New Zealand, Scotland, Ireland, Northern Ireland, the United States and England.
Reducing and Eliminating Seclusion and Restraint	International	As this report has detailed, there are multiple programmes, practices and policy-measures designed to reduce and eliminate the use of seclusion and restraint in mental health settings. These include: Six Core Strategies and Safewards (see below).[27] The approaches include seclusion rooms, improvements to ward physical environments, having more opportunities for support and connection, and greater access to peer workers, family and other informal support.

	Description	Jurisdiction
'Representation Agreements', Nominated Persons Schemes, etc.	There are multiple forms of representation agreements. Most advance planning measures will include a form of representation agreement, in which a person is nominated by the planee, to assist in some way during a future crisis. One legislative form of representation agreement that is often promoted as being closely in line with the CRPD is the Canadian province of British Columbia's *Representation Agreement Act 1996*, which provides an example of statutory advance planning and representation agreements.[28] Powers of attorney may also provide a simple legal avenue for appointing a representative on certain decisions. Others, such as Joint Crisis Planning, and informal representation agreements among users and prior users of services, are discussed in this report.	International
Respite Houses	There are many types of respite houses. The term typically refers to non-hospital environments to which people can go for short periods of time when they are experiencing mental health crises. Laysha Ostrow has written of 'peer-run crisis respites', and distinguishes within this category between 'hybrid' and 'peer-run' models. 'Hybrid' models refer to respites under the auspices of a non-peer-run organisation, but where the respite under its control has a director and staff who are peers. 'Pure peer-run', for Ostrow, respites are those in which 'peers staff, operate, and oversee the respite at all levels'. This centre would be a stand-alone programme in a residential neighbourhood that is not attached to a 'traditional provider, and has no onsite or contractual potential to offer psychiatric or medical services.'[29] There are also examples of respite houses that are not peer-run, and which may be attached to clinical mental health services, and which offer a 'step down' from hospitals. Some examples of crisis respite houses are: – Soteria House (see below) – Western Massachusetts Recovery and Learning Centre (see below) – Awhi Rito – Maternal Crisis Respite (NZ) (a maternal crisis respite service for mothers and their babies)[30] – The Berlin Runaway House (see below). A small number of such programmes operate throughout the world, including 21+ in the United States of America.[31]	International
Safewards	Safewards is a series of strategies amounting to a systems approach aiming to change culture around 'flashpoints' that can lead to seclusion and restraint in inpatient units. Originating in the UK, the Model depicts six domains of originating factors: the staff team, the physical environment, outside hospital, the patient community, patient characteristics and the regulatory framework. These domains give risk to flashpoints, which have the capacity to trigger conflict and/or containment. Staff interventions can modify these processes by reducing the conflict-originating factors, preventing flashpoints from arising, cutting the link between flashpoint and conflict, choosing not to use containment, and ensuring that containment use does not lead to further conflict. The model is used to devise strategies for promoting the safety of patients and staff.[32]	Poland, Norway, Australia, England, Scotland, Ireland, Canada, Germany, Denmark
Shared Decision-Making	Shared decision-making is a formalised process in mental health service by which clinicians and consumers engage in a collaborative decision-making process for healthcare decisions. It is premised on the idea that optimal decision-making occurs when a decision is informed by the most relevant evidence and the service user's personal preferences and values.[33]	Canada, England, Germany, the Netherlands, United States, Peru, Wales, Australia, Italy, and Saudi Arabia

