The Use of Coercive Measures in Forensic Psychiatric Care

Legal, Ethical and Practical Challenges

Birgit Völlm
Norbert Nedopil
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Introduction

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Birgit Völlm and Norbert Nedopil

This book is dedicated to the use of coercive measures in one area of psychiatry—forensic psychiatry. Forensic psychiatry is a subspecialty of clinical psychiatry which operates at the interface between law and psychiatry. It is concerned with patients who have committed an, often serious, offence and are frequently detained in secure and mostly highly restrictive settings. The purpose of this detention is seen as twofold: care and treatment for the *patient* (for their own sake as well as in order to reduce future risk) and protection of the public from harm from the *offender*. This dual role can cause dilemmas for the practitioner who has conflicting obligations to the community, third parties, other healthcare professionals as well as the patient.

Due to the nature of forensic psychiatry, both in terms of its clientele and the settings it operates in, the use of coercion seems to be therefore—rightly or wrongly—an integral part of its practice. It is thus surprising that—despite the plethora of academic writing about coercion in psychiatry in general—very little literature exists focusing specifically on forensic psychiatry—maybe a reflection of what Perlin (in the first chapter of this book) refers to as '*an extra level of social isolation*' of this '*most hidden*' patient group.

What is coercion? According to the Oxford Dictionary of English, it is an '*action or practice of persuading someone to do something by using force or threats*'. Coercion usually occurs when one party has power over the other and does not necessarily have to involve obvious threats or use of force but can purely consist of

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an implication that such force could be used. It is therefore important to distinguish between objective and subjective coercion, objective coercion being the actual use of coercive actions while subjective coercion describes the perception that such measures may be used.

Objective and subjective coercion do not correlate well—some people may perceive actions which are not objectively coercive or intended to be coercive nevertheless as threats or compulsion while others may perceive objectively coercive measures in fact as helpful rather than coercive, making the delineation of the subject area even more challenging.

In psychiatric settings, coercive measures may be used in three principle situations, though in practice they may not be clearly distinguished: (1) To restrict a patient's freedoms on a medium to longer term basis to prevent harm towards self or others (e.g. offending), (2) to force a patient, who may or may not lack competency to accept treatment he or she refuses and (3) in the short-term management of a situation where there is a high likelihood of aggression or violence perpetrated by the patient.

Though this book is primarily concerned with this kind of coercion, the concept of a 'sliding scale' of pressure to accept treatment, introduced by Szmukler and Appelbaum (2008), is a useful starting point in describing the various forms coercion may take in (forensic) psychiatric settings. The sliding scale includes:

- Persuasion—the appeal to reason and/or emotions to accept the suggested course of action
- Interpersonal leverage—where the patient–clinician relationship is used to put pressure on the patient, e.g. by pointing out the disappointment caused by the patient to his or her mental health worker if refusing the suggested course of action
- Inducement—the use of positive rewards if the action suggested by the mental health professional is accepted
- Threats—e.g. the threat to lose particular benefits such as the therapeutic relationship itself or threats to use more aversive measures such as detention or physical force
- Compulsory treatment finally is the situation where all choice is taken away from the patient and the treatment is delivered against his or her wishes

In forensic psychiatry, coercion is mostly thought of in the short-term management of aggression or violence (see further below). There are, however, also long-term coercive measures applied, e.g. forcing the patient to accept depot medication in order to be transferred to a lower level of security or to be released into community treatment. Generally, accepted definitions of coercion hardly exist. While we would have preferred all authors using the same definitions for coercive methods within their chapters, it has soon become apparent that this aspiration was not achievable. This is an authors' practice in different countries using different definitions and they write from their own experience within their countries. We have therefore decided to not edit out the overlap between chapters to allow the reader to appreciate the particular author's viewpoint and definitions used within

their chapters. This has the additional advantage that all chapters are self-contained, facilitating the selective reading of chapters of particular relevance to individual readers.

There are four main methods of coercion in the short-term management of patients [descriptions mainly according to Department of Health (2008) and National Institute of Clinical Excellence (2015)]:

1. Physical restraint: The patient is manually held by at least one member of staff to restrict movement. This is often the first step to other interventions (2–4 below) but may occasionally also be used as the sole method of intervention.
2. Mechanical restraint: A device, such as a belt, is attached to a patient with the aim of restricting patient movement. Equipment used in this way should be approved for such use and staff trained in its application.
3. Seclusion: The placement of a patient alone in a (largely) bare room, usually locked or otherwise preventing free exit, that either has or has not been assigned for this purpose. The room provides a low-stimulation, safe environment for an acutely psychiatrically disturbed patient.
4. Involuntary medication (also termed 'chemical restraint' or 'pharmacological restraint' or 'rapid tranquillisation'): The administration of medication, typically via intramuscular injection, against the patient's will with the aim to lightly (but not heavily) sedate, thereby allowing improved communication.

This volume consists of four parts. Part I addresses some of the context in which coercion in forensic psychiatry happens—legal, sociological and ethical. It covers legal aspects of coercion by describing some of the key legal frameworks concerned with the protection of human rights of those institutionalised in (forensic) psychiatric institutions, emphasising the importance of scrutinising the conditions of confinement and ensuring procedures are in place to challenge any violations of human rights. Part I also includes a sociological viewpoint challenging us to embrace a wider perspective of psychiatry than a biological one, recognising the contribution social sciences makes to understanding the complex interplay between societies, organisations and individuals. In the context of coercion, this means that psychiatry must reflect on the role assigned to it in the control of socially undesirable behaviour. Adshead and Davies, in their chapter on ethical issues, again invite us to take a broader view when they argue that care and coercion in forensic psychiatry are linked and that patients are constrained by their life stories in many ways, even without overt coercion by healthcare professionals. Steinert finally reminds us that, while psychiatric practice in all countries relies on the use of coercion, there is wide variation in which methods are seen as acceptable in different countries, indicating that policies and practice are shaped more strongly by values and attitudes of the general public as well as professionals than by the application of scientific evidence.

Part II of this volume is dedicated to the use of coercive measures in particular settings. Curtis et al. give an overview of the use of such methods in general adult settings. Their chapter also gives a good outline of the various means of coercion,

ranging from coercive removal from the community, over admission to hospital and treatment against a patient's will, to seclusion and restraint. While their chapter is UK specific as far as the legal context is concerned, it also offers an excellent overview of the international literature on patient and non-patient related factors associated with the use of coercive measures. Nedopil then introduces special considerations in forensic psychiatry before Hui et al. present an overview of the literature on the use of coercive measures in this subspecialty. Again, the dual role dilemma is apparent here, leading potentially to slightly different considerations in forensic–psychiatric patients with regard to the balance between self-determination and paternalism—this is as they are detained for a disorder that is also deemed to make them dangerous; therefore not treating this disorder would invariably result in longer detention. However, Nedopil points out recent legal developments in Germany resulting in much higher standards for the application of coercive pharmacological treatment, even in non-capacitous patients. Future research will show whether such restrictions will lead to increased lengths of stay—therefore shifting one form of coercion to another—because patients may not receive the treatment they need to reduce the risk they pose to others. Brink and Goosens add a US/Canadian perspective, also pointing at the lack of research in this field despite the wide use of coercive practices. Importantly, the authors point out that, maybe somewhat surprisingly, violent incidents in forensic–psychiatric settings are actually less prevalent compared to general psychiatry. Tort et al. complete the picture by focusing on coercive measures in a prison setting. Prisons are important settings for forensic psychiatry to consider, not least as the majority of prisoners suffer from some form of mental disorder (e.g. Fazel and Seewald 2012) and, in actual numbers, more mentally disordered offenders can be found in prisons than in psychiatric institutions. Crucially, the authors also touch upon the topic of misuse of coercion and make suggestions regarding the prevention of such instances.

Part III is dedicated to the experience of coercive measures by the two key groups involved: patients and staff. While the consideration of the patients' perspective is obvious, it is also important to appreciate the experience of staff. Except some small percentage of staff who may overtly misuse their power to unnecessarily but deliberately overuse coercive measures on patients, most staff strive to reduce the use of such interventions and find their use highly stressful. The patient perspective is presented in two chapters: one is a traditional academic contribution outlining, amongst other things, the importance of patient information and engagement in order to enable them to integrate the negative experience of coercion into their life narrative. The other chapter breaks new ground in that it gives a voice directly to a patient writing first hand about his experience of being the recipient of psychiatric 'care'. Staeves' contribution will be challenging to some but without listening to patients, we cannot learn much relevant about how to improve the care we provide.

It is generally accepted that coercive measures should be minimised as much as possible. However, how this can be achieved is far from clear. A recent systematic review (Price et al. 2015), including 38 relevant studies on de-escalation techniques training in general psychiatric settings, found that such training appears to impact

primarily on staff knowledge and performance in artificial training scenarios but no strong conclusions could be drawn regarding the impact on actual incidents, containment or organisational outcomes. Nevertheless, it is important that we continue to strive to reduce the use of coercive measures; Ewington's chapter on how this could be achieved in forensic settings is therefore particularly welcome. A final chapter addresses the use of mechanical restraint, often considered the most severe form of coercion, its introduction in a forensic setting and the challenges posed in this process. While this may seem at first glance like a retrograde step, one must remember what the alternatives are; in the case of the few patients for whom mechanical restraint is used, as a planned intervention, it is a longer period of seclusion. In fact, it is important to note that the strong opposition against mechanical restraint in the UK is not fully mirrored in patient surveys: One study showed that mechanical restraint was the most aversive method for both, staff and patients, but patients viewed it as less aversive than staff whilst staff saw involuntary medication much less aversive than patients (Hui 2014). This reminds us that we must include patients in all policy development, planning and evaluation of services and research if our endeavours are to make a positive contribution to patient care. The Editors hope that this volume will contribute to this process.

While editing the contributions to this book and compiling the different views of the authors, we became even more aware than we were before how little research has been conducted on coercion in forensic settings. We hope that this book will encourage researchers and practitioners to study the topic, which is so omnipresent in forensic psychiatry more thoroughly. We strongly believe that an increased knowledge of the intentions, regulations, practices and consequences of coercion for all parties involved is not only be the precondition for its evidence-based application but also for an evidence-based restriction. We also hope that the knowledge provided in this volume will help to reduce and in some cases prevent the use of force so often seen in forensic hospitals. As the primary goal and purpose of forensic psychiatry is the prevention of harm to potential future victims, and we try to increase our knowledge about perpetrators and the circumstances in which they are inclined to reoffend, we should also pay attention to the prevention of harm within our institutions. Experiments in some countries, e.g. the Netherlands, have shown that coercion cannot be abolished totally but it can be limited substantially. The demonstration of alternatives to force and coercion by staff might be a role model for the patients who are in the institutions in order to learn to apply alternatives to their previous violent behaviour. Our hope in compiling this book is therefore also to contribute to a less violent climate in our institutions.

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Part I

The Context

International Human Rights and Institutional Forensic Psychiatry: The Core Issues

2

Michael L. Perlin

Abstract

Forensic patients have traditionally been hidden from view of the public, the legal system and the mental health system, a set of circumstances that has, for the most part, been fine with all parties (for a variety of reasons, none of which inure to the benefit of those institutionalised). Very little of the "civil rights revolution" that has made civil psychiatric hospitals and facilities for persons with intellectual disabilities less hidden from view (and has led to those individuals raising their voices in protest of dehumanising conditions, after decades/centuries of being silenced) has had a spillover impact on those in forensic facilities. The ratification of the Convention on the Rights of Persons with Disabilities (CRPD)—when read in light of the Convention Against Torture (CAT)—makes it more likely, for the first time, that attention will be paid to the conditions of confinement, worldwide, of this population, how those conditions regularly violate international human rights law and how those who are in charge of these institutions do so with impunity. In this chapter, I focus on the relationship between the CRPD and the CAT in questions related to the treatment of institutionalised forensic patients (those admitted to psychiatric institutions following involvement in the criminal justice system) and highlight some of the key issues that must be examined in this context. I argue further that shedding light on the deplorable conditions on forensic facilities and spreading awareness about the treatment in which patients are subjected is the first step in ensuring equality and reducing the stigma of mental illness. I also consider these issues in the context of the theory of therapeutic jurisprudence and conclude that the current state of affairs violates the precepts of that school of legal thought.

Some of this chapter is adapted from Perlin and Schriver (2013).

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2.1 Introduction

Persons institutionalised in psychiatric institutions and facilities for persons with intellectual disabilities have always been hidden from view (Mental Disability Rights International 2006). Facilities were often constructed far from major urban centres; availability of transportation to such institutions was often limited, and those who were locked up were, to the public, faceless and often seen as less than human (Perlin 2000c; Lusthaus 1985). Although there were sporadic exposes in the nineteenth century, and then later in the mid-twentieth century (Perlin 1998a, § 2A–2.1b),[1] it was not until the civil rights revolution reached psychiatric hospitals and facilities for persons with intellectual disabilities in the early 1970s that there was any true public awareness of the conditions in such facilities (Perlin 1987).

A series of court cases brought by young public interest lawyers shone a harsh light on the brutal and inhuman conditions in such facilities—one expert referred to the Pennhurst State School, in suburban Philadelphia, as "*Dachau without ovens*" (Lippman and Goldberg 1973, p. 17, as quoted in Perlin 1991, p. 100 & n. 215)—in many US jurisdictions in the early and mid-1970s (Perlin 1998a, § 1–2.1), and other cases soon followed in Western Europe (Perlin et al. 2006). These cases led to the predictable empowerment of blue-ribbon commissions, the issuance of lengthy reports excoriating states for the shameful conditions in which individuals were treated and eventually, if tardily, the legislative passage in the United States of so-called Patients Bills of Rights (Perlin 1999b, § 3A–3.2c), that created substantive and procedural protection for those in danger of being deprived of their liberty, and those who had been so deprived (Perlin 2008b).

A similar progression was occurring in Western Europe at this time, and community-based treatment was scrutinised and discussed in government policies known as, e.g. "Better Services for the Mentally Ill" and "Community Care with Special Reference to Mentally Ill and Mentally Handicapped people" (Killaspy 2006). Perhaps as a by-product of all of this, those individuals who had been hidden and whose voices had been silenced began to raise their voices to protest the dehumanisation of the conditions in which they had been confined (Chamberlin 1979; Milner 1987; Chamberlin and Rogers 1990).

Much of the case law ignores forensic patients entirely (Perlin 2008a). By and large (although not exclusively) (see *Davis v. Watkins* 1974, pp. 1201–1202; Perlin 2008a) the facilities that were the subject of this litigation (and the concomitant press scrutiny) (Davis 2011) were facilities that mostly housed patients who had never been charged with or tried on criminal charges, a fact that is, interestingly and ironically, discordant with the false, self-referential and non-reflective "ordinary common sense" (Cucolo and Perlin 2012, p. 38) that posits that "*most mentally ill*

[1] The third edition of this treatise will be published in 2016, and, at that time, all section numbers will change. That version should be cited as Perlin, M. & Cucolo, H. (2016). *Mental Disability Law: Civil and Criminal* (3rd ed.). Newark NJ: LexisNexis Publishing.

individuals are dangerous and frightening [and] are invariably more dangerous than non-mentally ill persons" (Perlin 2003, p. 724 & n. 220). Even in this hidden world of those institutionalised because of psychiatric disability (or alleged disability), forensic patients—mostly those awaiting incompetency-to-stand trial determinations, those found permanently incompetent to stand trial, those who had been acquitted by reason of insanity, and, in some jurisdictions, individuals transferred from correctional facilities—remain the most hidden. This extra level of social isolation was generally just fine with most of those who had been involved in the patients' rights revolution that has restructured mental health care around the world. It was fine to the advocacy groups that came forward at this time, since the existence of a forensic "world" could be used as evidence that there was a causal relationship between mental illness (or intellectual disability) and "dangerousness" (Perlin 1999a, p. 30 & n. 158). It was fine to the lawyers who brought the bulk of the first generation of public interest cases since one of the significant underpinnings of the initial right to liberty/least restrictive alternative civil rights suits was that the plaintiff had never been "*alleged to have committed any crime*" (*Lessard v. Schmidt* 1972, p. 1096). It was fine to the state hospital system, since it was clear that if it appeared that *this* population was being released or deinstitutionalised, there would be a predictable public outcry (Lemay 2009). And it was fine to prosecutors and police officials since it insured that this population would remain locked up indefinitely, as it always had been (Perlin 2002, § 14–7, pp. 119–121, reprinting *Dixon v. Cahill* 1973; Perlin 2000b). As a result of all of this, things have remained basically *status quo* for about 40 years, and the changes in conditions for civil patients have had very little impact on those in forensic facilities.

This state of affairs, however, must be radically reconsidered in light of the ratification of the United Nations' Convention on the Rights of Persons with Disabilities (CRPD) (Perlin 2011), "*regarded as having finally empowered the 'world's largest minority' to claim their rights, and to participate in international and national affairs on an equal basis with others who have achieved specific treaty recognition and protection*" (Kayess and French 2008, p. 4 & n. 17). This Convention is the most revolutionary international human rights document ever created that applies to persons with disabilities (Perlin and Szeli 2012; Perlin 2009, 2011). It furthers the human rights approach to disability and recognises the right of people with disabilities to equality in most every aspect of life (Dhir 2005). It firmly endorses a social model of disability and reconceptualises mental health rights as disability rights—a clear and direct repudiation of the medical model that traditionally was part-and-parcel of mental disability law (Fennel 2008). "*The Convention sketches the full range of human rights that apply to all human beings, all with a particular application to the lives of persons with disabilities*" (Lord and Stein 2009, p. 256). It provides a framework for insuring that mental health laws "*fully recognize the rights of those with mental illness*" (McSherry 2008, p. 8). There is no question that it has "*ushered in a new era of disability rights policy*" (Harpur 2011, p. 1295).

The Convention describes disability as a condition arising from "*interaction with various barriers [that] may hinder their full and effective participation in*

society on an equal basis with others" instead of inherent limitations (CRPD, Art. 1 & Pmbl., para. E). and extends existing human rights to take into account the specific rights experiences of persons with disabilities (Mégret 2008). It calls for "*respect for inherent dignity*" (CRPD, Art. 3(A) and "*non-discrimination*" (*Id*., Art. 3(B)). Subsequent articles declare freedom from "*arbitrary or unlawful interference*" with privacy (*Id*., Art. 14(1)), "*freedom from torture or cruel, inhuman or degrading treatment or punishment*" (*Id*., Art. 15), "*freedom from exploitation, violence and abuse*" (*Id*., Art. 16) and a right to protection of the "*integrity of the person*" (*Id*., Art. 16).

The CRPD is unique because it is the first legally binding instrument devoted to the comprehensive protection of the rights of persons with disabilities (Perlin 2012). It not only clarifies that States should not discriminate against persons with disabilities but also sets out explicitly the many steps that States must take to create an enabling environment so that persons with disabilities can enjoy authentic equality in society, such as changes in civil commitment laws (Lee 2011), changes in capacity law (Hoffman and Könczei 2010), and changes to the imposition of solitary confinement in prisons (DeMarco 2012). One of the most critical issues in seeking to bring life to international human rights law in a mental disability law context is the right to adequate and dedicated counsel. The CRPD mandates that "*States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity*" (CRPD, Art. 12, as discussed in Perlin 2008c). Elsewhere, the convention commands: "*States Parties shall ensure effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural and age appropriate accommodations, in order to facilitate their effective role as direct and indirect participants, including as witnesses, in all legal proceedings, including at investigative and other preliminary stages*" (CRPD, Art. 13).

The ratification of the Convention must be read hand in glove with the United Nations Convention Against Torture (CAT 1984). Together, these documents make it more likely—or *should* make it more likely—that, for the first time, attention will be paid to the conditions of confinement, worldwide, of this population, how those conditions regularly violate international human rights law, and how those who are in charge of these institutions do so with impunity. The purpose of the CAT was to establish a comprehensive scheme with the aim ultimately to end torture around the world (Hall 2007), to strengthen existing prohibitions on torture in international law, (Burgers and Danelius 1988), and it was motivated by a desire "*to make more effective the struggle against torture and other cruel, inhuman or degrading treatment or punishment throughout the world*" (CAT 1984).

The CAT defines the term torture to mean any act by which "*severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted*

by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions" (*Id.*, Art. 1).

The relationship between the CAT and the CRPD has begun to come under scrutiny. Importantly, the Special Rapporteur on Torture has indicated that involuntary treatment and confinement are contrary to Articles 14 and 15 of the CRPD (Wildeman 2013, quoting Interim Report 2008). In writing about prison "supermax confinement", Kathryn DeMarco thus considers the Convention against Torture to be "quite relevant to the interpretation of Article 15 of the CRPD" (DeMarco 2012, p. 550).

Janet Lord has written eloquently about the "*anti-torture*" framework of the CRPD (Lord 2010) concluding: "The adoption of the CRPD clearly constitutes an important development in the anti-torture framework under international human rights law. Its principal contribution is to apply the torture prohibition within a disability context, consistent with core principles of the CRPD including dignity, non-discrimination, autonomy, and independence. It also contributes to the framework by introducing explicitly, for the first time in an international human rights treaty, the requirement that reasonable accommodations be provided and that the failure to do so results in a finding of discrimination. These principles add content to the overall anti-torture framework and should thus find ready application as a guide to regional and international regimes applying the prohibition against torture and other cruel, inhuman, and degrading treatment or punishment" (*Id.*, pp. 78–79).

But, there has been little follow-up literature on this connection, and that gap is truly problematic if we are ever to fully and effectively contextualise the two Conventions in the context of the treatment of persons with disabilities, especially those institutionalised because of mental disabilities. I seek to address that gap in this chapter. As part of this enterprise, I will consider six core issues that must be "on the table" if the scope of the underlying problems is to be understood:

(a) Although there is a robust literature on the CRPD and on the CAT, there is virtually no mention of the plight of forensic patients. So, even within the world of those who focus broadly on these human rights issues, this population has remained invisible.
(b) Conditions at forensic facilities around the world continue to "shock the conscience", and it is essential that any "anti-torture" publication (such as this one) highlights this.
(c) Even when regional courts and commissions have found international human rights violations in cases involving forensic patients (e.g. *Victor Rosario Congo v. Ecuador* 1999 [*Congo*]), the discussion of these cases largely ignores the plaintiffs' statuses as forensic patients.
(d) There are few lawyers and fewer "mental disability advocates" providing legal and advocacy services to this population.
(e) There is little mention in the survivor movement literature about the specific plight of forensic patients.

(f) Forensic patients in facilities for persons with intellectual disabilities are particularly absent from the discourse.

2.2 The Six Factors

2.2.1 How Forensic Patients Are Ignored

Scholars have, for years, written extensively about the CAT and, for the past 5 years, robustly about the CRPD (Perlin 2011). But there has been little—shockingly little—about the applications of either of these Conventions to forensic patients. Some 6 years ago, I listed the five core factors of the overlap between mental disability law and international human rights law. One of those factors was "*Failure to Provide Humane Services to Forensic Patients*" (Perlin 2007, p. 354). This discussion followed: "*Virtually all studies and reports referred to in this article have focused on the status (and plight) of civil patients: those whose commitments to the mental health system were not occasioned by arrest or other involvement in the criminal court process. Depressingly, persons in the forensic system generally receive—if this even seems possible—less humane services than do civil patients*" (*Id*., citing Fellner 2006).

Although this article has been referred to in the literature frequently, not a single reference deals with this issue. Given the conditions in such facilities, this lack of academic interest raises serious questions as to the extent to which ongoing and serious violations of both Conventions will ever adequately come to public light.

2.2.2 Conditions in Forensic Facilities

Studies about forensic facilities tell—with deadening similarity—stories of mistreatment, lack of treatment, wholesale violations of civil and constitutional rights, and abuse (Hafemeister and Petrila 1994). It is as if the CAT and the CRPD were not intended to apply to this population. More stunningly, there is virtually no mention in the legal academic literature of this turn of events.

Historically, psychiatric facilities around the world have been beset with conditions so deplorable and inhumane that their very existences have been a shock to the conscience (Butora 2013). Revelations of residents subjected to excessive electroshock therapy, prolonged isolation, hours of being shackled to the walls, and other practices raised awareness to this vulnerable population and sparked advocates to begin a slow journey toward change and equality. The ratification of the Convention for the Rights of Persons with Disabilities (CRPD) and the Convention Against Torture (CAT), logically, should have led to an amelioration of conditions and an expansion of humane treatment options, but, in many jurisdictions, this clearly has not happened. Instead, "*these practices have simply been transformed rather than abandoned*" (Butora 2013, p. 219). Forensic psychiatric patients, in particular, still suffer in unlivable conditions that offer no

hope for rehabilitation and little optimism for the future. Research has shown that conditions in forensic facilities tend to be even more abysmal than in civil facilities (Perlin 2013b). Torture is still widespread in the treatment of forensic patients, and vastly ignored by advocates and policymakers, despite advances in the world of mental disability law and advocacy.

Remarkably, there is no specific mention of forensic facilities or forensic populations in the CRPD. How does this continue to happen? What needs to change so that the rights of all human beings are taken into consideration? What makes it so easy to overlook an entire population and subject them to less than human conditions around the world?

Heuristics surrounding individuals with mental disabilities come into play with a vengeance when they are linked with the criminal justice system (Perlin 1997, 2013a; Cucolo and Perlin 2012). While statistics make clear that the majority of individuals with mental disabilities and disorders are not any more prone to violence than those without a mental illness diagnosis (Insell 2011), the public at large operates under a general impression that mental illness breeds violence, and therefore those with a disability or disorder are unpredictably violent and capable of heinous acts that we cannot fathom (Perlin 2003). Distortions such as these are exacerbated by the media, who prioritise crime stories that involve perpetrators with suspicion of a mental illness, promoting a subculture of fear and misunderstanding (Cucolo and Perlin 2013) that feeds into sanism[2] and pretextuality.[3] It is no surprise that this fear is reflected in public attitudes towards the care and rehabilitation of these individuals when they enter into the criminal justice system.

This is not only a domestic issue but an international problem as well. Consider the following:

- Studies conducted at two Argentinean forensic wards showed unlivable conditions where individuals were housed in small, extremely overcrowded cells by approximately 75 %, with no running water or toilets. Many were denied routine medical care, a basic human right for all individuals regardless of legal status, and some were subjected to unwanted sexual practices and rape. In extreme cases, there were no appropriate treatment facilities in which to release the patients, and some were housed in the facility for over 20 years, receiving no medication or other treatment (MDRI 2009).
- Prison facilities in England revealed a number of discrepancies, including "the lack of treatment facilities, lack of a clear legal framework for treating prisoners with severe mental illness, inadequately designed prison health care wings, and considerable delays in hospital transfers" (Exworthy et al. 2012).

[2] 'Sanism' is an irrational prejudice of the same quality and character of other irrational prejudices that cause and are reflected in prevailing social attitudes of racism, sexism, homophobia and ethnic bigotry (Perlin 1992).

[3] 'Pretextuality' refers to ways that courts accept and even encourage, either implicitly or explicitly, testimonial dishonesty, especially on the part of expert witnesses (Perlin 1993).

- Convicted prisoners from a Budapest prison were used to "keep an eye on" patients housed in the nation's only high security forensic psychiatric institution. Many of the patients in the institution were deemed "high suicide risk". One can opine that the prisoners tasked with this responsibility were not given adequate training in the treatment of those with mental illnesses or disabilities, especially those in such vulnerable conditions, begging the question of how appropriate care could be rendered (Perlin 2007, p. 354, citing MDAC 2005).
- Albanian law requires that individuals with mental disabilities who have been convicted of criminal offenses be housed in prison units and must comply by all prison rules. Some were institutionalised for 5 years before their conditions were re-evaluated (Perlin 2007, p. 354, quoting Weinstein et al. 2001).

Many institutions use prolonged confinement as a way of managing or disciplining individuals deemed dangerous. Tamms Correctional Center in Illinois, for example, held a prisoner with a well-documented history of schizophrenia in solitary for nearly 6 years (Human Rights Watch 2009). While solitary conditions can be psychologically harmful to any individual, they are particularly damaging to one with a mental disability. In fact, a federal judge once equated putting mentally ill prisoners in isolated confinement with "*putting an asthmatic in a place with little air*. . ." (*Madrid v. Gomez* 1995, p. 1265). Conditions in forensic facilities thus continue to "*violate the 'decencies of civilized conduct'*" (Perlin 2009) and highlight the dire need for intervention on behalf of those with a mental disability who are subjected to such treatment. It is essential that any anti-torture initiatives highlight these issues and work to expand the reach of documents such as the CRPD and any subsequent UN treaties or conventions to include forensic patients. This marginalised and often forgotten population continues to be neglected by the very individuals working to end such injustices. How can this be rectified?

In order to begin any transformation of the current policies or views of mental illness, we must first examine, understand and reject the pretexts before us. Individuals who are mentally ill and involved in the criminal justice system face a vast amount of discrimination from multiple perspectives, making them more susceptible to ill treatment (WHO 2010). Within the community, persons with mental disabilities are a particularly vulnerable group and often stigmatised and defenceless against a number of different abuses, which causes further victimisation (Butora 2013). For example, persons with mental disabilities are typically barred from engaging in public affairs, such as policy decision-making processes (Karlan 2007; Waterstone 2005), and are often restricted in their efforts to exercise their own civil rights because of incorrect assumptions that their diagnoses make them unable to responsibly manage their own affairs (WHO 2010). According to Article 29 of the CRPD, those with a disability have the right to participate in political and public life, which includes the right to vote (CRPD, Art. 29). Regardless, this right is often curtailed by those who have "bought into" the myths of sanism and thus continue to deny fundamental rights to those with mental disabilities.

Access to appropriate healthcare is also a regular barrier (Chen 2013), and lack of treatment can often cause individuals with mental disabilities to be

inappropriately and disproportionately arrested (North Carolina State University 2013). Consider here that many persons with mental illness are brought to jails rather than mental hospitals *in the first place* [in what are sometimes referred to as "mercy bookings" (Canales 2012, p. 1735)] because of how much more time-consuming mental hospital "drop offs" are, and for a variety of other reasons related to the work conditions of the police officers involved and to what is perceived as the lack of "supportiveness" of the relevant mental health facilities. There is also a lack of coordination between the police and mental health professionals and more significance placed on the arrest itself rather than the acts or the clinical conditions of the apprehended individuals (Slate and Johnson 2008, p. 89).

Once members of this population enter the criminal justice system, they face an entirely new set of barriers. There is a prevalent underlying "culture of blame" (Feigenson 1997, p. 60 & n. 258) that follows the individuals and continues to accuse them, demonise them, for their mental illnesses and disabilities (Perlin 1998b). After criminal justice involvement, they are not only categorised as "mentally ill", but have a second label of "criminal", being labelled as both "mad" and "bad" (Margulies 1984). Society in general adopts a "lock them up" mentality when it comes to this dual marker, believing that rehabilitation is not an option (Farabee 2006, p. A9). Once again, sanism and fear come into play. It is seen as far easier and safer to lock someone up behind prison or forensic facility walls than to focus on rehabilitation. While this attitude is enraging, it is doubly upsetting when many of the patients in forensic facilities have not been convicted of a crime (awaiting determination as to incompetency to stand trial, permanently incompetent to stand trial, awaiting trial, post-insanity acquittal). These individuals are placed into inhumane conditions, often kept longer than their criminal counterparts and may not even receive the rehabilitation that would allow for successful reintegration back into the community (Human Rights Watch 2009). Both the general public and institutional staff and officials operate under the impression that punishment is the main objective of the criminal justice system, which reinforces the belief that harsh conditions are acceptable (Cullen et al. 2009). Perhaps a shift of focus is needed from reliance on punitive measures to that of rehabilitation. This is especially crucial when it comes to those in the criminal justice system with a mental illness. Rather than locking them away, the goal of forensic facilities should be to help the patients so that they may re-enter into society as contributing and productive members of their communities rather than victimise them further and hinder their futures.

Shedding light on the deplorable conditions on forensic facilities and spreading awareness about the treatment in which patients are subjected is the first step in ensuring equality. Once this population is seen as human beings who are entitled to healthcare and humane conditions, the stigma of mental illness will begin to fade and we can begin to focus on people rather than labels.

2.2.3 Regional Courts and Commissions

Although some of the most important cases decided by regional human rights courts and commissions have dealt with forensic patients, this fact is ignored, even in the decisions themselves. By way of example, *Victor Rosario Congo v. Ecuador*, involved a 48-year-old Ecuadorian who, as a result of the State's gross negligence and willful acts, died of malnutrition, hydro-electrolytic imbalance and heart and lung failure. Specifically, a guard beat Mr. Congo with a club on the scalp, deprived him of medical treatment, kept him naked and forced him to endure complete isolation (*Congo* 1999, 9).

The Inter-American Commission on Human Rights (Inter-American Commission) found that the State was responsible for its agents' conduct that violated Mr. Congo's right to humane treatment under Article 5 of the American Convention on Human Rights (American Convention). The Inter-American Commission determined that Article 5 of the American Convention must be interpreted in light of the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (MI Principles *Id*., 54). This is particularly important because it made the MI Principles hard law, or in other words, binding upon the U.N. members who have signed it (Neuman 2008, p. 111). Thus, it guarantees more extensive rights for persons with mental disabilities.

The Inter-American Commission found that the solitary confinement of Mr. Congo constituted inhuman and degrading treatment in violation of Article 5 (2) of the American Convention, especially in light of the fact he was left in isolation unable to satisfy his basic needs (*Congo* 1999, 59). Thus, the State violated Mr. Congo's right to "*be treated with respect for the inherent dignity of the human person*" (*Id*.). Further, the Inter-American Commission found that there is a duty upon the State to ensure the physical, mental and moral integrity of persons suffering from mental illness (*Id*., ¶ 62).

The Inter-American Commission also found that the State violated Article 4 (1) of the American Convention because the State failed to take measures in its power to ensure the right to life of a person who "*partly because of his state of health and in part owing to injuries inflicted on him by a State agent, was defenseless, isolated and under its control*" (*Id*., 69). Under Article 25(1) of the American Convention, Mr. Congo had a right to judicial protection, a right which the State violated because there were no judicial avenues available to establish the responsibility for his sustained injuries and death (*Id*., 86). As a result of this case, the Inter-American Commission recommended that the persons responsible for the violations be punished, the family of Mr. Congo be compensated, medical and psychiatric care be provided for persons suffering from mental illness, and individuals confined to the penitentiary system be assigned specialists to identify any psychiatric disorders (*Id*., 98).

This case is just one of the many that highlights the need for mental health advocates and services within forensic settings. Shocking examples such as these underscore the extent to which the forensic population is particularly bereft of legal

advocacy. Again, this lack of advocacy flies frontally in the face of both the proscriptions and the prescriptions of the CRPD and the CAT.

2.2.4 Lack of Lawyers and Advocacy Services

With these issues coming to light, one may question the role of lawyers and mental disability advocates who should be working to protect and ensure the rights of individuals who are mentally and intellectually disabled. There are, however, few lawyers and fewer mental disability advocates providing legal and advocacy services to this population, which adds to the continued inequity and misuse of punitive measures. Treatment options that would provide appropriate services in the least restrictive alternative have dwindled causing jails and prisons to become, in essence, the new mental hospitals (Acquaviva 2006, p. 978). Aside from the issues inside the cell walls, such as inappropriate treatment and less than humane conditions that arise in jails and prisons, lawyers and mental disability advocates alike face numerous hurdles in assuring that their clients are treated with dignity and receive the care that they need and deserve. Because victories on this level are so few and far between, the burnout rate of advocates tends to be extremely high, and the job itself underpaid (Human Rights Watch 2009). As such, there are fewer advocates willing and able to do such hard work for few successes.

Recent mental health services budget cuts also contribute to the lack of advocates (Kinsler and Saxman 2007). In fact, "*twenty-two out of forty state correctional systems reported in a recent study that they did not have an adequate number of mental health staff*" (Human Rights Watch 2009). In response, overburdened staff may find it difficult to provide the most appropriate treatment that would encourage rehabilitation. Oftentimes, such recourse perpetuates the revolving door' trend between the community and the criminal justice system without getting to the root of the issue, which is appropriate mental healthcare (Barr 1999). This practice violates Article 26 of the CRPD, granting the right to habilitation and rehabilitation. In essence, each individual possesses the right "*to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life*" (CRPD, Art. 26). Burnt-out staff who may not be able to provide the best services and budget cuts that impede on adequate treatment do little to uphold the principles mandated by this article.

Lack of training and adequate education in the field of mental disability also contributes to the lack of effective counsel and advocacy services in this area (Perlin 2010). Lawyers may not receive enough education in regard to individuals with mental illness and their specific needs, which affects how they advocate for their clients. As such, they may shy away from cases with defendants with mental illnesses. Additionally, they, too, may be overwhelmed "*by the tsunami of prisoners with serious mental health needs*" (Human Rights Watch 2009), and be hard-pressed to take the time to consider or research the most appropriate course of action with each client, which may inadvertently do them an injustice. Also, even in

instances in which training has been adequate, some advocates may still have underlying fear when it comes to the mentally ill population, which places both them and the client at a disadvantage and makes effective representation nearly impossible.

Consequently, there is a pressing need for advocates for people in the criminal justice system who have mental and intellectual disabilities. Because this population is silenced and marginalised, it becomes even more essential that lawyers and advocates step forward and aid this population in finding its voice and providing it with the tools that enable it to fight for rights and equality. This will also raise awareness about this neglected population and educate the general public, leading, optimally, to real and lasting change, a change that will stop the demonisation of people living with mental and intellectual illnesses and focus, rather, on the person's humanity and his or her treatment and well-being.

Both the CAT and the CRPD attempt to correct this academic deficit. Article 10 of the CAT and Article 4 of the CRPD both seek to promote proper education and training to professionals. Article 10 of the CAT states that "*Each State Party shall ensure that education and information regarding the prohibition against torture are fully included in the training of law enforcement personnel, civil or military, medical personnel, public officials and other persons who may be involved in the custody, interrogation or treatment of any individual subjected to any form of arrest, detention or imprisonment*". Similarly, Article 4 (i) of the CRPD tells us that it is essential "*to promote the training of professionals and staff working with persons with disabilities in the rights recognized in the present Convention so as to better provide the assistance and services guaranteed by those rights*". With such protections in place, it would seem that those working directly with individuals with a mental disability in any capacity would—or, at least, *should*—receive formal training as to appropriate treatment and care of such individuals. Education is the first step to changing the persistent misconceptions and "*nurtur[ing] receptiveness to the rights of persons with disabilities*" (CRPD, Art. 8).

In regards to the education of the general population at large, Article 8 of the CRDP promotes "*awareness throughout society, including at the family level, regarding persons with disabilities, and to foster respect for the rights and dignity of persons with disabilities*". This includes combating the "*stereotypes, prejudices and harmful practices relating to persons with disabilities. . .*".

There is insufficient available counsel to enforce these articles (Perlin 2004). Certainly, without such counsel, the likelihood that the CRPD and/or the CAT are considered as sources of rights for this population is negligible.

2.2.5 There Is Little Mention in the Survivor Movement About the Specific Plight of Forensic Patients

Articles written by those who self-identify with the "psychiatric survivor movement" by and large ignore this population as well. So, even within the world of those who focus broadly on these human rights issues, this population has remained

invisible. It may be possible that survivors feel forced into continued silence because of the additional stigma that perpetuates individuals with mental and intellectual disabilities in forensic settings. Speaking out about their personal experiences in a forensic facility, for example, may further ostracise survivors in their communities, causing supplementary discrimination that paves the way for even more victimisation and abandonment, which may negate positive strides in rehabilitation. It needs to be stressed that there is significant tension between those who characterise themselves as anti-psychiatry survivors and those who adopt alternative perspectives to the impact that institutionalisation had on their lives, and there is often "*fraught and embittered advocacy*" between these groups (Lord 2010, p. 39 & n. 60).

There may also be a fear that bringing disabilities to the forefront of the conversation may further categorise individuals into "us" and "them", "undiagnosed" and "the other", demeaning the very purpose of the psychiatric survivor movement. Furthermore, those in the community who are undereducated in the field of mental and intellectual disabilities may then make judgments regarding the entire population with very limited information, only to reinforce the stigma that survivors and advocates alike seek to transform (Chavarria 2012).

Survivors may also be hesitant to speak out because of learned helplessness while in forensic institutions (Winick 2002, p. 555 & n. 137). Living in deplorable conditions and contending with staff who may not completely understand the population may make one hesitant to speak about what he or she endured and advocate for change (Chavarria 2012). There may be lasting feelings and issues revolving around being unheard and about feeling their voices will not make a difference; this reality forces many into further silence. Such silence makes it far more likely that international law will not be a source of remedies in cases involving this population.

In discussing the split in approaches to CRPD issues by NGOs representing persons who have been institutionalised, Professor Janet Lord makes the important point that many important issues "*have received little breadth of dialogue within the NGO community and appear to have narrowed the terms of the debate among States as well*" (Lord 2004, p. 101). Although forensic issues are not the focal point of Lord's paper, we believe that this observation holds equally true in this precise context.

2.2.6 Forensic Patients in Facilities for Persons with Intellectual Disabilities Are Particularly Absent from the Discourse

It is imperative that, as we continue to focus on this population, we do not omit the rights of persons with intellectual disabilities who are in forensic facilities, as they are particularly absent from discourse, notwithstanding the fact that they have been found to comprise 12.8 % of all patients with forensic involvement (Lunsky et al. 2011, p. 19). Although there is "*increasing recognition*" that this cohort of individuals "*are a particularly complex patient group whose needs are not well*

met" (*Id*., p. 9), there has still been minimal focus on the high rates of abuse and neglect experienced by this population (*id*., p. 20; Glaser and Florio 2004). Aside from the issues that plague those in forensic facilities with mental disabilities, individuals with intellectual disabilities face a unique set of circumstances because of what is perceived as the permanency of the disability. Unlike mental illnesses that can, for some, be treated with a prescribed medication regimen aimed at quelling active symptoms of the disorder, intellectual disabilities are believed to be more permanent, making it even less likely that potentially ameliorative interventions would even be attempted in forensic facilities (Tsiouris 2010). Without proper training and rehabilitation programmes, holding an individual under such circumstances with intellectual disabilities can be defined as a form of torture, especially if he or she is detained indefinitely.