Sharing Voices Bradford	England	Sharing Voices Bradford is a support programme particularly for Black British and migrant people in mental health crisis, particularly those facing social exclusion, isolation and discrimination. Sharing Voices is more of a community development mental health project than a traditional service, focusing on developing and raising awareness of mental health wellbeing amongst marginalised Black and migrant communities (who are over-represented among those facing forced psychiatric interventions). The service was reportedly established on the basis that 'an individual's mental health experiences often arise from issues around: poverty, racism, unemployment, loneliness, family conflicts, relationship difficulties and cannot be merely understood through biological terms alone' and emphasises 'listening to people's own explanation and helping them find their solutions to problems'.[34]
Soteria House	Sweden, Finland, Germany, Switzerland, Hungary and the United States	The Soteria model is a type of respite house (see above). It was founded in California, United States, as an alternative community-based, non-medical approach to traditional hospitalisation for people diagnosed with schizophrenia.[35] The approach consists of a small, community-based, residential treatment environment with strong use of peer and allied-professional staffing rather than clinical staff. Soteria House reportedly focus on empowerment, peer support, social networks, and mutual responsibility. It tends to involve minimal use of psychotropic medication based on personal choice of each resident. According to the Department of Mental Health Vermont, 'further analysis may be warranted to assess how Vermont's future support and implementation of the Soteria model can reduce the need for involuntary medication for individuals experiencing a psychiatric crisis'.[36]
TCI-Asia – Community Development	South Asia, East Asia, South East Asia and the Pacific	Transforming Communities for Inclusion of Persons with Psychosocial Disabilities, Asia, is an Asian alliance of people who self-identify as people with psychosocial disabilities, their organisations and their 'cross-disability' supporters. TCI Asia is an independent, regional Disabled People's Organisation (DPO) focussing on the monitoring and implementation of all human rights for persons with mental health problems and psychosocial disabilities. TCI-Asia essentially undertakes community development work, facilitating multi-stakeholder dialogues, technical inputs to governments, capacity building and trainings on the CRPD and inclusion, and through the 'empowerment of emerging leaders and national DPO'.[37]
The Institute for the Development of Human Arts (IDHA)	United States	According to Valerie Canady, '(t)he Institute for the Development of Human Arts (IDHA) is defined as a learning community that advances holistic, democratic and transformative mental health practices. She writes, '[t]he training initiative focuses on community-based, recovery-oriented and peer-driven alternatives…'.[38] The IDHA is located in New York City. The website describes the group as consisting of: 'mental health workers, clinicians, psychiatrists, current and prior users of mental health services, advocates, artists, and survivors of trauma and adversity.'[39]

Name	Country	Description
The Runaway House, Berlin	Germany	The co-ordinators of the Weglaufhaus 'Villa Stöckle' (or Runaway House) describe it as 'an anti-psychiatric oriented crisis facility in Berlin'.[40] It is positioned as a crisis centre for 'homeless ex-users of psychiatry'. Residents reportedly have the 'opportunity to live through their crisis without psychiatric treatment and to withdraw gradually from psychiatric drugs with support and intensive counselling.'[41]
Trauma-Informed	International	There are many models of 'trauma-informed' services, which refer to services designed in recognition of the impact of interpersonal violence and victimisation on an individual's life and development. Maxine Harris and Roger Fallot have pointed to evidence suggesting most mental health and welfare recipients have survived physical or sexual violence, and argue that current '[s]ystems serve survivors of childhood trauma without treating them for the consequences of that trauma; more significant, systems serve individuals without even being aware of the trauma that occurred'.[42] Trauma-informed services arguably reduce the likelihood of coercive practices by responding with greater understanding to individuals in crisis, and by designing services that avoid replicating the harm already caused to service users.
Trieste Model	Italy	According to the World Health Organization (WHO), the 'Trieste model' of public psychiatry is one of the most progressive in the world. It was in Trieste, Italy, in the 1970s that the radical psychiatrist, Franco Basaglia, sought to create an anti-institutional, democratic approach to supporting people with mental health conditions and psychosocial disabilities. The model has a strong focus on citizenship and social inclusion.[43]
Trialogue	Poland, French-speaking Switzerland, Germany, France, and Ireland	In trialogue groups users, carers and friends and mental health workers meet regularly in an open forum that is located on 'neutral terrain' – outside any therapeutic, familial or institutional context – with the aim of discussing the experiences and consequences of mental health problems and ways forward. Trialogues offer new possibilities for gaining knowledge and insights and developing new ways of communicating beyond role stereotypes.[44] A similar model was used in Foxlewin's seclusion reduction pilot study (see Appendix Two).
Afiya, Western Massachusetts Respite and Learning Center	United States	A peer-run crisis respite centre, according to the Afiya website, 'is located in a residential neighbourhood in Northampton, Massachusetts and is central to a variety of community resources'. It is available to adults experiencing distress who "feel they would benefit from being in a short-term, 24-hour peer-supported environment with others who have "been there"' – others who 'identify as having lived experience that may include extreme emotional or altered states, psychiatric diagnoses, trauma histories, living without a home, navigating the mental health and other public systems, addictions and more'.[45]

Appendix Endnotes

1. 'Not peer reviewed' is meant in the strict sense of subjecting an author's scholarly work, research, or ideas to the scrutiny of others who are experts in the same field and are independent to the study, at a stage before a paper is published in a journal or as a book. However, other forms of peer review in the broader sense may have been included in the few 'non-peer reviewed' studies listed here. Bradley Foxlewin's study, for example (see below), was conducted using an advisory group consisting of fellow service users who monitored and guided the study. A similar process guided the report authored by the Users and Survivors of Psychiatry – Kenya (see below).