Just as prison facilities are not the appropriate places to treat persons with mental disabilities, so are they not appropriate places to treat persons with intellectual disorders, and may even exacerbate secondary symptoms (Human Rights Watch 2009). Community-based treatment alternatives are crucial for this population, as is proper education; such alternatives and education can help to reduce the fear and uncertainty that surrounds them, and help them to be seen in a different, more human light.

2.3 Therapeutic Jurisprudence (See generally, Perlin and Lynch 2014)

One of the most important legal theoretical developments of the past two decades has been the creation and dynamic growth of therapeutic jurisprudence. (Wexler 1990; Wexler and Winick 1996; Winick 2005).Therapeutic jurisprudence presents a new model for assessing the impact of case law and legislation, recognising that, as a therapeutic agent, the law that can have therapeutic or anti-therapeutic consequences (Perlin and Lynch 2015). The ultimate aim of therapeutic jurisprudence is to determine whether legal rules, procedures, and lawyer roles can or should be reshaped to enhance their therapeutic potential while not subordinating due process principles (Perlin 2003, 2008a).There is an inherent tension in this inquiry, but David Wexler clearly identifies how it must be resolved: "*the law's use of mental health information to improve therapeutic functioning [cannot] impinge upon justice concerns*" (Wexler 1993, p. 21; Wexler 1996). As I have noted elsewhere "*An inquiry into therapeutic outcomes does not mean that therapeutic concerns 'trump' civil rights and civil liberties*" (Perlin 1998b, p. 782; 2000a, p. 412).

Therapeutic jurisprudence "*asks us to look at law as it actually impacts people's lives*" (Winick 2009, p. 535) and focuses on the law's influence on emotional life and psychological well-being (Wexler 2006, p. 45). It suggests that "*law should value psychological health, should strive to avoid imposing anti-therapeutic consequences whenever possible, and when consistent with other values served by law should attempt to bring about healing and wellness*" (Winick 2003, p. 26).

Therapeutic jurisprudence "*is a tool for gaining a new and distinctive perspective utilising socio-psychological insights into the law and its applications*" (Freckelton 2008, p. 582). It is also part of a growing comprehensive movement in the law towards establishing more humane and psychologically optimal ways of handling legal issues collaboratively, creatively and respectfully (Daicoff 2006). It supports an ethic of care (Gilligan 1982).

One of the central principles of therapeutic jurisprudence is a commitment to dignity (Winick 2005, p. 161). Professor Amy Ronner describes the "three Vs": voice, validation and voluntariness, arguing:

> What 'the three Vs' commend is pretty basic: litigants must have a sense of voice or a chance to tell their story to a decision maker. If that litigant feels that the tribunal has genuinely listened to, heard, and taken seriously the litigant's story, the litigant feels a sense of validation. When litigants emerge from a legal proceeding with a sense of voice and validation, they are more at peace with the outcome. Voice and validation create a sense of voluntary participation, one in which the litigant experiences the proceeding as less coercive. Specifically, the feeling on the part of litigants that they voluntarily partook in the very process that engendered the end result or the very judicial pronunciation that affects their own lives can initiate healing and bring about improved behaviour in the future. In general, human beings prosper when they feel that they are making, or at least participating in, their own decisions. (Ronner 2002, pp. 94–95; see also, Ronner 2008, 2010)

The question to be posed here is this: to what extent can international human rights law reach out to therapeutic jurisprudence to best insure that these principles written about by Professor Ronner—the principles of voluntariness, voice and validation—be fulfilled in matters involving residents of forensic institutions?

There has been astonishingly little written about this question (but see, Perlin 2014). There *has been* some important work done on the relationship of therapeutic jurisprudence to the application of international human rights principles to prisoners and detainees with a mental illness, much of it a response to the reality that the conditions of prison facilities and forensic facilities around the world are textbook examples of anti-therapeutic conditions (van ZylSmit 2010; Cohen and Dvoskin 1993). Astrid Birgden argues forcefully that "*applying therapeutic jurisprudence can assist forensic psychologists in actively addressing human rights in general, as well as prisoners and detainees with mental disabilities in particular*" (Birgden 2009, p. 59; see also, Birgden and Perlin 2008, 2009). By way of example, in relation to prisons, Ivan Zinger has argued that the best approach to ensure that the rule of law is upheld is to view corrections as being in the human rights business:

> The best argument for observing human rights standards is not merely that they are required by international or domestic law but that they actually work better than any known alternative—for offenders, for correctional staff, and for society at large. Compliance with human rights obligations increases, though it does not guarantee, the odds of releasing a more responsible citizen. In essence, a prison environment respectful of human rights is conducive to positive change, whereas an environment of abuse, disrespect, and discrimination has the opposite effect: Treating prisoners with humanity actually enhances public safety. Moreover, through respecting the human rights of prisoners, society conveys a

> strong message that everyone, regardless of their circumstance, race, social status, gender, religion, and so on, is to be treated with inherent respect and dignity (Zinger 2006, p. 127).

But again, this focus is on prisons and not on forensic facilities. Conditions in forensic facilities across the world "*shock the conscience*" (*Rochin v. California* 1952) and, in some instances, are so bereft of humanity that they challenge the notion that we are a civilised society (Perlin 2007, pp. 343, 349; 2013d). "*These conditions scream out for an in-depth TJ* [therapeutic jurisprudence] *analysis, to demonstrate their destructiveness and their negative impact on the mental health of those unlucky enough to be housed in such facilities*" (Perlin 2014, p. 539). And this is especially so, because the CRPD is a document that "*resonates with TJ values*" (Perlin 2012, p. 36). Although there has been recent interest in the overlap between TJ and the CRPD (Perlin 2011, 2013c), by and large, this has not extended to the specific problems raised by forensic institutions (but see, Perlin 2014, p. 541, calling for, as part of a new therapeutic jurisprudence research agenda, the study of "*the TJ implications of instituting reform of forensic facilities*"). I hope that this chapter will lead others to consider these issues.

2.4 Conclusion

Forensic facilities and their populations have classically been hidden from view. There has been scarce notice, and most of those involved in all the relevant systems seem passively comfortable with the *status quo*. But this state of affairs violates international human rights law as well as the precepts of therapeutic jurisprudence. We can no longer keep this state of affairs so hidden.

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Legal Aspects of the Use of Coercive Measures in Psychiatry

3

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Abstract

Coercion appears to be an integral component of psychiatry, particularly forensic psychiatry, and its use strongly influences the way the public sees this specialty. Coercion takes place when individuals are placed in hospital involuntarily and entails measures taken against their will during admission. The use of coercion is, however, increasingly scrutinised with a clear shift in perspectives from a medical- to a rights-based approach. A number of laws and declarations have been passed on a national and international level restricting the use of coercive measures. Particular aspects of psychiatric care and coercion have been met with particular concerns, e.g. electroconvulsive treatment and solitary confinement, and some forms of coercion may amount to inhumane and degrading treatment. The importance of thorough reporting of the use of coercive measures to allow for analysis and evaluation has been emphasised. The introduction of individual complaints procedures allowing patients to raise concerns about their treatment has further led to an improvement of conditions in psychiatric institutions. This chapter will outline the key hard and soft international and European law, including the UN Convention on the Rights of Persons with Disabilities and the European Convention on Human Rights, and their application to forensic psychiatry. Key cases brought before the European Court of Human Rights are reviewed.

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3.1 Introduction: Coercion, Treatment and Law

Psychiatry and coercion are strongly correlated (Georgieva 2012; Rushforth 2014). Coercion, of course, plays a particular role in forensic psychiatry which even has been called an institutionalised symbol of coercion (Saimeh 2013, 143). Coercive measures in many forms are part of the symbolic inventory of psychiatry and evidently they still influence strongly the public's view of psychiatric treatment (Steinert 2011, 349). Not least has Szasz gone so far to understand psychiatry as selling "coercion as cure" (Szasz 2007). While involuntary treatment is certainly a centrepiece of controversial debates on coercion in psychiatric institutions and results in difficult legal questions, the general concept of coercion from a legal perspective is wider. Coercion is implemented when individuals are involuntarily committed to a psychiatric hospital, and it entails all measures which can be taken against the will of patients during their period of confinement. Of course, coercion still is effective and operational although patients may submit to treatment without signs of opposition because they believe that any opposition will be useless in face of superior force available to treatment staff. Insofar coercive measures in psychiatry partially overlap with coercive measures applicable in prison facilities, and community-based psychiatric coercion creates a parallel to community-based criminal corrections. As in other closed institutions, where inmates are detained against their will, coercion plays an important role in psychiatric hospitals in upholding discipline and institutional order, in preventing escape, in protecting the life and health of inmates and staff and ultimately also in achieving the principal goals of the respective institutions.

Course and development of national and international legal frameworks of regular and forensic psychiatry clearly show that coercion is increasingly scrutinised and placed under normative restraints (Saks 1986; Sörensen 2013). The development of normative restraints placed on coercive measures in psychiatric institutions follows a path which some time earlier had been paved by the movement for prisoner rights and prison laws. This resulted in a shift of perspectives: A treatment and discretion based on medical approach to patients detained in psychiatric institutions is complemented and partially replaced by a rights-based approach (European Union Agency for Fundamental Rights 2012, 7) which provides for defensive and positive rights (Gooding and Flynn 2015, 249). Most important in setting off a process of establishing legal boundaries to coercion in psychiatric facilities was (and still is) the meta-level of human rights and those international actors to whom the implementation and monitoring of human rights is entrusted. The United Nations and regional bodies like the Council of Europe or the Organization of American States as well as the human rights courts operating within their respective boundaries (European Court of Human Rights; Inter-American Court of Human Rights) have contributed significantly to building a body of norms and regulations which amount today to a minimum set of common normative standards and internationally endorsed principles (World Health Organization 2005, 15).

3.2 Coercion in Psychiatric Hospitals and International Law

3.2.1 United Nations' Hard and Soft Law

On the level of the United Nations, the Declaration on the Rights of Mentally Retarded Persons Proclaimed by General Assembly resolution 2856 (XXVI) of 20 December 1971 was followed by the drafting of the United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (1991). Resolution 46/119 on "The Protection of Persons with Mental Illness and for the Improvement of Mental Health" of 1991 and, more recently, the Convention on the Rights of Persons with Disabilities and its Optional Protocol of 2006 have created international hard law which is for the assessment of coercive measures as relevant as the United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment 1987 and the 1966 International Covenant on Political and Civil Rights. The monitoring systems established on the basis of the anti-torture convention and the disabilities convention request regular reporting by state parties. They also provide regular reviews of these reports by the Committee against Torture and the Committee on the Rights of Persons with Disabilities as well as the formulation of recommendations which also address conditions of detention and coercive measures applied in psychiatric hospitals and in community care together with their legality. The international system of monitoring is supplemented by obligations to install national monitoring instruments in terms of independent bodies entitled to visit places of detention (including psychiatric hospitals). In addition to these mechanisms, a Special Rapporteur on Torture operating under the Human Rights Council of the United Nations has the mandate to report from thematic or country perspectives. A topical report, presented in 2013, focused on torture and ill-treatment in health settings (Méndez 2013). Although Committees and Rapporteurs have no judicial functions—they do not make decisions on the legality or illegality in individual cases—reports and reviews provide for important information addressing particular aspects of legal frameworks and practices which raise concerns with respect to fundamental freedoms.

Recent reports of the Committee for the Prevention of Torture show that the Committee places a special focus on the use of physical restraints (Committee for the Prevention of Torture 2012, p. 47 for Germany). They raise concerns about wide discretionary powers and arbitrary decision-making and the administration of disputed treatment approaches like electroconvulsive treatment (Committee for the Prevention of Torture 2013, p. 33 for Norway). Furthermore, they criticise the use of solitary confinement, restraints and forced medication which may amount to inhumane and degrading treatment as well as the frequent lack of effective and impartial investigation of the excessive use of restrictive measures in mental healthcare institutions (Committee for the Prevention of Torture 2013, p. 161, for The Netherlands). The Committee emphasises the availability of documentation and statistics on coercive methods which allow a thorough analysis and evaluation of the situation of persons placed under psychiatric care (Committee for the

Prevention of Torture 2013, p. 161). In general, the Committee seems concerned about high numbers of persons involuntarily admitted to psychiatric hospitals for lengthy periods of time and the lack of alternatives to compulsory placement in psychiatric hospitals and points to the vagueness of laws authorising civil or criminal psychiatric commitment (Committee for the Prevention of Torture 2013, p. 33). These concerns are reiterated by the Committee on the Rights of Persons with Disabilities in its latest review of the report presented by Germany (Committee on the Rights of Persons with Disabilities 2015). The Committee points to a widespread practice of involuntary placement in psychiatric institutions, a lack of protection of patients' privacy, the use of chemical and other means of restraint and, in particular, also the lack of data on the situation of detained persons. It stresses the importance to reduce involuntary placement in psychiatric care and calls for the promotion of alternative (and less coercive) measures.

In 1999, the Human Rights Committee which deals with individual complaints on violations of fundamental rights enshrined in the International Covenant on Political and Civil Rights has held (Human Rights Committee, CCPR/C/66/D/754/1997, 3 August 1999) that compulsory psychiatric treatment is a form of deprivation of liberty the legitimacy of which depends on medical criteria which necessitate treatment (and detention). If these criteria cannot be established, compulsory treatment turns into arbitrary detention prohibited by Article 9 International Covenant on Political and Civil Rights. Such substantive criteria have to be supplemented by procedural mechanisms which result in mandatory and periodic review, including review by an independent judicial body.

3.2.2 Council of Europe: European Conventions and European Soft Law

In Europe, the European "Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment" (November 26, 1987) seeks to effectively implement the prohibition of torture and inhuman treatment enshrined in Article 3 of the European Convention on Human Rights. The European Anti-Torture Convention provides also for close monitoring of all detention places and facilities of European state parties to the convention (as does the United Nations Anti-Torture Convention), but in addition foresees a strictly enforced system of visits by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (Morgan and Evans 1994). The Bio-Convention of the Council of Europe (Oviedo-Convention 1997) states in the first article the obligation of state parties to protect the dignity and identity of all human beings and guarantee everyone, without discrimination, respect for their integrity and other rights and fundamental freedoms with regard to the application of biology and medicine. Article 2 declares the primacy of the human being prevailing over the sole interest of society and science while Articles 5–9 deal with the principles of full information and informed consent when it comes to interventions justified with health arguments. The Bio-Convention then addresses

individuals not able to consent. In that case, a medical intervention may only be carried out with the authorisation of his or her representative or an authority or a person or body provided for by law. However, the individual shall still participate as far as possible (Article 6). Article 7 of the Bio-Convention declares a medical intervention aimed at treating a mental disorder without the consent of the patient admissible only if serious harm for their health would be the result of omitting the medical intervention. Here, the threshold for intervening legitimately is raised through requesting that serious future harm will outweigh lack of consent. Article 9 points, moreover, to the concept of the "advance directive" as previously expressed wishes relating to medical interventions and made when able to consent shall be taken into account when deciding on treatment against the natural will of a person. Preparatory work on an additional protocol to the Bio-Convention dealing specifically with the protection of basic rights of persons with mental disorders with regard to involuntary treatment will be concluded in November 2015 (Committee on Bioethics 2015a, b).

The European Convention on Human Rights then provides for fundamental rights also for patients detained in psychiatric hospitals or falling under the authority of psychiatric care in the community. From the viewpoint of assessing substantive legal issues related to coercion in psychiatric settings, besides the prohibition of inhuman and degrading treatment in Article 3 of the European Convention on Human Rights, the right to liberty (Article 5), the right to privacy (Article 8) and ultimately also Article 9 (freedom of thought, conscience and religion) are of particular relevance. Procedural aspects of coercion are covered by Article 6 which in case of restrictions of basic rights establishes the right to a fair hearing before an independent tribunal.

As early as 1983, the Council of Europe issued Recommendation No R (83)2 on "Legal protection of persons suffering from mental disorder placed as involuntary patients". Recommendation 1235 (1994) addresses general issues of psychiatry and human rights. The "White Paper" on the protection of the human rights and dignity of people suffering from mental disorder, especially those placed as involuntary patients in a psychiatric establishment, was published in 2000. Recommendation (2004) 10 concerns "the protection of the human rights and dignity of persons with mental disorder". Of relevance is also Recommendation (2014) 3 concerning dangerous offenders.

Standards and jurisprudence have also been developed within the framework of the Organisation of American States and on the basis of the Inter-American Convention on Human Rights. Here, the Inter-American Court on Human Rights has issued "Recommendations for the Promotion and Protection of the Rights of the Mentally Ill 2000". The recommendations emphasise priority of mental health care in the community and consider confinement and involuntary treatment in a psychiatric hospital as a last resort. Any deprivation of liberty, but also other infringements on fundamental freedoms, must be reviewable by an independent and impartial tribunal in a fair procedure and within a reasonable time.

The European Convention on Human Rights allows individuals to bring complaints on violations of fundamental rights before the European Court of

Human Rights. The individual complaint procedure has contributed to developing jurisprudence on the conditions under which persons may be committed to psychiatric hospitals, subject to involuntary treatment and to coercive measures in general.

3.2.3 European Union and Forensic Psychiatry

The European Union has no special competences in the field of general or forensic psychiatric commitment and treatment, besides competences which may follow from general issues of prevention of discrimination and the regulation of a common market (Verbeke et al. 2015). However, European Union member countries are bound by the European Union Human Rights Charter when implementing European Union law and shall respect the fundamental rights following from the Charter.

The European Union Human Rights Charter prohibits torture as well as inhuman and degrading treatment (Article 4) and essentially grants the same fundamental freedoms as does the European Convention on Human Rights. But, interestingly, from a legal point of view, the Charter in Article 3 guarantees not only the right to respect for physical integrity but also respect for mental integrity. While the focus of fundamental freedoms (and their interpretation) historically has been put on the body and physical integrity, new developments consider mental integrity and mind apart from bodily integrity.

Furthermore, the European Commission has published the "Green Paper" on mental health in 2005 (European Commission 2005) which holds that involuntary placement and treatment heavily infringe on the basic rights of patients. The Paper adopts the view that compulsory measures should only be taken as a last resort and where other, less intrusive measures failed.

3.2.4 Coercive Measures and Individual Rights

The fundamental rights of the ECHR (and corresponding rights in national constitutions as well as endorsed by other human rights instruments) which are most relevant for the legal assessment of coercion in psychiatric settings are:

- Prohibition of torture, degrading or inhuman punishment or treatment (Article 3)
- Right to liberty (Article 5)
- Right to fair proceedings and trial (Article 6)
- Right to privacy (Article 8)

Interestingly enough, Article 9 of the European Convention on Human Rights, which guarantees freedom of thought, conscience and religion, until now has not been invoked by complainants nor has it been dealt with in the jurisprudence of the European Court of Human Rights or national (constitutional) courts adjudicating cases of involuntary psychiatric treatment (see in this respect Bublitz 2011).

In general, with some exceptions (e.g. prohibition of torture), the fundamental (individual) rights spelled out in international and European human rights instruments as well as in national constitutions can be restricted in order to pursue an overriding public interest. However, normative standards such as the rule of law and proportionality apply when imposing such restrictions. Rule of law requires that any form of coercion is based on a law which is free from vagueness and allows predictability, accountability and judicial review. The procedures through which individual rights can be restricted must guarantee that risks of arbitrary decision-making are effectively contained. The principle of proportionality requests a test which screens coercive measures concerned for necessity, subsidiarity and a proper balance of interests involved (European Union Agency for Fundamental Rights 2012).

3.3 Coercive Measures and the Law

3.3.1 Involuntary Committal to a Psychiatric Hospital

Two avenues may lead to an involuntary committal to a psychiatric hospital and subsequent detention and treatment: Civil (and/or administrative) commitment and criminal commitment. Civil commitment to psychiatric hospitals is regulated in mental health laws which—from a substantive point of view—allow involuntary admission and detention in case a person, due to mental problems, presents a grave danger for him- or herself or to others (see for an overview of legal conditions of committal in European national mental health laws European Union Agency for Fundamental Rights 2012; Dawson and Kämpf 2006). Historically, civil commitment to a psychiatric hospital was designed as indeterminate detention. However, concerns about proportionality of indeterminate confinement has increasingly resulted in legislators resorting to determinate periods of time.

Differences in the legal framework of criminal committal to forensic hospitals in Europe can be observed as some countries have adopted a two track system of criminal sanctions. Two track systems include on the one hand criminal punishment (for criminally responsible offenders) which is determined on the basis of the seriousness of the criminal offence and personal guilt. On the other hand, in case of offenders with diminished or completely excluded criminal responsibility, so-called measures of rehabilitation and security step in. Such measures of rehabilitation and security are imposed by the criminal court and include detention in a (forensic) psychiatric hospital and are justified by the danger the offender poses for the public because of his or her mental illness. These measures are grounded on the normative principle of necessity and regularly imposed as indeterminate sentences. Termination of detention in a forensic hospital results from continued detention becoming disproportional either due to disproportion between the length of confinement and the assumed risk to the public or because the mental state has improved in a way no longer establishing dangerousness. Other countries operate a one track system of criminal sanctions which provides only for criminal

punishment and transfers criminal offenders assessed not to be responsible for their crimes due to mental illness to the regular mental health system. This results in the application of general mental health law and possible committal to a forensic psychiatric hospital through general mental health administration. A small number of countries (e.g. the UK) admit offenders to forensic-psychiatric care on the basis of their presentation at the time of sentencing regardless of criminal responsibility.

In the legal assessment of admission and (continued) detention in a regular or a forensic hospital, the principles of rule of law and proportionality are of paramount importance (see for a comprehensive review of the jurisprudence of the European Court of Human Rights Niveau and Materi 2007). The rule of law principle requires a clear statutory basis and predictability of situations which may result in detention in a psychiatric hospital. Proportionality is established by making detention dependent on a range of substantive and procedural criteria.

Article 5 ECHR allows for detention in case of a conviction by a competent court (Article 5 para 1) and detention of persons of unsound mind, alcoholics or drug addicts (Article 5 para 1e). In case of criminal or civil commitment to a psychiatric hospital, jurisprudence deals with substantive and procedural aspects of the concept of "unsound mind" (Dougin 1998). Evidence on a mental disorder must be based on objective medical expertise. The mental disorder must then be of a kind or degree warranting compulsory confinement. The ECtHR leaves room for the legislator when defining unsound mind, mental illness or insanity as its meaning is—according to the Court—continually evolving (Winterwerp v. the Netherlands, judgment of 24 October 1979; Case of Rakevich v. Russia, Application no. 58973/00, Judgment, Strasbourg, 28 October 2003). National legislators are not obliged to provide for an exact definition of "unsound mind". Leaving some leeway to legislative bodies is justified with the argument that advances in scientific knowledge and corresponding changes in understanding and definition require some flexibility. However, no arbitrariness is allowed.

Article 5e therefore also serves as a protection against minimising the threshold of "unsound mind" in order to allow indeterminate detention of persons considered to be dangerous but not suffering from a "true" psychological disorder. The question of the legal threshold of a "true" psychological disorder has recently been raised again after a Law on Committal for Therapy (Therapieunterbringungsgesetz) was enacted in 2011 in Germany. This law was a response to a series of judgments of the ECtHR which declared Germany to be in violation of Article 5 and Article 7 of the ECHR for allowing preventive detention of dangerous offenders after expiry of their sentence (Kinzig 2010). The law aims at preventive detention of dangerous offenders who had to be released from custody because of the judgments of the ECtHR. It stipulates that dangerous offenders suffering from a psychological disorder (which does not amount to insanity or an "unsound mind", thus completely excluding or significantly diminishing criminal responsibility) may be committed for an indeterminate period of time to a treatment facility. However, neither the ECtHR nor the German Federal Constitutional Court found a violation of the right to liberty (Article 5 ECHR) by lowering the threshold of "unsound mind" to a psychological disorder which does not result in a finding of not guilty for reason of insanity.

The German Federal Constitutional Court accepts a lower threshold of the seriousness of a mental disorder. It argues that neither the jurisprudence of the ECtHR nor the German Basic Law request that a mental disorder in the sense of Art. 5 para 1e ECHR must result in a finding of insanity and exclude (or significantly diminish) criminal responsibility. Moreover, the Federal Constitutional Court argues that the jurisprudence of the ECtHR or human rights may not prevent national legislators to introduce a "third track" of criminal sanctions (besides regular criminal punishment and imposition of a measure of rehabilitation and security) which opens the way to indeterminate detention in a treatment facility in case of a person assessed to suffer from a "psychological disorder" or a mental impairment that does not reach the threshold of insanity nor establish a mental illness on the basis of psychiatric expertise (Federal Constitutional Court, Judgment, 11 July 2013, 2 BvR 2302/11, §104). The Federal Constitutional Court grounded its decision also on the parliamentary documents explaining the motives to enact the Law on Committal for Therapy. According to these legislative documents, the "disorder" must only amount to a "clinically recognisable complex of symptoms and behavioural abnormalities" which results in impairments and strains on the individual and social level (Federal Constitutional Court (BVerfG) Judgment 11 July 2013, 2 BvR 2302/11, §91). In particular, anti-social personality disorders and problems related to sexual preference such as paedophilia or sadism have been mentioned by the legislator (Federal Constitutional Court, Judgment 11 July 2013, 2 BvR 2302/11, §91). In addition, a "psychological disorder" shall call for treatment in a special facility in order to prevent that most serious crimes are committed. Indeed, this is an argumentation which carries in particular the risk of lowering the threshold of an "unsound mind" and its impact on cognitive and volitional capacities to a minimum on the one hand while on the other hand the consequences in terms of indeterminate admission to a psychiatric hospital are fully upheld. The involuntary detention of persons of unsound mind is certainly a legitimate aim of Article 5e ECHR. But justification of this aim is based on a causal chain which joins unsound mind, the inability to control one's acts or the inability to recognise a wrong and dangerousness.

In fact, the ECtHR has held also that the Law on Committal for Treatment is not in violation of Article 5e ECHR. The Court recalled that Art. 5e is to be interpreted narrowly and that a mental condition must be of a certain gravity to be considered a "true" mental disorder and thus justify detention on the basis of Article 5 para 1e ECHR. The threshold, however, is defined by the necessity of treatment which has to be effected in a hospital (ECtHR, Case of Glien v. Germany, Judgment, Strasbourg, 28 November 2013, Case of Kronfeldner v. Germany, Judgment, Strasbourg, 19 January 2012) and not by a mental disorder resulting in a finding of not guilty for reason of insanity.

The mental disorder must be causally related to a risk to others or the person him- or herself. Detention in a psychiatric facility based solely on the fact of "unsound mind" does not comply with the principle of proportionality which requests that coercive measures (infringement on basic rights) must be necessary. Validity of continued confinement depends then on the persistence of such a

disorder (European Court of Human Rights, Winterwerp v. the Netherlands, 1979, §§ 36–43). The requirement of persistence of disorder and danger is also a consequence of the principle of proportionality. This opinion was also adopted by the Human Rights Committee (CCPR/C/66/D/754/1997, 3 August 1999).

In order to effectively implement substantive criteria of proportionality and protect against the risk of arbitrary decision-making, procedural safeguards apply. Under the rule of the European Convention of Human Rights, European countries must have mental health systems in place guaranteeing valid medical assessment of threat to others and regular examinations of the mental state of individuals committed to psychiatric hospitals. The law must then provide for the possibility of initiating a review process and allow for review of detention by an independent (judicial) body. Art. 5 para 4 ECHR grants the detained person the right to have—on his or her application—the question of lawfulness of detention reviewed by an independent judicial body (ECtHR, Case of Rakevich v. Russia, Judgment, Strasbourg, 28 October 2003, §44; ECtHR, Case of X v. Finland, Judgment, Strasbourg, 3 July 2012, §170). However, a formally valid detention order does not necessarily fulfil the requirements of Article 5 para 1. A decision to detain a person must be grounded on sufficient reasons which have to be presented in writing. Furthermore, while a judge, assessing a significant danger to others or to the detained person him- or herself, has to rely on psychiatric expertise, an independent and impartial judicial decision requires an in depth legal discussion of such expertise from the viewpoint of proportionality of deprivation of liberty (European Court of Human Rights, Case of Pleso v. Hungary (Application no. 41242/08) February 1, 2013).

The ECtHR has also stressed that the decision to continue detention (or treatment) of a patient in a forensic hospital needs to be based on the medical evaluation and opinion of an independent psychiatrist not belonging to the staff of the hospital (ECtHR, Case of X v. Finland, Judgment, Strasbourg, 3 July 2012, §169). The importance of having independent opinions is underlined by the Council of Europe Recommendation (2004)10 concerning the protection of human rights and dignity of persons with mental disorders.

3.3.2 Involuntary Treatment

Involuntary treatment in psychiatric hospitals is an unresolved and disputed issue (European Union Agency for Fundamental Rights 2012, 7). The legal landscape in Europe displays significant variation (Kallert et al. 2007). This issue must be separated from involuntary committal to a forensic hospital as well as from the statutory basis of commitment and the statutory basis of involuntary treatment. A decision of involuntary hospitalisation may not be conceived as including automatically the authorisation to treat a patient against his or her will (Committee for the Prevention of Torture 2015, 53). Involuntary treatment decisions have to pass a separate track of examination and decision-making which contain safeguards against arbitrary decisions adjusted to the particularly sensitive decision on medical treatment against the will of a person.

Article 17 of the United Nations' Disabilities Convention implicitly addresses involuntary treatment but refrains from a clear conclusion when stating that "Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others". The wording of Article 17 and the lack of an unambiguous opinion have been interpreted as a compromise in a field where a consensus is difficult to achieve (Kämpf 2010). However, from a legal and comparative perspective, it can be said that, in general, involuntary treatment is accepted by national and international courts and law makers and considered to be legitimate although the conditions under which forced treatment is considered legal vary significantly (European Union Agency for Fundamental Rights 2012). While detention in a psychiatric hospital must comply with Article 5 ECHR and corresponding rights in national constitutions, the European Court of Human Rights until now has judged situations of involuntary treatment on the basis of Art. 8 (right to privacy, private life; see for example ECtHR, Case of X v. Finland (Application no. 34806/04), Judgment, Strasbourg, 3 July 2012). Restrictions of the right to privacy are legitimate if they comply with the standard of proportionality. In principle, involuntary treatment could also establish a violation of Article 3 ECHR, but coercive measures applied in mental health settings until now have only rarely been found to go beyond the threshold established for inhuman or degrading treatment (European Union Agency for Fundamental Rights 2012, 24). The leading case in this respect is Herczegfalvy v. Austria, decided in 1992 [European Court of Human Rights, Case of Herczegfalvy v. Austria (Application no. 10533/83), Judgment, 24 September 1992], deals with a range of coercive measures applied in a psychiatric hospital with consent of the guardian but against the will of the patient. The case covered forced feeding, forced treatment, isolation and the application of mechanical restraints but did not find a violation of Article 3 ECHR (prohibition of inhuman and degrading treatment). The Court underlines that patients involuntarily admitted to a psychiatric hospital are placed in a situation where they may experience feelings of inferiority and powerlessness. This calls for increased (legal) vigilance and patients who lack capacity to consent completely remain under the protection of the prohibition of inhuman or degrading treatment (Article 3 ECHR). In general, the European Court of Human Rights asserts a medical measure which is a therapeutic necessity (in terms of preserving physical or mental health of patients) and is applied according to good medical practices that cannot be considered to be degrading or inhuman. However, medical necessity has to be shown in a convincing way. Furthermore, the situation of forced treatment has to be judged from the viewpoint of the situation (which should comply with the standards of a treatment setting) and the amount of force applied (and possibly pain resulting from force as well as the treatment itself). The Committee for the Prevention of Torture in this respect holds that electroconvulsive therapy applied without anaesthetic and muscle relaxants cannot be considered to be acceptable in modern psychiatric practice (Committee for the Prevention of Torture 2015, 52).

Of greater legal relevance in judging involuntary treatment certainly is Article 8 ECHR which protects individual privacy from interferences by the state. If any interference occurs, it must have a statutory basis and must be necessary in a

democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals or for the protection of the rights and freedoms of others. The European Court of Human Rights has—starting with the case of Herczegfalvy v. Austria (Application no. 10533/83), Judgment, 24 September 1992, §86—adopted the view that a patient not capable to make decisions may be subject to involuntary treatment if the preconditions spelled out in Art. 8 are fulfilled. In a decision of 2013, however, the Court has said that it was "largely sharing" the view adopted by the German Federal Constitutional Court in a series of cases related to involuntary treatment in forensic psychiatric hospitals (European Court of Human Rights, Case of Pleso v. Hungary, Application no. 41242/08, Judgment, Strasbourg, 2 October 2012, §66). The Federal Constitutional Court in a landmark decision in 2011 (Federal Constitutional Court Judgment Beschluss March 23, 2011, 2 BvR 882/09) has adopted a rather restrictive view on involuntary medication as has been done by the Committee for the Prevention of Torture. The latter has argued that every competent patient, whether voluntary or involuntary, should be given the opportunity to refuse treatment or any other medical intervention. Any derogation from this fundamental should be based on law "and only relate to clearly and strictly defined exceptional circumstances" (Committee for the Prevention of Torture 2015, 53).

There is no doubt that the forced administration of medication represents a serious interference with a person's physical integrity. The German Federal Constitutional Court understands involuntary treatment as an infringement of the right of physical integrity as well as the related right to self-determination (Article 2 German Basic Law, Federal Constitutional Court Judgment March 23, 2011, 2 BvR 882/09) as does the European Court of Human Rights. With this perspective, however, the focus is placed on the impact involuntary psychiatric treatment has on the body of a patient in the form of side effects of medicaments applied to achieve improvement of the mental state. But, the Federal Constitutional Court acknowledges that pharmaceutical agents are applied in order to positively influence mental processes in psychiatric hospitals. Therefore, the impact of involuntary treatment goes beyond physical coercion used to apply medicaments and adverse side effects such medicaments might have (Federal Constitutional Court Judgment, March 23, 2011, 2 BvR 882/09, §44).

The effect which the treatment (including medications) has on the mind and the functioning of the brain is rather sidelined (or completely neglected) in the jurisprudence and literature on forced medical treatment. Adopting this view will result in problems if physical side effects are minimal and the impact of medication on the mind (or the functioning on the brain) is large. This is what involuntary psychiatric treatment aims at: a maximum impact on psychological (and behavioural) functioning and a minimum of physical and unwanted side effects of the medication (Bublitz 2011, 718). At stake is therefore the "core of privacy". The principle of human dignity requests a space which may not be penetrated (without consent).

If, however, involuntary medication affects the "core" of the personality with particular intensity, then—according to the jurisprudence of the German Federal

Constitutional Court—any interference would be forbidden. While this conclusion was not drawn and held that involuntary treatment (in the form of applying neuroleptica) can in principle be justified, several substantive and procedural criteria have been established by the court, which have to be taken into account by the legislator when determining the conditions of forced medication. Only strict observance of a range of criteria to be established by law will prevent involuntary treatment to be in violation of the fundamental right of privacy and human dignity. But, justification cannot be drawn from the patient posing a danger to others as detention in a forensic hospital will effectively neutralise such danger (and danger for staff or other patients may be monitored through other measures). The Court then states that involuntary treatment is in line with Art. 12 para 4 UN Disability Convention which evidently holds that involuntary treatment can be legitimately applied. Involuntary medication can only be justified by an interest of the detained person him/herself to restore the foundations of self-determination. This in turn means that involuntary treatment is ruled out in the case of detainees who have full capacity of consent; mental health laws must restrict involuntary treatment to cases of a lack of capacity which is a consequence of the mental disorder which shall be treated. The precondition of involuntary treatment therefore is a patient who lacks the capacity to judge his or her situation as well as treatment options due to a mental illness (which will be treated by applying medication). The Federal Constitutional Court held in this respect that the state is not obliged to give precedence to the "natural" will of a patient not to be treated and as a consequence to deliver him or her to the fate of indeterminate and possibly lifelong detention.

Another substantive criterion of proportionality concerns a well-founded prospect of restoring self-determination of the detainee and with that a prospect of release from custody. This includes also a strict limitation of the time period of involuntary treatment. Limitation of application is found to be particularly important in case of applying neuroleptica in order to comply, on the one hand, with the substantive element of taking into account adverse side effects and, on the other hand, with the procedural element of allowing recurrent judicial review in case of continued treatment. The test of proportionality then demands that a less invasive and comparably effective alternative treatment is not available. Furthermore, although valid consent of a patient who lacks capacity cannot be attained, there must have nevertheless been serious attempts to build trust and to achieve the consent of the detainee with treatment. Attempts to receive consent from an unwilling patient must be accompanied by full information about the nature and the aim of treatment as well as on possible adverse side effects (see also Committee for the Prevention of Torture 2015, 53; United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care 1991, 11, §9 as well as the approach of a 'supported decision-making regime' developed by Gooding and Flynn 2015). Full information, attempts to build trust and make patients understand the reasons of treatment seem to be followed by more acceptance (Wyder et al. 2015). Involuntary treatment then has to be preceded by an examination of necessity of treatment in a procedure which is independent from the psychiatric hospital where the treatment will be applied. The law maker has to

provide for such a procedure. However, the Federal Constitutional Court held that parliaments have some room for manoeuvre when regulating such procedures (which could require the agreement of a substitute decision maker or authorisation by a judge). However, the procedure must guarantee that a substantive (legal) review of the plan to treat a patient against his or her will take place. Of relevance in this respect is also external psychiatric expertise.

Adverse side effects have to be proportional to the expected main effect of medication. Involuntary treatment has to be ordered and monitored by a psychiatrist. Medication has to be announced early enough to provide the possibility of a legal remedy and judicial review including in cases where a guardian has given consent to treatment. Full documentation of treatment is requested in order to allow for an effective judicial review of psychiatric decisions on involuntary treatment. The Federal Constitutional Court is furthermore of the opinion that effective documentation is necessary for thorough evaluation of involuntary treatment approaches and thus will serve as an important instrument providing for an improved protection of fundamental rights in the future. Finally, involuntary treatment may not result in adverse side effects which are disproportionate to the expected main results.

Full documentation of involuntary treatment is also important from the viewpoint of civil and criminal liability. Illegal application of medicaments, for example, may establish a criminal offence of bodily injury and at the same time result in civil litigation seeking compensation for pain and suffering.

Compulsory treatment of patients not committed to a psychiatric hospital but placed under community care is not permitted in most countries. Sweden has in 2008 introduced legislation allowing for involuntary community treatment but has not implemented legislation which could effectively impose sanctions for not complying with orders to undergo treatment (Zetterberg et al. 2014, see also Molodynski et al. 2010). For the situation in other countries, see relevant chapter in this volume.

A parallel to involuntary treatment can be seen in the practice of forced feeding in case of hunger strikes. In general, the state has a particular duty to care for detained persons as detention in a psychiatric hospital or in a prison will come with particular risks (Jacobs 2010). Seen from the duty to protect life and health of inmates (also from risks of suicide), force feeding can in principle be justified in order to prevent irreversible physical damage (necessity, Callaghan et al. 2013). However, a majority of European countries, in line with medical ethical codes, accept that a competent adult may choose to refuse medical treatment even if it could save his life. If forced feeding is authorised, the CPT requests:

1. Medical necessity
2. Suitable conditions that reflect the medical nature of the measure
3. The decision-making process should follow an established procedure, which contains sufficient safeguards, including independent medical decision-making
4. Legal recourse should be available
5. Implementation of the decision should be adequately monitored.

3.3.3 Physical Force, Restraints, Sedation and Seclusion

General management of patients committed to psychiatric hospitals (e.g. violent incidents or self-harm) and in particular application of involuntary treatment will sometimes result in the use of physical force, various types of (mechanical) restraints (handcuffs, straitjackets, enclosed beds), sedation or seclusion and isolation. The Committee for the Prevention of Torture scrutinises the use of restraints and other forms of physical coercion. It emphasises the need to develop special policies for the use of various forms of restraints and to operate information systems which account for number and type of coercion applied (Committee for the Prevention of Torture 2015, 59, 62). However, difficulties in finding even simple descriptive data on various forms of restraints used in psychiatric hospitals have been reported (Stewart et al. 2009). The European Court of Human Rights has also found cases where record keeping was judged to be "very rudimentary" (Bureš v. the Czech Republic, Judgment, 18 October 2012).

The use of these forms of coercion can be judged on the basis of fundamental rights but will also raise the question of criminal or civil liability of staff. As a general legal rule, the Committee for the Prevention of Torture has stated that the principle of proportionality applies (Committee for the Prevention of Torture 2015, 59). Transgressions of proportionality will give rise to questions of ill-treatment prohibited by Article 3 ECHR and result in criminal and/or civil liability. The legal obligation of states under Article 3 ECHR entails:

1. the introduction of effective criminal-law provisions suited to deter the commission of offences against personal integrity (European Court of Human Rights, Đurđević v. Croatia, Judgment, 19 July 2011, § 51),
2. effective and thorough investigation of allegations of offences against personal integrity which amount to ill-treatment under Article 3 ECHR (European Court of Human Rights, Filip v. Romania, Judgment, 8 December 2005; Bureš v. Czech Republic, Judgment, 18 October 2012, § 81).

From the viewpoint of criminal liability, restraining practices or sedation may establish criminal offences such as bodily injury, medical malpractice or criminal deprivation of liberty.

Physical force, restraints and seclusion can be justified from two perspectives. Restraints might be necessary in emergency situations to respond to dangers for other patients or staff or to dangers for the patient him- or herself (risk of suicide or self-harm). Restraints may also be necessary for therapeutic reasons. Of course, restraints may not be used for the purpose of punishing patients. The therapeutic perspective on restraints (and legal assessment) will be dependent on what good medical or psychiatric practice prescribes. This implies that standards of using restraints may change. Such a change has been noted by the Committee for the Prevention of Torture with respect of a "clear trend in modern psychiatric practice in favour of avoiding seclusion of patients" (Committee for the Prevention of Torture 2015, 54). Significant variation in rules and standards on restraints demonstrates also that there is room for change and accordingly change in legal assessments (Bak and Aggernaes 2012; Steinert 2011).

The European Court of Human Rights has held that ill-treatment (through using restraints and falling under the prohibition of inhuman or degrading treatment, Article 3 ECHR) must attain a "minimum level of severity" (Bureš v. The Czech Republic, Judgment, 18 October 2012). In assessing ill-treatment besides objective factors (duration of restraints, physical or mental effects), the purpose of applying restraints, motivation of staff and the context of the situation of implementing restraints are also considered. Summarising European and national standards on the use of restraints, the European Court has stated that these are "unanimous in declaring that physical restraints can be used only exceptionally, as a matter of last resort and when their application is the only means available to prevent immediate or imminent harm to the patient or others". When using restraints, legal standards include periodical checks and close supervision by medical staff (Bureš v. the Czech Republic, Judgment, 18 October 2012, §86). According to the jurisprudence of the European Court of Human Rights, restraining a merely restless patient for a period of 2 h establishes inhuman and degrading treatment and is in violation of Article 3 ECHR. Failure to establish an imminent harm to the patient or others will always raise an issue under Article 3 ECHR (European Court of Human Rights, Case of M.S. v. Croatia, Judgment, Strasbourg, 19 February 2015, §109).

With respect to physical force, the Committee for the Prevention of Torture has advised against deployment of electric discharge weapons in closed institutions, in particular in psychiatric settings (Committee for the Prevention of Torture 2010, 36).

3.3.4 Disciplinary Measures and Punishment in Psychiatric Hospitals

Coercion may then be exerted through disciplinary measures (punishment) applied in situations of serious violations of rules or orders. If disciplinary measures are at all considered in mental health institutions, then they are in need of a statutory basis defining behaviour which will establish a disciplinary infraction, the measures which can be applied and the procedure under which disciplinary measures can be imposed (Lindemann 2007). Procedures must provide for the necessity of full information in writing, proportionality, accountability and the possibility of a formal review. The general problem of disciplinary measures in psychiatric settings concerns of course the question of how punishment will influence the treatment process. While medical staff in general is opposed to (formal) disciplinary measures, lawyers support establishing a formal system of disciplinary measures which complies with rule of law standards. However, disciplinary measures may not be disguised as treatment measures. This would carry the risk of the emergence of hidden potentials of punishment without effective control in place.

3.4 Conclusions

Coercion in psychiatric settings are increasingly subject to legal restrictions. This process is pushed by general developments of human rights law and by the increasing attention mentally ill persons receive under international law. In particular, the UN Disabilities Convention has opened a new debate on coercion in psychiatry with stressing issues of non-discrimination. At the core of coercion, involuntary placement and treatment in psychiatric hospitals are found. Comparative analyses show wide variation in legal approaches to these issues. However, under the rule of the European Convention on Human Rights, some common standards have been established. It is in particular the principle of proportionality which places restraints on coercion.

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Sociological Perspectives of Coercion in Psychiatry

4

Hugh Middleton

Abstract

In this chapter, consideration is given to ways in which psychiatric inpatients' experiences of coercion and the use of coercive measures by staff might be influenced in ways best understood from a social sciences perspective. It opens with some reflections on what a sociological perspective might be and how that might differ from other, perhaps more medical perspectives. Reference is made to the unhelpful stereotyping that has developed around the expression "anti-psychiatry".

Against this background two classic studies of psychiatric inpatients' experiences (Goffman. Asylums, essays on the social situation of mental patients and other inmates. New York: Anchor Books, 1968; Rosenhan. Science 179:250–258, 1973) are revisited with a view to revealing how "inpatient hood" is widely experienced as coercive, even when particularly coercive measures are not used. This is echoed by empirical data from the EUNOMIA project (Fiorillo et al. Acta Psychiatrica Scandinavica 125:460–467, 2012; Kalisova et al. Social Psychiatry and Psychiatric Epidemiology 49:1619–1629, 2014) which can be considered as pointing to important influences of social context and micro-social processes upon the experience of coercion by inpatients and the use of coercive measures by staff. Bowers' explorations of student nurses' experiences (Bowers et al. Nurse Education Today 24:435–442, 2004; International Journal of Nursing Studies 44:357–364, 2007; International Journal of Nursing Studies 44:349–346, 2007) can be interpreted in a similar way.

Consideration is also given to the interface between law and medical practice, where the use of coercive measures is legitimised. The Law and Medicine can be

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considered differing logical frameworks, and when they intersect compromise is inevitable. The legitimation of coercion on the grounds of "ill health" can be understood as a pragmatic solution to an inconvenient truth; that conceptualisations of the human being as one governed by individualised reason are not in themselves a sufficient description of "the nature of Man".

4.1 Introduction

The very expression "Sociological Perspectives … of *anything*" immediately draws attention to the fact that there can be more than one way of considering … *anything*. The notion of sociological perspectives of psychiatry, and particularly coercion in psychiatry, can be challenging because it makes the assumption that they stand alongside other perspectives; medical, neuro-scientific, psychoanalytic, judicial or behavioural, with equivalent authority. In recent decades, the relationship between psychiatry and sociology, which was once quite intimate and collaborative, has been troubled and very much tainted by the inferred implications of "anti-psychiatry" (Rogers and Pilgrim 2013). This is unfortunate. The term "anti-psychiatry" has such pejorative connotations that its use closes down any discussion at all critical, or questioning of medical psychiatry's orthodoxies. This stifles genuine and constructive debate. Along with other comparable contributions to the mental health literature, this chapter is an attempt to rise above the tribal conflict that has so often characterised social scientists' recent contributions to the field and responses to them (e.g. Craddock et al. 2008). It sets out to illustrate how a sociological perspective can provide insights into the activities and responsibilities of mental health services that complement others and does not have to be read as a conflicting and incompatible ideology. It begins with two conceptually framing reflections in order to set what follows in appropriate context.

4.2 Sociology *of* and Sociology *in* Psychiatry

Firstly, consideration of interactions between sociology and psychiatry: Across the wider, embracing field of medical sociology, the relationship between sociology and medicine has fluctuated as the two disciplines have shaped and reshaped it. Robert Strauss (1957) famously distinguished between a sociology *of* medicine, situations in which sociologists maintain their disciplinary base such as an academic sociology department, and medicine and its subdivisions, such as psychiatry serve, effectively, as objects of study offering an opportunity to address sociological questions; and sociology *in* medicine, situations in which sociologists work, for example, in a medical setting and employ sociological concepts and perspectives to solve problems that are identified as such by medical practitioners and investigators. In the field, this is an unhelpful polarisation of positions. One reflects a situation in which medicine is sociology's passive object of study. The other

reflects a situation in which sociology is medicine's technician. In either position, one or the other is demeaned and so neither satisfies both and, historically, this has been a cause of tension. Nevertheless, the distinction does offer a method of framing differing ways of how the disciplines can contribute to one another.

Psychiatry is an area of medicine, but it is one in which only the most diehard ideologue would insist that relational interactions between participants, whether they be service providers, recipients or both, are not of direct and material significance. Thus, ways in which participants in mental health service settings interact with one another and experience and frame their work are of direct relevance to an understanding of how such settings function and influence outcomes. Social sciences have a significant part to play in elucidating these phenomena as they operate *in* psychiatric settings. They offer insight into the activities of organisations and teams and the challenges that implicit in coercing others.

Furthermore, only the most diehard ideologue would argue that psychiatry is entirely non-controversial and that all who question what it does and why are naïve and partisan. In particular, this volume is explicitly concerned with an overtly controversial aspect of psychiatry, the use of force and other forms of coercion in settings specifically designed for the accommodation of individuals considered too dangerous or unpredictable to be left at large. In these respects, psychiatry is operating as part of the larger social system, and it is commonly pressures arising from outside of psychiatry that determine why, how and where individuals are accommodated on account of danger or unpredictability and become subject to coercive measures. Sociologists' interests in these matters reflect interests in the parts psychiatry, and in this case forensic psychiatry, plays in the wider social system, in particular, by providing for certain forms of socially challenging behaviour. The formation and maintenance of ordered social arrangements are social scientists' core interests and alongside these are legitimate and central interests in how disturbances of social order, deviances, are accommodated and contained. In essence, this is what might be considered a sociology *of* psychiatry, the study of how, why and where psychiatry contributes to the wider social system as an institution responding to certain forms of threat to social order. Landmarks of this perspective are Foucault's reflections upon the nature and exercising of power (Foucault 1961, 2006) and Scheff's explicit outline of psychiatry as a response to deviance (Scheff 1999). These can and have been read by medical psychiatry as ideologically confrontational, but they can also be read as contributions to how medical psychiatry might be understood as part of the wider social world in which it is embedded.

Forensic psychiatry and notably the use of coercive measures in forensic–psychiatric settings are fields of study where sociology has had, might have or should have legitimate contributions to make both to how such practices are conducted in the settings that employ them and also why and how they are legitimated and governed. On the one hand, sociological perspectives of coercive measures in forensic psychiatry settings can be considered as a subset of sociological perspectives upon psychiatry as a whole, and on the other, sociological

perspectives can contribute to an understanding of what is happening on the ground where and when coercive measures have to be used.

4.3 Epistemology and Research Methods

A second framing reflection is to consider the implications of frequently distinct and potentially divisive approaches to knowledge. Psychiatry and sociology share a conceptual challenge. Both concern the study of human beings and the relationships they form and are formed by, and this inevitably straddles otherwise irreconcilable epistemological differences. As co-inhabitants of their subjects' social worlds, those who would research psychiatry or social processes associated with it can locate themselves and the orientation of their research as that of an impassive observer or that of an interactive explorer. These have implications for the kinds of knowledge obtained and developed, its reach and generalisability and the methods employed in obtaining it. The distinction is well trodden and finds expression in the longstanding use of *Verstehen* and *Erklären* to characterise it. Both are translated into English as "to understand", but the former as "to understand" in an interactive, relational sense and the latter in a mechanistic, causative or explanatory sense. In a social sciences context, the epistemological implications of a distinction between *Verstehen* and *Erklären* were first outlined by Wilhelm Dilthey (1833–1911) in the course of establishing legitimacy for the study of *Geisteswissenschaften*: human or moral sciences, as opposed to *Naturwissenschaften*: natural sciences. The former are inescapably rooted in social context, where meaning, purpose and relationship are relevant considerations, whereas the latter are rooted in the natural world and assumed to reflect phenomena—physical, chemical and biological processes that operate independently of direct human influence (Bransen 2001). In a psychiatric context, the differing contributions of *Verstehen* and *Erklären* are first referred to by Karl Jaspers (Jaspers 1913), and the importance of respecting their complementarity is emphasised in contemporary psychiatric textbooks and teaching (Cowen et al. 2012). Understanding or making sense of either patients' complaints and difficulties or the social worlds in which they are realised, recognised and responded to is incomplete unless it incorporates knowledge drawn from each of these orientations. In the context of a forensic–psychiatry setting, it may be possible, for instance, to consider a blow struck by one patient against another as a clearly observable phenomenon, but it could have happened in the course of playful repartee, quite unintentionally or indeed, as an act of aggression. Any response to it will have to incorporate interpretation of its meaning or inferred intentions. Clearly, it is often quite easy to make such a judgment but doing so involves a different approach to understanding the blow beyond simply observing that it has happened. The blow's strength, the assailant's posture, antecedents, prior knowledge of the combatants' relationship with one another and a host of other potentially relevant considerations all contribute to an appraisal of why, in terms of human meaning and intentions, the blow was struck, and it is only in the light of such an appraisal that an appropriately judged response can be made.

Systematically, researching such phenomena involves similar considerations. When coercive measures are used, which inferred meanings, threats and intentions are more likely than others to evoke them might be relevant topics to research, but answering such questions will depend upon methodologies that explore phenomena such as meaning, intent and experiences of threat. These tend to be qualitative and interpretive rather than quantitative and positivist. Although social scientists do use quantitative research methods, perhaps most notably in the form of surveys, mapping and social network analyses (Schutt 2015), the singular contributions sociology brings to psychiatric research are qualitative methods and a constructivist epistemological position. These support the development of knowledge Dilthey and Jaspers would recognise as *Verstehen*. It elaborates understanding of human processes associated with the development of troubling states of mind, the conduct of troubled, disabled or disturbed individuals, reactions to them and the form and activities of organisations charged with their care. All of these are reflections of human interactions or relationship and as a result they are social, human or moral phenomena; *Geisteswissenschaften* rather than natural world phenomena or *Naturwissenschaften*. The study of *Geisteswissenschaften* may not contribute to psychiatry from the perspectives of those who see it as an empirical discipline rooted in the natural sciences, but insofar as psychiatry and the institutions it inhabits are respected as subsets of human interaction and relationship, which they undoubtedly are, it has much to offer. Unlike natural sciences, which pursue knowledge that can be generalised beyond the context in which it developed, social sciences tend to develop knowledge that is more contextually specific, but it is also knowledge that tends to pursue enquiry into the context in which it is generated. Thus, investigation of how or why coercive measures might be used in a particular setting is likely to result in explanatory proposals concerning the nature of that environment, the expectations of staff and clientele, staff training, staff morale, case mix and severity and other variables. The relevance of all of these immediately points to a need for understanding of the organisation within which staff are employed and clients accommodated. Furthermore, any one secure psychiatric institution is inevitably set within an even wider context of mental health law, public policy, resource allocation and historical precedent. Sociology facilitates the ordered and theoretically grounded study of all of these, which are so often felt to be central to the business of forensic–psychiatric care by those who conduct it.

4.4 Tribal Conflict

Despite this potential, sociology has made very few direct contributions to forensic psychiatry. As a result of ideologically framed tribal distinctions, those outside of psychiatry and particularly outside and critical of forensic services have tended to criticise them as unjustifiably oppressive and overly dependent upon the use of medication. Those within psychiatry have tended to identify their critics with the label of “anti-psychiatry”. Both are unhelpfully stereotyped positions.

The term "anti-psychiatry" developed quite specifically out of associations between certain psychiatrists and more politically oriented commentators during the late 1960s, and as a result it has become available as a rhetorical turn that can be used to close down debate by association with a politicised agenda. A notable contributor to this was R. D. Laing. His criticisms of contemporary psychiatric practice became associated with wider social critique (Crossley 1998, 2006). As a result, those who dared to criticise psychiatry were readily identified as unrealistic ideologues promoting radical social and political change towards an anarchic or Marxist utopia. His and others' more narrowly focused commentary upon psychiatric practice was lost. Another was Thomas Szaz who maintained a vocal and persistent insistence that the concept of mental illness is unfounded for more than half a century (Szaz 1961). At heart, this is a semantic debate over what the terms "illness", "disease", "pathology" and "diagnosis" actually mean and apply to, but Szaz's resolute criticism of psychiatry and his association with the scientology movement resulted in more visceral differences. In fact, both Laing and Szaz expressly disavowed descriptions of themselves as "anti-psychiatrists", but the mud has stuck and the term remains identified with them and their positions. In Szaz's case, the stereotype has been that of a harsh neoliberal ideologue unconcerned for the suffering of those otherwise deemed to have mental illness and in Laing's case that of a starry eyed left wing idealist agitating for something that could only be realised by the collapse of society as we know it. To associate any substantive criticism of psychiatry with one or other of these positions effectively shuts down debate, and it is barely surprising that this has hindered healthy discussion and contributions with and from academics who are not identified with orthodox psychiatry. Anyone who dares to suggest that the medical approach to psychiatry might not be what it purports to be is immediately associated with Szaz, and anyone who dares to suggest that psychiatry is primarily concerned with the maintenance of social order is immediately associated with Laing.

This is a sterile position. Views might differ to a degree, but few would argue that an exclusively medical orientation offers a totally sufficient response to mental health difficulties, and particularly within the context of forensic psychiatry, to argue that mental health services have nothing to do with the maintenance of social order would be equally untenable. Clearly, a more balanced relationship between psychiatry and sociology is possible but the legacy of several decades' mutual antipathy is that the literature offers very little evidence of constructive collaboration and in particular very little empirical evidence derived from research in or of forensic mental health facilities grounded in social or organisational theory. Many of the other contributions to this volume begin to address this. Here, the focus will be upon what can and has been drawn from selected empirical studies from a constructivist approach to data they offer concerning the use of coercion *in* psychiatric settings and of the wider implications of the very presence of psychiatric settings in which coercion might play a part; sociological perspectives *of* psychiatry as an institutionalised activity involves coercion. The story begins, however, with two now unrepeatable studies that date from earlier times which were able to use

ethnographic, observational methods to investigate the experiences of psychiatric inpatients.

4.5 Two Classic Studies and Their Legacy

Until the middle part of the twentieth century, coercion and psychiatric institutions were virtually synonymous. In the UK, it wasn't until 1930 that the notion of voluntary admission to hospital for treatment of mental disorder was formally enshrined in legislation, but the two outstanding pieces of social research conducted within psychiatric institutions during succeeding decades suggest that this alone did not result in significant change. Using ethnographic data on particular aspects of patients' social life in his seminal 1968 work *Asylums*, Goffman identified the hospital as operating as an authoritarian system where its residents are compelled to redefine themselves as being "mentally ill". His main concern was with the development of relationships between individuals confined within what he called "Total Institutions". Goffman (1968) defines a Total Institution as:

> A place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life. (1968, p. 11)

Traditional mid-twentieth century mental hospitals conformed to this definition along with similar institutions such as prisons, monasteries and military barracks, and there are compelling similarities with present day secure psychiatric establishments. Within such institutions, a large group of individuals are situated in a place of residence and work; their private life is all but eradicated and communal. Activities are highly structured, and the institution is overseen by an influential elite. Through ethnographic study of individuals resident in such settings and their behaviour with one another, Goffman came to the conclusion that specific roles are learned by those labelled as "mentally ill". Individuals who are so labelled come to accept the label as their own self-image. Divisions that exist between "staff" and "inmates" coupled with a highly structured regime, and little or no private life, result in "mortification of the self", whereby an individual has their old "self" stripped of previous roles in the outside world and is forced to be reconstituted by the social arrangements and restrictions of the institution. One implication of this mortification of the self and re-identification, Goffman argued, is that the "mentally ill" person ventures on a "moral career" in which their self-identity is re-formed. As he writes:

> The self in this sense is not a property of the person to whom it is attributed, but dwells rather in the pattern of social control that is exerted in connection with the person by himself and those around him. This special kind of institutional arrangement does not so much support the self as constitute it. (1968, p. 154)

Therefore, for Goffman, due to the social experiences of living in a total institution, an individual has their previous "self" removed from them and is subject

to a re-identification process whereby the individual learns their new role according to the "mentally ill" label that is attributed to them. They are coerced into adopting an identity formed by the institution.

Goffman's illustration of the extent and ways in which mental hospital "inmates" lost their individuality and became subject to an institutional regime played a significant part in encouraging changes in policy away from a focus upon longer term institutional care. Although Goffman's work enjoys little present day respect in conventional psychiatric circles because it was so clearly drawn from experiences of now historical institutional arrangements, Rosenhan's account of pseudopatients' experiences is much more recognisable.

Being Sane in Insane Places (Rosenhan 1973) is most widely known for the revelation of diagnostic uncertainty and perhaps the part it played in encouraging the development of more reliable diagnostic guidelines that first appeared in the form of DSM-III (American Psychiatric Association 1980). Eight pseudopatients approached 12 US mental hospitals requesting an appointment. Upon arrival, each complained that they had been hearing voices and when asked what the voices said they replied that they were often unclear but appeared to be saying "*empty*", "*hollow*" and "*thud*". The voices were unfamiliar and were of the same gender as the pseudopatient. One of the pseudopatients was a psychology graduate student in his 20s. The remaining seven were older, and amongst them there were three psychologists, a paediatrician, a psychiatrist, a painter and a housewife. Immediately after admission all ceased simulating any symptoms of abnormality, but nevertheless all remained in hospital for significant lengths of time. The mean length of stay was 19 days. As a result, in addition to being able to comment upon diagnostic procedures and criteria for admission, the project also offered an unprecedented opportunity for ethnographic study within the inpatient unit. The pseudopatients were able to observe life on the ward and record what they encountered quite unsuspected. Field note-taking was not recognised for what it was and indeed, in one case, a pseudopatient's note-taking was identified in nursing notes as an aspect of their "psychopathology". The repeated entry was "*patient engages in writing behaviour*" (Rosenhan 1973, p. 253).

These notes and related reflections provided an unprecedented set of insights into life in a psychiatric ward. Observers quickly became aware of strong demarcations between staff and patients; the former had their own segregated spaces, including dining facilities, toilets and meeting places. Amongst patients, the glass-windowed ward office came to be known as "the cage" and their experience was that staff rarely emerged from it for any other purposes than in order to conduct a specific task; "*to give medication, to conduct a therapy or group meeting, to instruct or reprimand a patient*" (Rosenhan 1973, p. 254). Individual members of staff spent between 3 and 52 (mean 11.3) per cent of their time outside of "the cage", and this included time spent on chores such as folding laundry, supervising patients whilst they bathed, clearing up the ward and attending patients as they went to off-ward activities. "*It was the relatively rare attendant who spent time talking with patients or playing games with them*" (Rosenhan 1973, p. 254). Medical staff were even less readily visible, and the observers remarked upon an apparently

hierarchical arrangement; it seemed that the more senior a member of staff was, the less time they spent in direct contact with patients. This apparently institutionalised propensity to avoid direct interpersonal interaction with patients was tested by pseudopatients in four of the centres by deliberately but courteously approaching staff with a harmless query such as "*Pardon me, Mr. (or Dr. or Mrs.) X, could you tell me when I will be eligible for grounds privileges?*" Only a tiny proportion of such approaches elicited a meaningful response. Rosenhan contrasted these experiences with those of stooges asking similarly relevant but harmless questions of university staff in the grounds of Stanford University and of hospital staff in the university medical centre. Here, courteous and connected responses were elicited in nearly all cases even though those approached were also busily engaged in their work.

Rosenhan's work has not been replicated, not because the same experiment has been conducted and contrasting findings have emerged, but because any proposal to repeat it is unlikely to find favour with a contemporary ethics review committee. Furthermore, it was carried out in an era when interested parties, in this case the pseudopatients, could be available to pursue their research interests without too much attention to the cost. It occupied eight mainly professional people for some 2 months a piece. There are ethnographies of mental health nursing from a variety of perspectives and of healthcare assistants in dementia wards, but the unique and possibly unrepeatable feature of Rosenhan's work is that the observations were conducted from the perspective of patients. Other, more recent observations of mental health nursing have confirmed that staff find it very difficult to span the demands of maintaining the safety of disturbed individuals, operate professionally and relate to psychiatric inpatients as people rather than "cases" (Bray 1999) and that direct contact between patients and staff is often very limited (Higgins et al. 1998). Reviewing such research at the turn of the century, Quirk and Lelliott (2001) confirm that little was then known about life within psychiatric inpatient units that had not been established in the 1970s. Deacon and Fairhurst (2008) identify particular characteristics of mental health nursing that reflect the need to negotiate between institutional demands and patients' requirements and expectations. Two ethnographic and interview studies conducted in forensic psychiatric settings and from a nursing perspective both point to impoverished interactions between patients and staff for reasons variously attributed to "burnout" and powerlessness, both reflections of institutional pressures upon practitioners (Dhondrea 1995; Cashin et al. 2010). Although it would be gratifying to think otherwise, there is no clear evidence that developments since the 1970s have significantly altered inpatients' experiences from those of Rosenhan's pseudopatients', an institutionalised existence barely, if at all, mitigated by embracing relationships with staff. Rosenhan describes the inpatient experience as that of being:

> . . . shorn of credibility by virtue of his psychiatric label. His freedom of movement is restricted. He cannot initiate contact with the staff, but may only respond to such overtures as they make. Personal privacy is minimal. Patient quarters and possessions can be entered and examined by any staff member, for whatever reason. His personal history and anguish is available to any staff member (often including the "grey lady" and "candy striper"

> volunteer) who chooses to read his folder, regardless of their therapeutic relationship to him. His personal hygiene and waste evacuation are often monitored. The water closets may have no doors. (p. 256)

Detailed experiences of a twenty-first century psychiatric inpatient might differ from this in some small ways, but the inescapable fact is that the patient's social world is one in which they are confined to an institutional setting where those nominally charged with making their stay as nurturing as possible find themselves socially distanced from their charges, and their roles and activities are defined as much if not more by institutional constraints as they are by their charges' needs and aspirations. In many cases, these circumstances can be understood as inescapable consequences of the need to balance safety and resources, and the very real difficulties that disturbed mental states can impose upon attempts to relate. Nevertheless, inescapable though they might be, they define the continuing experiences of many psychiatric inpatients (Rose 2001; Healthcare Commission 2008) despite the fact that an emotionally supportive and unconditional relationship is widely considered a key feature of experiences that result in recovery from mental health difficulties (Middleton et al. 2011). In one interview, study of psychiatric inpatients reported that that the main barrier to the formation of a therapeutic relationship was the experience of coercion. Relationships that were perceived as coercive were always described as negative and resulted in negative patient experiences. Experiences of coercion included specific interventions such as the deprivation of liberty, the use of seclusion, restraint and enforced medication that are legitimated by mental health law but also experiences of coercion by service users who were not formally detained (Gilburt et al. 2008). These appeared to derive from the same clearly apparent power imbalances between patients and staff Rosenhan's pseudopatients experienced. Despite considerable effort and even formal guidance to change (National Collaborating Centre for Mental Health 2012), inpatient mental health facilities continue to be experienced by many obliged to use them as a coercive and oppressive environment overseen by staff who maintain distance and find it difficult to engage in the core task of generating a therapeutic relationship. This inconvenient truth raises the question of whether or not the use or application of specific interventions formally defined as coercive measures can be separated from the overall conduct of inpatient care or is better understood as an inevitable extension of what psychiatric care inescapably is. More detailed consideration of two selected sets of empirical data concerning the experience and use of coercive measures offers some further insight into this. They are examples of questionnaire data collected and reporting upon patients' experiences of coercion and nursing staff's reports upon how and when formally identified coercive measures are used in practice.

4.6 The Experience and Use of Coercion in Inpatient Settings

Information about the use of coercive measures in psychiatric settings comes from a variety of sources: formal reports, observations, patient and staff surveys and interviews. Other contributions to this volume will undoubtedly provide more detail, but for the purposes of this chapter the focus is upon two chosen sets. The first are data obtained by the EUNOMIA project and published in particular by Fiorillo et al. (2012) and by Kalisova et al. (2014), and the second is questionnaire data obtained and published by Bowers and colleagues in the course of several separate studies (Bowers et al. 2004, 2007a, b, 2011).

Fiorillo and colleagues focus upon correlates of perceived coercion amongst some 9000 patients admitted to psychiatric inpatient facilities across 11 EU countries during a 2 year period. Perceived coercion has become recognised as an experience felt by significant numbers of psychiatric inpatients, and it refers to the experience of an obligation to conform to institutional expectations, often supported by the threat of more overtly coercive measures such as physical restraint, seclusion or enforced medication. In this report, two self-report scales were used, the MacArthur Scale of Perceived Coercion which scores experiences of coercion at the time of hospital admission and a Cantrill Ladder designed for this purpose. The MacArthur Scale scores answers to questions such as; "*Which had more influence on your being admitted: what you wanted or what others wanted?*", "*How much control did you have?*", "*You chose or someone made you?*" and "*How free did you feel to do what you wanted?*" (Gardner et al. 1993; Hiday et al. 1997). The Cantrill Ladder is effectively a Likert scale scored from 1 to 10, originally in response to the instruction: "*When a person gets admitted to a mental hospital or ward, different things will be of importance in each case. In some cases, a lot of pressure and even physical force is used when a person is admitted, while in other cases patients come to the ward totally at their own will. If you think of your own admission to this hospital this time, try to consider if you were subjected to any kind of coercion, threats, pressure, or inducements. Then try to figure what step on the ladder shown below best corresponds with the amount of pressure from others you experienced when admitted, and mark the step with an X. For instance, if you came entirely on your own initiative put an X on step 1, but if you were subjected to the maximum use of coercion, then you put the X on step 10*" (Høyer et al. 2002). Both scales generate a reflection of patients' subjective experiences of coercion. Instructions for scoring the Cantrill ladder can and have been modified to estimate experiences of ongoing coercion after the point of admission.

Earlier studies (Gardner et al. 1993; Hiday et al. 1997) identified a bimodal distribution of scores on the MacArthur Scale, suggesting that experiences of coercion at the time of admission fall into two groups: those who feel coerced and those who don't, rather than the experience of coercion being continuously distributed across a range of intensity. The EUNOMIA study, with a much larger sample taken from a variety of settings and employing a longitudinal approach, was able to explore associations between socio-demographic variables and symptomatology with experiences of coercion and changes in coercion over time. In essence,

these are that higher levels of coercion were experienced, predictably, by those who were detained by statute, but also amongst females and amongst those who were more disturbed. Levels of perceived coercion fell with time and with improvements in mental state. All of these associations were embedded within quite considerable variations in overall experiences of coercion between sites and jurisdictions. The investigators offer their own interpretations of these findings including some that could be considered to be from a sociological perspective: that the gender effect reflects higher levels of experienced threat amongst women finding themselves in the environment of a psychiatric inpatient unit, that more disturbed patients are a greater challenge to staff's need to maintain order and safety, and thus attract more coercive attention and that as time passes and, to a limited extent disturbances of mental state resolve, patients become more able to adapt to the ward environment and make constructive sense of their predicament. None of these are altogether surprising. What is striking, from these data, is that nearly half of all recruited into the survey experienced coercion and that it seemed to be more the passage of time than improvements in mental state that was associated with reduction in such experiences. It would appear that the experience of coercion is influenced by contextual factors such as locally determined interpretations of what it means to have been admitted to a psychiatric inpatient unit, familiarity with it and individualised reactions to it such as those somewhat reflected in gender differences. Fully unravelling these in ways that might enable changes resulting in much lower rates of experienced coercion will require appropriate approaches to further research which, the investigators point out, have to include qualitative studies exploring these issues from an interpretive perspective. The earlier reported bimodal distribution of MacArthur Scale scores suggests that the experience of coercion is very much an individualised phenomenon. Thus, these data concerning the experience of coercion, whether subjected to coercive measures or not, unsurprisingly point to a need for understanding of the social environment within which the inpatient unit is embedded and that which has developed within it.

Also drawing upon data collected by the EUNOMIA project, Kalisova and colleagues attempt to answer the question; "*Do patient and ward-related characteristics influence the use of coercive measures?*" There was already clear evidence that the use of formally defined coercive measures such as restraint, seclusion and enforced medication varies widely across hospitals within a given jurisdiction (Lay et al. 2011) and even between wards within the same hospital (Husum et al. 2010). Kalisova and colleagues have been able to explore these variances in a much larger sample. Socio-demographic and clinical characteristics and centre-related characteristics were compared between 770 patients who had been subjected to at least one of restraint, and/or seclusion, and/or forced medication during an involuntary hospital stay and 1257 involuntary patients who had not. In contrast to findings in relation to experiences of coercion, there was no gender difference between those who were and those who were not subjected to coercive measures. There were small, but given the sample sizes, statistically significant between-group differences in symptomatology and levels of function, with those subjected to coercive measures scoring higher for impairments of function,

psychotic, manic and negative symptoms and signs of suspiciousness and hostility, and lower for symptoms of anxiety and depression. These illness-related associations are unsurprising, though disappointing in that they suggest an association between levels of disability and the use of coercive measures. What is once again more striking is that these data, too, identify wide regional variations in the use of coercive measures. Fifty-nine per cent of all Polish recruits into the study were subjected to coercive measures, whereas the same was true for only 21 % of Spanish recruits. The data made it also possible to investigate whether these considerable variations could be explained by differences in physical resource. The mean number of beds per ward varied from 14 (Sweden) to 50 (Greece), the mean number of beds per room varied from 1.2 (Sweden) to 8 (Lithuania) and the staff to patient ratio, expressed as the number of staff on duty per bed per week, ranged from 77.2 (Italy) to 19.9 (Bulgaria). Even these wide variations in resource allocation and the potential for variations in the quality of patient:staff relationships and ward atmosphere that they offer did not explain, from a statistical point of view, the considerable variance in rates of coercive measures between centres. In their own words, as the authors conclude:

> Despite many international guidelines on the management of agitated patients, clinical practice still relies mostly on local and national traditions rather than on scientific evidence. (Kalisova et al. 2014, p. 1626)

A comparable study of some 718 instances of seclusion across 29 wards in seven Dutch hospitals came to similar conclusions (Janssen et al. 2013). Fuller understanding of what determines how, whether and in what ways coercive measures are used appears to require theory and related research methods that are suited to investigating the social microcosms in which they occur rather than seeking more "scientific" explanations.

Bowers' work in this field has considered the use of coercive measures from the nurse's perspective. It does so in the form of self-report questionnaires exploring attitudes to different forms of coercion or containment within and between jurisdictions, associations between these attitudes and attitudes to aggression and to personality disorder, and associations between attitudes to the use of containment measures and experiences of team working and leadership amongst acute psychiatric inpatient nurses. Attitudes to different forms of coercion or containment have been quantified in the form of ratings of acceptability, efficacy, safety for staff, safety for patients, patients' dignity and preparedness of the respondent to use each of 11 methods of containment on a five-point Likert scale. This ranged from "strongly disagree" to "strongly agree" in relation to each method. Contrary to expectations, relative distaste for the use of physical restraint and net beds and relative approval of additional medication, intermittent observation and time out amongst student nurses did not change during training and increased familiarity with the use of coercive measures (Bowers et al. 2004). In a separate study (Bowers et al. 2007b), the same approach was used to compare attitudes to different methods of containment between practitioners in the UK, Netherlands and Finland. There were significant between-group differences in ratings of all forms of containment and in overall ratings of different measures of the desirability of using them. Overall

approval for the use of containment measures was less in the UK, highest in Finland and intermediate in The Netherlands. Dutch and Finnish practitioners found mechanical restraint and net beds less distasteful than their British counterparts. These differences broadly matched parallel differences in the use of such measures, quite possibly reflecting identifiable subcultural differences in attitudes and practices. That these did not appear to arise from experiences during training suggests that they reflect wider subcultural and individual differences in attitudes and approach towards those who might present a need for coercive measures or containment.

The potential for such subcultural effects has been explored by investigating associations between attitudes to the 11 forms of containment, attitudes to patients with personality disorder and perceptions of aggression (Bowers et al. 2007a). Perhaps predictably, UK student nurses with a more positive attitude towards such patients rated forms of containment such as intermittent or continuous observations least distasteful and were less likely to approve of time out. The former offer opportunities for constructive engagement whereas the latter can be considered punitive. Students who considered aggression to be unacceptable were less likely to have a positive overall attitude to personality disordered patients and less likely to be accepting of them. Significantly, during the course of training as estimated in terms of differences between cohorts of students, attitudes to personality disordered patients became less accepting, with potential implications for associated attitudes and approaches to the use of coercive measures. Although this change with time conflicts with earlier findings, it does possibly point to some effects of socialisation into the workplace and the significance of related influences. These include the nature and quality of leadership and teamwork and their effects upon risks of burnout.

It could be considered intuitive that ward atmosphere, however conceptualised, is likely to be associated with the occurrence of challenging or conflictual behaviour, the related use of coercive measures and their effects upon staff morale and well-being. These interactions were amongst the concerns of the City 128 Study (Bowers et al. 2006). In a report of some of those data (Bowers et al. 2011), attention was given to associations between scores on the same attitude to personality disorder questionnaire referred to above, a ward atmosphere scale assessing order and predictability, a team climate inventory assessing variables such as participation, trust, support for innovation and clarity of purpose, a multifactorial leadership questionnaire and the Maslach Burnout Inventory. A large number of questionnaires (6661) were collected from 136 wards, which was a large enough sample to enable meaningful structural equation modelling of relationships between leadership, team climate, ward atmosphere, burnout and attitudes to patients. What emerged was a linear model in which leadership only influenced ward atmosphere, burnout and attitudes to patients insofar as it influenced team climate. In other words, although variations in rates of burnout, attitudes to patients and related variations in the use of coercive measures might be crudely associated with external influences such as leadership and management style, these effects are or were only manifest through their facilitative or hindering

effects upon the quality of team working. Alongside local and national traditions, one of the important influences upon how and when coercive measures are used also appears to be the clearly micro-sociological phenomenon of working relationships between those on the ground. There is an unfortunate gap in the literature and traditions of research which could otherwise address this.

4.7 Applying the Law

Any overt use of coercion in psychiatry is predicated by the fact that it can be lawful. Mental health difficulties include situations in which a person may be a serious risk to the safety of others or themselves, and as a result all jurisdictions include provision for such situations. In general, these are arrangements whereby a disturbed (or sometimes potentially disturbed) person can be deprived of civil rights, detained and forcibly treated. This is very much the territory of forensic psychiatry, although more mundane use of mental health legislation is very much part of everyday psychiatric practice. In detail, provisions differ from jurisdiction to jurisdiction but the fundamental principles are universal. They are respect for the fact that there can be situations in which a person is acting or will act dangerously, and such behaviour cannot be understood as wilfully motivated and thus considered criminal. Jurisdictions have differing definitions of what are and what are not sufficient grounds to invoke locally agreed powers of detention and enforced treatment, but grounds of some sort can be found in all of them, as are arrangements for review, transfer between psychiatric and criminal detention and the clarification of who is invested with authority to oversee these various processes. This is an intriguing interface between the logic of jurisprudence which is essentially categorical; judgements are made about whether or not an act was unlawful, a person guilty or a contract binding, and the logic of the natural world which is essentially dimensional. The intensity of symptoms, behaviours, risks and responses to treatment are all contnuously distributed across their various spectra. They are considered *dimensional* phenomena. In cotrast a court is required to judge which one of a small number of *categories* of "responsibility for their actions" applied in realtion to a particular perpretator in the course of a particular misdeed. This confrontation of logics creates a space in which actors and activities can flourish as they try and move between them. Well-known manifestations are disputes over expert professional opinion, decisions about the release or discharge of notorious malefactors, questions of responsibility for wrongdoing and charges of psychiatric detention for reasons of social convenience. Within this space (mainly) professional actors exercise skills and power to determine whether or not patients' difficulties and conditions merit the loss of liberty and self-determination not upon the basis of forensic evidence attempting to answer the question "*Did they commit this act?*", but upon the basis of medical opinion attempting to answer the questions "Were they (criminally) responsible for the act?", "*Do they suffer from this or that condition?*" and "*Will they respond to this or that treatment?*". In the case of

criminal proceedings, any doubt about the provenance or implications of evidence is resolved by the stamp of judicial or juridical judgement. This may be arbitrary and it is sometimes wrong, but the authority of the court is such that it is constituted to overrule such uncertainties. Medical opinion, however, embraces uncertainty, particularly in a psychiatric context where objective, third party laboratory findings are rarely available to support an opinion, and the effects of treatment are commonly unpredictable. Uncertain, or at least only partially corroborated opinions acquire the status of judicially determined fact and situations that might be interpreted in other ways become formalised as grounds to detain and treat without consent.

Under these circumstances, discourses and practices that develop from them reflect underpinning social dynamics rather than the specific logics, languages and frameworks of judgement that authorise them. A particularly thorough and illustrative study of this is provided by Stefan Sjöström (1997). His was an ethnographic study of interactions between legal and psychiatric bodies in an anonymised Nordic context. The work includes observations of activities in the psychiatric ward including compulsory admissions and the use of coercive measures, and the work of the judiciary in relation to these such as the conduct of tribunals as they determined the legitimacy of continuing detention and its implications. He illustrates how judicial criteria for detention and enforced treatment (in this jurisdiction, that the patient suffers from mental disorder, that there is an indispensable need for psychiatric care that cannot be satisfied in any other way and that the patient either opposes this or is judged unable to express a considered view on the issue) are expressed and determined in the language of psychiatry rather than as externally referenced judgements (pp. 269–303). This is very similar to findings from an earlier, comparable study of UK proceedings:

> The tribunal's decision, like that of many other decision-making bodies hearing evidence, amounts largely to ratification of a decision which has been structured by earlier choices. (Peay 1989, p. 210)

In relation to decisions about the use of mental health legislation, it is interesting to reflect upon what those "earlier choices" might be and by whom and under what authority they might have been made. Sjöström's and Peay's evidence is that it is the psychiatrist's judgement that weighs most strongly. Interestingly, the most frequently stated reason for involuntary admission in a UK sample was the risk of deteriorating mental health (Priebe et al. 2009), a judgement that falls very squarely within the psychiatrist's field of expertise. Thus, from these points of view, the application of mental health legislation and all that flows from it appears to be a tool in the psychiatrist's hand rather than a truly judicial process, and in this context psychiatrists are seen as and experience themselves (often reluctantly) as sole guardians of public safety. It is a role that legitimises their status and fulfils a widely felt need. Seventy per cent of a Swiss sample agreed that compulsory hospital admission should be available (Lauber et al. 2002) and, as already noted, legislation enabling it is found in all jurisdictions. What emerges from more careful scrutiny of how it is conducted is that medical constructs, discourse and related

paternalism are used to justify coercive measures in situations where there are widely felt concerns for safety or well-being, but little or no forensic evidence to support their use as a sanction against criminality (Sjöström 1997, pp. 310–313).

The natural, otherwise unregulated human world includes distressing, disturbing and potentially self-destructive behaviours—consequences perhaps of unsatisfactory developmental experiences, inherited psychological vulnerabilities or traumatic events but manifested as disruptions of social order that interfere with productive and congenial interactions. As Foucault illustrates, the need to defend social order against such disruptions has always been with us. As both Foucault and Scheff argue, medical psychiatry and the legal apparatus that accompany it can be understood as a contemporary mechanism for doing just that (Foucault 1961, 2006; Scheff 1999). Thus, from this perspective and particularly in relation to the fact that psychiatry incorporates practices that involve legally enforceable coercion, a sociology *of* psychiatry includes the part it plays in maintaining social order. Sjöström's scrutiny of ways in which this was operated in the jurisdiction he studied in the mid-1990s suggests that medicine's language and therapeutic claims are not imported into this task because they genuinely offer effective means of fulfilling it but because they offer acceptable grounds for doing what would otherwise be considered unacceptable. Perhaps, when it acts as an organ of social control under the guise of "treatment", psychiatry and particularly its use of coercive measures disguises an inconvenient truth, that amongst us there really are those who appear unable to live in safe and peaceful relationship with others or are for a period of time at least, in such a state. Those familiar with secure hospital settings may be more used to this perspective than others, but wider discourse concerning the nature of human beings is challenged by the possibility that someone might be socially inadmissible without also being criminal. Nevertheless, the very existence of mental health services and secure psychiatric settings in particular reflects a harsh truth; that human societies have always had to find one means or another of accommodating the disturbingly deviant. Perhaps it is not surprising that coercive measures in psychiatry remain, at the same time, both a focus of controversy and a ubiquitous practice, and as a result are variably applied and not uncommonly a source of difficulty for those charged to conduct them. From this perspective, a sociology *of* psychiatry suggests that coercion is an inescapable and integral part of psychiatry as a whole, which is charged, in part at least, with responding to challenges against social order.