2. Berliner Krisendienst, Berlin, Germany <www.berliner-krisendienst.de/en/>.

3. Claire Henderson et al, 'A Typology of Advance Statements in Mental Health Care' (2008) 59(1) *Psychiatric Services (Washington, D.C.)* 63.

4. Kim Sutherby and George Szmukler, 'Crisis Cards and Self-Help Crisis Initiatives' (1998) 22(1) *Psychiatric Bulletin* 4.

5. Clubhouse International, 'Clubhouse Stories' <https://clubhouse-intl.org/hopeclubhousestory/>.

6. Gert Schout, Ellen Meijer and Gideon de Jong, 'Family Group Conferencing—Its Added Value in Mental Health Care' (2017) 38(6) *Issues in Mental Health Nursing* 480.

7. Anna Ruddle, Oliver Mason and Til Wykes, 'A Review of Hearing Voices Groups: Evidence and Mechanisms of Change' (2011) 31(5) *Clinical psychology review* 757.

8. Government of Western Australia, Mental Health Commission, *Draft Safeguards Framework for Individualised Support and Funding* (May 2013) 2 <www.mentalhealth.wa.gov.au>.

9. Alan Quirk, Paul Lelliott and Clive Seale, 'Risk Management by Patients on Psychiatric Wards in London: An Ethnographic Study' (2005) 7(1) *Health, Risk & Society* 85.

10. Shery Mead and Beth Filson, 'Mutuality and shared power as an alternative to coercion and force' (2017) 21(3) *Mental Health and Social Inclusion* 144.

11. See Center for the Human Rights of Users and Survivors of Psychiatry, 'Good Practices', n.d. <www.chrusp.org>.

12. Sherry Mead, David Hilton and Laurie Curtis, 'Peer Support: A Theoretical Perspective' (2001) 25(2) *Psychiatric Rehabilitation Journal* 134.

13. Jacobus Jenner, *Opnamevoorkómende strategieën in de praktijk van de sociale psychiatrie* (Erasmus University Rotterdam, 1984) <http://hdl.handle.net/1765/38522>.

14. See Gert Schout, Ellen Meijer and Gideon de Jong, 'Family Group Conferencing— Its Added Value in Mental Health Care' (2017) 38(6) *Issues in Mental Health Nursing* 480.

15. Familjevårdsstiftelsen, Gothenburg, Sweden <www.familjevardsstiftelsen.se>

16. Carmela Salomon, Bridget Hamilton and Stephen Elsom, 'Experiencing Antipsychotic Discontinuation: Results from a Survey of Australian Consumers' (2014) 21(10) *Journal of Psychiatric and Mental Health Nursing* 917; Laysha Ostrow et al, 'Discontinuing Psychiatric Medications: A Survey of Long-Term Users' (2017) 68(12) *Psychiatric Services* 1232.

17. Peter C Groot and Jim van Os, 'Antidepressant Tapering Strips to Help People Come off Medication More Safely' (2018) 10(2) *Psychosis* 142.

18. Tapering Strip Project, Maastricht, The Netherlands <www.tapering-strip.org>. Research at Maastricht University is being undertaken into the use of Tapering Strips. See 'Project Tapering' (website), Maastricht University <https://urc.mumc.maastrichtuniversity.nl/node/13125>.

19. Lisa Wood and Russell Razzaque, *Open Dialogue in psychosis: a systematic review of current evidence* (PROSPERO, 2014) <http://www.crd.york.ac.uk/PROSPERO/display_record.php?ID=CRD42014013139>

20. Julie Repper and Tim Carter, 'A Review of the Literature on Peer Support in Mental Health Services' (2011) 20(4) *Journal of Mental Health* 392.