4.8 In Summary

A sociological perspective of coercive measures in psychiatry cannot be isolated from considerations of psychiatry as a social phenomenon that is found in all jurisdictions. Inpatient settings remain places of social containment where institutional dynamics exert powerful influences which can interfere with relational therapeutics. Within such settings, many experience coercion even when not subject to formally defined coercive measures. When such measures are used,

how, why and when that happens reflect both the wider cultural context of local attitudes and history, and the social atmosphere of the setting such as the quality of working relationships amongst staff. From a social scientist's perspective, the need to lawfully contain and coerce someone who is not formally criminal is a challenge to conceptualisations of the human being as one governed by individualised reason. As a result, the practice is shrouded, inconsistently applied and controversial, and it is likely to remain so until or unless there are significant shifts in public discourse concerning psychiatry as a whole. That does not mean that coercive measures should be considered inadmissible but their contextual determinants could be better understood, and this has consequences for the well-being and governance of those charged to conduct them.

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Wise Restraints: Ethical Issues in the Coercion of Forensic Patients

5

Gwen Adshead and Theresa Davies

You are ready to aid in the shaping and application of those wise restraints that make men free.
Harvard Law School Library

Abstract

In this chapter, we will argue that when thinking about coercion in forensic psychiatry, any analysis of ethical issues needs to include reflection and discussion of the relationships that arise between patients who are detained in secure care, and those who are caring for them, while maintaining security. We come from the perspective of forensic psychiatry as the therapeutic treatment of mentally abnormal offenders in *long term residential secure care* and suggest that in that context, care and coercion are intimately linked. We suggest that coercion and freedom cannot be set up as alternatives; rather we will suggest that there needs to be a richer understanding of what it is to be free; especially in the aftermath of a serious offence, which also changes the lives of the perpetrators. We will draw on the literature on relational autonomy, and explore how this might help us to understand the use of coercive measures, and patients' experiences of coercion and choice in secure psychiatric care.

5.1 Introduction

Coercion is deemed to be a negative experience for human beings. It violates not only every human's right to liberty to make free choices for oneself, it also violates a person's right to freedom from interference (Berlin 1969). In ethical terms, coercion of any kind is a violation of the principle of respect for autonomy; the

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principle that one ought to respect the choices made by individuals, and not seek to influence those choices unduly or force people into actions or experience that they do not want to have.

In this chapter, we explore how coercion and choices are experienced in forensic psychiatric care; by both patients and staff. We will argue that coercion and freedom of choice are not alternatives but rather are intimately linked in long stay residential secure care (such as prisons or secure psychiatric units), where people have to live together in close social contact for long periods. We argue that forensic patients are constrained in many ways that do not involve direct coercion by staff; such as their offending history, their experience of social exclusion and their identity as offenders. Drawing on the work of Carol Gilligan and George Agich, we suggest that autonomy as "freedom of choice" is lived out in a complex way in forensic psychiatric care and that issues of consent and freedom are less simple than they might first appear.

Our discussion is intended to apply to all forensic healthcare professionals; doctors, nurses, psychological therapists and support workers, who though unqualified, carry out much of the work in long stay secure settings. We have used clinical vignettes to illustrate our argument: although clinically authentic, these are imaginary cases and any apparent similarity to existing cases is coincidental. We also refer to forensic patients as "he", not because there are no female offenders but because 80 % of violent offenders worldwide are male, and so make up the majority of forensic patients.

5.2 Coercion: The Ethical Background

It is an essential principle of medical ethics that patients should be left to make their own choices and that it is both an ethical wrong and a harm to force patients into actions or experiences that they have not chosen for themselves. This principle emerged in the post-war debates and discussions of civil liberties, which led to the civil rights movement in the USA, the development of feminist thought and increased discussion of the rights of patients to make their own choices. In particular, the Nazi war trials exposed the grotesque involvement of many doctors, including psychiatrists, in the murder and enforced sterilisation of thousands of patients and prisoners; and generated a determination to ensure that such events could not happen again.

The disclosure of medical atrocities led to a backlash against the paternalistic nature of the doctor–patient relationship, especially that version called "strong paternalism" in which doctors override the decisions of patients who have full capacity to make their own choices. Many jurisdictions passed laws limiting the potential for vulnerable people to be coerced or detained, and institutions such as the World Medical Association developed ethical guidance for doctors in relation to respect for patient choice, in both general clinical settings and research.

The principle of respect for autonomy underlies the law on consent in medicine. In English law, physical touching without consent is battery and may be an assault

in law: only the patient's informed consent protects the doctor from this charge. However, the patient who lacks capacity may not be able to give consent. Much legal attention focussed on the rights of patients to refuse medical treatment and challenge medical opinion; the orthodox position is summed up in a famous American case involving medical treatment, that went to the New York Court of Appeals, at which Justice Cardozo opined vigorously: "*Every human being of adult years and sound mind has the right to determine what to do with his own body*" (Schloendorff 1914).

5.3 Autonomy, Liberty and Choice

Cardozo's famous quote reflects the value that is placed on autonomy and choice in medical care. Respect for the autonomy of patients is only one of the "Four Principles" of bioethics (Beauchamp and Childress 2001), but it is arguably the "first among equals". The idea that the doctor knows best has been superseded by the right of the patient to make their own treatment choices, even if these are poor choices with risky outcomes. Contemporary debates consider the limits of autonomy: whether people have the right to maim themselves; the continuing debates about abortion and international debates about whether people have the right to end their own lives. Most jurisdictions have laws that state that people cannot compel doctors to do *anything* they demand as patients; doctors can refuse to respect a competent choice, but they may be expected to help the patient find a doctor who will help them (as is the case for abortion).

Box 5.1. Four ethical principles in bioethics (Beauchamp and Childress 2001)
Respect for autonomy
A duty of beneficence
A duty of non-maleficence
Respect for justice

The commonest limit on respect for autonomy is the lack of capacity to exercise it. As Gillon (1985) notes, there is autonomy of will, thought and action, and there is equally *capacity to exercise* autonomy of will, thought and action. What Gillon is describing here is a distinction between different types of freedom and the absence of different types of restraint. Autonomy of will means that the ability to make free choices is not constrained and that choices are voluntary; autonomy of thought refers to the freedom of belief and lack of censorship; and autonomy of action refers to absence of restrictions on actions. Gillon gives an example of a person in a wheelchair who has full autonomy of will and thought, but whose autonomy of action is compromised, not only by their neurological condition but also by the absence of facilities to make movement easier.

In England and Wales, there are two different types of legislation that relate to autonomy, consent and treatment for medical conditions. Under the Mental Capacity Act (MCA), people seeking treatment for general medical or surgical conditions are assumed to have the capacity to make decisions for themselves, even if the outcome is life threatening. No treatment can be given involuntarily to a person who has full capacity and who refuses treatment. The MCA also offers a framework for doctors who are treating people who lack capacity to choose for themselves. Treatment can be given in the absence of consent if it is in the patient's best interests; and doctors are expected to consult widely to try and make sure they have a good grasp of what the person themselves would want, if they were able to express a choice.

However, there is separate and different legislation for people who are thought to have psychiatric disorders. The Mental Health Act (MHA) gives powers to treat people with psychiatric conditions against their will, even if they have full capacity to make choices. A patient detained under the MHA cannot refuse to have treatment and can be forcibly medicated and restrained physically under this legislation. When the MHA was passed into law in 1983, there was considerable professional concern about the introduction of such coercive legislation (e.g. Gostin 1976), which is not found to the same degree in other European countries. There have also been expressed concerns that people with physical conditions seem to be treated very differently from those with psychiatric conditions (Eastman and Dhar 2000).

Because of their considerable legal powers in relation to detained patients, it could be argued that psychiatrists have particular duties to fulfil their ethical principles of respect for autonomy and justice. Psychiatrists have a duty to help patients regain the capacity to exercise their own autonomy again and make their own choices. It follows that there may be a time when the psychiatrist has to share the autonomy with the patient in some sense: to act as an accessory who can support the patient's choices while he cannot exercise choice.

Mental disorders can compromise the capacity to be autonomous, and this loss may be acute, chronic, short term or long term. They limit the capacity to exercise autonomy in a variety of ways. Persistent delusional beliefs (especially those that involve a sense of being controlled), e.g. may interfere with the capacity to experience a sense of agency in the world. Severe mood disturbance (depression, mania or anxiety) may also impair the capacity to make choices. It can even be argued that mental disorders affect the experience of personal identity, so that the choices that are made are not the "true" choices of the "real" person: a situation which most obviously occurs in dementia, but can also be seen in other mental disorders.

It could also be argued that lack of insight into the fact that one has a mental disorder also has a profound influence on one's capacity to make choices, insofar as that is informed by a degree of self-awareness and self-reflection.

The philosopher Harry Frankfurt (1971) argued that a defining quality of moral agents is the ability to have, what he calls, "second order desires", i.e. the ability to think about one's choices and to "want to want". He argues that mental illness may overwhelm the person's second order desires in favour of their first order. An

example would be the patient who, when well, is law abiding and enjoys time with his family and does not wish to be in prison (like most people). When he is psychotic, his psychosis gives rise to a first order desire to commit an assault, which overwhelms his second order desires to remain free of prison and with his family. Thus, it could be argued that the psychiatrist who detains the patient against their will is not, in fact, disrespecting their autonomy, but is in fact assisting the person to move towards their second order desires, which reflect a more authentic self or desire. The question then is how to distinguish between those first and second order desires and which really reflects the authentic view of the person making the choices.

It is relevant here to consider the relationship between autonomy and freedom. People are assumed to have capacity to make their own decisions, and if they have capacity to make decisions, then those decisions must be respected, no matter how foolish they may seem to be to others. In the same way, Article 5 of the Human Rights Act assumes that all are free to exercise liberty as they see fit and that human beings can only be constrained and their liberty removed after a proper legal process, and not in some arbitrary way. There are in effect two aspects to freedom, as described by Isaiah Berlin (1969): the freedom from interference (which is to some extent guaranteed by human rights legislation) and the freedom to be one's own person (which is the sense implied by the concept of autonomy). Prisoners lose their liberty as a punishment for offences against society; mentally ill patients lose their autonomy as a result of mental disorders.

Strous (2011) has argued that psychiatrists have a "mandated" social contract to "*describe, understand, predict and modify behaviour, particularly in cases of mental illness*". On this argument, psychiatrists are expected to not only help patients feel better (just like other doctors), they should also make them behave better. There is extensive literature going back to the 1960s which has criticised the role of psychiatrists in supporting social conformity and oppressive social norms and medicalising dissent: Thomas Szasz is arguably the most famous past exponent of this view.

5.4 Coercion in Psychiatry as a Moral Wrong and Harm

There are many definitions of coercion. At its most basic, it is a "subjective response to an intervention by others" (Newton-Howes 2010), but this can be expanded to include "the use of force that limits a person's choices or which involves physical or psychological distress" (Wynn 2006). Beauchamp and Childress (2001) go further and define coercion as "when one person intentionally uses a credible and severe threat of harm or force to control another" (p. 94). Coercion may be more subtle involving disrespect, insufficient giving of information, ignoring the patient or not listening to them. Coercion is generally assumed to be unpleasant and distressing, and patient groups have formed around the idea of being "survivors" of coercive treatments.

Coercion in psychiatry inevitably involves the overriding of competent refusals to have treatment and the ignoring of clearly expressed views and choices. It is then *wrong* in ethical terms because those who do the coercing are violating a right to liberty and freedom from interference and also violating their duty to respect autonomy. It is also a harm insofar as people who are coerced lose liberty and may also suffer humiliation and shame. If human persons have rights to be left alone, then a person who is coerced and forced into actions or experiences against their will is someone who then feels like less than a full human being and so experiences shame and a loss of dignity. The experience of feeling belittled or helpless can be both distressing and long-lasting, as confirmed by studies of the experience of coercion in psychiatric patients (Haw et al. 2011; Larue et al. 2013).

The ethical anxieties about coercion in psychiatry relate not only to the wrongs and harms described above, but the potential for frank abuse of patients by psychiatric staff. Staff who use coercion will usually justify their actions with reference to harms prevented and benefits achieved; even those who are later deemed to be have acted abusively (Blom-Cooper 1992). This may be a particular issue in long-stay residential care of people whose capacity to make choices is limited by their mental disorders or intellectual disabilities. Most countries sadly have historical evidence of how easy it is for vulnerable people to be abused in the name of treatment, health and safety, risk reduction or research.

Coercion would seem to be a straightforward moral wrong, insofar as it violates respect for autonomy. Even in those circumstances where patients have limited capacity to be autonomous, any intervention that causes distress is morally questionable because it causes harm, particularly because such patients are vulnerable and demand extra protection. How then is the use of coercion justified by forensic healthcare professionals?

Most jurisdictions have legal frameworks by which citizens can be detained against their will for treatment of mental disorders, and involuntary detention is probably the most common type of coercion that people with mental disorders will face. Involuntary detention and treatment is usually justified with reference to the patient's lack of capacity and the loss of their capacity to make good quality decisions for themselves. Detention is also justified with reference to the risk that a person poses (either to themselves or others), as a result of that lack of capacity and/or the choices arising from the mental disorder. Finally, detention is also justified on the basis of the anticipated benefits that detention will provide in reducing that risk.

In relation to forced medication, mental health professionals sometimes frame the argument in this way: if this patient was his "true" self, he would be able to see that this treatment is necessary for his welfare, and he would accept it. The patient's refusal is not a competent refusal; when he is well and "himself" again ("in his right mind"), then he would consent, and he may even be grateful to us for ensuring that he had the treatment (what Alan Stone (1985) called the "Thank-You" theory of civil commitment).

Such an optimistic analysis is contradicted by a variety of studies that indicate that people detained in psychiatric services do not feel grateful or cared for. Hooff

and Goossensen (2014) carried out a literature review of the experience of coercion by psychiatric patients and found patients repeatedly described the sense of not being listened to and a related sense of not being respected. A Swedish qualitative study of people who had been detained in psychiatric care found that people felt objectified when they became aware that staff were talking about them when they were not physically present to contribute to the discussion (Enarsson et al. 2011). Although they did report feeling safe because someone else was responsible for them, they also reported feeling coerced, empty and afraid.

In relation to physical seclusion or restraint, the argument usually rests on the value of the coercive intervention in reducing risk of harm to self or others. In forensic settings, reduction of risk of harm to others is a key professional value, which often trumps other values. Professionals who deploy coercive interventions claim that they are protecting not only the patient himself but his fellow patients, staff and others, e.g. visitors (at least in the short term) and that this benefit justifies the harm and wrong done to the patient who is secluded or restrained. Just as the police are given a public mandate to restrict the liberty of citizens in the name of public safety, so psychiatric professionals argue that they have a limited mandate to exercise control over people who are known to be dangerous in certain circumstances in the name of violence and harm prevention. The Human Rights Act recognises that societies may limit freedom and restrict citizens in a variety of ways; it is only when these restrictions and limitations are applied in arbitrary or cruel ways that there is a violation of Article 5. It is for this reason that most healthcare services are legally required to have scrutinised and ratified policies about the use of physical coercion or seclusion, and these policies must be subject to external independent review. There are interesting cultural differences between coercive practices in different countries; the USA and Canada, e.g. utilise physical restraints on disturbed patients that prevent them from moving, but see seclusion on one's own in an isolation room as cruel; whereas the reverse is true in the UK.

One NGO—MindFreedom—(described by Russo and Wallcraft 2011) has argued that such coercive treatments are "incompatible with healing". A stronger argument claims that coercion is the antithesis of healing: that no one can be healed without their cooperation and against their will (Russo and Wallcraft 2011). Although intuitively this seems to have some validity, there are some counterarguments. It could be argued that many patients with general medical disorders (especially small children or those who lack consciousness) get better without their active will or cooperation being involved. Many people take medication or treatment reluctantly; a degree of ambivalence about accepting treatment or help is not unusual in all patient groups, not just psychiatric service users. Although absolute refusal to consent or cooperate with any treatment is probably a bar to recovery, most experienced healthcare professionals know that such a stance may change with time, because it reflects a very understandable anxiety or distress about their situation. It is not only the patients who experience distress, psychiatrists too report real distress as they try to balance respect for autonomy with risk reduction and minimisation (Austin et al. 2008).

Very few medical conditions permanently and completely abolish the capacity to make choices, and psychiatry is no exception. Even if patients are detained and have limited choices, mental health professionals have a duty to help service users exercise what autonomy they have and pursue their own choices as best they can. It can be stigmatising and discriminatory to treat those with mental health disorders differently to those with physical ones (Burns 2011). It is important for well-being and dignity that detained patients exercise what choices they can, despite being detained, and healthcare professionals have a duty to include service users in all decisions that affect them: as the slogan goes, "No decisions about me without me" (Department of Health 2012).

The literature on coercion has focussed on the use of physically coercive treatments, i.e. the use of seclusion, restraint and IM medication. It could, however, be argued that there are far more subtle forms of coercion and restraint that affect all citizens, not just psychiatric patients. As the quote from Harvard Law School at the top of the chapter reminds us, rules and boundaries are vital for the healthy functioning of communities of people; those processes that we call "laws" are codifications of a social agreement that regulates the limits of individual liberty in the name of community welfare and liberal social life. For example, we are all free to kill anyone we choose, but most of us will be constrained and restrained by the laws that reflect serious social condemnation of such an action and which mandate severe penalties for doing so. Penal policies and criminal laws are often argued to act as restrictions on choices that society considers "bad" (although whether such laws and punishments actually act as deterrents to citizens is a different argument).

In the twenty-first century, it is noteworthy that jurisdictions have been increasingly happy to restrict individuals with regard to their choices to do *themselves* harm. Usually, the restrictions are couched in terms of benefits to "public health": for example the requirement to wear a seat belt, get vaccinated and not drink while driving. What these restrictions convey is how one person's health impacts on everyone's health, especially in publicly funded health systems: the ban on smoking in public places that now exists in most countries overtly addresses the risk of harm to others, but indirectly restricts the ability of the smoker to harm themselves. There is an interdependence of interests here.

5.5 Forensic Psychiatry and Coercion: Context

This chapter will focus only on forensic psychiatry as a therapeutic service, i.e. forensic healthcare services that provide psychiatric care to men and women who have committed offences, or behaved violently, and who simultaneously require treatment for a mental illness. To summarise briefly: prisoners serving a sentence or awaiting trial may need psychiatric treatment or psychiatric patients may commit offences while mentally ill. Both groups will need treatment in secure psychiatric settings, although in some countries (e.g. some states in the USA and Australia) forensic psychiatrists treat "patients" in psychiatric healthcare units

within prisons. In most European, Australasian and US states, psychiatric treatment is provided to convicted offenders with mental illnesses in secure psychiatric treatment settings. Forensic psychiatrists working in such settings are expected to treat their patients in the usual way, but also to negotiate and liaise with the public bodies that have mandated detention. For example, in England and Wales, forensic psychiatrists liaise with the Ministry of Justice, whereas in Holland, the psychiatrists liaise with the sentencing judge. There is an expectation that the psychiatrists working in these settings have a duty to reduce risk of harm to the public, as well as a duty to care for their patients.

Offenders with mental illnesses are subject to the loss of two forms of freedom: they have lost their liberty as a result of their offending, and they have lost their autonomy as a result of their disorders. Although detention in hospital as an alternative to custody is intended to be an alternative to punishment, in practice those detained in forensic psychiatric care are expected to serve an equivalent time in secure care (no more and no less), as a matter of justice. Those prisoners who become mentally ill while serving a sentence are expected to go back to prison to continue their sentence when they recover, even though they are likely to become ill again.

Forensic healthcare professionals are subject to the ethical codes and professional regulations of their particular professional group, including the traditional bioethical principles outlined by Beauchamp and Childress (2001). They must also be conversant with both psychiatry and law and aware of the ethically ambiguous position in which they find themselves. They are required to think not only about the welfare of their patients but also about the risk that those patients may pose to other people when discharged; they arguably have duties to not only make their patients feel better but behave better (Adshead 2000).

There is a limited amount of research about how forensic patients experience coercion in hospital. One study in a UK medium secure facility (Haw et al. 2011) asked patients about their last experience of restraint and/or seclusion. Most patients expressed negative views about their experience, as one might expect: but of the 57 patients asked, a small minority subgroup (16 %) stated it was a positive experience overall providing them with a time to reflect and calm down. A larger subgroup (36 %) were similarly positive about the use of forced medication. Over half the patients thought the coercive measures had been necessary.

A recent study in a Swedish secure service (Hörberg et al. 2012) found similarly negative responses from patients detained in forensic institutions. In their study, forensic patients described only “moments” of good care and an on-going struggle to adapt to the demands of their care givers. Resignation and hopelessness were recurrent emotions for patients, whereas for staff in forensic settings, fear is the most common emotion and resistance to thinking about what the patients have done. Staff describe how their fear and their wish to help the patients make negotiating risk decisions more complex.

5.6 Coercion in Forensic Psychiatry

Choice and consent is particularly complex in secure psychiatric care. Patients detained under mental health legislation lose the capacity to refuse treatment; they are not able to make free choices about whether they take medication or not. The medication is prescribed to restore their capacity to be autonomous, but arguably also to reduce their risk of re-offending. There is a sense in which the medication is fulfilling a penal role in reducing the risk of re-offending, in addition to the therapeutic role. Patients may not be allowed to refuse to take medication if professionals think that taking medication will reduce their risk. There is an especially painful ethical tension here for forensic patients and their doctors, because psychiatrists may compel patients into taking medication that is intended to reduce their risk of behaving violently to others, but may also reduce patients' life span through cardiovascular and obesogenic effects.

Patients in secure settings may also find that their freedom to choose is also constrained by their identities as offenders; there is an expectation that they should accept constraint and coercion because of their convicted offender status. We have experience of hearing staff who work in secure settings talk about the "injustice" that the offenders are getting care that their victims are not getting and express criticism of patients who do not appear grateful for the opportunity to have treatment in nicer surroundings than prison. It is sometimes commented that the perpetrators of violence get better help than the victims.

Forensic psychiatrists are also often invited to balance the harm done to the patient by the loss of their liberty against the benefit to the patient of having treatment and/or the benefit to the community of being protected from the patient's risk: in what seems like an impossible conflict between the patients' rights to liberty and autonomy and the professional duty to reduce harm and risk. There is, however, little guidance for forensic psychiatrists about how to weigh up these conflicting duties and interests: consider the example below:

5.6.1 Case 1: Henry

Henry has a long history of a bipolar affective psychosis, and when he relapses, he obtains weapons and claims he is an international super-soldier who must fight for peace and justice. He can be very hostile and threatening when ill, although he is calm and pleasant when he is taking medication. The history suggests that when Henry is on oral medication, he gradually stops taking it and relapses. Henry is now well; and he asks to be taken off his depot medication (i.e. long-acting medication that is injected intra-muscularly) and instead take oral medication. He does not accept that he has behaved in a risky way in the past. He does not agree with the doctors that he has a mental illness, saying that he is only ill if he smokes cannabis, and he says he will not do this again in the future. This is now Henry's third admission in similar circumstances.

Usually, if a recovered patient asks to have a different medication, then doctors are obliged to work with the patient and in general respect his wishes. Of course, this does not always mean doing exactly what the patient asks, but in general doctors are not expected to refuse reasonable requests from patients. Here, the only reason that the psychiatrist will not change the medication is that they are worried about the future risk of breakdown and recurrent offending. Henry is not worried about it, and he does not want his doctor to worry about it. But the psychiatrist is likely to experience a strong tension between respecting Henry's autonomous choice and their duty to reduce the risk of Henry acting riskily in future.

Ethical reasoning involves reflection on, and respect for, different sets of values, especially when there appears to be no obvious way to resolve the difference (Woodbridge and Fulford 2004). Such irresolvable clashes of value are an inescapable part of human life in social communities (Berlin 1991). We could say that there is an inescapable clash of values between Henry's world view of himself and his place in it; his psychiatrist's view of Henry and his future and society's view of Henry and the risk he poses. Henry does not see or accept that society wishes to exclude him for what he has done; he wants to be free to make his own choices. Although he is apparently "well", he does not accept that there is a high risk of future breakdown, and he wants to be free to take the risk.

There are other forms of coercion that can take place in psychiatric care; consider this case:

5.6.2 Case 2: Tom

Tom is a long stay resident in a low-secure service. He has complex psychopathology (epilepsy, personality dysfunction and mental illness), and he is very aggressive to staff when he refuses to take his medication which is frequently the case. The team decided to medicate him covertly, on the grounds that he lacked capacity and the benefits outweighed the risks. In this case, the identified benefits were that Tom's mental state improved; he did not have to be physically restrained and forcibly medicated and he was much easier for staff and fellow patients to live with. The risk was the effect on Tom when/if he found out: and sadly, when he did find out, he became very upset. He was even more aggressive and suspicious of staff and again refused to take his medication. The team decided that they must medicate him; and again decided to deceive Tom by medicating him covertly. Tom got better; instructed lawyers and sought to be released from hospital on the grounds that he was much better, without any treatment at all. His solicitors refused to go along with the treating team's deception of Tom, saying that they could not take instruction from him under false pretences.

Tom's case is a real one (*RM v. St Andrew's Healthcare*, 2010 U.K.U.T. 119) and is a nice example of the moral limits of uncritical consequentialism and the importance of time scales. Tom's mental state was better in the short term, but he ultimately felt belittled, humiliated and treated as less than a full person. It is hard

not to think that although Tom had short term benefits, the long term effects on therapeutic relationships with healthcare staff are likely to be negative. Deceiving Tom was a high risk strategy: any benefit gained was obtained by doing him both insult and injury, and the future therapeutic relationship with him was jeopardised.

Of course, one can imagine that this was not an easy decision for the treating team, and one imagines that they did consider many other options. It is hard not to think, however, that the exigencies of having a disturbed and aggressive man in a small confined space, affected the way that they weighed up the values of different courses of action. Of course, Tom was suffering from being untreated, and so there was a benefit to him of being free from symptoms: the complexity here is that he got this benefit at a high cost. Usually high cost decisions in medicine require a high level of patient involvement in the decision making; if the patient is so lacking in capacity they cannot be involved, then a proxy needs to speak for them in their best interests. What is missing here is any therapeutic plan to manage Tom's distress at being deceived, his sense of shame and humiliation.

5.7 The Ethics of Long Term Residential Secure Care

In this section, we want to set out another way to thinking about ethical tensions in forensic psychiatric care, especially the issue of coercion. We start by observing that the forensic psychiatrist is delivering a very particular type of treatment intervention, namely *long term residential secure* care. This means that the patient and the psychiatrist are both operating in a very particular ethical context. There are a number of parameters in long stay residential care that change the ethical reasoning context significantly.

Firstly, the time parameters in long stay secure care are quite different to those of treatment in general adult psychiatry or general medical care, and this extended time scale has a significant effect on therapeutic relationships. In general adult psychiatry, most periods of inpatient care are brief; lengthy inpatient stays and long term relationships with doctors are now comparatively unusual. In contrast, the forensic patient and the forensic healthcare professionals may have to relate to each other over months and years. The forensic nurses, in particular, may spend so much time with the patients that they spend more time with them than with their own families, which means that the relationships between them may be different from the traditional relationships that occur in health care.

Secondly, as already mentioned, the aim of treatment is not simply to make the patient feel better, as defined by them. The forensic patient is also invited to consent to behaving better and to *changing their mind* about their previous behaviour and way of relating. They will be strongly encouraged to see their past as "bad" and to participate in a range of interventions that will help them have a better future. Unlike general medical or psychiatric patients, the forensic patient does not make a series of distinct treatment decisions in relation to his diagnosis and prognosis, but rather is invited to consent to a package of interventions that are continuous, not discrete (Olsen 2003). This pack of treatment is designed to help a forensic patient

"change his mind" about his former life and actions, and it involves a change *of personal identity* (Maruna 2001), a decision which is ethically profound and affects a person's relationships in profound ways. Further, it will be made plain to offender patients that future liberty relies on this change taking place and being seen to have taken place.

This second point relates to the third, namely that the forensic psychiatric care service is also doing some of the work of the prison service. The patient's offender identity is not split off from their patient identity but is intimately entwined. This means that forensic patients are constrained by their offender identity, and the fact that their stay in hospital may be related to their prison sentences. In some jurisdictions, the courts or penal system continue to influence what happens to the patients and affects their recovery process. In England and Wales, e.g. the English Ministry of Justice have a role in regulating the treatment pathways of forensic patients: they can restrict whether patients are allowed to leave the secure service and influence decisions about discharge. They may stay much longer in the secure psychiatric services than they would have done if they had served a prison sentence for the same offence.

The stigma of being an offender does not disappear when an individual is sent to secure forensic psychiatric care. Patients cannot reject their offender identity when they have treatment in secure care (no matter how much they might wish to), and staff cannot let them forget it. They cannot choose their personal narratives in quite the same way as non-forensic patients can.

Fourthly, the residential quality of the experience itself has ethical ramifications. In general hospitals, patients travel a parallel path, and the treatment progress of one patient does not much affect another. In secure psychiatric care, the forensic patients join a community of the excluded and the stigmatised. They have to reside with others as part of their recovery from mental disorder, and their rehabilitation as offenders, and therefore relationships with others becomes crucial to their experience. In particular, they are dependent on nursing staff for almost every aspect of their care, including their movements; secure services remove agency from forensic patients in the name of risk reduction. Their relationships with the forensic nurses, doctors and fellow patients become crucial to their recovery or lack of it. Consider Peter's case:

5.7.1 Case 3: Peter

Peter was sent to prison after he was convicted of attacking a young man with a knife. He was not thought to be mentally ill at the time, although he was drunk. Peter's behaviour in prison is difficult for the prison staff to manage; he gets into fights with other prisoners, steals their medication, self-harms and seems distressed and psychotic. Peter is transferred to a secure psychiatric unit, where he continues to show similar behaviours, although he is easier to manage and he likes it better in hospital. He is always regretful after he has assaulted someone; but the more vulnerable patients are afraid of him and he cannot make progress from the

acute ward because of this. Peter does not want to go back to prison, but he seems unable to give up his antisocial attitudes. Staff are divided in their views: some think he should go back to prison soon, others think he should stay in psychiatric care because he is likely to be much worse in prison and will probably be re-referred quickly.

Peter's case is typical of many ethical dilemmas in mental health care, where one ethical principle is pitted against another. This seems especially true in forensic psychiatry, where forensic psychiatrists are often invited to set the interests of their patient against the interest of third parties in a dichotomous or adversarial manner (Olsen 2003). Here, Peter's welfare and preferred choice of treatment in hospital is pitted against an issue of justice: Peter is likely to end up staying in hospital much longer than his prison sentence for his offence. Peter does not seem to mind this, but it does not seem just in terms of either his detention, or allocation of resources. There are many "Peters" in prison: it is arbitrary that this "Peter" got a bed, a bed which is expensive and which is not available for another man in prison who may be just as needy, if not needier. Peter's case is a good example of the need for forensic healthcare professionals to pay attention to Beauchamp and Childress's respect for justice principle: a principle often overlooked in bioethics but of crucial importance in forensic psychiatry (Adshead 2014).

5.8 Relational Autonomy and Relational Security

In the last decade, there has been increasing interest in the possibility of taking a different approach to choice and autonomy in mental health care, drawing on the work of Carol Gilligan (1984) and George Agich (1993). These authors have suggested that our sense of self-hood and autonomy is constituted in our relationships with people we care for, or by whom we are cared for, and that discussions of the ethics of autonomy cannot rely on appeals to rights to liberty alone. Gilligan noted that young people, in particular, are highly conscious of the impact of their ethical decisions on how they see themselves in relation to others; they can see that they may have the right to have something or to take action, but that "right" may not take into account their moral identity as a son, daughter or carer. Similarly, Agich has studied how elderly or disabled people exercise choice when they are dependent on others 24/7; and concluded that there is a special type of autonomy for those adults who are in long term dependency relationships with other adults. Gilligan described her relational way of thinking about ethics as an "ethic of care"; and Agich described his participants as having "interstitial autonomy": these terms can be summarised by the concept of "*relational autonomy*".

Relational ethics may be helpful in forensic psychiatry as an antidote to the suspicion and risk-based ethics usually practised in forensic settings and as a way of acknowledging the complexities of relationships in long term care. Several forensic professional writers (e.g. Austin 2001; Rose 2005; Austin et al. 2009; Hunt and Ells 2011) have commented on the potential advantages of using a relational autonomy perspective when thinking about ethical issues in secure psychiatric care. Urheim

et al. (2011) used qualitative methods to study the experience of autonomy in a high secure psychiatric service and found that using a relational perspective had contributed to patients having an enhanced sense of choice and autonomy.

In a review of ethics in the forensic nursing literature, Gildberg et al. (2010) comments that paternalism and relational autonomy seem to have equal attention, but that there is little discussion in that literature of the impact on relationships with patients. Their review did not include an earlier paper by Verkerk (1999), who describes the advantages of "compassionate interference" in the treatment of drug-addicted patients. Drawing on the work of Charles Taylor, she argues that our selves are constituted in dialogue with others, especially those with whom we are in caring relationships and that those caring relationships are the background on which one might restore an autonomous sense of self.

Verkerk is alive to the risk that her "compassionate interference" is a form of "modern paternalism". However, we suggest that her notion of "compassionate interference" may be a particularly helpful way to think about the types of therapeutic relationships that exist in long term secure care. We would argue that in long term psychiatric secure care, there is a need for forensic patients to build up a new sense of self that is pro-social and able to both receive care and potentially give it to others. This will take time, and there may be conflicts and ruptures of relationships along the way, including times where parties are resentful of one another, and actions are taken *by both patients and staff* that are hurtful and frightening. Obviously, these will be kept to a minimum, but when they do occur, they need to be used as opportunities for growth and reflection by all parties. Reflective practice can involve both patients and staff in a process that allows people to articulate their hurt and distress and explore ways of accepting that bad things can happen but can be survived.

There is a psychological reason why this relational approach may have advantages in long term residential secure care. The majority of forensic patients have had early childhood experiences that have resulted in insecure attachment states of mind (see Pfafflin and Adshead 2003 for review). Such insecurity of attachment becomes a pattern of relating to others that is repeated with staff in long stay residential care. It is likely that some of the coercive and abusive practices that take place in secure settings arise because of unresolved and unexplored attachment dynamics (Adshead 2012). Professional attention to relationship between staff and patients, and between fellow patients, may be psychologically helpful as well as helping develop a base for ethical reflection.

We suggest that care and coercion are not adversaries, but are intimately linked when people have to rely on each other for support and safety. This is precisely the situation in which patients and staff find themselves in within secure settings. Those who live and work in secure psychiatric units have to join together to make safer communities; not act as competing bands of strangers who cannot share the same vision and who threaten each other. If this stance is taken up by staff, what happens is that the forensic patients who live in these units become a dangerous "other" or monster who has to be constrained and restrained (Peternelj-Taylor 2004) and who cannot be allowed to develop a new non-offending identity. As a patient in a

maximum security hospital once said to a psychotherapist colleague, "If you could talk to me the more human way, the night would come in slowly". That patient may have had a psychotic illness when they were speaking, but his meaning was plain.

5.9 Conclusion

We conclude our chapter by suggesting that what may be needed in forensic secure care is a deeper and more nuanced discussion about the nature of freedom and what it means for a person to be free. We would argue that "freedom" to be yourself and make your own choices is not the same as being free to do whatever you like, no matter what the consequences. We acknowledge the strength of the argument that competent agents should be free to make their own decisions, no matter how "dumb" they may seem to others, and we note that the English courts have respected competently made refusals to have life-saving treatment, even where this results in death.

However, we suggest that patients in secure care have compromised autonomy by virtue of their offender identity. Whether they like it or not, their personal identity and range of choices are different to non-offenders; they have restricted choices by virtue of their social exclusion and the damage that their offence has done to their identity as citizens. Their "recovery" pathway is not like that of other psychiatric patients (Mezey et al. 2010) and helping patients understand the effects of their offences on how they are seen by others is an important therapeutic task for forensic healthcare professionals. It is not helpful to pretend that mentally ill offenders are free to make their own choices because their "freedom" is dependent on both the network of therapeutic relationships they make in secure care *and* the choices and views of the society that detain them. The secure forensic psychiatric service is part of the social system that detains the patients and condemns their offences and seeks to help them to change for the better.

Changing oneself for the better can be a long and painful process and one about which most of us are ambivalent. It is inevitable that forensic patients will feel coerced and will be distressed and angry at the effect of their offences on their lives and choices. It is the role of forensic healthcare professionals to help the men and women we care for come to terms with their offender identities; mourn them and move on. We need to help them understand that some restraints can paradoxically increase freedom of will, thought and action.

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An International Perspective on the Use of Coercive Measures

6

Tilman Steinert

Abstract

Coercive interventions of many kinds are the oldest problem of psychiatric institutions and still today are considered as necessary in seemingly all countries in the management of dangerous behaviour against self or others. Though a huge variety of coercive interventions has been in use, basically there are only four different types: therapy by coercion (typically by antipsychotics), use of therapeutic measures without primary therapeutic purpose (e.g. chemical restraint), separation (e.g. seclusion) and mechanical restriction (e.g. restraint by belts). Traditions still determine preferences in the use of coercive interventions. Interventions being considered as least restrictive in some European countries and frequently used there are considered as inhuman and inacceptable in other countries. Seclusion is banned in Denmark, mechanical restraint in the UK and parts of Switzerland, net beds are used in parts of Austria and Eastern European countries but are strongly disapproved in most other countries; involuntary medication is used as a last resort in some countries and as first choice in others. In recent years, epidemiological data and evidence from randomised controlled trials and studies with patient interviews have become increasingly available. Results allow an empirical approach to the claim of the 'least restrictive intervention'. A ban of one kind of measure seems to lead to an increase of others and which is least restrictive is dependent on individual patient preferences and the context of action. Country comparisons yield valuable insight into the consequences of traditions and attitudes if they are different in the respective countries.

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6.1 Coercion in Psychiatry: An International Problem

History and psychiatry textbooks date the beginning of modern psychiatry to the year of 1793 when Philippe Pinel liberated the inmates of the French hospitals Bicêtre and Salpétrière from their chains. However, the oldest inherent problem of psychiatric institutions has not been resolved since. To the contrary, coercion soon returned to the newly founded psychiatric hospitals in many different facets such as coercion jackets, coercion chairs and a variety of sophisticated devices where patients were exposed to hot or cold water, electric current or spinning accelerations (Kraepelin 1918). Coercion had not been abolished but used to be a kind of therapy, against the background that not much other therapy was available. However, a counter movement arose some decades later in the form of the no-restraint movement, initiated by Connolly and Hill in England (Jones 1984). The no-restraint movement aimed for the total abolition of compulsory measures in the treatment of mentally ill people which lead to controversy and ongoing discussions in several European countries at the time (Colaizzi 2005). Effectively, the complete abolition of such freedom-restricting coercive interventions has never been convincingly reported in any country or period until today. Authors of contemporary as well as historical publications agree that it is not possible to completely abolish such measures, even in psychiatry of the twenty-first century (Fisher 1984; Steering Committee on Bioethics of the Council of Europe 2005; Steinert and Lepping 2009; Molodynski et al. 2014). It is sometimes necessary, particularly in public and political debates, to put this strong association between psychiatry, coercion and violence into question and to ask whether there is a reasonable cause for it, distinguishing psychiatry from other medical disciplines. Even if that certainly is not justification enough, there is a clear reason indeed for a special situation in psychiatry compared to other branches of medicine. Mental diseases are by definition (ICD-10, Chapter V) mental and behavioural disorders. That means these disorders, which are essentially disorders of brain function, induced in many cases by environmental circumstances, manifest themselves either as disorders of individual experience (such as anxiety) or as disorders of behaviour in a social context, such as agitation or violence. Violence against others or self can be a symptom of a mental disorder and is the main reason for the use of coercion (Raboch et al. 2010). Most people with such behavioural disorders can be successfully treated on a voluntary basis. However, for a minority of them this does not seem possible due to lack of insight, antisocial behavioural traits or skills among involved staff and others. Thus, the use of coercion remains the last resort to protect the patient and other people, a viewpoint that is in substance shared all over the world. A possible exception which has been under some discussion in recent years is the case of Iceland. It has been reported, mostly anecdotally, that seclusion and restraint have been successfully abolished in the psychiatric hospital which serves the whole island (Snorrason 2007; Gudmundsson 2012). However, due to visiting experts from other countries, at least some kind of seclusion and physical restraint is practised also in Iceland.

6.2 Variety of Containment Measures

Though infinite forms of coercive measure have been used worldwide, the basic principles used to contain dangerous behaviours are only three: Medication and other therapeutic measures under coercion, separation and mechanical restriction of mobility. Table 6.1 gives an overview.

Basically, the difference between therapy by use of coercion, separation and mechanical restriction is that therapeutic interventions aim to stop the dangerous behaviour by a causal intervention while separation and mechanical restriction are primarily safety measures not intending to influence the reason of the dangerous behaviour. However, this is not completely true. Separation, though undoubtedly associated with negative psychological impact, can lead to calming and reduction of over-stimulation (Steinert et al. 2013). Physical restraint, if well done, can be very interactive and can induce not only immobilisation but also patient-staff contact and de-escalation (Steinert 2011). On the other hand, the use of medication and electroconvulsive therapy (ECT) does not imply a therapeutic purpose automatically. If it is used with the primary intention to immobilise and sedate a patient, this is not a treatment in the patient's interest but an application in the interest of others. At least in some countries this would be considered as a misuse of psychiatry (Steinert 2014), while in others there is much less concern about this issue.

'Leverage' denotes many aspects of indirect coercion used inside and outside psychiatric hospitals. The basic principle is that freedom and/or support in terms of housing, money, etc. are offered under the condition of adherence to proposed therapies and accepting rules. The implicit threat on the other hand is to use or to continue coercion in case of non-compliance (Burns et al. 2011).

Table 6.1 Containment measures in history and present

Therapy by use of coercion	Use of therapeutic measures without primary therapeutic purpose	Separation	Mechanical restriction
Medication by use of coercion	Medication (chemical restraint)	Locked doors	Mechanical restraint (belts, chains)
ECT	ECT	Seclusion	Physical restraint (holding)
Leverage (indirect coercion)		Open area seclusion ("schaerming")	Coercion jacket
		Placing in remote areas	Plugboards, barred wheelchairs, special blankets and other devices used for people with dementia and mental handicap
			Net bed, cage bed
			Wrapping in moist cloths

Locked doors and seclusion are very traditional and well-known containment measures in psychiatric institutions. Somewhat different is a practice in Scandinavian countries called 'schaerming', maybe best translated as open-area seclusion. This means that the patients are not separated in a single room but rather in an area of the ward, and, in contrast to seclusion, accompanied by staff. Another variation of separation is placing patients or psychiatric institutions in remote areas such as islands or in institutions inside large forests. This was a leading principle during the foundation period of psychiatric hospitals in the nineteenth century.

Mechanical restraint also shows many different facets, the most distasteful being the use of simple metal chains for many years such as reported from Indonesia (Suryani et al. 2011). An individually adapted variant of a chain in an institution for mentally disabled people also gave rise to a public scandal in the Netherlands in 2012.

Physical restraint means immobilising a patient by the use of manpower, typically well-trained staff, by application of special techniques. Again, there are variations and controversies as to whether a face up or face down position is safer for patients and staff and whether pain-inducing techniques are admissible in this context (Parkes 2008; Stewart et al. 2009).

Coercion jackets are mostly a thing of the past, but in single cases have been reported to be in use even nowadays in Western countries.

A variety of devices and special equipment are used in old age psychiatry and in the care of people with a mental disorder or dementia, all of them leading to a restriction of freedom of movement. These measures are thus to be considered as variants of mechanical restraint.

A very unique device is the so-called net bed or cage bed, which consists of a net (or cage) stretched over a frame above the patient's bed, allowing free movement in a very limited space and enabling free communication.

Wrapping agitated patients in moist and warm cloths is a very traditional technique which is still in use at least in some places in Switzerland and the Netherlands. The idea is that it is safe for patients and staff as well and it takes some time and physical effort until the patient can work himself/herself out of the cloths, thus allowing staff to leave the seclusion room without danger and leading to some desired exhaustion and a workout on the patient's part.

6.3 Traditions

Being used as long as psychiatric institutions have existed in all countries, the application of coercive measures is clearly not based on evidence but on opinions, attitudes and traditions, varying strongly between and even within countries. Table 6.2 shows preferences of used containment measures in some selected countries, according to literature and some anecdotal evidence. From most countries, no internationally accessible literature (published in journals in widespread languages) is available. For example, a report on a very successful project in Bali/Indonesia (Suryani et al. 2011) provided data on the former use of coercive

Table 6.2 Preferences of containment measures in some selected countries (selected according to available literature)

Country	Preferences	Comments
Austria	Mechanical restraint > seclusion, net beds in some places (Vienna)	Net beds under discussion locked wards not allowed except for forensic psychiatry
Denmark	Mechanical restraint, medication	Seclusion not allowed (Bak and Aggernæs 2012)
Germany	Mechanical restraint > seclusion > medication (Steinert et al. 2014a)	Involuntary medication legally restricted since 2011 ECT rarely used
Iceland	1:1 surveillance, medication; no seclusion rooms or restraint belts available (Gudmundsson 2012)	According to visitors occasionally some kind of seclusion (locking patient's room)
Indonesia	Long-term restraint over years by chains reported	Report on a single project (Suryani et al. 2011); scarce literature on general practice
Japan	Mechanical restraint, seclusion, medication	Much longer duration in comparison to European countries (Steinert et al. 2010)
Netherlands	Seclusion > medication > restraint	National programme for reduction of seclusion due to very extensive use (Vruwink et al. 2012) well-equipped seclusion facilities (up to 120 m^2/patient) Restraint rarely used Use of medication facilitated in recent years (Steinert et al. 2014b)
Sweden	Seclusion, mechanical restraint, medication	Open area seclusion in some hospitals
Switzerland	Seclusion > medication > mechanical restraint	Mechanical restraint not allowed in some States (Kantone)
United Kingdom	Physical restraint and medication > seclusion	Mechanical restraint not allowed Staff highly trained in physical restraint techniques, seclusion rarely used
United States	Mechanical restraint, seclusion > medication	Use of involuntary medication restricted ('right to refuse treatment')

measures, in this case simple chains under desperate conditions, for many years. This does not mean at all that the practice in Indonesia is worse than in other developing countries. Rather, the fact is that apart from some European countries and North America, very little is known about the common practice of containment of mentally ill persons posing danger to self or others (Molodynski et al. 2014). As Table 6.2 shows, in some countries some types of coercive measures are prohibited which are very common in most others. Mostly ethical reasons are claimed—the respective measure is viewed as 'barbaric'. For instance, in Austria it is not allowed to treat voluntary patients on locked wards, with the consequence that all wards are kept open. On the other hand, the practice of net beds is appreciated in parts of

Austria such as Vienna under practical considerations, while in most other countries there is considerable concern with regard to net beds due to ethical reasons ("*Human beings don't belong in cages*") (Whittington et al. 2009). In Denmark, seclusion is not allowed due to ethical reasons, while in the Netherlands the same measure is preferred, due to ethical reasons as well. In the UK, mechanical restraint with belts is not allowed and strictly disapproved of, while there is little concern about the use of medication for purposes of restraint ('chemical restraint'). The latter is, however, considered as irreconcilable with a doctor's duties in Germany (Steinert 2014).

Besides ethical considerations and traditions not called into question, availability of measures certainly plays a role. In the absence of mental healthcare systems in developing countries, archaic practices such as chaining persist. In extremely resource-constrained countries, practices such as seclusion are quite uncommon because no room is available for doing so. In contrast, in the Netherlands, where seclusion is viewed as the least restrictive alternative, well-equipped seclusion units with several rooms and open air access for single patients have been implemented (Mierlo et al. 2013). The duration of such measures is, thus, obviously not a question of patient characteristics but also of tradition and attitudes. This is demonstrated by the fact that a physical restraint episode in the UK typically takes some minutes, while seclusion and restraint take some hours in most countries and about tenfold that in Japan (Steinert et al. 2010).

6.4 Epidemiology

With regard to forensic psychiatric units, there is very limited information as to the frequency of use of coercive measures. Precise data has been collected during a cluster-randomised controlled trial of reducing seclusion and restraint in one of two large forensic psychiatric hospitals in Finland (Putkonen et al. 2013). However, the study population comprised only men and included difficult-to-manage civil patients referred from other hospitals due to violent behaviour. Time in seclusion or restraint was reported to be 110 h per 100 patient days at baseline, dropping to about a half after a comprehensive intervention.

More data is available from civil psychiatric units from an international perspective. Steinert et al. (2010) provided a literature review of published research papers and other reports containing data from countries with more than a single hospital, published after the year 2000. Such information was obtainable only from a very limited number of countries (Austria, Finland, Germany, Japan, the Netherlands, New Zealand, Norway, Spain, Switzerland and the UK). Most data referred to the use of seclusion or restraint, while little precise information was found with regard to involuntary medication. Admissions were exposed to any kind of coercive intervention between 3 % (Norway) and 16 % (New Zealand), mostly around 10 %. Considerable differences were seen in the duration of application of seclusion and restraint. A single intervention was reported to last about 6 h in Germany, 40 h in Switzerland, about 3 days in Japan and 16 days in the Netherlands (only

seclusion); on the other hand, physical restraint episodes in the UK very rarely last more than 20 min.

A different approach was used by the EUNOMIA project which assessed and compared the use of coercive measures in psychiatric inpatient facilities in ten European countries in a sample of 2030 involuntary admitted patients (Raboch et al. 2010). The included countries were Germany, Bulgaria, Czech Republic, Greece, Italy, Lithuania, Poland, Spain, the United Kingdom and Sweden. Patients with schizophrenia represented about two-third of the sample. 38 % of the involuntary detained patients were subjected to any kind of additional coercive measure, with a great variability between countries (21 % of detainees in Spain and 59 % in Poland). Forced medication was the coercive intervention used most frequently with 56 % of all interventions (from 31 % in Greece to 81 % in Sweden), followed by restraint with 36 % of all interventions (from 15 % in Bulgaria to 69 % in Greece) and seclusion with 8 % of all interventions, from 0 % (not occurring) in Germany, Greece, Lithuania and Poland to 30 % in the United Kingdom.

An epidemiological study from Denmark investigated the level of use of coercive measures during the first year of contact with psychiatric services among patients diagnosed with a schizophrenia-spectrum disorder (Øhlenschlaeger and Nordentoft 2008). 2222 patients were identified, out of whom 22.9 % experienced coercive measures of any kind. 10 % were admitted involuntarily, 13.9 % were detained, 3.2 % received antipsychotic medication against their will and 7.1 % other involuntary medication. 14.6 % were subjected to mechanical restraint by belts with a mean cumulative duration of 2.66 days. Seclusion was not reported as it is considered unlawful in Denmark.

6.5 What Is Better?

The use of coercion causes severe subjective distress and has a detrimental impact on the therapeutic relationship (Jaeger and Roessler 2010). Thus, there is definitely not a better alternative, that is, the question is rather which one is less harmful. Nevertheless, the question is very important if containment measures seem inevitable: which one is the least restrictive, least harmful and safest for patients and staff? Many important international organisations, psychiatric associations and political authorities, among them the World Psychiatric Association, the World Health Organization (2005), the US Congress and the European Council (Steering Committee on Bioethics of the Council of Europe 2005), have passed statements that coercive measures should be avoided and that only ‘the least restrictive measure’ should be applied. However, how can we find out what is ‘the least restrictive measure’? Obviously, this question cannot be answered based on opinions, attitudes and general considerations, taken into account that experts prefer medication and physical restraint in the UK, chemical restraint in Germany, seclusion in the Netherlands and net beds in parts of Austria.

Important qualitative approaches are *medical ethics* and *human rights*. According to the principles of medicals ethics, the principle of beneficence should

determine the patient–doctor relationship; further, physicians need to avoid harm, respect the patient's autonomy and act under aspects of fairness (Beauchamp and Childress 2009). Obviously, safety measures such as the interventions mentioned above restrict patients' autonomy severely, but probably to a different extent. Restriction of autonomy is greater in case of immobilisation by use of belts than by an enforced stay on a locked ward or within a seclusion room. Whether such mechanical interventions or medication by force exert deeper impact on the patient's autonomy remains a topic of discussion, however. Which of the interventions has beneficial effects or causes less harm is difficult to state based on theoretical considerations. The aspect of fairness is relevant related to the use of medication, if the displayed dangerous behaviour is symptomatic of an illness. Mostly, in such cases of severe mental disorder, such behaviour is associated with a lack of insight into the illness and into treatment. Applying treatment against the patient's will would be a severe intrusion into the patient's autonomy but withholding treatment would be against the principle of fairness since it is obviously unfair to withhold treatment for the most severely ill who are not able to recognise the necessity of treatment due to their illness.

The human rights perspective is different in its approach. Human rights are viewed as universal, indivisible and belonging to every human being. The validity of these general rights has been exemplified for special subgroups, mostly noted in recent years for people with disabilities in the Convention of the rights of persons with disabilities (United Nations 2007). Whether people with mental disorders should be considered as 'disabled' or not does not play a special role in this context because the rights exemplified in the UN Convention are viewed as universal and applicable to everybody anyway. Important general claims of the UN convention on the rights of persons with disabilities are unrestricted respect for human dignity and social inclusion. Under these aspects, a special report to the UN has sharply criticised the use of all kinds of coercive measures in mental healthcare, particularly involuntary medication, and has solicited governments to ban such practices (without suggesting how to manage dangerous patients alternatively). From the viewpoint of human rights and human dignity, it could be argued that placing humans into cages or net beds offends human dignity more severely than placing them in a seclusion room or even immobilising by the use of belts. The difference is that the use of specially designed cages is commonly associated with animals but never happens in any other context with humans, which suggests they are being treated like animals. This point is (at least in the author's view) stronger than any practical considerations such as advantages of a net bed with respect to mobility and communication.

6.6 Evidence

Theoretically, three different objectives can be investigated in the comparison of different coercive interventions: Safety, efficacy and subjective distress for patients. Safety for patients and staff as well is an important issue. All interventions

can have detrimental side effects: Patients and staff can be hurt in fights; patients can hurt themselves during seclusion, e.g. by banging their head against the wall; physical restraint can lead to fatalities due to exhaustion combined with pressure on the thorax; mechanical restraint can lead to deep vein thrombosis and pulmonary embolism and strangulation in belts, if not supervised continuously. It should be supposed that such complications associated with the most invasive interventions used in psychiatry would be monitored and reported regularly, thereby allowing comparisons of the safety of different interventions in large sample sizes. However, surprisingly, to our knowledge such data has never been published so far except for single case reports (Rakhmatullina et al. 2013; Dickson and Pollanen 2009). Thus, at present, there is no evidence available as to whether one intervention should be preferred to another under aspects of safety, even if 'safety' is restricted to the occurrence of physical damage, not taking into account psychological sequelae which undoubtedly can result, including full posttraumatic stress disorder (Steinert et al. 2013).

Regarding efficacy, it would be expected that medication is effective in reducing psychotic symptoms, agitation and aggression caused by an underlying mental disorder. It has been convincingly shown that antipsychotics have such effects in patients with schizophrenia or bipolar disorder and that rapid tranquilisation with antipsychotics and benzodiazepines is effective. Literature reviews are available in guidelines where a clear recommendation for the use of rapid tranquilisation for aggressive behaviour is given (National Institute for Clinical Excellence (NICE) 2005; German Society for Psychiatry and Psychotherapy (DGPPN) 2010). There is evidence that the effect of medication is not significantly smaller if medication is applied involuntarily, so the effect is definitely not a placebo effect (Steinert and Schmid 2004). Studies investigating the efficacy of rapid tranquilisation compared to pure mechanical safety interventions such as seclusion or restraint, to our knowledge, are not available. This is probably due to the fact that most psychiatrists would consider the use of restraint in agitated patients without accompanying rapid tranquilisation as unethical. However, at least in Germany, some patient organisations, denying any use of involuntary medication, claim to do so.

The question whether pure safety measures such as seclusion or restraint might have any efficacy on psychopathological symptoms may sound somewhat strange considering that the use of such measures should definitely not be called a kind of psychiatric 'therapy'. However, out of 60 patients who were interviewed about their experiences during seclusion or mechanical restraint, 67 % of those secluded and 46 % of those restrained indicated that they had experienced some calming even in the absence of additional pharmacological interventions by the measure (Steinert et al. 2013).

From the current research perspective, the most important viewpoint is a patient's subjective distress due to coercion which is associated with aspects of human rights and human dignity. In order to conduct research in this area, we developed an instrument designed to measure subjective distress and impairments of human dignity during coercive measures: the Coercion Experience Scale (CES) (Bergk et al. 2010). The CES addresses aspects of human dignity, freedom of

movement and social contact, each of which is rated as to the extent of impairment and distress about this impairment. In addition, other sources of distress are assessed, such as physical environment and negative feelings. We used this instrument in the first randomised controlled study comparing two different coercive interventions, seclusion and mechanical restraint (Bergk et al. 2011). We found a high degree of subjective distress, partly accompanied by impressive reports about feelings of helplessness, shame, humiliation and fear of death, particularly in association with co-existing psychotic experiences. No significant differences in subjective experience of distress, as measured by the CES, were detected between seclusion and mechanical restraint. However, in the follow-up interview 18 months later, those patients who had experienced mechanical restraint indicated significantly more subjective distress. Feelings such as helplessness, tension, rage, anxiety, horror and shame each were reported by one- to two-thirds of the patients (Steinert et al. 2013).

The same instrument, the CES, was used in an observational study in the Netherlands by Georgieva et al. (2012), who compared patients who had received involuntary medication with those who had received seclusion and those who had received both measures combined. Subjective distress in those patients who had only received involuntary medication was considerably lower compared to those patients who had experienced seclusion. Subjective distress was highest among those patients who had received combined measures.

Another approach to compare different measures is to show pictures of various coercive measures to patients and to ask them about their preferences. Such a study was done by our working group and a working group in England (Bergk et al. 2009; Whittington et al. 2009). In both studies, patients were asked to rank different measures from the most to the least uncomfortable. The pictures included mechanical restraint, physical restraint, seclusion and net beds in both studies. Mechanical restraint and net beds were judged as most uncomfortable. However, it has to be taken into account that patients might reject measures more strongly which they never experienced if suggested in pictures. The patients in the UK never experienced mechanical restraint and net beds; those in Germany never experienced net beds. Therefore, these results are not free from bias. A similar approach was used in a study by Veltkamp et al. (2008) in the Netherlands. 104 patients who had received either seclusion or involuntary medication were interviewed and asked which of the two measures they assessed as less distressing. Overall, there were no significant differences from the patients' point of view with respect to distress and efficacy between the two measures. However, it transpired that patients had clear but individually different preferences. One or the other measure was preferred (or less disapproved) by about a half of patients. Men preferred seclusion more frequently, women involuntary medication.

Still of interest today is a series of descriptive studies which Finzen and coworkers conducted more than 20 years ago in Switzerland interviewing 54 patients who had received involuntary medication (Finzen et al. 1993). At that time, it was rather uncommon in all areas of medicine to ask for patients' subjective experiences. 40 % of the patients had experienced the involuntary medication as

severe humiliation and insult, 31 % as punishment, but 13 % as salvation. Retrospectively, 20 % viewed involuntary medication as worse than seclusion, 13 %, however, as less distressing. In hindsight, 18 % considered the medication as necessary; 34 % reported that it was terrible at the time but had also led to relief. 44 % considered medication as also not useful even afterwards.

6.7 What Can Be Learnt from Comparisons Between Countries?

We look back on approximately 10–15 years of discussions about the use of coercive measures in an international context, ethical and political debates and attempts to gain evidence from sound study designs with many different outcomes. At present, the following conclusions can be made:

- A continuous critical appraisal of the use of coercive interventions is necessary, both from the quantitative perspective (for whom? how often? how long?) and a qualitative perspective (how? in which context? with which outcomes?).
- The use of coercive measures has to be put in perspective with many other aspects of mental healthcare (resources, organisation, role in society, jurisdiction, user involvement).
- Patients' subjective views and experiences are important in establishing guidelines and as an outcome of studies.
- Comparisons of different practices are possible and necessary. Appropriate methods have been established.
- A reasonable theoretical framework has to be applied for research, guidelines and clinical considerations. This framework needs to imply clear distinctions between objectives of safety and therapy and between aspects of ethics, human rights and of therapeutic intentions.
- Comparisons should be based on research studies and on the analysis of routinely collected data; for the latter, the increasing availability of such data in electronic format facilitates their use.

6.8 Future Perspectives

Progress in the future can be expected with respect to the availability of data from routine care from an increasing number of countries. An important area which is not covered at all so far is mental health institutions outside psychiatric hospitals such as nursing homes. In particular, data on safety aspects from routine care are urgently required, thus also allowing for comparisons between different practices. However, it is not probable that further research and ongoing debates will lead to an agreement that a single method of the current different practices in different countries should be generally preferred for all patients. Rather, we should learn more about different needs and preferences of different patients and we should learn

to provide a broad range of possible interventions everywhere instead of only a single one which is based purely on tradition. Eventually, it is necessary to further develop the current practices, away from safety measures imposing severe distress to patients and staff toward interventions which integrate relationship-building, trust and the search for agreement into every coercive approach.

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Part II

Coercion in Different Settings

Coercive Measures in General Adult and Community Settings

7

Peter Curtis, Bradley Hillier, Rachel Souster, and Faisil Sethi

Abstract

Coercion is defined as '*the application of force to control the action of a voluntary agent*'. The use of coercion on mental healthcare patients constitutes an exception to the principle that healthcare is voluntary and based on consent. Coercion is generally unwelcome to patients, and there is a declared international goal to reduce its use. In describing the extent of the use of coercion in general adult settings, it is important to consider the entire care pathway, from the community through inpatient services to discharge, and the interactions that may occur along it. Some measures are more concrete, such as the removal and detention of individuals against their will, use of physical, chemical and/or mechanical restraint and seclusion, which can be measured in terms of frequency and trends over time. Other less tangible forms are more difficult to quantify, including situations which may be termed 'negotiation' or 'leverage' over care pathway items such as leave and medication (including type and route of administration). The only available data on coercion tend to relate the former.

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7.1 Capacity and Coercion

No discussion of the use of coercion within psychiatric settings would be complete without mention of mental capacity, that is, the ability of an individual to give informed consent or make a capacitous decision in relation to a specific issue, including treatment decisions for both mental and physical health problems. The Mental Capacity Act (2005) enshrined in statute for the first time in England and Wales, fundamental principles which had evolved through case law. This act rationalised the test to be used to determine whether an individual has capacity in relation to the matter under question. This is a decision-specific test which is used routinely in clinical practice by any doctor to assess whether an individual is suffering from an impairment or a disturbance in the functioning of the mind or brain. The effects may be temporary or permanent, but as a result the individual is unable to do one or more of comprehending, retaining or weighing information or communicating a decision about a particular issue. Additional specific underlying principles are also inherent, including the assumption of capacity until proven otherwise, taking all practicable steps to maintaining capacity and allowing unwise decisions to be made. In the case where capacity is lacking, the principle of least restriction applies in terms of the intervention or decision under consideration and that a decision made on behalf of the person who lacks capacity is in their best interests.

A lack of capacity cannot be established merely by reference to a person's age or appearance, a condition or an aspect of behaviour which might lead others to make unjustified assumptions about his capacity. Any question of whether a person lacks capacity must be decided on the balance of probabilities; it cannot be applied to individuals under the age of 16. In some cases where 'bad decisions' are being made, the motivation for which is not entirely clear to the assessor, referral to the Court of Protection may occur and a decision reached both regarding capacity and, if required, the question at hand.

For those even only remotely aware of the legal structures for detention, treatment and supervision, it will be immediately clear that there is a complex and uncomfortable tension between the Mental Capacity Act (2005) and some of the interventions that have and continue to be administered in mental health settings. Indeed, in England and Wales, it is possible to coercively treat capacitous individuals against their will under the Mental Health Act (1983, as amended 2007) in a number of scenarios. This tension, as well as the role of human rights legislation, is beyond the scope of this chapter. It may seem an obvious point, but it should be stated that the only justification for using coercive measures within mental health settings is on the basis of the 'best interests' of the patient and those around them and for the 'greater good' purpose of reducing risk or harm. The potential for coercion to become perverse and used for abuse must be constantly guarded against, as it is well established that power imbalances can lead to abuse, even in settings where the intentions are not abusive (e.g. Haney et al. 1973; Department of Health 2012).

We discuss here a cross section of the available data and evidence regarding the use of coercive measures that may be experienced by patients in relation to their

mental health, treatment and management of behaviours associated with mental disorders.

7.2 Coercive Removal from the Community

In a number of jurisdictions, there are provisions for the police to detain individuals under mental health legislation as an alternative to criminal justice measures at the point of initial contact. Within England and Wales, these powers are defined under Sections 135 and 136 of the Mental Health Act (1983; as amended 2007) and provide for the removal and/or conveyance by the police of individuals suspected of suffering from mental disorder to 'a place of safety'. This may be an emergency department, police cell or specialised hospital suite staffed by trained professionals. There are some important differences between these powers and their use in terms of safeguards, reflecting the increased degree of coercion perceived in their use.

Section 135 is a Court order allowing for 'search and removal to a place of safety' access to premises if an individual is suspected of suffering from a serious mental disorder. It is most often used when the individual is suspected of becoming unwell in the community and has disengaged from their team; the place of safety is usually a hospital. The warrant is executed by the police accompanied by an Approved Mental Health Professional (or 'AMHP')[1]; sometimes a psychiatrist attends. Section 135 is noteworthy for giving the police the power to access a private residence without a suspected life-threatening emergency situation, under which circumstances a warrant is not required.

Between 2008 and 2013, use of Section 135 has appeared relatively stable, with some minor fluctuations, at about 250 episodes per year (Care Quality Commission 2014) and is approximately equally split between males and females (slight male preponderance at 54 %). However, it is known that the figures captured by National Health Service (NHS) are an underestimate of its use as they do not include assessments which result in hospital admission under a civil detention order (Section 2 or 3 of the Mental Health Act 1983), informal admission, removal to a police custody suite or no removal at all. This is an active area of improvement in terms of data collection.

Section 136 of the Mental Health Act (1983) provides for individuals suspected of suffering from mental disorder to be removed by the police to a 'place of safety', as defined above. At any of these locations, an assessment may be carried out, although not necessarily by a trained mental health professional (Royal College of Psychiatrists 2011a). This is a clear, concrete coercive measure with a mental health

[1] An 'Approved Mental Health Professional' ('AMHP') is a legal term within the Mental Health Act 1983' (as amended 2007) defining an individual who is authorised on behalf of the Local Authority (i.e. a County Council or City Borough) to make an application for admission to hospital under the Mental Health Act, the individual having a professional background in mental health and having undergone specific training. Previously, this was the role of an 'Approved Social Worker', and in practice it is usually a role that continues to be held by Mental Health Social Workers.

implication, which can be applied to any member of the public on the basis of police suspicion of mental disorder.

Within recent years, there has been a significant escalation in the use of this police power in England and Wales (Care Quality Commission 2014), and policy concerning its use has been developed by the Royal College of Psychiatrists (2011a) in the UK. There has been a sixfold increase in the use of this power (Keown 2013), which relies solely on police judgment at the time of encountering the individual. In 2012–2013, approximately 22,000 detentions in a combination of custodial and hospital settings were recorded in England and Wales. Understandably, controversy has arisen from the view that custodial settings are not an appropriate place of safety, given that the individual is 'processed' in the same manner as those suspected of committing an offence. There have also been a number of incidents attracting media interest, involving the death in custody of Section 136 detainees. Historically, the police have not recorded data on the use Section 136 to detain individuals in a custodial setting, but there is an appetite to rectify this and data are becoming available, indicating 8667 detentions in 2011–2012 and 7761 in 2012–2013.

Data are much more readily available and reliable on detentions of individuals under Section 136 who are brought to hospital. The reasons for their increase are complex and unclear. The report by the Royal College of Psychiatrists (2011a) noted that this may be due to improved recording on behalf of the police and hospital services, although additional factors such as improved training of officers to recognise mental disorder (e.g. Mind 2013a) and greater use of mental health rather than custodial settings may also be significant. Alternatively, the increase may be associated with an increased use of Section 136 to inappropriately detain people who are intoxicated with alcohol or drugs (Zisman and O'Brien 2014).

7.3 Informal Admission and Detention in Hospital

Hospital admission is indicated in any situation in which an individual is deemed to pose a sufficient risk to their own health, safety or to others by virtue of mental disorder and where intensive community treatment is not sustainable.

In England and Wales, the 'least restrictive option' is the gold standard (Department of Health 2015), which in practice requires primary consideration of 'informal' admission. It should be noted that the term used is in 'informal', rather than 'voluntary', indicating a subtlety in legal status with coercive implications. Capacitous 'voluntary' admission to hospital outside of the structure of the Mental Health Act indicates that individuals are consenting to being liable to detention, hence the term 'informal' rather than 'voluntary'. Given that these patients are not detained, issues of care and treatment are through an ongoing negotiation with the clinical team, and require their consent, since they are also subject to the procedures and policies of the hospital unit into which they are admitted, which is likely to also contain detained ('formal') patients. A tension arises from the 'duty of care' of

healthcare providers to consider the safety and well-being of patients. Potential sources of coercion for informal patients may include the following:

- The patient's perception that if they do not agree to informal admission, they will be admitted anyway under a detention order (Katsakou et al. 2011);
- The way in which services are structured and operated, with informal and detained patients in the same clinical setting, who may be subject to 'blanket rules' emphasising control and coercion rather than dignity and care, without regard to their detention status (Care Quality Commission 2012);
- The use of 'leave' being agreed in a similar manner to that of detained patients, and the associated patient perception that they need to 'comply' with the agreement, or risk being detained (Care Quality Commission 2014);
- The view of services that detention powers can be resorted to if the informal patient wishes to leave and the clinical team does not agree for specific risk-related reasons (Mental Health Act 1983).

Thus, even an 'informal' status can be imbued with coercion. Approximately, one quarter of individuals admitted informally to hospital perceive that they were coerced into admission, and half of these continue to feel coerced throughout their admission (Katsakou et al. 2011). In a recent study in Ireland, O'Donoghue et al. (2014) interviewed 161 individuals using the MacArthur Admission Experience Interview; half of those interviewed were informal admissions. They found that a significant minority (22 %) of the informal patients experienced equivalent levels of coercion to detained patients, using the coercion perception subscale. This was broadly comparable to a previous study in Norway in which Iversen et al. (2002) found that the term 'coerced voluntary' patients was applicable to 33 % of the study group using a similar method. O'Donoghue et al. (2014) found that factors relating to the process of admission and security of the locked ward significantly affected this. They also noted that clinicians, while attempting to ensure the least restrictive option through informal admission, may inadvertently insinuate a coercive structure, whereby informal status patients lose the protections offered by mental health legislation, such as right of appeal against detention. The use of 'blanket rules' in inpatient mental health settings can lead to inadvertent restrictions on the liberty of movement, such as freedom to leave the ward without permission, or for fear of detention, with de facto equivalence of informal and detained patients (Care Quality Commission 2014).

In circumstances where there is sufficient concern regarding the risks posed by an informal patient were they to leave hospital, short-term holding powers may be enacted by a nurse or doctor, lasting up to four and 72 hours, respectively, and triggering an assessment to consider whether formal detention under mental health legislation is warranted. Between 2007 and 2013, there was a steady but significant increase in the use of such powers, from approximately 8300 records in 2007 to almost 10,000 occasions in 2013 (Care Quality Commission 2014).

Some informal admissions may terminate in detention under mental health legislation, or the process of admission may be involuntary from the outset. Mental health legislation in England and Wales is carefully monitored, with local, regional

and national scrutiny, including by 'arm's length bodies' (funded by, but not accountable to, government) such as the Care Quality Commission (CQC), government departments and Ministerial oversight (such as the Department of Health in the UK) and through independent organisations (such as Mind, a mental health charity) and 'Freedom of Information' requests. Detention and compulsory treatment as an archetypal form of coercion has, appropriately, evolved with multiple 'checks and balances' to ensure that it is appropriately enacted, scrutinised and open to independent legal appeal, indicative of the controversy and seriousness with which its historical and continued use is associated. As noted in the most recent CQC report '*detainees under the 1983 Act are particularly vulnerable, unable to choose whether to engage or disengage with services and subject to legal powers of coercion which can extend to physical force*' (Care Quality Commission 2014).

In non-forensic settings, the most pertinent orders are Sections 2 and 3 of the Mental Health Act (1983), which are the most commonly used civil detention orders. Section 2 is an order for up to 28 days' detention on the grounds of suspected (or known) mental disorder for assessment in the interests of managing the risks of one or more of: the health or safety of the individual, or the safety of others. The aim of the period of detention is usually to assess and manage the acute risk, as well as to characterise and potentially treat the underlying mental disorder, including considering whether voluntary treatment can occur, or whether a new treatment strategy is required in circumstances where known mental disorder is present. Section 2 can be rescinded should it be considered appropriate to do so, allowing a patient to become 'informal' or be 'converted' to Section 3.

Section 3 is an order for up to six months of treatment and is more specific in the criteria for detention in that a mental disorder of a nature or degree must be already present, that one or more of the risks described above are identified and that additionally 'appropriate treatment is available'. Section 3 has the potential to be renewed, initially six-monthly, and subsequently annually without limitation of number of renewals, should it be considered appropriate to do so on the grounds of mental disorder and risk. For either Section 2 or 3 to be enacted, two specially approved doctors (one of whom is independent of the hospital authority) and an AMHP carry out the assessment and must agree that detention is warranted. There is a legal right of appeal to an independent tribunal. It is of note that Section 3 does not require an initial period of Section 2 if mental disorder is known and the legal criteria are satisfied. If the patient has capacity to consent and is willing to agree to an informal admission, this is preferable, although issues of risk may outweigh the ability to sustain informal status safely, and formal admission may be justifiable. For interested readers, full information about the application of the Mental Health Act can be found in the Code of Practice (Department of Health 2015).

The CQC publishes an annual report detailing the use of compulsory detention and treatment in England and Wales. In 2012–2013, the highest ever use of the detention for assessment or treatment under the Mental Health Act (1983) was recorded (Care Quality Commission 2014). As shown in Fig. 7.1, the use of the Mental Health Act (1983) has shown a year on year increase since 2008 with over 50,000 incidences of detention in the last observation period (including Section 136). This has corresponded with a rising inpatient detained population,

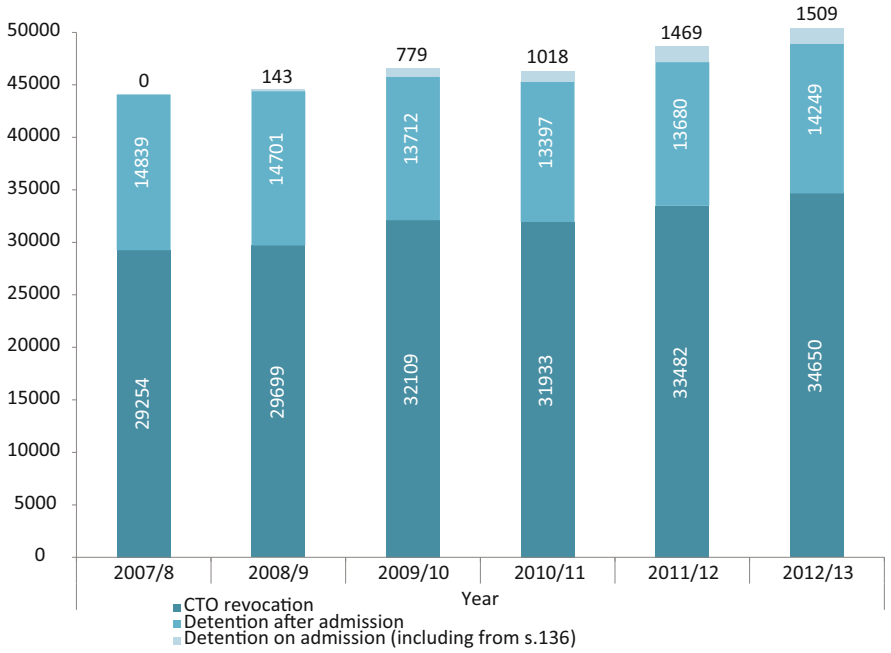

Fig. 7.1 Detentions under the Mental Health Act (admissions and detentions of informal patients), 2007/2008–2012/2013. *Source*: Care Quality Commission (2014)

from around 15,000 in 2008 to almost 17,000 in 2013. Although over the last five years there has been an increasing use of Section 2 as opposed to Section 3 (in keeping with the 'least restrictive option' principle), there has also been a gradual increase in the proportion who are subsequently 'converted' to Section 3. Consequently, England and Wales has never before detained so many people under mental health legislation as at present. The reasons for this are hotly debated and include arguments such as financial pressures leading to admission only being prioritised if an individual is detained or that society is becoming increasingly risk averse. The underlying basis is unclear and likely to be multi-factorial and beyond the scope of this chapter.

7.4 Coercive Treatments and Interventions

When an individual is under detention it is possible for the Responsible Clinician[2] (or 'RC') to prescribe without patient consent, including capacitous consent, for the first three months of an admission in both emergency and routine situations. After

[2] The Responsible Clinician is legally defined within the Mental Health Act (1983) at s34, as an individual who is responsible overall for the care of a detained individual, with some subtleties arising as to whether the patient is in hospital, under Guardianship or under Community

3 months, the detained patient must either consent 'voluntarily' to their treatment plan or a second opinion assessment by a doctor (SOAD) is sought, who can approve, modify or certificate the treatment plan for a specific time period. Almost 11,000 of these assessments occurred in 2013. There are, however, powers to treat patients in an emergency (under Section 62 of the Mental Health Act 1983) should it be deemed appropriate by the RC to prevent deterioration, suffering or risk, amongst other criteria, should such certification not be in place, have been refused or be unavailable for other reasons (Care Quality Commission 2014). It is more common for SOADs to make changes to the medication plan in cases where approval of 'high dose' medication is sought (i.e. above 100 % of the British National Formulary recommended limits) as compared to those in which the plan falls within limits.

Increasingly coercive measures may be used in situations of behavioural disturbance associated with risks to self and or others, although particularly the latter. There is a usual escalating pathway of intervention, some of which will be applicable to detained and informal patients alike (e.g. enhanced observations and rapid tranquilisation not involving restraint or intramuscular medication) and others whose use would in themselves strongly indicate an inability to continue to provide treatment under informal status. In the latter scenario, this would be the use of physical restraint (with or without rapid tranquilisation), seclusion and mechanical restraint.

Enhanced observations constitute a coercive measure used by staff to assess and manage the risk to the patient or others (NICE 2015). NICE guidelines define three main levels of enhanced observations including: intermittent (checked every 15–30 minutes), within-eyesight and within arm's length at all times. The level of coercion varies depending on the type of observation and number of staff involved but may approach the level of intrusion of a restraint. However, it is seen as more therapeutic and acceptable by staff and is consistent with informal status. The extent to which enhanced observations are used is unknown; it is not subject to national reporting in the UK, but only to local monitoring for service planning and improvement purposes.

In 2011, the BBC television programme *Panorama* exposed criminal abuse at a learning disability hospital called Winterbourne View, where patients were being subjected to extreme levels of abuse and coercion whilst being detained under the Mental Health Act (1983). The programme caused a national outcry and prompted ministerial intervention. In combination with the MIND (2013b) report and in the broader political climate which followed publication of the Francis Report (Francis 2013) urging improvements in quality of care, collection of data on the use of restraint and restrictive practice is to be collected by the Health and Social Care Information Centre in the Mental Health and Learning Disability Minimum Data

Treatment. In addition, the clinician must be 'Approved' undergoing additional training to fulfil the duty. It does not necessarily have to be a medical doctor, although this is the most common. Some functions of a Responsible Clinician require medical registration, such as making medical recommendations for detentions and prescribing.

Set (MHMDS). At the time of writing (2015), additional approaches include the NHS Benchmarking Network undertaking a pilot to benchmark good practice in Oxford and Liverpool prior to a potential future national rollout of this scheme.

Rapid tranquillisation (or 'pharmacological restraint') describes the use of enforced medication to manage acute aggressive behaviour, with the goal of calming down a patient who is acutely disturbed, to enable communication. Rapid tranquillisation is one of several strategies commonly used in the management of severely disturbed behaviour in mental health inpatient settings. Where the risk is assessed as both severe and imminent, rapid tranquillisation may be employed. 'Tranquillisation' means calming without sedating. 'Rapid' implies that it is necessary to achieve calming as quickly and as safely as possible. It is used when other less coercive techniques of calming a patient, such as verbal de-escalation or intensive nursing techniques, have failed. It usually involves the administration of medication over a time-limited period of thirty to sixty minutes, in order to produce a state of calm/light sedation. The intervention poses risks to both patients and staff and as such adherence to good practice is particularly important (Baggaley et al. 2013). Administration may be through oral or intramuscular administration, and the process may be associated with physical restraint (see below). When orally administered, this is consistent with informal status, although is likely to indicate a significant tension with coercive undertones, and consideration should be given for detention under mental health legislation dependent on the specific scenario. The extent to which rapid tranquillisation is used in the UK is not readily quantifiable, since there are no nationally collected data. Research data give some indication of the frequency with which forced medication is used. For example, Raboch et al. (2010) found in the EUNOMIA study that amongst seven hundred and seventy detained patients who experienced coercion, forced medication (fifty six per cent) was the most frequently used of three interventions included (forced medication, restraint and mechanical restraint).

In situations of acute behavioural disturbance, detention allows for the use of contact restraint. This can be in the form of physical and pharmacological methods, to prevent or limit violence that has not responded to de-escalation techniques, and may be associated with placing a patient on an increased level of observation or, in more extreme cases, seclusion. These may be used individually, or in combination with each other, and there is a lack of consensus within and between countries on the best method of dealing with such psychiatric emergencies (e.g. Raboch et al. 2010; Steinert et al. 2010). Physical restraint refers to holding the patient down to prevent injury to self or others using a manual or 'hands on' technique. It is the most fundamental intervention and often comes before anything else. Mechanical restraint, rapid tranquillisation and seclusion often rely on physical restraint as a first step, but this is not always the case. Mechanical restraint involves the use of belts, handcuffs or any other equipment, which restricts the patient's movement. This approach is not collectively accepted and in some countries, including the UK, it is emphatically disapproved of (Bowers et al. 2004), although reintroduction into High Secure Forensic settings is a recent development and is included in NICE guidelines for management of violence (NICE 2015).

In 2013, the mental health organisation MIND reported on the extent of use of physical restraint through freedom of information requests to NHS mental health services (MIND 2013b). They identified significant variation in the use of physical restraint across the UK, with organisations reporting between 38 and 3000 incidents over the course of a year. They also collated 1000 episodes of physical injury following physical restraint and noted that there was no framework to govern its use. In total, with a response rate of eighty seven per cent of all NHS trusts, MIND counted almost 40,000 episodes of physical restraint occurring in 2013, with 3500 of these occurring face-down and 4300 in the context of administering medication. This influential report made recommendations that face-down physical restraint should be stopped and that a national framework with guidance and training standards developed, as well as monitoring on the use of this coercive intervention. Their recommendations were supported by the Care Quality Commission (2014).