21. Leslie Salzman, 'Guardianship for Persons with Mental Illness – A Legal and Appropriate Alternative?' (2011) 4 *St. Louis University Journal of Health Law and Policy* 279.

22. Council of Europe: Commissioner for Human Rights, *Report by Nils Muižnieks Commissioner for Human Rights of the Council of Europe Following His Visit to Sweden*, 16 October 2018, CommDH(2018)4 paras [76]-[78].

23. Ibid.

24. Office of the High Commissioner for Human Rights, 'Chapter Six: From Provisions to Practice: Implementing the Convention, Legal Capacity and Supported Decision-Making', *United Nations Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities* (Geneva, 2007) 89.

25. Working to Recovery, Isle of Lewis, United Kingdom <www.workingtorecovery.co.uk>.

26. Pamela Fisher, 'Questioning the Ethics of Vulnerability and Informed Consent in Qualitative Studies from a Citizenship and Human Rights Perspective' (2012) 6(1) *Ethics and Social Welfare* 2, 12.

27. For a full list of these approaches, see Melbourne Social Equity Institute, 'Literature Review'. in Melbourne Social Equity Institute, *Seclusion and Restraint Project: Report* (Melbourne: University of Melbourne, 2014) <https://socialequity.unimelb.edu.au/__data/assets/pdf_file/0017/2004722/Seclusion-and-Restraint-report.PDF>.

28. *Representation Agreement Act* R.S.B.C. 1996 c 405, ss 2(a), 8.

29. Laysha Ostrow, 'A Case Study of the Peer-Run Crisis Respite Organizing Process in Massachusetts', Heller School for Social Policy and Management, Master of Public Policy Capstone, 2010.

30. Kāhui Tū Kaha, Auckland, New Zealand <http://kahuitukaha.co.nz/>

31. See 'Directory of Peer-Run Crisis Services', National Empowerment Center Website <https://power2u.org/directory-of-peer-respites/>

32. Len Bowers, 'Safewards: A New Model of Conflict and Containment on Psychiatric Wards' (2014) 21(6) *Journal of Psychiatric and Mental Health Nursing* 499.

33. Patricia Deegan, 'A Web Application to Support Recovery and Shared Decision Making in Psychiatric Medication Clinics' (2010) 34(1) *Psychiatric Rehabilitation Journal* 23.

34. Sharing Voices, Bradford, United Kingdom <www.sharingvoices. net>

35. Tim Calton et al, 'A Systematic Review of the Soteria Paradigm for the Treatment of People Diagnosed With Schizophrenia' (2008) 34(1) *Schizophrenia Bulletin* 181; Pesach Lichtenberg, 'From the Closed Ward to Soteria: A Professional and Personal Journey' (2017) 9(4) *Psychosis* 369; Ingrid Lindgren, Margareta Falk Hogstedt and Johan Cullberg, 'Outpatient vs. Comprehensive First-Episode Psychosis Services, a 5-Year Follow-up of Soteria Nacka' (2006) 60(5) *Nordic Journal of Psychiatry* 405.

36. Department of Mental Health, *Vermont Reforming Vermont's Mental Health System Report to the Legislature on the Implementation of Act 82, Section 5: Involuntary Treatment and Medication Review*, 15 December 2017

37. Transforming Communities for Inclusion – Asia Pacific, Pune, India <http://www.tci-asia.org>.

38. Valerie Canady, 'Learning Community Promotes Holistic, Trans-formative Practices' *Mental Health Weekly - Wiley Online Library* (24 October 2017).

39. Institute for the Development of Human Arts, New York City, United States <www.idha-nyc.org>.

40. Weglaufhaus "Villa Stöckle", Berlin, Germany <www.weglaufhaus. de>.

41. Ibid.

42. Denise E Elliott et al, 'Trauma-Informed or Trauma-Denied: Princip-les and Implementation of Trauma-Informed Services for Women' (2005) 33(4) *Journal of Community Psychology* 461, 462.

43. The Trieste Mental Health Department, English language website, Trieste, Italy <www.triestesalutementale.it/english/mhd_depart-ment.htm>.

44. Mental Health Trialogue Ireland, Dublin, Ireland <http://trialogue. co/>.

45. Afiya, Massachusetts, United States <http://www.westernmassrlc. org/afiya>.

Contact the
Melbourne Social Equity Institute