Seclusion consists of putting and maintaining a patient in a bare room, either by locking the door or by placing staff at the door to ensure that the patient cannot leave (alternatively referred to as 'open seclusion'). There are variations in the type and size of room used. For example, the room can range from a patient's bedroom to a large area specially designed for observations, but the main characteristics are enforced isolation from the ward community in a bare un-stimulating environment to reduce risk to others. Seclusion is usually a last resort intervention, when other interventions have failed, and the risk of violence remains too high to manage through other means. In 2010, a national census of inpatients reported that four per cent of patients had experienced one or more episodes of seclusion (Care Quality Commission 2011). In its 2014 annual report, the CQC highlighted the risks that seclusion facilities may be unfit for purpose, too hot and, on occasion, patients were being nursed without respect to their dignity (Care Quality Commission 2014). All mental health services are required to have policies and procedures in place to monitor the use of seclusion facilities, although the CQC noted that there was significant variability in how these are followed, and that there has been no impetus for their use to be reported centrally until recently (Care Quality Commission 2014).

Mechanical restraint is used extremely rarely in England and Wales and is usually only associated with patients in secure services when all other interventions have failed. Two recent developments in the use of mechanical restraint are of significance. First, it has recently been reintroduced as an accepted procedure in the High Secure hospitals, and secondly, this has been enshrined in NICE guidance (NICE 2015). Patterns of the use of mechanical restraint vary significantly between countries, although research carried out in the UK indicates universal disapproval by both service users and staff (Whittington et al. 2009). The extent to which its use in High Security occurs remains to be seen.

Finally, there are other invasive treatments such as electroconvulsive therapy and other physical treatments which hold a special place in both the history and public perceptions of psychiatry, not least owing to films such as *One Flew Over the Cuckoo's Nest* and the extent to which frontal lobotomy psychosurgery was used in the mid-twentieth century as a psychiatric treatment. Within the UK, there is

significant scrutiny and rigorous checks and balances when the use of such treatments is under consideration. Electroconvulsive therapy (ECT) is used for a variety of psychiatric indications, most notably depression, mania and catatonia (NICE 2003, 2009), but is also used in other illnesses including certain subgroups of patients with schizophrenia (e.g. Taylor and Fleminger 1980; Pompili et al. 2013). ECT is subject to special conditions within the structure of the Mental Health Act (1983) under Section 58A and is appropriately associated with significant regulation, monitoring and quality control by various organisations, including the CQC and the Royal College of Psychiatrists, who operate an accreditation scheme for ECT services (Hodge and Buley 2015). Patients may choose to have ECT voluntarily, subject to assessment, capacitous consent and assessment of medical fitness by an anaesthetist. Coercive use of ECT, including in situations where it may be used as a life-saving treatment (such as catatonic or stupor states, for example), is exclusively within the context of the Mental Health Act (1983). Emergency powers can be used to administer two treatments under Section 62, after which an independent SOAD must approve further treatments. Between 2009 and 2013, the number of SOAD authorisations for ECT (with or without medication) fluctuated between 1200 and 1400 each year, the bulk of these being for ECT alone (Care Quality Commission 2014), although it is not known exactly what proportion of these approvals lead to the actual delivery of the treatment. Similarly, it is not known how often Section 62 emergency powers are used. Of particular note in relation to ECT, a patient who has made an 'advance directive' (through powers defined in the Mental Capacity Act 2005) that they do not want to have ECT if they become unwell *cannot* be administered *except* in life threatening situations. Thus, this is an unusual situation where capacity considerations are placed in an exalted position over the power of coercion available under the Mental Health Act (1983).

Psychosurgery is extremely rarely employed and (within the UK) only for cases of intractable depression, severe obsessive-compulsive disorder (OCD) and anxiety when all other treatments have failed. Section 57 of the Mental Health Act (1983) provides a safeguard that such treatment *cannot* be given without both capacitous patient consent (including informal and/or outpatients) *and* a second opinion, unless it is necessary to save life. Coercive psychosurgery therefore does not have a role in the UK. The last case of Section 57 approved psychosurgery was for intractable depression in 2010.

A controversial coercive treatment which has exceptionally been given under the Mental Health Act (1983) in the UK is force feeding in the context of anorexia, personality disorder and psychosis. Such situations, when they arise, frequently require the legal process to provide further guidance and clarification of the appropriate application of law, including the rationale for treatment amongst other considerations. It is not known what the exact figures are for this form of intervention, but it is likely to be extremely low.

7.5 Coercion in the Home: Supervised Community Treatment

Following amendments to the Mental Health Act in 2007, the ability to provide more coercive forms of treatment within the community was introduced, known as supervised community treatment (SCT) (sometimes referred to as a 'community treatment order' [CTO]) which can be imposed on a patient who has been detained in hospital under Section 3 at the point of discharge. This was envisaged as providing a structure to allow greater access to certain patients who were difficult to engages or who were undergoing so-called revolving door presentations. The conditions do not require agreement with the patient, can be broad and may include specifications on compliance with medication, place of residence, access for assessments and providing specimens of blood or urine for substance misuse or medication monitoring. SCT remains subject to the same scrutiny as inpatient detention in terms of checks and balances, rights of appeal, etc. Crucially, in order to justify the use of SCT, the power of 'recall' must be required and proportionate. Patients under SCT are liable to being recalled to hospital should they not comply with the conditions of their discharge to the community and subsequently reassessed for detention under an order which is akin to Section 3 of the Mental Health Act (1983).

Figure 7.2 shows the UK population subject to CTOs by gender between 2008 and 2013. Since their introduction in 2008, the power had been used 18,942 times by 31 March 2013, with 4500 patients discharged from hospital onto a CTO in 2012–2013 alone. Their use remains controversial and subject to considerable debate. The Oxford Community Treatment Order Evaluation Trial (OCTET) concluded in 2013 that there was no significant reduction in admission rates by

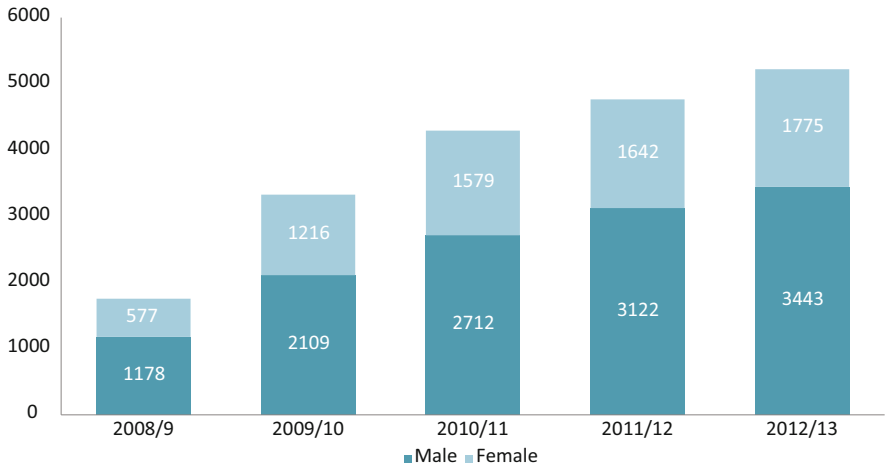

Fig. 7.2 Population subject to CTOs, by gender, as at 31 March 2013. *Source*: Care Quality Commission (2014)

virtue of their use, and that the long-term duration of coercion which they represent could not be justified (Burns et al. 2013). However, others have argued that re-admission is not the only outcome with which effectiveness should be measured. It is suggested elsewhere that being subject to a CTO provides a framework for a legal recognition of the need for care (Stroud et al. 2014). The use of CTOs will undoubtedly continue to attract controversy and debate, as well as variability in practice, until further evidence is available.

7.6 Factors Associated with Coercive Measures

A whole series of coercive measures have been highlighted above, but this section will focus more on inpatients, and relate to the management of violence and aggression, as the scope of the topic is otherwise vast. This includes the following four measures (as outlined above): restraint, enforced medication, seclusion and enhanced observations.

In order to create strategies to prevent violence and the use of coercive measures, one needs to have an understanding of which factors are associated. This will reduce the risk of needing to use coercive measures and ultimately enhance the therapeutic work achieved protecting patients and staff from physical and psychological harm.

On examining the research in Northern and Western Europe, one can see that most studies of coercive practice have been of retrospective design with various national and methodological differences. Differences also arise from variations in the definition of coercive practices in other regions, and results have shown a marked variation in the frequency of coercive measures both internationally and in different hospitals. To address the lack of robust studies and heterogeneity, the European Commission funded the EUNOMIA project (European Evaluation of Coercion in Psychiatry and Harmonization of Best Clinical Practice). This study recruited patients using exact inclusion criteria and clearly defined the coercive measures. However, it is important to highlight that although there is a legal framework for involuntary admission in all European countries, when it comes to coercive measures, only some countries have regulations, increasing the variability of practice and making it harder to draw clear conclusions.

A recent review by Bowers et al. (2014) pooled the extensive range of papers, around 1180 that existed on the topic of coercion and associated factors. It is important to note that the majority of the research including the papers reviewed by Bowers et al. (2014) are descriptive in nature with very few controlled trials. This generally limits the strength of conclusions that can be drawn. Although evidence-based conclusions cannot be provided, this section seeks to explore the most likely associated factors of coercion and to provide a proposed structure to reduce both.

We will look at the associated factors individually, in broad domains including patient, environmental and staff factors, and how they are associated with the

coercive measures outlined above. As factors often interact with one another, we will also explore combined factors when relevant.

7.6.1 Patient Factors

Factors associated with coercive measures that relate directly to the patient can be divided into three categories: socio-demographic factors both fixed (gender, age and ethnicity) and variable (employment, housing, education and social circumstances), degree of illness (positive symptoms, severity and acuity of symptoms and irritable or disinhibited behaviour) and nature of illness (diagnosis, substance misuse, personality disorder, history of violence and aggression, formal detention, history of detention and previous admissions).

There are numerous socio-demographic factors that can play a role in coercive measures, but we explore the fixed and variable ones as outlined above. In considering gender, one would presume significant association with all four of the coercive measures highlighted above. This starts with the premise that there are higher rates of violence in males in acute but not forensic settings (Bowers et al. 2014) and particularly in males with schizophrenia who are shown to be more likely to commit more severe acts of violence (Elbogen and Johnson 2009). Therefore, in an inpatient setting it may be expected that there would be higher levels of aggression and secondarily that more coercive measures are associated with men. In a specific paper on gender, schizophrenia and coercion Nawka et al. (2013) described a higher use of enforced medication in women, compared to men who were more likely to be manually restrained. However, in more systematic reviews, there is insufficient evidence for a gender association with enforced medication (Bowers et al. 2014). Of note, coerced women were significantly older than men, were more likely to be married, divorced or widowed and were less frequently unemployed. In Nawka et al.'s (2013) study, very similar numbers of male and female patients were involved in some kind of aggressive behaviour, with slightly higher rates in females. Although this difference was not significant, this finding may suggest a discrepancy with the literature on violence in outpatient psychiatric populations, where men are more at risk of being violent than women (Elbogen and Johnson 2009). There are several factors that may explain this discrepancy. Firstly, assaults by men are associated with substance abuse and property crime (Krakowski and Czobor 2004). These factors predominantly have less influence on inpatient settings, although as we are all aware it is not impossible to get drugs on to an inpatient unit. Secondly, the presence of major mental disorders, including schizophrenia, increases the risk of violent offending relatively more in women than in men (Hodgins 1992). Also consistent with other literature, female patients were more frequently aggressive but with lesser intensity, whereas males were responsible for the most severe aggressive acts (Nawka et al. 2013). In relation to gender, the use of special or enhanced observations appears to have received little research attention; however Bowers et al. (2014) suggested that females are more likely to be subject to enhanced observations. This could relate

to managing higher rates of para-suicidal and self-harming behaviour rather than aggression.

Other studies have failed to identify any role of gender in the use of coercion (Husum et al. 2010; Kalisova et al. 2014). However, again in examining the studies, it is important to remember the heterogeneity that exists, including different definitions and different coercive measures. For example, Husum et al. (2010) defined involuntary medication as receiving a depot rather than rapid tranquillisation. Similarly, Kalisova et al. (2014) did not find any significant gender differences associated with the use of coercion and postulated that this could be due to the choice of dependent variable. In fact, the majority of studies have looked at the effect of gender on a specific coercive measure (e.g. seclusion, physical or mechanical restraint, forced medication, involuntary hospitalisation), whereas Kalisova et al. (2014) tested the effect of gender on coercive measures as a whole group.

Overall, on review of the literature, there only appears to be a clear association between male gender and manual restraint and between female gender and enhanced observations. The manual restraint is most likely to be due to the perceived risk that males pose over women and the perceived severity of potential injury, based on history of aggression.

In examining age, younger age has been shown to be associated with increased use of seclusion, but from the literature there is insufficient consistent evidence for an association with physical restraint, coerced medication and enhanced observations (Bowers et al. 2014). In European studies where mechanical restraint is used in preference to pharmacological restraint, those more frequently mechanically restrained were young (Knutzen et al. 2014). This could relate to the higher risk of physical injury in those who were older and reluctant to mechanically restrain or it may instead relate to the clear association between younger age and violence. There is little research on the relationship between age and enhanced observations. However, one old study found that those on enhanced observations were significantly younger, with the highest number of patients in the 17–24 and 25–34 age groups (Tardiff 1981).

When examining the relationship between ethnicity and coercion, as the rates of detention are higher in black and ethnic populations, one might postulate that the same would be true for coercive methods. However, in a large three-year study in South London, Gudjonsson et al. (2004) found no significant correlation between coercion and ethnicity after confounding factors were accounted for (including age, nurse being the target of violence, extent of injury and mental health act status). Bowers et al. (2014) further corroborated this by showing no systematic association between ethnicity and coercive measures.

For the variable factors of employment, education and marital status, there is limited evidence of any correlation with coercive measures (Bowers et al. 2014). However, a correlation has been established between enhanced observations and being unmarried (Ashaye et al. 1997). The mechanism of this correlation is unclear.

With regard to social circumstances in general, by the time many patients are admitted to hospital, a variety of interventions may have been attempted at home.

The crisis associated with admissions can include deterioration in coping with many of the stressors of community living and similarly contribute to the need for further mental health support. These may include accrued debts, interpersonal conflicts and relationship breakdown, caring responsibilities, housing problems, access to finances and benefit problems to name but a few. It is therefore important that staff remain mindful of the potential for these stressors to acutely affect the behaviour of patients and the subsequent response from the service. These stressors may manifest themselves in escalated behaviour, which one can postulate might lead to coercive measures. There is little direct evidence that exists around this topic, but is important to consider the areas in examining coercive measures.

Overall, the degree of illness plays a substantial role in leading to coercive measures. As might be expected, increased severity and acuity of symptoms are correlated with increased use of all coercive measures. Predictably, patients with higher levels of psychotic and hostility symptoms and of perceived coercion had a higher risk of being coerced at admission (Kalisova et al. 2014). Specifically in relation to the risk of being secluded, Kalisova et al. (2014) found a positive association between aggressive or overactive, self-injury or suicidal and hallucinations or delusional symptoms, and there was a negative association between depressed mood and seclusion. A positive association has also been found between risk of being mechanically restrained on all the parameters above, except hallucinations or delusional symptoms (Husum et al. 2010). Underlying this, Bowers et al.'s (2012) meta-analysis of violence and aggression found that a patients' symptoms (rather than specific diagnosis) were antecedents in 28 % of violent incidents.

Although limited, the literature has shown an increased risk of use of enhanced observations if the patient had mild or severe suicidal intent, paranoid or delusional beliefs, questionable suicidal intent, severe agitation, moderate agitation or withdrawn behaviour, as highlighted by Kettles et al. (2004). In addition, Bowers et al. (2003) found that patients categorised as 'self-harmers' were more likely to have received continuous enhanced observation, as were 'angry absconders' (which included physical aggression, attempted absconding, missing without permission) and 'angry-refusers' (which included aggression, refusing regular and as required medication).

Identifying an association between coercive measures and the nature of illness, most specifically diagnosis, is challenging due to the different diagnostic systems that exist. However, there appears to be a clear correlation between coercive measures in general and schizophrenia and in particular an association between seclusion and schizophrenia and mania (Bowers et al. 2014). Interestingly, no consistent association has been found with physical restraint, and there is mixed or inconclusive evidence for any correlation between schizophrenia and mania with either coerced medication or physical restraint (Bowers et al. 2014).

A large Finnish study (Keski-Valkama et al. 2010) found that the use of restraint and seclusion was most prevalent in the substance-abuse-related diagnosis group, followed by patients with schizophrenia. However, the differences between these two groups were markedly diminished when the diagnosis variable was adjusted for

the variables of year, age, gender and phase of hospital stay. In addition, the risk of being restrained or secluded was smaller in those with mood disorders than with schizophrenia. This emphasises the importance of not relying solely on patient factors when trying to assess, predict and reduce coercive measures, but of having a dynamic model in which situational and contextual factors are also considered. There is inadequate evidence to reach any robust conclusions about an association between enhanced observations and diagnosis. However, Stewart et al. (2010) conducted a large review of enhanced observations including a range of studies indicating a significant correlation with schizophrenia, but found contradictory results in other studies in which depression was more frequent and no significant effect of any diagnosis apparent.

On further examination of the association between diagnosis and coercion, the most frequent associated diagnosis after schizophrenia and mania is personality disorder but, other than self-harm and suicide (for which a positive link has been identified), the evidence for associations between any coercive measure and other diagnoses is weak (Bowers et al. 2014). Of note, primary Axis I disorders with additional personality traits (especially features of antisocial personality disorder) may lead to instrumental aggression while borderline personality disorder may lead to self-harm, increasing the likelihood of use of coercive measures.

Although violence is a separate topic in itself, it is important to consider its place and connection with coercive measures. When considering violence as an antecedent to coercive measures, it is important to recognise that research on the relationship between mental illness and violent behaviour is contentious. Many of the factors that are closely associated with violent behaviour and people with disorders such as psychopathy, anti-social behaviour, drug abuse or dependence and anger, are also predictors of significant violence for subjects without mental disorders. The independent effect of the mental illness on violence is therefore less apparent than may appear if not taking into account these additional factors. The discrepancy between studies may be secondary to the use of different diagnostic criteria, different definitions of violence, the use of heterogeneous study samples and the frequent existence of psychiatric co-morbidity (Sirotich 2008).

Current published data do not allow systematic meta-analysis of predictors of inpatient violence due to different sample characteristics, different measures and definitions of violence and different time frames of observation. However, history of violence appears to be the only robust static predictor of violent inpatient behaviour, reflected in numerous studies confirming this finding and a lack of published contradictory results (Steinert 2002). This not only applies to violence prior to admission but also previous inpatient violent behaviour, pre-morbid violence outside of institutions and violence in family of origin (Richter and Whittington 2006). One can postulate that inpatient violence has a very high risk of leading to coercive measures, although this may vary in clinical practice depending on whether the victim is a member of staff, patient or visitor.

In examining violence itself, several studies have provided some evidence that personality disorders represent a significant clinical risk of violence. Esbec and Echeburúa (2010) examined the risk of violence among patients with certain

personality disorders, in terms of four fundamental personality dimensions: impulse control, affect regulation, threatened egotism or narcissism and paranoid cognitive personality style. Threatened egotism is when a person feels at threat to their ego, which particularly affects those with inflated, grandiose or unjustified favourable view of themselves. They will encounter and be those who are most intolerant of these threats, which is more likely to lead to an aggressive response. Two of these dimensions, impulse control and affect regulation, are probably substantially affected by virtually all personality disorders linked to violence. Narcissism, threatened egotism and paranoid cognitive personality style have also been empirically linked to violence and mental disorder. A considerable proportion of people who demonstrate violent behaviour do not have the full set of symptoms to reach a formal diagnosis of personality disorder. Personality disorder symptoms (i.e. traits in the absence of a formal diagnosis of personality disorder) are proven to be even stronger predictors of violence than a diagnosis of personality disorder as such. In fact, increased symptoms of DSM-IV cluster A or cluster B personality disorder, such as paranoid, narcissistic and antisocial personality disorder symptoms, correlate significantly with violence.

Bowers et al. (2014) found a consistent association between formal detention and violence as a precursor to coercive measures. They also found a consistent association between formal detention and all coercive measures (forced medication, mechanical or physical restraint, seclusion and enhanced observations). A correlation was identified between patients with previous admissions and forced medication, but no information was available on a potential relationship with mechanical or physical restraint, or enhanced observations, and there have been mixed results for seclusion.

In summary when looking at patient factors, violence and subsequent coercive measures were closely linked with younger age, male gender, a diagnosis of schizophrenia, formal admission and previous admissions. Repetitive violence was also associated with young age, male gender and those who were formally detained (Bowers et al. 2014).

7.6.2 Environmental Factors

Environmental factors include the dynamic and static. Dynamic factors explored here include other patients, staff and visitors, and the static factors relate to physical space with size and number of rooms and beds per room, privacy, outside space and types of space available, including de-escalation areas and type of ward, e.g. psychiatric intensive care unit. The environment can be a source of many challenging events and the starting point for many related problems of aggression and other conflict behaviours. The average psychiatric ward has many potential sources of conflict for the patient in terms of physical environment as well as the people who are in it including staff, other patients and visitors.

It appears that a significant proportion of assaults which may lead to coercive measures occur in the context of aversive stimuli (Cheung et al. 1996; Grassi

et al. 2001). It is noteworthy that these studies also highlighted that a considerable proportion, around fourty per cent of incidents, had no apparent aversive stimuli; however, this only demonstrates that none were observed or were not considered appropriate for documenting. This would be consistent with the idea that due to resources and time pressures, in most general adult settings, it is not uncommon that incidents are not explored in detail to truly formulate the antecedents. When specifically looking at staff role in violent incidents, a meta-analysis by Bowers et al. (2011) found that patient–staff interaction contributed to more than thirty nine per cent of patient violence.

In considering enhancing the therapeutic relationship between patients and staff, it is important to emphasise the violent act and interaction rather than the violent patient. For the patient, this allows their perspective and feelings to be taken fully into account, and this enables staff to develop an awareness of their role in conflict giving them a chance to change and improve their practice and interaction in an area where staff face high demands and challenges.

As well as patient–staff interactions, there is a role for patient–patient interactions, which has received limited research attention. Of those actually observed and recorded, it has been shown that a quarter of violent incidents among inpatients are preceded by patient–patient interaction; this includes physical contact and intrusion into psychological space (Bowers et al. 2011). Common antecedents to violence between patients are bullying, theft and damage to property. As with patient–staff interactions, patient–patient conflict can potentially be reduced with increased understanding of each other's illness, limitations and their dynamic interaction in the ward community.

When examining physical space contrary to what might be expected, Kalisova et al. (2014) found no significant association between coercive measures and either the number of patients per room or size of ward. In contrast, in a large review of the literature, Bowers et al. (2013) showed that those wards with relatively low levels of conflict behaviours (aggression, absconding, medication refusal) but high usage of coercive measures had higher numbers of beds. This could possibly link to staff perception of the need for coercion or containment in looking after a larger group of patients; however, again one would need to factor in the number of staff and other dynamic factors.

Unsurprisingly, a higher total private space per patient, higher level of comfort and greater visibility on the ward have been shown to decrease the risk of being secluded (van der Schaff et al. 2013). Also, from clinical practice, the use of communal toilets and bathrooms can be a source of much frustration and anger. However, there is also a negative affect associated with private space, as it is known that suicides are more likely in private areas (e.g. bedrooms, bathrooms and toilets).

A retrospective Dutch study specifically looking at outdoor space showed that the presence of outdoor facilities was associated with an increased risk of seclusion (van der Schaff et al. 2013), an interesting finding. However, there was limited information on the outdoor space in question, including only its presence or absence, and the height of the fence. In this study, only three and a half per cent of wards had no outdoor space so the effect may have been subject to bias. This

finding is somewhat counterintuitive and not consistent with those of other published studies, which demonstrate that natural elements, such as gardens, are associated with a positive affect and fewer behavioural problems (Ulrich et al. 1991).

Permanently locked wards are associated with decreased levels of absconding but increased aggression (Bowers et al. 2009) and medication refusal (Baker et al. 2009). The locked door most likely acts as a symbol of imprisonment and confinement and reaffirms the impact of formal detention. Psychologically, this can lead to a sense of disrespect and injustice, which may fuel frustration and can lead to anger.

The availability of a Psychiatric Intensive Care Unit (PICU) and seclusion is, predictably, strongly associated with how frequently they are used. We may also assume that the use of extra care or intensive care areas on the wards depends strongly on the provision of purpose built ward rooms. The availability of specific rooms to calm patients including sensory, de-escalation or quiet rooms may be highly advantageous in managing disturbed and agitated patients without resorting to the methods of coercion outlined above; however, little conclusive evidence exists about their use.

7.6.3 Staff Factors

There is a very wide range of staffing factors that affect the frequency and type of coercive measures used within an inpatient environment. This will depend on the service area, team structure, outside influences and available resources, amongst many others.

Bowers et al. (2014) found that wards with a strong 'internal structure', including a clear ideology and efficient organisation, tended to appear calmer. These elements were associated with a greater sense of safety, predictability and regularity within the environment, which reduced patient anxiety. The same elements would also have an effect on reducing staff anxiety and stress. Strong leadership, whether in the form of a ward manager, consultant psychiatrist or senior team, creates clear staff roles and an open and transparent culture and ethos within the team. Katz and Kirkland (1990) showed that violence was less frequent in wards with clear staff roles and standardised and predictable events. Leadership and role modelling allow all team members to be clear about what is expected from them as well as what they can expect from their senior team. Open and honest feedback ensures that staff are supported and that poor practice is challenged.

The burnout rate amongst staff tends to be lower in a team with strong leadership, and this in turn is associated with reduced rates of coercion (Bowers et al. 2012). Increased anxiety amongst staff will lead to increased use of coercive measures, particularly involving the referrals to PICU from acute wards. Bowers et al. (2007b) found that there were lower rates of physical restraint on wards that had a clear structure. In this study, structure was defined as clear rules for patient conduct and routines for ward life as well as efficiency, cleanliness and tidiness.

Effective leadership will ensure that there are robust policies and procedures in place. The formal complaints procedure and its effective operation as well as the hospital policy over prosecution for assaults and property damage can have an effect on the rates of conflict, which can affect coercive measures. Clear consequences for assaultive behaviour have been shown to reduce levels of assault.

National policies have been shown to influence containment use. Smith et al. (2005) showed that national policy can lead to a reduction in seclusion, in this case by establishing new standards to limit the use of seclusion and mechanical restraint.

On any given day, there will be numerous things that influence the attitude of the staff members on a ward. However, in the longer term, one of the most significant factors is the level of violence, aggression and other risk incidents. Consistently, high levels of risk and aggression can often lead to a fire fighting approach. This can in turn lead to less focus on therapeutic collaborative care and risk assessment (i.e. primary interventions).

In a ward with high levels of aggression where staff anxiety is increased, there is also likely to be a reduction in secondary interventions (such as de-escalation) and a reliance on tertiary interventions (such as physical restraint). If tertiary interventions are relied upon, the team becomes increasingly reactive as opposed to proactive, which can lead to an increase in the use of coercion to manage what is perceived to be an unsafe environment.

The interpretation by staff of the cause of disruptive behaviour displayed by a patient influences their response to a situation. If the staff member or team considers that the patient is in control of their behaviour (as opposed to it being symptomatic of their illness), the response is likely to be more coercive or punitive. Leggett and Silvester (2003) found that staff were more likely to use seclusion if they felt that patients were able to control their behaviour.

It is also apparent that the staff's understanding of the reasons and antecedents for behaviour is generally limited, which inevitably leads to low levels of appropriate response (Bowers et al. 2014). Ongoing use of overly coercive or inappropriate responses to challenging situations is likely to further escalate patient behaviour.

Poor quality staff–patient interactions will reduce the effectiveness of primary interventions. A collaborative care plan can be a highly effective tool in helping to understand and reduce challenging behaviour. However, if this interaction is conducted in an unskilled way, it may lead to feelings of resentment or mistrust in the patient and frustration on both sides. This may not only escalate the situation but also lead to a more reactive approach to risk management as the team are less able to predict and assess the risks associated with individual patients.

Similarly, one-to-one therapeutic interventions are extremely beneficial in building rapport, allowing time for patients to express worries or concerns and explore issues. If these do not occur, or are managed in an unskilled way, it can lead to those concerns being expressed in less functional or productive ways.

The quality and frequency of interactions between staff and patients has a significant effect on the rapport and therefore the efficacy of de-escalation attempts. If a staff member has a good rapport and relationship with a patient, they are more

likely to be able to intervene and verbally de-escalate as there is increased trust in the relationship and a shared history of successful and positive interactions.

Bowers et al. (2014) found that poor communication and disrespectful or rude behaviour increased patients' perceptions of the staff as aggressive. This is therefore highly likely to increase defensive or challenging behaviour in response. The study stresses the importance of positive appreciation and a regularity of emotional response from staff.

The number of staff on an inpatient unit is a crucial element of risk management. Having enough staff ensures that patients' needs are met and that there is an adequate response to incidents so that they are managed safely. However, it is important to note that excess staff, particularly if the individuals are not familiar with the ward (agency staff), may not increase safety and in fact may adversely affect the milieu, increasing risk and therefore the likelihood of coercive interventions. The reasons for an increase in staffing numbers are in themselves likely to be risk orientated: when patients require enhanced observations, there is increased risk or there is a reduced number of substantive staff. Having more staff on the ward can alleviate staff anxiety but often not with any actual decrease in risk. In fact, Bowers et al. (2013) found that wards with higher levels of containment had more total staff than those with lower levels. Having said that, it is clearly important to have enough regular permanent staff, both to meet the needs of the patients as well as to ensure the safety of the staff team.

In a large study by Kalisova et al. (2014), the staff:patient ratio was tested in a univariate association as a predictor for the use of coercive measures, but did not have any significant impact. The age and gender mix of the staff on the ward will influence the ward environment, as well as affecting the way staff practice and react. It is important that the demographics of the staff group reflect those of the patient group. The recommended gender ratio on a single sex ward is 70:30 with the higher amount reflecting the gender of the patients. There is limited conclusive research on the impact of staff demographics on the levels of coercive measures used within inpatient settings, but Bowers et al. (2013) found that an increased number of male staff led to higher levels of conflict and containment.

Older professionals and those with a more recovery focused approach are more likely to approve of, and use, less coercive interventions (Jaeger et al. 2014). Staff who are fully trained will be better skilled in all aspects of patient care and interactions. As described above, the quality of those interactions may significantly influence the need for any coercive measures. Staff training should also include prevention and management techniques for dealing with challenging behaviour. This will provide staff with the full range of options for addressing these issues, and therefore coercive interventions should be used only when absolutely necessary. Staff with more training and experience tend to be more confident in attempting to use verbal and non-coercive techniques for dealing with challenging situations before turning to coercive interventions. Training in interaction skills has been shown to reduce levels of seclusion use (both frequency and duration), and seclusion reviews are conducted in a more positive way; a suggested structure has been described by Bhavsar et al. (2014).

Less-skilled staff members may turn to more coercive interventions at an earlier point if they do not feel skilled in verbal interactions and de-escalation. Temporary and agency staff receive much lower levels of training and supervision due to the nature of their changing roles and therefore wards that rely on high numbers of these staff tend to have higher rates of conflict and use of containment measures (Bowers et al. 2013). Wynn et al. (2011) found that more highly educated staff were less likely to favour seclusion and restraint, and unskilled staff are more likely to accept the use of highly restrictive interventions without challenge.

7.7 Practical Measures to Reduce Coercion in Inpatient Services

Having identified the various relevant patient, staff and environmental factors, this section explores a series of interventions to reduce coercive measures and ensure the delivery of safe secure and high quality care. This is not an exhaustive list but is a useful suggested framework for clinicians to use.

7.7.1 Patient-Related Factors

It is important that a comprehensive assessment is conducted, to be clear about symptoms and diagnosis, and to assess for co-morbidity, including personality disorder and traits, anxiety disorders and substance misuse. A holistic approach is necessary, which would include meeting physical, psycho-social, cultural and spiritual needs. Clinicians should identify those pharmacological and psychotherapeutic interventions that have worked historically, establishing timely evidence-based treatments to bring quick symptom resolution. Psychotherapeutically, it is advantageous to make a dynamic formulation of the patient and any subsequent conflict behaviours, coupled with appropriate behavioural treatment strategies to extinguish these.

Outside hospital, patient stressors are likely to have practical solutions that may involve simple supportive liaison with housing or benefit agencies, for example. Relationship stressors may be more sensitive and complex to address.

An important first step is for staff to acknowledge the patient's problems. A 'problem list' can be drawn up, jointly owned by the patient and staff, to engender a collaborative relationship. Domains may be helpful (e.g. finances, housing, family, etc.) to enable structured thinking and to be as inclusive as possible. These can be addressed through good 'social work' by any members of the MDT and do not necessarily need a qualified social worker.

In terms of relationship stressors with family and friends, it is important that staff identify positive and negative impacts on the patient, attempting to encourage the former and anticipate the latter. Awareness of potentially 'toxic' relationships may enable a plan for short-term contacts (e.g. during visits or after phone calls), acknowledging the difficulties and offering the potential to modify subsequent

responses. In the medium term, identifying 'flashpoints' early in particular relationships offers the potential for therapeutic approaches, including couple or family therapy, which aims to improve the patient's mental health and subsequently reduce the need for coercion. Psychoeducation of friends and relatives may be an important part in fostering a positive environment for recovery and reducing coercion in the medium term.

Clinical experience demonstrates particular benefit from a supportive carer, who can use their positive influence on the patient. Although it is impossible for the carer to be present at all times when situations may occur needing coercive interventions, there is wisdom in encouraging their involvement by acting as a bridge between the patient and the clinical team. This is especially useful where there have been recent or historical conflictual incidents. Unfortunately, some patients do not have such supportive figures, but where they exist, they should be at the forefront in care planning decisions. The Care Programme Approach (CPA) provides a framework for many of the outside stressors to be identified and an action plan to be prepared collaboratively with the patient. The CPA is a UK national system used to organise and record a patient's care and includes a full assessment of their mental and physical health and social care needs to develop a comprehensive programme of care to address these needs including a patient's safety and risk.

7.7.2 Environment and Organisation

Better quality environments and warm welcoming spaces symbolise comfort, cleanliness, respect for patients and attention from staff. Staff can have a direct impact in this area by ensuring that the ward is readily maintained; repairs, redecoration and replacement of damaged or worn furniture should be a concern for all staff, from cleaner to manager. It is important to enable choice for patients and to give a sense of ownership over their environment to increase sense of security, comfort and empowerment. Giving patient's choices over colour and decorations, from bed coverings through to availability of posters or whiteboards to personalise bed space, can facilitate this.

As mentioned above, conflict between patients is common and antecedents to violence include bullying, theft or damage to property. Staff clearly have a role in modelling a response to challenging behaviour and therefore need the appropriate skills to manage the behaviours. It is important to facilitate a positive and defined response, which can be assisted directly by nursing staff or in the form of community reflective groups. Patients can be given general information about illness and symptoms to foster a greater understanding and tolerance of each other.

The ideal goal would be to have a fully comprehensive formulation of patients and their individual dynamics or inter-patient conflicts. This could be used to predict potential conflicts and thus reduce the risk of incidents and further escalation to coercion. An appropriate safe forum for patients to air their views and to collectively come to solutions to resolve issues may be beneficial.

Staff on the ground cannot alter regulation but can change the method of delivery. This includes providing accurate information, particularly in relation to appeal, advocacy, rights and complaints procedures. All of these can be delivered in accessible forms through ward admission packs, staff speaking directly to patients and carers to help patients understand the information available. This empowers patients as they feel they have advocacy and a clear right to appeal.

Potential conflict points may include enforcement of Mental Health Act (1983), refusing to allow patient to leave hospital, the enforcement of treatment and the failure of a complaint or appeal. These are times to be particularly vigilant about the increased risk of conflict, and it would be important to put measures in place including providing reflective and psychotherapeutic skills.

If there are episodes of violent acts it is important for the responsible authority to have a clear response to aggressive and assaultive behaviour, i.e. whether criminal damage, threats and assaults on staff and other patients will be reported to the police and prosecutions sought. Clear consequences of behaviours should be highlighted to patients, carers and staff from the point of admission. Staff must feel that appropriate courses of action are available to them and that they will be supported in these if they are the victims of assault. Staff are more likely to react and manage situations with coercive interventions if they feel there are no other consequences.

As a part of clinical governance, monitoring the use of coercive measures should play a key role in attempting to reduce them. As discussed earlier in the chapter, there is only recent data on the use of interventions such as restraint and seclusion, although the use of the Mental Health Act (1983) has been monitored extensively over time. The collection of data regarding the use of coercive measures is of interest to service commissioners and providers, policy makers and the public, to provide accountability and scrutiny for their use as well as to inform future directions and improve quality. As noted earlier in the chapter, there are plans in the UK to significantly increase the amount of data requested from services regarding their use of coercive measures, particularly in the light of the Winterbourne View and MIND Reports (Department of Health 2012; MIND 2013b).

7.7.3 Staff-Related Factors

The structure of the ward is dictated by staff leadership and the organisation's core values, which will then relate to the ward. This reflects on the rule for patient conduct and the daily structures and routines. The leadership and structures then dictate the efficacy of patient care delivered.

In order to encourage and develop a culture of openness, it is important to provide forums for staff support and discussion. These may include reflective practice, staff support groups and individual supervision. They will also provide an opportunity to manage and challenge staff attitude and to allow the team to plan and implement strategies for high quality care. Case discussion groups may provide a forum to manage particularly challenging cases as well as staff anxiety and

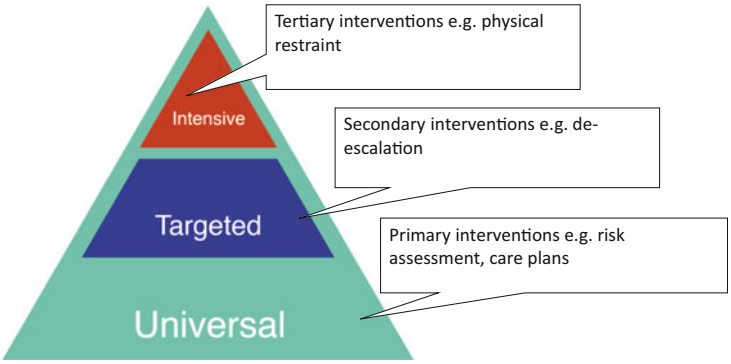

Fig. 7.3 Public health model (after 'Every Moment Counts' programme)

attitude towards the patient. It is important for clinical leaders to be aware of the team's response to individual patients and to intervene to reduce the likelihood of coercive measures.

Staff training should include techniques for the prevention and management of challenging behaviour, and in particular verbal de-escalation skills and identifying causes and triggers for the behaviours. In addition, it is important to enhance the quality of staff–patient interactions, which can be delivered by training in interaction skills to enable collaborative therapeutic interventions.

To reduce coercion, it is important that more focus is placed on primary interventions such as risk assessment, collaborative care planning, therapeutic one-to-one time and community meetings (Fig. 7.3). These interventions are key to identifying issues and risks early and for planning on how they may be addressed and managed. In a well-functioning ward, most time would be spent on primary interventions, with less on secondary and only a minimal amount on tertiary ones when all other options have been unsuccessful.

Since June 2014, it has been a requirement within England and Wales for all hospitals to publish information about nurse staffing levels on wards, including the number of shifts meeting their agreed levels. This initiative is part of the NHS response to the recommendations from the Mid Staffordshire NHS Foundation Trust public inquiry chaired by Robert Francis QC (Francis 2013), which called for greater openness and transparency in the health service. Adequate staffing with people of the right skill level and skills mix is necessary for wards to function. Although there is no statutory minimum establishment, the Royal College of Psychiatrists (2011b) suggested that a minimum of one registered mental nurse per five patients on a general psychiatric ward is an appropriate ratio, but this should be higher for a PICU. However, they also noted that setting minimum levels may not be helpful for patients or services, and this area would benefit from discussion and negotiation between stakeholder groups. Guidance has also been issued by the Royal College of Nursing (2010) proposing various methods for addressing minimum staffing levels.

Table 7.1 Reflective questions for the ward team

Domain	Questions to reflect on with multidisciplinary team
Patient	Do we know everything we need to know about our patients? Do we know what the triggers are for all our patients? Can we spot when something is wrong? Do we talk to patients enough about how they are feeling? Does our ward environment help us engage with patients?
Environment	Do we know what is really going on, on the ward? Are we tackling discrimination, bullying, harassment? Do we talk enough about this? How do the ward dynamics feel for us and for patients?
Staff	Are we positive role models? Do we have core values for the ward, a vision and mission statement? Are we engaging with patients enough in a meaningful way? Are we confident to speak to patients if in high levels of distress or exhibiting challenging behaviour? Are we aware of our limitations and strengths and how we can build on these as a team? Do we have core values for the ward? Do we know what the boundaries are?

As important (if not more so) as the minimum staffing level is the staff mix. According to the Royal College of Nursing (2010), this cannot be adequately addressed without high quality data on:

- Patient mix (acuity/dependency) and service demands
- Current staffing (establishment, staff in post)
- Factors that impinge on daily staffing levels (absence, vacancies, turnover)
- Evidence of the effectiveness of staffing.

Those planning staffing levels and mix are operating at a more strategic level in terms of managing the challenges posed by patient–staff/staff–staff/staff–service interactions and the potential for all of these to lead to coercive measures. With increasing amounts of data on staffing levels, mix and coercion being collected and made publically available, we anticipate that this will become an increasingly scrutinised and discussed area in the years to come. In general terms, in order to deliver high quality care, it is important that the team has time and space to reflect on its practice. Table 7.1 illustrates some suggested questions adapted from the See Think Act scale (Tighe and Gudjonsson 2012) which may be useful for this exercise.

Enhanced observations may be seen as a less coercive measure and may indeed be regarded by some patients and staff to have therapeutic benefit, if there is clear engagement and support from the staff member.

Lehane and Rees (1996) suggested that enhanced observations can be used as an alternative to seclusion. In one sense, this represents a positive reduction in the use of restrictive containment measures, but it also suggests that at least some form of

containment is still required. Alternatively, reduced enhanced observations can be couched in terms of a broader attempt to reduce coercive interventions and to offer more structure to the organisation of the ward and to interaction with patients (Dodds and Bowles 2001). In this study, this approach appears to have decreased the rate of deliberate self-harm, absconding and violent incidents and thus the need for enhanced observations. The implied role of organisational support and technical mastery is made more explicit by another study in which better training and giving authority to nurses to review and adjust levels of enhanced observations reduced its use and improved the experience for patients (Reynolds et al. 2005).

7.8 Conclusion

General adult and community settings in mental healthcare manage some of the most acutely unwell patients in the adult mental health service structure. In England and Wales, there is currently renewed vigour in a debate about the philosophy of care in mental health settings, and the focus is on the balance between therapeutic interventions and those that are more likely to be perceived as coercive. The issues have been brought to the fore in high profile investigations which have highlighted abuses in the use of restrictive interventions. The interventions cover a wide range of clinical practice and can display a divergence of opinion across clinical and academic lines. The moral, ethical and legal debates surrounding coercive interventions can lead to passionate polarisation, which can be challenging. The work required in re-examining and changing the culture in mental health settings will involve better use of data, workforce training and development and innovative solutions to a wide range of difficult questions.

General adult and community settings routinely employ a wide spectrum of coercive interventions. The factors associated with coercive treatment in these settings include intricacies of the legal frameworks, the nature of the clinical interventions used (which are often less secure and more acutely focussed version of clinical interventions utilised in more secure settings), factors related to the patient's clinical presentation, factors related to the clinical setting, factors associated with staff characteristics and organisational/cultural variables. It is difficult to elucidate the relative weighting to apply to each of these contributory domains, but one could hypothesise that different domains are more or less significant for different types of patients in different clinical settings at different points in the care/disorder pathway.

It would seem that the use of coercive measures in England and Wales appear to be increasing at every juncture, for reasons which are not entirely clear. Best practice should have bottom-up and top-down structures in place to monitor the presence of coercion and the impact of this on patient safety and care. The clinical governance systems should be integral to the functioning of the clinical team, engendering a collaborative approach using the least restrictive option, in an organisational culture which understands the challenges inherent in the risk-benefit decisions required to manage patients therapeutically and safely. The more

practical considerations in the final section of this chapter derived of the research available attempt to assist clinicians in general adult settings to think about coercion and coercive interventions in a more structured manner.

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Special Considerations in Forensic Psychiatry

8

Norbert Nedopil

Abstract

Coercion is one of the major ethical issues in psychiatry. Seclusion, isolation, physical or mechanical restraint and especially forced medication have been debated fiercely between patient's rights activists, psychiatrists, philosophers, politicians and even courts. Forensic psychiatry was not much involved in this debate for many years. Coercion was part of the toolkit applied with the understanding that the patients in forensic psychiatry were hospitalised involuntarily, that these patients were considered to be dangerous and treatment, hospitalisation and avoiding criminal or violent recidivism with or without or against their will was the job of the staff of forensic hospitals. This has changed dramatically in the last few years, when, e.g. the Committee on Bioethics (CDBI) of the Council of Europe or the Convention on the Rights of Persons with Disabilities (CRPD) started to advocate a guarantee of human rights for the mentally ill even if they had committed crimes. Different national and international courts have ruled that that the basic human rights principles (rule of law, proportionality, legal certainty, subsidiarity) are to be applied in forensic psychiatry as well as in other medical specialties. In Germany, the consequence of such a ruling was that involuntary treatment was not possible for a while, because there were no legal provisions for it in the laws. The legal abolition or at least severe restriction of coerced medication led to a severe deterioration in some patients. The current situation forces us to rethink the ethical principles of coercive measures and their practical application within the framework of international conventions and national laws and to advise law makers and courts accordingly. The author advocates soft paternalism as a guiding principle for dealing with these issues.

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8.1 Introduction: The Situation in Germany Until Recently

Coercive measures in forensic psychiatry are to some extent applied differently from general psychiatry. Even though the underlying ethical, legal, medical and practical principles are similar, some differences have to be considered. In Germany, in general psychiatry, treatment, especially psychopharmacological treatment, could only be applied if informed consent was obtained from the patient. The patient can only provide informed consent, if effects, potential side effects, consequences of non-treatment and the possible alternatives to the proposed treatment have been explained and understood. If the patient appears unable to give informed consent, a legal guardian—who has different names in different legislations where such arrangements exist—will be authorised to decide according to the assumed will of the patient (substitute decision making, according to the legal provisions). In this context, a sound consultation with the physician in charge is of utmost importance. The physician suggests, informs about and advises but does not impose treatment. In Germany, this regulation could not be put into practice for many years with regard to forensic patients.

For a long time treatment followed rather paternalistic practices in forensic psychiatry. The argument was that the patients are hospitalised against their will and therefore coerced to treatment as part of this detention. Based on the main purpose of 'safe rehabilitation', it appeared unethical to refuse treatment to a group, who is by law coerced into an inpatient status in high or medium security hospitals. This would prolong their 'coerced' hospitalisation unnecessarily—sometimes for many years. According to German legislation, legal commentaries and forensic literature written before 2011, there was general agreement on a number of principles (Foerster and Dreßing 2009; Nedopil 2007): When treating forensic patients, one has to differentiate between the disorder, which was causally linked to the crime and consequentially led to the admission to a forensic institution (causing disease) and other diseases. Regarding the 'causing disease', treatment was possible against the will of the patient, if it was medically necessary and urgent and a significant risk to the health of the patient or a danger to others was anticipated without treatment. As the danger for others was the primary cause for the hospitalisation, treatment including medication seemed self-evident. In these cases, the state that hospitalises the patients has a healthcare obligation towards them, so the patients could even claim a right to compulsory treatment (Schöch 2004). Forensic patients therefore had an obligation to accept the treatment of the 'causing disease' if the potential danger could be reduced in this way. Concerning other disorders or diseases, however, the principles, which are established in medical ethics elsewhere, regulate the doctor–patient relationship also in forensic psychiatry, including the right to refuse treatment.

This position was not challenged or disputed except by some patients' rights activists, and forensic psychiatrists felt safe to use medication to prevent critical situations. Therefore, medication was the primary measure of coercion, and patient consent was rarely considered. One can assume that these preconditions and procedures were and probably still are valid and practiced in most countries.

A look into the older English textbooks of Forensic Psychiatry (Bluglass and Bowden 1990; Gunn and Taylor 1993; Rosner 1998) where the term 'coercion' is hardly ever mentioned indicates that involuntary treatment was not one of the major problems to the authors. The books provide advice about managing and dealing with situations, which normally include compulsory or coercive measures and sometimes use of force. However, legal limits or a hierarchy of ethically preferable measures are seldom discussed. Coercion seems to have been such a routine in forensic psychiatry that nobody bothered to look at it more in more detail or to invest into some research on these issues.

8.2 Reactions to Coercion by Patients and Staff of Forensic Psychiatric Institutions

Völlm (2013) has shown in a remarkable report how staff in forensic hospitals perceive coercion and how this contrasts with the reactions of the patients to measures against their will. Members of staff see themselves under high pressure caused by the dangerousness of the patients, the high standards for security in public and the media allegations in case of an incident. They mostly find coercive measures inevitable and necessary to prevent incidents, and they experience a feeling of job security and a strengthening of team cohesion by the possibility to apply coercion, as well as a more respectful behaviour on the part of patients. Finally, they find that these measures allow creating distance from patients who have committed serious crimes. Staff also thinks more often than patients that coercive measures are helpful for patients, to give them time out, to calm down and think, that some patients feel safer in seclusion than on the ward and that some provoke and expect a response from the staff. Staff believes that some patients are grateful in retrospect, because they feel better again and that worse events might have been prevented. Patients on the other hand express their feelings of being humiliated, abandoned and punished. This corresponds quite well with the literature about the reactions to coercion on general psychiatric wards (Kaliski and de Clercq 2012; Kjellin and Wallsten 2010; O'Donoghue et al. 2010; Van Der Merwe et al. 2013).

So, on the one hand, forensic patients are coerced into treatment; on the other hand, they are regarded ethically as 'vulnerable patients', who, due to their involuntary status, can only be treated according to established guidelines. This means, they cannot consent to treatment methods, which are not approved by the respective agency of a country, e.g. the FDA in the USA, even if the treatment appears to be promising and the patient wishes to try it. Only in rare circumstances and after overcoming a number of legal obstacles such a non-established treatment might be permitted. Treatments which are regarded as 'experimental' (like, for a long time, the use of new anti-andronergic medication for sex offenders in Germany) are very difficult to apply to these patients.

8.3 Recent Developments

In Germany, the situation in respect of treatment of forensic–psychiatric patients has changed dramatically in Germany in March 2011, when the German Constitutional Court (Bundesverfassungsgericht) decided that all coercive medication, as applied until that time, was unconstitutional, since it did not meet the constitutional rights of the patients and the principles of Human Rights Conventions. The court concluded that the principle of rule of law, proportionality, legal certainty and subsidiarity were not observed in forensic psychiatric treatment. Since no laws regulating coercive measures explicitly existed, the 'Rule of Law' was not applied, and since it was never documented whether a less intrusive measure compared to forced medication would be sufficient to achieve the same result, the principle of proportionality was not respected. Therefore, coercive medication cannot be applied until the legislator will have provided the legal standards for such a treatment.

The ruling of the constitutional court not only led to an uproar among psychiatrists and their professional associations (Müller et al. 2012) but also to a refusal of a number of patients in forensic psychiatry and in general psychiatry to continue on their medication. For some of them this led to an intolerable deterioration of their mental condition. In general psychiatry, where the same regulations have to be observed, similar patients were sometimes released into the community, since they could not be treated in hospital; some were transferred to forensic psychiatric settings, because they were thought to be dangerous or committed offences (Schanda et al. 2009); there some of these patients had to be secluded or restrained and for some of them the police had to be called into the hospital, because they posed an immediate threat to the staff or to fellow patients.

8.4 The Players in the Field of Forensic Psychiatry and Their Positions

Besides the above-mentioned turbulences, the decision of the constitutional court created enhanced awareness of the problems of coercion and reflections about methods to prevent coercion as far as possible. In doing so, one has to be aware that ethical and practical conflicts exist between the positions of the patients, the staff and even the courts. Treatment in forensic psychiatry implies a hierarchy of principles, which have been laid out in many publications (Hornsveld et al. 2007; Müller-Isberner 1994; Rice et al. 1990; Wong et al. 2007).

From the staff's point of view, the hierarchy looks like this: The predominant task, although not regularly mentioned, is the safety of staff and patients. Secondary to this is the prevention of adverse incidents, which negatively affect the therapeutic atmosphere. Only if these two preconditions are fulfilled, the therapeutic agents can actively treat the disorder and the patient's propensity for delinquent behaviour. Based on this, rehabilitation and reintegration of the patient can be advanced. In

order to promote safety, the prevention of aggression and violence are of utmost importance and coercion or at least the threat of it might be an appropriate method.

From human rights' perspective, coercion, which exceeds the involuntary hospitalisation itself, can only be the last resort, if all other means fail to avoid an immediate danger. If coercion is applied, the human rights issues have to be observed; the most important one in this context is the principle of proportionality, i.e. the least harmful intervention sufficient to prevent the anticipated harm by the patient has to be applied. The German Constitutional Court holds a certain view on what appears proportional. Video supervision interferes with the right to privacy, but it appears to be the least harmful violation of the individual's rights. Seclusion and isolation are graver violations, because they interfere with the right to free movement and free communication. Physical restraint comes next in this hierarchy because it additionally interferes with the physical integrity of the person. Finally antipsychotic or psychotropic medication is at the highest level of interference, because it does not only interfere with the physical but also with the mental integrity of the individual. For each of the four measures mentioned here, there is a sliding scale of severity: e.g. there might be a difference in the degree of coerciveness depending on whether a patient is restrained by physical force of staff members or strapped to a fixation bed. However, coercion might even start before any of these measures are applied: Szmuckler and Appelbaum (2008) identified a number of techniques similar to coercion, like forceful persuasion, interpersonal pressure, threat etc., which undermine the free consent to treatment.

From the patient's point of view, neither the hierarchy of the hospital nor the hierarchy of human rights might be applicable for his or her personal needs. Patients often perceive coercive measures and forced medication as punishment and disciplinary intervention (Kaliski and de Clercq 2012; Keski-Valkama et al. 2010). In order to further elucidate preferences for coercive methods, we conducted a survey of both psychiatrists and patients in general and forensic psychiatry asking a simple question, which all of those knowing psychiatric practice should be able to answer. The question was put into the following statement: '*Should I become unable to make own decisions or to consent to treatment due to a psychiatric condition, and should an emergency arise in which I could be a danger to myself or others, I would like the following measures to be taken*'. A rank order could then be applied to a list of different measures so that the measure with the lowest rank (1) should be tried first and the measure with the highest rank (7) should be applied last. Participants were asked to rank from one to seven: (a) video supervision, (b) seclusion in own bedroom, (c) physical restraint (by staff), (d) mechanical restraint (strapping), (e) forced medication, (f) inducement and threats and (g) isolation in a special room. More than 200 individuals have answered this question so far without giving us any clear conclusion: All measures except for 'seclusion in own room' and 'inducement and threat' received at least some proportion within all rankings. Both 'seclusion' and 'inducement' went up to five. There was little difference between patients and staff regarding the rank order. However, staff favoured forced medication more than patients. From this survey, we concluded that guidelines on how to react to escalations often conflict with the individual and autonomic preferences of

those upon whom coercion is exercised. We cannot conclude on a general level that a particular type of coercion such as forced medication is better or worse than another one, e.g. isolation or seclusion.

8.5 Special Issues Pertaining to Forensic Psychiatry

Forensic psychiatry, however, poses some additional problems. By definition, its purpose and aim is a dual one. The Ghent Group, a loose association of forensic psychiatrists in Europe, agreed on the following definition: [Forensic psychiatry is] 'a specialty of medicine based on detailed knowledge of relevant legal issues, criminal and civil justice systems, mental health systems and the relationship between mental disorder, antisocial behaviour and offending. Its purpose is the assessment, care and treatment of mentally disordered offenders and others requiring similar services; risk assessment and management and the prevention of further victimisation are core elements of this' (Nedopil et al. 2012; see also Gunn and Taylor 2014, p. 1).

The responsibility of the forensic psychiatrist is not only the well-being of the patient but also, and even more so, the safety of society (the prevention of further victimisation). The ethical guidelines of the American Academy of Psychiatry and law stress the responsibility towards courts and public safety even more and almost neglect the responsibility towards the clients of forensic psychiatry.

Forensic patients have caused harm, and forensic psychiatry is obliged to prevent harm. Forensic psychiatric institutions are sometimes more similar to prisons than to general hospitals. Whereas competent patients of general psychiatry, who do not cooperate with the institutions and are not willing to be treated according to the guidelines and rules of the hospital, can be released even if the release might pose a risk to their health, forensic patients cannot be released if they do not comply with house rules, even if they constitute a threat to fellow patients or to staff. A task force for the German Psychiatric Association (DGPPN) puts it like this: From the perspective of proportionality, hospitalisation [of a patient in general psychiatry] might not be justified in some cases if treatment cannot even be tried (Falkai and Gruber 2012). This is not true for forensic patients, where judges and tribunals decide about hospitalisation, release and proportionality. Forensic patients remain hospitalised even if they successfully refuse treatment and if they remain dangerous within the hospital due to their untreated disorders. A position paper of the DGPPN (Müller et al. 2012) warned about the consequences if the legislation (as outlined above), which might be appropriate for psychiatric patients in general, was to be applied unchanged to forensic psychiatry:

1. Physicians are forced to deprive treatable patients of effective assistance.
2. Mentally disordered patients are left to their health and social fate, which depend on the uninfluenced course of their illness.
3. Patients who are dangerous due to their mental disorder will loose their social skills and remain excluded from society.

4. Physicians will be exposed to an ongoing conflict between negligence, if untreated patients cause harm, and doing harm themselves, if they coerce patients into treatment. Both decisions can have legal consequences and lead to punishment.
5. Staff will be forced to physically interfere with violence of patients, who insist on their right to refuse treatment.
6. Coercive measures such as isolation and fixation are cynically declared as more humane treatment forms that should be preferred over forced medication.

These pessimistic predictions were fulfilled in a few cases. Data from Haina, a large forensic hospital in the State of Hesse with 380 beds, show an increase of isolations from a steady 100–180 per year until 2011 to 403 in 2014 (Müller-Isberner 2015, personal communication). Similar trends could be observed in two forensic hospitals in Bavaria, the high security hospital Straubing and the forensic hospital of Munich. In Straubing, there are 240 beds for patients who are thought to be so dangerous that they cannot be treated in other forensic hospitals in Bavaria. Over the years until 2010, around 70 patients were isolated for a total of 27,000–29,000 h, including 815 h of fixation (being strapped to the bed). These figures increased for the year 2013 to 84 patients and 44,184 h in isolation with 4581 h of this time being strapped to the bed and in 2014 the figures were: 81 patients, 41,740 h in isolation and 2834 h in fixation. A more detailed look reveals that in 2013, 32 patients refused to continue on their medication leading to long-term seclusions of 10 of them and to part-time seclusions of 5 of these patients; 17 patients could continue to live on the ward. In 2014, 45 patients refused to continue treatment leading to long-term seclusion of 19 of them and part-time seclusions in 8 of them, whereas 18 continued to live on the ward. Some patients resumed their medication after some time (Lausch 2015, personal communication). The data from the forensic hospital demonstrate a similar trend. Additionally, adverse incidents and the sick leave of staff was monitored in this hospital. Adverse incidents, which led to interventions of staff and had to be documented, increased from 160 in 2010 to 245 in 2013, and sick leave increased by 110 % during the same time (Steinböck 2015, personal communication).

The problems are even better illustrated by case studies than by numbers: A schizophrenic patient (patient A) was admitted to the hospital because he had damaged several cars, among them two police cars, with a hammer and a knife. He had felt persecuted by these cars, believing the cars wanted to harm and kill him. Before admission to the forensic hospital, he was socially withdrawn, unemployed and without initiative to engage into any activities. He had been admitted to general psychiatric settings several times. In the forensic hospital, he gradually improved under antipsychotic medication leading to a decrease in his delusions and participation in some occupational therapy. However, he did not feel he was ill and refused treatment. After the decision of the Federal Constitutional Court in March 2011, this refusal was successful. The patient started to withdraw from all activities, started to become suspicious again and did not leave his room. He then started to smear the walls with his faeces and refused any requests to clean his room.

He refused to talk to other individuals and did not answer questions about his motives. Finally, he had to be forcefully transferred into another room on another ward with higher staffing levels, where he continued his behaviour and started to throw faeces at anyone, who would open the door to his room. He could not be treated against his will because his behaviour did not constitute an 'immediate threat' to another person.

Another patient (patient B) of the same ward with a severe personality disorder, who was in the hospital because of raping several young women, had observed the behaviour of patient A and also refused all treatment measures including medication and started to smear the walls of his room with faeces, explaining that this was a protest against his long hospitalisation and that the institution was powerless and had no chance to force him into anything.

Such a situation is intolerable for staff and anti-therapeutic for the whole ward, indirectly causing harm to other patients on the ward, and in the long run will keep people from working in forensic psychiatry.

From the perspective of patients, the situation might be quite different, however. They are exposed to four different measures forced upon them:

1. Because they have committed a crime, they are forced to live behind high walls and closed doors, and because this crime is attributed to their mental illness, the institution they live in is called a hospital. Most of them and large parts of the public and the media say that they are imprisoned in psychiatry. Large portions of their freedom and their autonomy is taken away from them.
2. If they misbehave and do not comply with the—sometimes very strict—house rules, disciplinary measures are forced upon them.
3. If they are an immediate threat to others because of their mental disorder, they are coerced to other treatment measures.
4. If they wish to be released, they have little alternative than to comply to treatment, take medication, participate in psychotherapy and all other therapeutic measures that the staff deems necessary.

8.6 The Dilemmas and an Attempt to Possible Solutions

This outline shows several dilemmas, which are quite difficult to disentangle. The first dilemma can be demonstrated by the question: Who has the power to impose coercive measures upon the patients? The answer seems simple for some of the four measures: In principle, the power to deprive people of their liberty and their autonomy lies with the courts or respective bodies established in a society. The beginning and the end of the hospitalisation are determined by judges or similar agents of the legal system. But who is in charge if disciplinary measures are imposed upon patients, and interventions are ordered against the will of the patient in anticipation of danger? As long as paternalistic principles were predominant in medicine, the answer was clear. The doctor was able and empowered to decide which step would be taken for the benefit of the patient and his environment. But is

that still true in a society, in which autonomy is the predominant principle in medical ethics?

A second dilemma arises from the interdependence of disciplinary and treatment measures. Talking about coercion in psychiatry, we impose these measures to avoid harm and they range, as already outlined, from close (video-)supervision to seclusion, isolation, fixation and forced medication. If we take a look at disciplinary measures in prison, they range from a ban from shopping to seclusion, isolation and fixation by cuffs, showing a considerable overlap with coercive measures in psychiatry. How can a patient distinguish whether his seclusion was a disciplinary measure or a medical intervention? The dilemma becomes even more serious because in many patients, their misbehaviour leading to disciplinary measures might be due to their illness and a warning sign for its deterioration and for a threat of potential violence (Daffern and Howells 2007; Nedopil 2012; Quinsey 2000). If that is the case, is the measure disciplinary or therapeutic? And how can we differentiate between the two?

In daily routine, a third dilemma arises, because often staff does not know or recognise or even might not have the time to distinguish whether patients' behaviour is due to their mental condition or simply because of bad intentions. On the spot they cannot make the distinction between mad or bad—a distinction philosophers, law professors and forensic psychiatrists have debated time and time again (Appelbaum 1997; Cosyns 1998; Höffler and Stadtland 2012; Moore 1984; Olley et al. 2009; Stone 1984). So sometimes clinicians as well as many lay persons extend the term mental disorder to undesirable and dissocial behaviour and justify the use of treatment and medication to clarify the situation. Such a solution is sometimes also sought by politicians and the courts (Carlsmith et al. 2007; Duggan 2011; Mullen 2007; Müller et al. 2011; Völlm and Konappa 2012). Here the necessary distinction between treatment and punishment is blurred not only from the patients' point of view but also for the independent observer.

8.7 Return to Paternalism

Things seemed easy when paternalism still determined the reasoning of psychiatrists and their patients (Hoyer et al. 2002; Koch et al. 1996; Schorsch 1990). In 2003, I wrote (Nedopil 2003): '*When I was a young doctor and paternalism prevailed as the ethical principle in medicine it was no question that forced medication was the first and in many cases the sufficient intervention when dealing with agitated or aggressive patients; and it was applied even with the help of police officers or other state authorities and sometimes even on their demand. In that traditional medical model, decisions were made by the psychiatrists, claiming that they—and society—had the welfare of the patients in mind: Treatment and commitment were inseparable and any violence was seen as a symptom to be treated by medication or at least by some calming procedures*'. Paternalistic positions, however, bear a considerable danger of misuse, so fundamental changes have been observed in the ethical and legal attitudes towards involuntary treatment and

management of mentally disturbed patients during the past 40 years. These changes can be summarised under the heading 'From paternalism to autonomy and partly back'. The 'White Paper on protection of the human rights and dignity of people suffering from mental disorder especially those placed as involuntary patients in a psychiatric establishment', which was published by the Working Party of the Steering Committee on Bioethics (CDBI) of the Council of Europe on January 3, 2000, outlined the principle guidelines, under which coercive treatment could be applied in member states of the Council: Treatment can only be administered for the benefit of the patient. If a patient is unable to consent to treatment proposals, the decision has to be made by a representative of the person. This decision has to be respected by the treating staff. In case of dissent, only a Court or court-like authority should have the power to overturn the decision of the representative.

In the USA, the legal debate about paternalism and autonomy tried to find a new way of solving the conflict by introducing the terms 'soft' and 'hard' paternalism (Pope 2005). '*Soft paternalism is the rationale for restricting an individual's self-regarding conduct where it is not substantially voluntary. Soft paternalism legitimizes intervention with an individual's conduct where the individuals decision to engage in that conduct is not factually informed, not adequately understood, coerced, or otherwise substantially cognitively or volitionally impaired. Soft paternalism is both justifiable and consistent with (Millian) liberalism. The core idea of the soft paternalism liberty limiting principle is that only substantially autonomous decisions, decisions free from cognitive and volitional defects, are worthy of respect. ... Indeed instead of counteracting autonomy, soft paternalism helps to protect and promote it by ensuring that an individual's choices reflect her true preferences.... Soft paternalism sanctions intervention only to protect the subject only from harm to which she did not consent or to ensure that the subject really did consent to the harm.*

The hard paternalism liberty limiting principle, on the other hand, legitimizes benevolent intervention in an individual's self-regarding conduct even when the individual's conduct is both substantially informed and substantially volitional'.

The dilemma is, however, not solved by these theoretical approaches as Taylor et al. (2013) formulated: '*The forensic psychiatrist may be required to act in multiple roles—as an individual and ordinary member of society, as an agent of the patient, as an agent of the Court, and as an agent of society and, in common law countries, as an agent of the patient's lawyer. The tensions between the ethical issues of autonomy and paternalism, which are relevant in all clinical practice, are even more prominent in forensic psychiatry, the latter generally requiring working towards the best interests of the patient, but the former carrying an expectation of following the patient's instructions (wishes). Among offenders with psychosis, a patient's wishes and a patient's best interests are not necessarily identical. If an individual poses an imminent threat to someone else in the context of his/her mental disorder, it is rarely, if ever, in that person's best interests to remain free to pursue that threat, but his/her wishes may well be to remain free to do so. The forensic psychiatrist must be equipped to make full allowance for such dilemmas in practice*'.

8.8 Legal Formalism and the Separation of Disciplinary and Therapeutic Coercion

If a return to paternalism is not the right solution, formalisation could be another helpful approach to solve some of the dilemmas. This implies to first separate therapeutical interventions from disciplinary measures as precisely as possible. The second step would be to establish strict and explicit rules in a statutory-like code outlining in detail which behaviours are defined as disciplinary infractions and which consequences will follow such infractions. This code would then be applied like a legal instrument, allowing for supervision and review, similarly to disciplinary measures in prisons (see Albrecht in this book). Even if this can be accomplished successfully, the application of these rules remains to be resolved. Who will be responsible for the observation of the rules, who will enforce them and who will solve a dispute about infractions and their consequences? Finally, what about infractions, which are not coded and how to apply such a code to the individual needs and responsivity?

Physicians and nurses are not trained to accomplish this task, and disciplinary procedures according to a statutory code are not part of their academic or vocational role model. However, if law professionals would be employed by the forensic institution to resolve these duties, it would interpose another hierarchical layer into the structure of the hospital, which could interfere with treatment and the developed strategies of motivation, by which adherence, advance and success of treatment are rewarded by more freedom and more possibilities to structure one's own life. In the long run, one would fear that such a facility would become more impersonal, being run by a statutory code and not by individuals, leaving the relational experience aside, which is so necessary for interpersonal learning, for a therapeutic alliance and for relational security in a forensic facility (Craissati and Taylor 2014, p. 596).

8.9 Preconditions for Coercive Treatment

After separating the disciplinary measures—as far as possible—from coercive measures pertaining to treatment, one would need to define the specifics of these therapeutically necessary measures. Disciplinary and therapeutic measures might look alike but are different by intention. If we look at the two patients described above, patient A has to be treated to refrain from his misbehaviour, whereas patient B might be disciplined, and yet both might be placed in seclusion, because their behaviour is intolerable to the other patients and to staff. Patient A might be forced to take medication, if the law allows for it, whereas patient B will not really profit from medication and should not be forced to be treated with sedatives or antipsychotics, since they then could be mistaken as disciplinary measures and thereby disqualify medication in a broader sense.

The analysis of such a situation gives a clearer perspective on the need and limits of coercive therapeutic measures. Their preconditions in terms of patient characteristics are:

1. The lack of appreciation of the own disorder and the inability to form and express one's own will, because the will is determined or largely influenced by the disorder, leading to a lack of competency regarding treatment decisions and treatment refusal.
2. A disorder which causes significant harm to the patient himself or others and will lead to other coercive measures because of that danger, including continuous high security hospitalisation.

The preconditions for coercion from the treatment providers' perspective are:

1. The proposed treatment is known to be effective, and the treatment benefits largely outweigh the negative side effects.
2. The treatment is applied with the aim to restore the competency of the patient.
3. The treating physician has unsuccessfully tried to convince the patient of the necessity to accept the treatment voluntarily.
4. The preconditions of coerced treatment are examined and approved by a person from outside the treating facility.
5. The patient is represented by a competent substitute decision maker, who enters into a discourse with the physician, and decides on behalf of the patient.
6. There is a regulatory procedure to solve disagreement between physician and substitute decision maker.

At first glance this approach, which is in part implemented in some of the laws and regulations established for forensic treatment facilities, seems to favour the formalistic solution of the dilemmas inherent in involuntary treatment in forensic psychiatry. The solution calls for a statutory basis defining behaviour, which will establish a disciplinary infraction, and measures, which will be the consequences for such infractions. It will formally separate disciplinary measures from coerced treatment and regulate when and how especially intrusive measures, like fixation or forced medication, can be applied. It will prescribe how the general legal principles like proportionality, accountability and formal review procedure are guaranteed and what kind of written information and documentation has to be provided by the facility.

Practitioners are likely to agree that formalisation alone, in order to overrule a psychotic and harmful decision of a patient who lacks his freedom of reasonable choice, will lead to a rather inflexible, inadaptive and finally inhumane situation, which is partly illustrated by the examples of the two cases above. Forensic psychiatrists, both in assessing and in treating mentally ill law breakers, seldom have only and explicitly the patient's will in mind; they are concerned with the requirements of the law and the consequences of their decisions for others and last but not least the best interests of their clients. They cannot avoid considering

paternalistic issues when having to decide about the alternative of long-term hospitalisation in high security combined with 'on and off' treatment of a psychotic patient who remains ambivalent about his treatment for years and can only be coerced to treatment when—and as long as—posing an imminent danger to others.

8.10 Conclusion

Coercive measures in forensic psychiatry do differ from those in general psychiatry, but just as in general psychiatry the primary aim should be to prevent and reduce their use as much as possible. This is, however, much more difficult with individuals who are treated because they have committed crimes and are thought to be dangerous because of their disorder. They cannot be discharged for disciplinary reasons, their lack of cooperation with the institution, non-compliance with medication or other treatments or because they want to be released. They have to remain hospitalised, and staff has to keep working with them against all odds. The tensions caused by this situation can cause dilemmas which are sometimes difficult to solve and may render coercion as the only possible way out, and this not only for short periods but sometimes for a long time. Coercive measures have the potential of being misused and have to be controlled to avoid excess. This can be done by establishing formal rules which satisfy the legal principles of international conventions and the control of their application. But we also have to keep in mind the disadvantages of formalism and allow for acting in the best interest of the patients. Forming a relational basis for interpersonal learning as role models for responsibility, meaningful interaction and for reliability will not be successful without some form of paternalism. The patient who has to learn and develop skills for an integrated life in a community has to accept advice of the role model. The provider of those skills has to have the power of some sanctions, if rules are not followed. If the patient is unable or unwilling to comply with the rules, it is the physician in charge who has the obligation to make decisions in the best interests of the patient: Soft paternalism should remain an option in forensic psychiatry (even if—in order to remain politically correct—we try to avoid the term), but it has to be combined with independent control and a discourse with a representative of the—legally incompetent—patient.

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The Uses of Coercive Measures in Forensic Psychiatry: A Literature Review

9

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Abstract

Coercive measures are controversial within healthcare and require closer inspection, particularly within forensic psychiatry, where security-orientated restrictions are commonplace. The uses of coercive measures are often justified as a necessity for maintaining safety. Yet, these interventions are in stark contradiction to the autonomous person-centered philosophies that healthcare professionals are trained with, and that healthcare services purport to provide. The examinations of these practices are timely, particularly in light of international legislations to reduce and even eliminate the uses of such interventions and where studies have suggested that coercive methods might have paradoxical effects in provoking further violent and aggressive behaviours [American Psychiatric Association et al. (Learning from each other: Success stories and ideas for reducing restraint/seclusion in behavioural health. 2003); Goren et al. (Journal of Child and Family Studies 2(1):61–73, 1993); National Mental Health Working Group 2005; NICE (Violence and aggression: short term management in mental health, health and community setting. NICE, 2015); Queensland Government (Policy statement on reducing and where possible

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eliminating restraint and seclusion in Queensland mental health services. http://www.health.gld.gov.uk/mentalhealth/docs/sandrpolicy_081030.pdf, 2008); The MacArthur Research Network (The MacArthur coercion study. http://www.macarthur.virginia.edu/coercion.html, 2004); National Association of State Mental Health Directors (Violence and coercion in mental health settings: Eliminating the use of seclusion and restraint. http://www.nasmhpd.org/general_files/publications/ntac_pubs/networks/SummerFall2002.pdf, 2002)].

This chapter presents a literature review, examining the findings of empirical papers published between January 1980 and June 2015. Particular attention will be given to the rates, frequencies and durations of coercive measures used within forensic psychiatry and the characteristics of those secluded and restrained. The possible predictors and indicators of using coercive measures will be examined, along with and staff and patient attitudes and experiences. In particular, discussions surrounding these findings will draw attention towards the factors that influence the uses of coercive measures and the current challenges and tensions between policy and practice. This chapter suggests that further research is required into exploring what it might mean to reduce the uses of restrictive practices and how this process might be facilitated.

9.1 Definitions

9.1.1 Coercive Measures

The term 'coercive measures' has multiple definitions within the literature, creating confusion and difficulties in drawing comparisons for those wishing to examine this topic (Davison 2005; Jarrett et al. 2008). For the purposes of this literature review, this term will encompass the uses of restraint, seclusion and involuntary medication.

9.1.2 Restraint, Seclusion and Rapid Tranquillisation

The term 'restraint' is defined in two ways: i) the use of physical restraint, where a patient is held by at least one member of staff, and ii) mechanical restraint, where a device, such as a belt, is attached to a patient. Both of these are with the aims of restricting patient movement (Department of Health 2008; National Institute of Clinical Excellence (NICE) 2015). 'Seclusion' will be considered as the placement of a patient alone in a locked room that has been specifically designed for this purpose (Department of Health 2008; NICE 2015). And 'involuntary medication' as the administration of rapid tranquillisation via intramuscular injection against a patient's will (NICE 2015).

9.1.3 Voluntary and Involuntary

As a consequence of on-going discussions surrounding 'truly voluntary' or 'covertly involuntary' uses of oral medication (Currier 2003, p. 60), the decision was made to examine rapid tranquillisation only as a measure of involuntary medication, since the act of administering intramuscular medication against a patient's will eliminates such ambiguities. Furthermore, whilst it is recognised that rapid tranquillisation may be administered either orally or parenterally, all identified papers focused solely on intramuscular administration.

9.1.4 Forensic Psychiatry

Forensic psychiatry has been defined as the sub-speciality of psychiatry that 'deals with patients and problems at the interface of legal and psychiatric systems' (Gunn and Taylor 1993, p. 1). Forensic psychiatric inpatients are generally those who have been deemed 'dangerous, violent or having criminal propensities' (Mason 1993a, p. 413) and who have usually 'interfaced with the law at one level or another' (Mason 2006, p. 3). Thus, those who are considered deviant within mainstream criminal and psychiatric systems require another set of institutional rules and boundaries. Patients who are admitted to forensic psychiatric settings, however, depend largely on the legal framework of the country.

Some countries detain only those patients found not guilty by reason of insanity or of diminished responsibility in forensic psychiatric settings. Other countries also detain those who are not manageable in other settings, or who pose a particular risk to the community (Department of Health 2008; Gunn and Taylor 1993). Secure hospitals may therefore detain mentally disordered offenders as well as non-offenders for assessment, diagnosis, treatment and risk management (Bluglass and Bowden 1990; Chiswick 1995; Mason 2006). To accommodate the variety of patients across different jurisdications, this review will focus upon forensic psychiatry within secure hospital settings, as outlined below.

9.2 Method

A systematic literature search was conducted using the electronic databases ASSIA, BHI, CINAHL, EMBASE, PAIS, PsycINFO, MEDLINE and Sociological Abstracts. All articles published between January 1980 and June 2015 were considered. In the UK, distinctions are made between high, medium and low secure units. However, in other countries lesser distinctions are made between these levels of security. As a result, the term forensic psychiatry was used to cover all of these eventualities. The main headings relating to 'forensic' and ('psychiatry' or 'mental'

or 'nursing') were combined with groups of subheadings relating to categories of coercion, restraint, seclusion, involuntary medication, violence and aggression. The search terms 'forced medication' and 'rapid tranquillisation' were also included alongside 'involuntary medication' since these are often used interchangeably within the literature. 'Involuntary treatment', however, was not used since this term tended to draw out papers on the legal aspects of patient detention in a pilot search.

A total of 67,994 citations were elicited using this method. The inclusion and exclusion criteria for this review were based on study design, themes of the papers and population samples. Papers were included on the basis that they reported empirical findings using either qualitative and/or quantitative methods. These criteria excluded the majority of citations which were opinion papers, reviews, debates and discussion based articles. Papers were also included on the basis of having a focus on healthcare and being conducted within hospital settings as opposed to prison environments. Papers with themes relating to incidence, prevalence and indicators for using coercive measures were included. Papers exploring themes relating to staff and patients attitudes and experiences of coercive measures were also included. Papers reporting solely on the pharmacological aspects of rapid tranquillisation, however, were excluded. With regard to population samples, this review included studies of forensic psychiatric inpatients, while excluding general psychiatric or community forensic psychiatric settings.

Papers were initially limited through processes of de-duplication and to English language publications only (see Fig. 9.1). Remaining citations were further excluded by title and then by abstract. Despite a large number of citations being

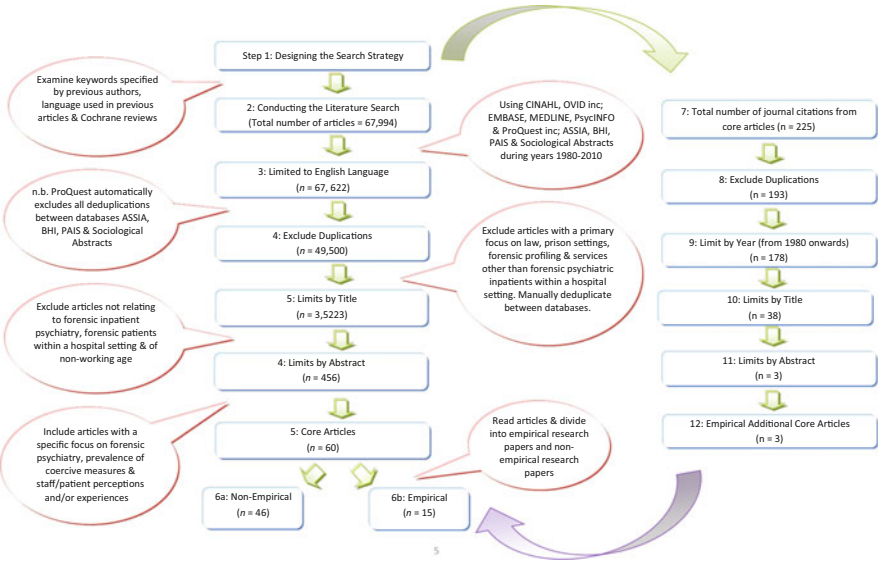

Fig. 9.1 Systematic search strategy

elicited at the start of this review, the majority of articles were excluded on the basis of not being empirical research. Articles were also excluded where they did not have a specific focus on coercive measures, where the sample did not include forensic psychiatric patients, where the context was not within a forensic psychiatric inpatient hospital setting, or where the focus was on legal rather than hospital detention. Following all exclusions by title and by abstract, only 15 empirical research papers remained. The citations from these 15 articles were then reviewed using the criteria outlined in Fig. 9.1. This resulted in a further three articles included for review. It is these 18 papers that will form the basis of the following discussion.

9.3 Findings

9.3.1 Overview of Studies

Of the 18 studies reviewed, 7 were conducted in the United Kingdom, 4 in the United States, 2 in Australia, 2 in Canada, 2 in Croatia and 2 in Finland (see Table 9.1). Six of these studies were conducted within maximum or high level security forensic hospitals and six within mixed level security hospitals. Levels of security were not reported in the remaining six studies. Rather than being a criticism, this is instead an acknowledgment that different levels of security are not necessarily recognised or distinguished in different countries. Where distinctions are made regarding levels of security, such as within the UK, hospitals of high or maximum levels of security tend to be for those patients who are assessed to pose a grave and immediate danger to the public, medium security for those who pose a serious danger to the public and minimum or low security for those who pose a significant danger to themselves or the public (Rutherford & Duggan, 2007).

The aim of twelve studies were to examine the incidence, prevalence and/or factors associated with the use of coercive measures, while a further six studies focused on staff and/or patient attitudes, perceptions and experiences of coercive measures. Eleven of the studies used predominantly numerical forms of hospital data, four used questionnaire or survey designs, two used qualitative interviews and one study used an action research approach. Eleven of the studies included patient data only, three included staff data alone and four incorporated varying degrees of both patient and staff data. Of the eleven studies examining patient data only, nine used mixed sample populations of both male and female patients, whilst two included male patients only.

9.3.2 Prevalence of Coercive Measures

Amongst the papers reviewed, ten papers focus solely on seclusion, three on restraint and seclusion in combination, three on the uses of restraint alone and two on the uses of restraint, seclusion as well as involuntary medication in

Table 9.1 Summary of empirical articles reviewed

Study	Country	Setting	Aims/research questions	Design	Sample/population	Outcomes measures	Findings
Ahmed and Lepnurm (2001) Seclusion	Canada	Multilevel security hospital	Examination of patients who are both admitted and secluded, between August 1996 and February 1999	Retrospective analysis of seclusion data	$n = 660$ ($m = 612$; $f = 48$)	Patterns and factors associated with seclusion • Age • Gender • Frequency • Duration • Reason	Mean age secluded = 31.6 years Mean age not secluded = 35 years Mean duration of seclusion = 90.3 h (min 1 h; max 908 h) $f = 60$ % secluded $m = 25$ % secluded Suicidal threats and self-harm = most frequent reason for seclusion
Beck et al. (2008) Restraint and seclusion	United States	Psychiatric hospital comprising minimum, intermediate and maximum security buildings	Trajectories of seclusion and restraint between September 2001 and September 2006	Retrospective analysis of hospital records	$n = 622$ ($m = 536$; $f = 86$)	To determine whether trajectories exist and to examine patient characteristics between these trajectories • Gender • Age • Diagnosis	Patients were divided into three trajectories based on number of times they experienced seclusion and/or restraint: low (71 %), medium (22 %) and high (7 %)

							Younger patients and female patients tended to fall into medium and high trajectory classes Patients diagnosed with schizophrenia fell into the low trajectory class while patients diagnosed with borderline personality disorder fell into the high trajectory class
Benford Price et al. (2004) Restraint and seclusion	United States	Maximum security inpatient facility	Episodes of restraint and seclusion amongst different racial groups between January 1993 and August 2000	Retrospective correlational study using hospital data	$n = 806$ (gender and age not reported)	Differences in violence Differences in episodes, durations and levels of restraint and/or seclusion amongst different ethnic groups: • Asian • Black	No significant differences in: • number of violent incidents between racial groups • episodes of restraint • types of restraint used • mean durations of seclusion Asian and Black patients were

(continued)

Table 9.1 (continued)

Study	Country	Setting	Aims/research questions	Design	Sample/population	Outcomes measures	Findings
						• Hispanic • White	secluded more often than predicted Hispanic and White patients secluded less often than predicted
Exworthy et al. (2001) Seclusion	UK	Three English maximum security hospitals and all medium security units in Southern England	Forensic psychiatrists' attitudes of using seclusion	Questionnaire	$n = 117$ (maximum security = 69; medium security 48)	Attitudes of forensic psychiatrists towards seclusion as: • Treatment • Punishment • Therapeutic	56.4 % agreed or strongly agreed that seclusion was a form of treatment 33.3 % disagreed or strongly disagreed that seclusion was therapeutic 7.7 % objected to seclusion 19.1 % did not view seclusion as punishment
Harris et al. (1989) Restraint, seclusion and rapid tranquillisation	Canada	Maximum security institution for males	Staff and patient perceptions of the 'least	Questionnaire Outlining four different scenarios of disturbed	$n = 78$ 40 patients (20 'experienced' having been secluded $\geq$3 times	• Comparisons of 'experienced' and 'inexperienced' staff and	• Overall, mechanical restraint were viewed as being most restrictive

			restrictive interventions'	behaviour. Staff and patients asked to rate restrictiveness, effectiveness, experiences, preferences and aversion to nine different restrictive interventions or combinations of restrictive interventions in relation to each scenario	in past year; 20 'inexperienced' having not been secluded in past year) 38 staff (19 'experienced' psychiatric attendants; $m = 18$; $f = 1$; 19 'inexperienced' $m = 9$; $f = 10$; 6 occupational therapists; 5 recreation; 4 psychology; 4 social work)	patients views of restrictive interventions, including physical restraint, mechanical restraint, seclusion, oral and intramuscular rapid tranquillisation • Each intervention was rated for use in four scenarios relating to: – Suicide or self harm – Violence to patient – Violence to staff – Non-compliance	and intrusive, followed by seclusion, rapid tranquillisation via injection, rapid tranquillisation taken orally and physical restraint. • Experienced staff and patients rated restrictive interventions as being less restrictive than those who were 'inexperienced' • Findings indicated general agreement between staff and patients as to which interventions were most/least restrictive • Staff indicated that the effectiveness of interventions declines as the number of

(continued)

Table 9.1 (continued)

Study	Country	Setting	Aims/research questions	Design	Sample/population	Outcomes measures	Findings
							restrictive interventions increase • Staff also indicated that 'heavier techniques' would be ineffective in preventing future incidents
Heilbrun et al. (1995) Restraint and seclusion	United States	Public mental hospital comprised of multilevel security	Comparison of physical control between forensic and civil patients in the year 1989	Retrospective analysis of hospital records	$n = 243$ ($m = 118$; $f = 125$) (civil = 124; forensic = 119) (unspecified how many *m* & *f* in civil and forensic groups)	• Overall incidents of physical control – Age – Ethnicity – Diagnosis – Comparisons of seclusion and restraint • Comparisons of seclusion and restraint between forensic and civil patients • Predictors for physical control	Mean age secluded and/or restrained= 31.1 years Of those physically controlled: • 52 % white; 48 % black • 47 % had primary diagnosis of schizophrenia • Seclusion used most frequently (46 %) > seclusion and restraint (32 %) > restraint (22 %) Restraint used

							more often among forensic patients; seclusion used more often amongst civil patients Predictors for forensic group; agitation, self-requested control, verbal hostility Predictors for civil group; property damage, physical aggression
Keski-Valkama et al. (2010) Seclusion	Finland	Two forensic psychiatric hospitals and general psychiatric inpatient units of two hospital districts	Comparison of forensic psychiatric and general psychiatric patients' views of seclusion between September 2003 and August 2004	Structured interviews; one interview post-seclusion and one follow-up interview 6 months after seclusion	$n = 83$ (forensic = 58; general = 25)	Patients experiences and perceptions of seclusion: • Understanding of why they have been secluded • Staff interaction during seclusion • Feelings surrounding seclusion	Forensic patients viewed seclusion as a form of punishment more often than general patients Seclusion is viewed negatively Most patients understand why they have been secluded Patients tend to be dissatisfied with interactions with staff during

(continued)

Table 9.1 (continued)

Study	Country	Setting	Aims/research questions	Design	Sample/population	Outcomes measures	Findings
							seclusion Patients' views of seclusion were consistent 6 months after the event
Klinge (1994) Restraint, seclusion and rapid tranquillisation	United States	Maximum security forensic hospital for male offenders	Staff opinions on seclusion and restraint between March and April 1991	40-Item questionnaire	$n = 109$ ($m = 52$; $f = 57$) (5 psychiatrists; 12 psychologists; 10 social workers; 4 unit supervisors; 23 nurses; 9 rehabilitation therapists; 46 level of care technicians)	• Medication versus seclusion and restraint • Seclusion versus restraint • Factors influencing views of restraint: – Gender – Education	63 % preferred medication over restraint or seclusion; 29 % preferred restraint or seclusion over medication; 8 % were uncertain Majority of staff felt restraint was more effective than seclusion Female staff with more education felt seclusion was more effective than restraint More educated staff felt that medication, seclusion and restraint were all over used

Lehane and Morrison (1989) Seclusion	UK	Secure psychiatric hospital for forensic patients and those unmanageable on other units (level of security not stated)	Trends in the use of seclusion from 1985 to 1988	Retrospective examination of official records of seclusion	$n = 748$ ($m = 471$; $f = 277$)	Prevalence of seclusion • Gender • Reasons for seclusion	Males secluded twice as often as females (actual figures not reported) 70 % seclusions as a result of 'difficult or disruptive behaviours'
Maguire et al. (2012) Seclusion	Australia	Forensic mental health hospital (multilevel security)	To develop, implement and evaluate strategies for reducing seclusion and sustaining less coercive practices	Longitudinal analysis of seclusion data (July 2005–June 2009) and standardised questionnaires	$n = 116$ (gender not stated)	Frequencies and durations of seclusion; staff confidence in managing aggression; staff attitudes towards seclusion; staff experiences of hospital environment	Frequencies and durations of seclusion reduced despite no changes in violence and aggression from patients Post-reduction strategies being implemented, there were no changes to staff confidence in managing aggression; however, staff viewed seclusion as being more therapeutic

(continued)

Table 9.1 (continued)

Study	Country	Setting	Aims/research questions	Design	Sample/population	Outcomes measures	Findings
Margetić et al. (2013) Restraint	Croatia	Forensic psychiatric hospital	Temperament and characteristics of patients who are mechanically restrained	Questionnaires/ surveys	$n = 56$ (all male)	Temperament and characteristics associated with restraint • Temperament and Characteristic Inventory (TCI) • Positive and Negative Syndrome Scale (PANNS)	Higher levels of 'novelty seeking' characteristics were positively associated with experiences of restraint Greater severity of psychotic symptoms increased the likelihood of being restrained
Margetić et al. (2014) Restraint	Croatia	Forensic psychiatric hospital	Opinions of forensic patients on the use of restraints	Interviews/ Likert scale	$n = 56$ (all male)	Views of patients on the use of mechanical restraint as punishment, the voluntary and involuntary uses of such methods and whether the uses of these methods should be shared with family	Patients were ambiguous surrounding whether the uses of restraint should be shared with family Patients agreed that restraint should be used as punishment where aggression towards others is intentional Patients agreed that restraints should be used when patients request this

Mason (1993a) Seclusion	UK	High security special hospital	Report on the preliminary findings of an exploratory study, investigating staff values, dilemmas and other factors associated with decision-making in the use of seclusion over a 12 week period	Action research	Registered and enrolled nurses working on one of two high dependency wards (actual numbers not stated)	Factors associated with decision making regarding the use of seclusion; experiences and perspectives of two groups of nursing staff from two wards, meeting at fortnightly intervals over a period of 12 weeks	Factors associated with using seclusion: • External pressures emanating from negative perceptions of seclusion practice as well as the forensic psychiatric system • Viewing seclusion as a clinical intervention • Control • 'Macho culture' of forensic psychiatry
Mason (1998) Seclusion	UK	High security special hospital	Gender differences in the use of seclusion over a 1 year period	Retrospective data analysis	$n = 725$ ($m = 625$; $f = 100$)	Comparisons of seclusion by gender • No of male/female patients secluded • No of times male/female patients secluded	823 episodes of seclusion during a 1 year period; attributable to 256 patients Proportionately more females secluded than males Females secluded

(continued)

Table 9.1 (continued)

Study	Country	Setting	Aims/research questions	Design	Sample/population	Outcomes measures	Findings
						• Durations of seclusion • Diagnosis • Time of date secluded • Type of section	more times but for shorter periods; female average time in seclusion = 20 h; male average time in seclusion = 4 days Majority of secluded females were 'psychopathically disordered'; majority of secluded males were 'mentally ill' Most seclusions occurred in the morning, just after release from night time confinement
Paavola and Tiihonen (2010) Seclusion	Finland	Forensic psychiatric hospital	Seasonal variation of seclusion incidents from violent and suicidal acts between	Retrospective examination of hospital records	$n = 385$ ($m = 324$; $f = 61$)	Patterns of seclusion • Diagnosis • Reasons for seclusion • Seasonal variation	36.6 % of secluded patients had a primary diagnosis of schizophrenia 40.7 % of seclusions was

			January 1996 and December 2002				due to the patient being 'dangerous to others' Seclusion rates were highest between July and November
Pannu and Milne (2008) Seclusion	UK	High security forensic psychiatric hospital	Examination of rates of seclusion and associated factors over a 1 year period (annual period not reported)	Retrospective descriptive survey	$n = 131$ ($m = 103$; $f = 28$)	Rates of seclusion and factors associated with seclusion: • Gender • Age • Ethnicity • Diagnosis • Reasons for seclusion	29.6 % of all patients in the hospital were secluded during the 1 year Females experienced more episodes of seclusion than men Men secluded for longer periods Secluded patients tended to be of younger age groups (<39 years) No significant differences between rates of seclusion and ethnicity Patients with a primary diagnosis of mental illness

(continued)

Table 9.1 (continued)

Study	Country	Setting	Aims/research questions	Design	Sample/population	Outcomes measures	Findings
							were more likely to be secluded than those with learning disability or personality disorder Most cited reason for seclusion was due to 'attacking staff and threatening behaviour'
Sequeira and Halstead (2004) Restraint, seclusion and rapid tranquillisation	UK	Secure psychiatric hospital	Psychological effects on staff administrating physical restraint	Semi-structured interviews/ thematic content analysis	$n = 17$ ($m = 9$; $f = 8$) (8 nurses; 9 nursing assistants)	Staff experiences before, during and after restraint events	Emotions relating to restraint: • Anxiety • Anger and abuse of interventions • Boredom, frustration and low morale – Role conflict – Distress and crying • Inhibition of emotional distress • Laughing and joking to release stress • Automatic

							responding • Ambivalence about support
Thomas et al. (2009) Seclusion	Australia	Secure inpatient hospital	Factors associated with seclusion between April 2000 and April 2002	Retrospective analysis of hospital records	$n = 193$ ($m = 139$; $f = 54$)	Factors associated with seclusion: • Gender • Age • Reasons for seclusion	47 % of males patients secluded over a 2 year time frame 35 % of female patients secluded Those secluded were significantly younger than those not secluded Aggression was the main reason for seclusion

comparison. These studies reported varying rates, frequencies and durations of restraint and seclusion.

Rates of seclusion have been found to be comparably higher than those of restraint, both by Heilbrun et al. (1995) in the United States and by Paavola and Tiihonen (2010) in Finland. Other studies reported between 29.6 % and 35.3 % of all patients having been secluded over a 1 year period within the UK (Mason 1998; Pannu and Milne 2008), 44 % of patients having been secluded over 2 year period within Australia (Thomas et al. 2009) and 27.7 % of patients having been secluded over a 2½ year period in Canada (Ahmed and Lepnurm 2001). Whilst the proportions of patients involved in episodes of seclusion appear to vary, differences in study duration as well as cross cultural policies for seclusion also need to be taken in consideration.

9.3.3 Demographic Indicators

9.3.3.1 Gender

A total of seven studies were reviewed in relation to gender and the uses of coercive measures. All of these studies were conducted retrospectively using patient and hospital records. Four reported on frequencies of restraint and/or seclusion by gender (Ahmed and Lepnurm 2001; Beck et al. 2008; Paavola and Tiihonen 2010; Pannu and Milne 2008), while a further two studies reported comparisons in durations of using restraint or seclusion by gender (Heilbrun et al. 1995; Pannu and Milne 2008). Only one study reported both frequencies and durations of seclusion by gender (Mason 1998).

Overall, comparisons of these findings suggest that females are likely to be restrained or secluded more often than males (Ahmed and Lepnurm 2001; Mason 1998; Paavola and Tiihonen 2010; Pannu and Milne 2008). Males tend to be restrained for longer periods than females (Heilbrun et al. 1995). However, there are some discrepancies as to whether males (Mason 1998) or females are secluded for longer periods (Pannu and Milne 2008). Findings also suggest that females tend to be restrained or secluded as a result of self-harm, whilst male patients tend to be restrained or secluded a result of harming others (Ahmed and Lepnurm 2001; Paavola and Tiihonen 2010).

9.3.3.2 Age

Four studies report findings on age. All four of these studies present a consensus that younger patients tend to be secluded more often than older patients (Ahmed and Lepnurm 2001; Beck et al. 2008; Pannu and Milne 2008; Thomas et al. 2009). Ahmed and Lepnurm (2001) found the mean age of secluded patients to be 31.6 ± 8.94 years, in comparison with the mean age of non-secluded patients being 35 ± 9.90 years. Similarly, Thomas et al. (2009) found the mean age of secluded patients to be 29.10 ± 8.33 years, in comparison with the mean age of non-secluded patients being 32.58 ± 10.23 years. One study also suggests that younger patients tend to be secluded for longer periods (Pannu and Milne 2008),

whilst another study reports that younger patients tend to be restrained and secluded, in combination, most often (Beck et al. 2008). There have been no studies, however, that reported age in relation to the use of restraint exclusively.

9.3.3.3 Ethnicity

Perhaps surprisingly, there have been few studies examining the use of coercive measures between different ethnic groups (Benford Price et al. 2004; Pannu and Milne 2008). Only two papers from this review examined ethnicity in relation to the uses of coercive measures. Benford Price et al. (2004) found that, within a maximum security facility in the United States, Asian and Black patients were secluded disproportionately more often, while the opposite was found for Hispanic and White patients.

Pannu and Milne (2008) reported similar findings in a high security hospital in the UK, with Asian and Black patients secluded more frequently. Neither of these study findings, however, reached statistical significance (Benford Price et al. 2004; Pannu and Milne 2008). In addition, these two studies used different categories for grouping ethnicity, thus, the scope for comparing these findings is somewhat limited.

9.3.4 Clinical Indicators

9.3.4.1 Diagnosis

Only four studies examine patient diagnoses, each in relation to the uses of seclusion. Paavola and Tiihonen (2010), in Finland, report that patients with a primary diagnosis of 'schizophrenia' are secluded most often. In their study, patient diagnoses are categorised as 'schizophrenia', 'schizoaffective disorder', 'personality disorder' or 'other primary diagnoses' (Paavola and Tiihonen 2010). Pannu and Milne (2008), in England, report that patients with a primary diagnosis of 'mental illness' are secluded most often, where diagnoses are categorised as 'mental illness', 'personality disorders' or 'learning disabilities'.

Furthermore, Mason (1998), in England, report that male patients with a diagnosis of 'mental illness' tend to be secluded most often, whilst female patients who are 'psychopathically disordered' tend to be secluded most. Thomas et al. (2009, p. 6) in Australia, simply report that patients who are secluded have a 'more established psychiatric history'. Again, however, comparisons between these studies have been challenging due to inconsistencies in the categorising of patient diagnoses.

9.3.4.2 Length of Admission

A study conducted by Beck et al. (2008) examined the frequencies of restraint and seclusion over a period of five years, using a sample of 622 patients. This study was conducted within a mixed level security State Psychiatric Hospital. This was the only study, of all those reviewed, which examined length of admission in relation to the uses of coercive measures. Findings from this study revealed that patients were

most likely to be restrained or secluded during their first two months of admission and that these patients would be restrained or secluded, on average, between two and six times per month during this period (Beck et al. 2008). Findings from this study suggested that after the first two months of admission, rates of restraint and seclusion were likely to decrease. The durations of using such interventions, however, were not reported.

9.3.4.3 Temperament and Character

Margetić et al. (2013) examined the temperaments and characteristics of patients who had experienced restraint, in comparison with those who had not. The study was conducted using the Temperament and Character Inventory (TCI) (Cloninger et al. 1993) and the Positive and Negative Syndrome Scale (PANSS) (Kay et al. 1987). Fifty six male patients were included in this study conducted in Croatia. Findings demonstrated that patients were more likely to experience restraint if they had a higher 'Novelty Seeking' personality temperament—that is, those who are generally quick-tempered, easily bored, impulsive and quick to disengage (Margetić et al. 2013). Margetić et al. (2013) also found that those who were more likely to be restrained also tended to experience greater severity of psychotic symptoms as measured by the PANNS assessment. The abilities to modify personality traits and associated behaviours were not addressed within this study, although a better understanding of these characteristics, as well as ways of working with these behaviours, were suggested as means of reducing restrictive practices.

9.3.4.4 Indications for the Use of Coercive Measures

Eight papers examined reasons for the uses of coercive measures. Seven of these were reasons in relation to the uses of seclusion only and one in relation to a combination of using both seclusion and restraint. One of these papers focused solely on violence and aggression as indicators for the uses of coercive measures (Thomas et al. 2009); one paper examined dangerousness towards self and others (Paavola and Tiihonen 2010), while a further paper reported findings of 'difficult or disruptive behaviour' being the main reason for using seclusion, without citing other possible alternatives (Lehane and Morrison 1989, p. 55).

The remaining five papers included much more specific categories for analysis, citing both patient and ward characteristics. These included agitation/disorientation, aggression, deterioration in mental state, disruptive/threatening behaviour, suicide/self-harm, timeout, violence towards staff and/or other patients, violence towards property and ward culture, as reasons for using seclusion or restraint (Ahmed and Lepnurm 2001; Heilbrun et al. 1995; Keski-Valkama et al. 2010; Maguire et al. 2012; Pannu and Milne 2008). Findings from these studies suggest violence and aggression (Heilbrun et al. 1995; Keski-Valkama et al. 2010; Pannu and Milne 2008), and suicide and self-harm (Ahmed and Lepnurm 2001) as the main indicators for using seclusion and/or restraint. Such conjectures, however, should be made with some caution given the different legislative frameworks surrounding the use of coercive measures between countries, which result in variances in categorisation.

9.3.5 Patient Perceptions of Coercive Measures

Two papers explored patient views of seclusion. Keski-Valkama et al. (2010) interviewed patients from both forensic and general populations to compare their experiences and perspectives. Harris et al. (1989) explored comparisons between patient and staff views of the least restrictive measures.

9.3.5.1 Experiences of Patients from Forensic and General Populations

Keski-Valkama et al. (2010) conducted interviews with patients. These were conducted, on average, six days after being secluded and again, at follow-up, six months later. Interestingly, forensic patients viewed their experiences of seclusion as punishment more often than patients in general settings. Most patients recognised a need for seclusion, citing actual or threats of violence as a justification, along with agitation/disorientation or the patient's own will. Reasons for the need for seclusion did not differ between forensic and general patients. The majority of patients overall, however, perceived seclusion negatively and around one-third of patients were confused over the reasons why they were secluded, even when interviewed again six months later.

Around half of all patients suggested that alternative methods would have been more effective interventions for them rather than seclusion. The majority of patients believed that resting in one's own room, verbal de-escalation, medication and activities, such as listening to relaxing music, would have helped. Staff–patient interactions and debriefing were found to be limited, and the investigators suggested that continued interaction during periods of seclusion may help to alleviate patient anxieties and promote better relationships and understanding (Keski-Valkama et al. 2010).

9.3.5.2 Patient Perceptions of the Least Restrictive Measures

Harris et al. (1989) included 40 patients in their study. (The views of staff included in the study will be explored in a later section.) These patients were divided into 20 patients who were 'experienced' with coercive measures, having been involved in at least 3 coercive incidents over the previous year, and 20 patients who were 'inexperienced', having not been involved in any coercive incidents over the previous year. All patients were male. Each participant was asked to complete a questionnaire outlining four separate incidents relating to i) self-harm and suicide, ii) violence towards another patient, iii) violence towards staff and iv) non-compliance. Nine coercive techniques were presented, ranging from 'light' to 'heavy'. These techniques were presented singularly, as well as in combination. Techniques presented included the removal of personal clothing, physical restraint, mechanical restraint, seclusion and rapid tranquillisation either by mouth or by intramuscular injection.

Participants were asked to rate each of these techniques in terms of restrictiveness and aversion. Both 'experienced' and 'inexperienced' patients agreed that mechanical restraint was most restrictive, followed by seclusion, rapid tranquillisation via injection, rapid tranquillisation via mouth, loss of personal clothing and finally physical restraint. Overall, 'experienced' patients rated the coercive techniques as being less restrictive than those who were 'inexperienced' (Harris

et al. 1989). 'Experienced' patients also rated 'heavier techniques' as being more acceptable than 'inexperienced' patients. It was unclear whether this was a result of habituation from having experienced coercive measures or whether 'heavier' techniques were actually less unpleasant than they appeared (Harris et al. 1989). Patient exposure to coercive measures therefore appears to have some influence on the perceptions of their use.

9.3.5.3 Patient Opinions and Legislative Issues

Margetić et al. (2014) asked patients to rate levels of agreement towards the following four statements (1) Should the patients' family be informed about the uses of mechanical restraint, (2) Should the physician ask the patient whether to inform the family about the uses of restraints, (3) Can the uses of restraints be a kind of punishment for intentionally aggressive behaviour toward people in their environment and (4) Should restraints be used if the patient requests to be restrained. Findings revealed that patients were ambiguous as to whether or not their families should be informed or whether they wished to be consulted about this decision. This largely depended upon the patients' relationships with their families and their mental state at the point of being restrained. Surprisingly, this study found that patients strongly agreed that restraints should be used as punishment where aggression is intentional and that restraints should be used where requested. These are in contention with current guidelines outlining that restraints should not be used for the purposes of punishment (Margetić et al. 2014; NICE 2015). In addition, this finding raises the question of whether restraint should be classed as 'coercion' when requested by the patient in order to feel safe (Margetić et al. 2014).

9.3.6 Staff Perceptions of Coercive Measures

The literature on staff perceptions points towards tensions between those who 'authorise and govern' and those 'who conduct', or are 'expected to conduct' coercive measures. Inherent conflicts appear to emerge between personal ethics and professional roles. Rather than being able to draw homogenous conclusions from these studies, what instead appears to emerge are the heterogonous views of staff, which may be influenced by personal and professional beliefs, gender and education.

Six studies explored staff perceptions of using coercive measures. Four studies adopted questionnaire designs; one to survey the attitudes of doctors regarding the use of seclusion in the UK (Exworthy et al. 2001), one to explore staff opinions and preferences of using seclusion, restraint and medication in the United States (Klinge 1994), one to explore staff perceptions of the least restrictive measures in Canada (Harris et al. 1989) and another to explore staff attitudes and perceptions pre- and post-measures aimed at reducing seclusion in Australia (Maguire et al. 2012). A further two studies adopted interview methods. One study used semi-structured interviews to explore the psychological effects of nursing staff using restraint and

seclusion in the UK (Sequeira and Halstead 2004) and a further study used focus group interviews (Mason 1993a).

9.3.6.1 Attitudes of Doctors Regarding the Use of Seclusion in the UK

Exworthy et al. (2001) used a postal survey to explore consultants, specialist registrars and non-training grade doctors views of seclusion. Within the UK, specialist registrars are doctors training to become consultants in their chosen specialty, and non-training grade doctors are those doctors who have chosen not to continue training to consultant or full GP status. From 150 questionnaires that were sent out, 117 were returned, giving a 78 % response rate. Findings indicated that seclusion was generally not perceived as a form of punishment. The majority of respondents supported the continued use of seclusion to prevent harm to others, even though there was ambiguity surrounding whether or not seclusion has any therapeutic benefits. Some respondents viewed seclusion as an 'adjunct' to other responses when managing aggressive behaviour, whilst other respondents were concerned that seclusion may disengage staff and patients. Interestingly, respondents who had roles in authorising the use of seclusion were significantly more likely to view seclusion as having some therapeutic benefits, than those who did not have roles in authorising seclusion. Professional role associated with seclusion therefore appears to influence attitude. Possible reasons for this, however, were not explored further within this particular study.

9.3.6.2 Staff Opinions and Preferences of Using Seclusion, Restraint and Medication in the USA

In the study conducted by Klinge (1994), staff opinions on the uses of restraint, seclusion and medication were obtained through the distribution of a 40-item questionnaire, within a maximum security in the USA. Respondents included psychiatrists, psychologists, social workers, rehabilitation therapists, nurses and level-of-care staff. 129 questionnaires were distributed, and 109 completed questionnaires were returned, giving an 85 % response rate. Of those who responded, 63 % preferred the use of medication over seclusion or restraint, and 65 % stated they would use seclusion over restraint where medication was not an option.

Reasons for using medication over any other coercive intervention were that medication was less physically restrictive, that medication would allow patients to continue participating in interactions in communal areas with staff and other patients and that medication had longer lasting effects. Reasons for not choosing medication, however, were that seclusion and restraint led to immediate control, medication administered by injection can be particularly invasive and that restraint and/or seclusion provide more opportunities for the patient to regain control on their own. The main reason for using seclusion was that this intervention was effective in allowing the patient to release more energy; whilst rationales for restraint were that this intervention is more effective in reducing injury to all involved. Staff with greater levels of education believed that coercive interventions were overused. Female staff believed that patients experienced restraint or seclusion as positive

attention whilst male staff believed this was a negative experience for patients. The investigators from this study concluded that both gender and education affected staff perceptions and decision-making. Reasons for such decisions appear to be based on perceptions of invasiveness, with staff appearing to opt for what they perceive to be the least restrictive measures possible (Klinge 1994).

9.3.6.3 Staff Perceptions of the Least Restrictive Measures in Canada

In a study conducted by Harris et al. (1989), the views of staff working with males in a maximum security hospital were explored, with regards to the least restrictive interventions. Thirty-eight staff were included in the study, divided into nineteen who were 'experienced' front-line psychiatric attendants and 20 who were 'inexperienced'. Staff in the 'inexperienced' group, included 6 occupations therapists, 5 recreation staff, 4 psychologists and 4 social workers. All but one of the experienced staff were male, while ten of the 'inexperienced' staff were female. The design of this study has been outlined above, with the exception of the staff questionnaire being phrased in relation to a staff perspective, as well as including additional questions on the effectiveness of such interventions in preventing further incidents.

Both experienced and inexperienced staff viewed mechanical restraint as being most restrictive, followed by seclusion. 'Experienced' staff rated rapid tranquillisation via injection as being next most restrictive followed by loss of personal clothing, whilst the opposite was found for 'inexperienced' staff. Agreement resumed for both 'experienced' and 'inexperienced' staff that rapid tranquillisation via mouth was the third least restrictive followed by physical restraint being the least restrictive.

Overall, no significant differences were found between staff of both genders (Harris et al. 1989). 'Experienced' staff rated the coercive techniques as less restrictive than those who were 'inexperienced' (Harris et al. 1989). 'Experienced' staff also rated 'heavier techniques' as more acceptable than 'inexperienced' participants (Harris et al. 1989). Staff, however, indicated that the effectiveness of 'heavier' techniques declined as the number of containment measures increased, indicating a point of saturation in the effectiveness of using multiple restrictive techniques (Harris et al. 1989). Staff were pessimistic regarding the effectiveness of 'heavier' techniques as preventing future incidents (Harris et al. 1989). It is unclear, however, whether differences between 'experienced' and 'inexperienced' staff were due to exposure to coercive interventions or to professional roles.

9.3.6.4 Staff Attitudes and Perceptions Pre- and Post-measures Aimed at Reducing Seclusion in Australia

Maguire et al. (2012) conducted a study into staff attitudes of seclusion pre- and post a national project aimed at reducing the uses of seclusion at a hospital in Australia. The study included three questionnaires. i) the Confidence in Managing Inpatient Aggression Survey (Martin and Daffern 2006) asks staff to rate their own and colleagues perceptions of safety and confidence in dealing with aggressive patients within the hospital. ii) the Heyman Staff Attitudes towards Seclusion Survey (Heyman 1987), asks staff to rate the validity of certain behaviours leading to the uses of seclusion, as well as rating seclusion as being therapeutic, punitive or

necessary for safety. And iii) the Essen Climate Evaluation Schema (Schalast et al. 2008) requires staff to rate the social and therapeutic atmosphere of their wards. Numbers of staff taking part in completing these questionnaires were not reported. However, the study does report that all clinical staff were surveyed on five wards where seclusion was used.

Findings indicated that following the project aimed to reduce seclusion, frequencies and durations of seclusion were reduced within the hospital. However, the number of patients who were secluded remained similar. Despite reductions in the numbers of seclusion episodes, there were no significant differences in staff confidence. Staff did, however, rate seclusion as being more therapeutic after implementation of the project. The reason attributed to this, wree staff being less complacent with regards the uses of seclusion following national scrutiny and initiatives.

9.3.6.5 Psychological Effects of Nursing Staff Using Restraint and Seclusion in the UK

Sequeira and Halstead (2004) conducted 17 semi-structured interviews with nursing staff. Each of the interviews were conducted within 96 hours of the staff members being involved in restraining and secluding a patient. The sample included eight qualified nurses and nine nursing assistants aged between 18 and 50 years. Eight interviewees were women and nine interviewees were men.

Overall, staff reported feelings of anger and anxiety surrounding the uses of restraint and seclusion. Staff reported anxieties with regard to hurting the patient, getting hurt themselves, as well as others getting hurt in the process. Feelings of anxiety were reported to decrease with familiarity. However, many staff reported continued anger and frustration towards patients who either do not respond to less restrictive interventions or who injure others. Interviewees cited low morale as being associated with the repeated use of coercive interventions. In addition, female nurses in particular expressed conflicts between the uses of restraint and seclusion with their role as a nurse. Those conducting coercive measures appear to have negative experiences of using these interventions. Some staff describe being 'hardened' to using restraint and seclusion and were ambivalent regarding the idea of receiving additional support.

9.3.6.6 Conflicts Resulting from Decision Making in the Use of Seclusion

Mason (1993a), reporting on the findings of an action research project, identified five areas of conflict resulting from decision making surrounding the uses of seclusion. These included: (1) negative perceptions of both seclusion as well as the forensic psychiatry as a discipline, (2) seclusion as a necessary clinical intervention, (3) control elicited through seclusion, (4) dangerousness as a rationale for using seclusion and (5) a perpetuation of seclusion practices resulting from a 'macho culture' (Mason 1993a). These findings appear to relate to the cultures and philosophies of working within the organisation as well as between the personal and professional views of staff.

9.4 Discussion

The uses of coercive measures are considered controversial practices within healthcare. Paramount to these controversies are the juxtapositions between the restrictions placed upon individuals and the ethos' of patient autonomy and respect for individual human rights. A number of international guidelines have called for the reduction, and even elimination, of the uses of coercive measures (American Psychiatric Association et al. 2003; National Mental Health Working Group 2005; NICE 2015; Queensland Government 2008). Those opposing coercive measures view these as infringements of liberty (The MacArthur Research Network 2004; National Association of State Mental Health Directors 2002). The uses of coercive measures have been described as 'an embarrassing reality for psychiatry' (Soloff 1979, p. 302).

The ethical and moral debates surrounding the uses of coercive measures are hightlighted particularly within the context of forensic forensic hospitals. These environments are already restrictive. Tensions between care and containment are a continual challenge and balances between safety and security are constantly sought. Coercive measures are suggested to have paradoxical effects in provoking further violent and aggressive behaviours, counter to the behaviours they purport to contain, manage and control (Daffern et al. 2003; Goren et al. 1993; Morrison et al. 2002; Patterson and Forgatch 1985; Thomas et al. 2009). With few alternative interventions currently available, these practices pose great dilemmas for those working in secure hospitals, and who are responsible for the care, treatment and safety of both psychiatric patients and the public.

Despite such dissonance, limited empirical research has been conducted in this area. Findings from general psychiatry indicate that there has been little consistency in research findings relating to the prevalence of coercive measures (Raboch et al. 2010; Steinert and Lepping 2009; Steinert et al. 2009). Cross-cultural comparisons indicate widespread differences in the numbers of patients, and number of times, patients are subject to coercive measures (Steinert et al. 2009). Similarly, differences have been found in the frequencies, durations and types of coercive interventions used (Raboch et al. 2010; Steinert et al. 2009).

Such variations have been apparent in the practice of coercive measures both within and between different psychiatric settings, indicating a lack of standardisation (Raboch et al. 2010; Steinert and Lepping 2009; Steinert et al. 2009). Where empirical findings on the prevalence and factors associated with coercive measures in psychiatry has been limited, even lesser attention has been given to the uses of coercive measures within the specialist division of forensic psychiatry.

What is apparent from this literature review, is a lack of empirical research on the uses coercive measures, specifically within forensic psychiatry. Different definitions and methods used between studies restricts the scope for meaningful comparisons. Several observations however, are worth noting. Variations have been found with regard to rates and frequencies of coercive measures. These have ranged from 27.7 % to 44 % of patients having being secluded with forensic psychiatric

settings (Ahmed and Lepnurm 2001; Pannu and Milne 2008; Thomas et al. 2009). Such a difference in range appears consistent with findings from the general psychiatric literature where rates of coercive measures are reported to range from 21 % to 59 %, (Raboch et al. 2010). Due to such vast variations in findings across all studies, it remains unclear whether coercive measures are used more commonly in forensic or general psychiatric services, and specifically whether the frequency of using coercive measures are influenced more heavily by patient or context.

Differences in the uses of coercive measures might arise as a result of sociocultural variations, including how each type of coercive measure is perceived (Bowers et al. 2007; Klinge 1994; Soloff 1984). Variations in cultural norms and preferences, as well as differences in local, national and international policies, may each contribute towards such wide-ranging figures ((Bowers et al. 2007; Maguire et al. 2012; Raboch et al. 2010; Soloff 1984; Steinert and Lepping 2009; Steinert et al. 2009). Indeed, there are varying legislations for the uses of coercive measures between countries. These depend on the type of coercive measure, the techniques involved and the circumstances, which each dictate when a patient may be restricted (Steinert and Lepping 2009). In the UK, for instance, mechanical restraints are only used in exceptional circumstances and do not permit patients to be tied to furniture (Department of Health 2008). In other countries, such as Finland, however, mechanical restraint most often involves the tying of patients to a bed (Raboch et al. 2010; Steinert and Lepping 2009). Such differences in legislation, restraint methods and practices are likely to alter perceptions of acceptability, as well as perceptions of what might be deemed the 'least restrictive' intervention (Bowers et al. 2007; Raboch et al. 2010; Steinert and Lepping 2009).

Perhaps implicit to such variations are differences in the methods and meanings associated with the terms seclusion and restraint. Studies have consistently reported variations in definitions of these terms, such that physical restraint techniques and training may vary between services (Ching et al. 2010; Davison 2005; Parkes 1996). Seclusion may or may not be recorded depending on whether the door is open or locked (Ching et al. 2010; Davison 2005; Mason 1993b). Whether or not episodes of seclusion are recorded may also depend on whether the intervention was elected by the patient or staff (Ahmed and Lepnurm 2001; Mason 1993b), whether seclusion was viewed as 'time out' or quiet time alone (Ahmed and Lepnurm 2001; Mason 1993b) and whether the patient was isolated within their own room or a room specifically designed for seclusion purposes (Mason 1993b). Furthermore, the concepts of seclusion, night time confinement and longer term segregation are not always clearly defined (Ahmed and Lepnurm 2001; Department of Health 2008; Mason 1993b). Such differences in interpretations, meanings and understandings of these terms will ultimately alter reports on the prevalence of coercive measures between settings.

9.4.1 Demographic and Clinical Indicators

Age, gender and length of admission all appear to have some influence on the prevalence of using coercive measures. Findings reveal that younger, newly admitted patients are likely to be secluded, or secluded and restrained in combination, more often than those patients who are older and who have been admitted for a longer period (Ahmed and Lepnurm 2001; Beck et al. 2008; Pannu and Milne 2008; Thomas et al. 2009). There are perhaps several reasons for this. Patients who are newly admitted are likely to be most acutely unwell. Both patients and staff are most likely to feel threatened during this initial period of admission, since staff are still getting to know the patient, while patients are still getting to know the staff and ward routine. Staff are perhaps most likely to feel threatened by those who are younger and most physically fit, while patients on admission are still learning the rules and boundaries of their new environments (Ahmed and Lepnurm 2001). More research, however, is required to substantiate these hypotheses. Further research is also required regarding age, gender and length of admission in relation to the uses of restraint alone.

Categorisations of ethnicity, diagnoses and indicators for the uses of restraint and seclusion have been particularly inconsistent. While some differences have been found between studies, these are largely inconclusive. If findings are to be comparable between studies, greater standardisation is required in how variables are arranged categorically. Since many of the studies were conducted retrospectively, perhaps this also points towards the need to standardise hospital data. Similar styles of data recording would enable cross-analyses to be conducted more effectively.

Whilst there has been some research conducted into reducing violence and aggression as means to reduce coercive measures (Ching et al. 2010; Daffern et al. 2003; Davison 2005; Fluttert et al. 2010), the uses of coercive measures have not been confined to violence and aggression alone. Violence, aggression, suicide and self-harm have all been reported as primary indicators for the uses of coercive measures (Heilbrun et al. 1995; Keski-Valkama et al. 2010; Pannu and Milne 2008). Other indicators have also been cited to a lesser degree, all of which require further exploration (Heilbrun et al. 1995; Keski-Valkama et al. 2010; Pannu and Milne 2008).

Little attention has been given to whether certain types of behaviour are more likely to lead to certain types of coercive interventions being used. Similarly, little attention has been given to whether specific interventions might be more effective in managing harm to self and others. Given the controversies surrounding the uses of coercive measures, such research would be important in providing necessary rationales and justifications for using coercive interventions.

9.4.2 Patient and Staff Perceptions

Only two studies explore patient experiences of coercive measures. This finding, in itself, is revealing of the direction further research might follow. Whilst it is particularly interesting to note that forensic patients perceive coercive measures to be more punitive than general psychiatric patients, there has been a lack of exploration as to why this might be. Similarly, while 'experienced' patients appear more accepting of coercive interventions than 'inexperienced' patients, reasons for this need to be explored. Furthermore, through exploring patient attitudes and experiences, patient preferences may be taken into account in the event of coercive interventions being required.

With regard to staff experiences and perceptions, those who authorise coercive measures are more likely to percieve the therapeutic benefits of these interventions. Those who employ coercive interventions, however, tend to view such practices with fear, anxiety, anger and even resentment (Exworthy et al. 2001; Klinge 1994; Sequeira and Halstead 2004; Whittington and Mason 1995). These findings reveal tensions between those who 'authorise and govern' with those who 'do' or are 'expected to do'.

Findings from this review indicate that conflicts emerge between personal values and professional expectations. Perspectives on coercive measures are far more complex than simply being either for or against (Whittington & Mason, 1995). Further research is required to better understand the experiences leading to, and resulting from, the uses of coercive measures. Greater understanding is also required towards the impacts and influences these experiences may have on policies and practice.

9.4.3 Review Limitations

The search strategy for this literature review was limited to healthcare and sociological databases and so articles relating to this subject, but not included within these databases, will inevitably have been missed. The search terms used for this review were carefully selected in formulating this search strategy. However, these search terms will ultimately influence those articles extracted and the subject matter within. This study has also been limited to hospital inpatient settings only, and so the practices of coercive measures amongst forensic patients within prison or community settings will have been excluded. Moreover, it is recognised that different definitions of coercive measures exist, as do different forensic psychiatric settings both within and between countries, further compounding the already complex nature of this review (Mason 1993b; Raboch et al. 2010; Steinert and Lepping 2009).

9.5 Conclusions and Implications for Further Theoretical Development

Limited research has been found on the uses of coercive measures within forensic psychiatry. The majority of research has focused on the uses of seclusion and restraint, while little attention has been given to the uses of involuntary medication as a coercive intervention. Younger patients and those who are newly admitted tend to be secluded most often. A common theme throughout many of these studies, however, has been a lack of coherence between research methods and, more significantly, a lack of research into this important area. Without such research, a lack of evidence will persist, with constant questions emerging as to why coercive measures are used and how they are justified.

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Coercion in Forensic Healthcare: A North American Perspective

10

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Abstract

The debate concerning non-consensual, or coerced, forensic mental healthcare continues to engage clinicians, scholars, lawyers, decision makers, bio-ethicists, and the judiciary across Canada and the United States. This chapter reviews and discusses the theoretical, clinical, legal, and ethical aspects of seclusion and restraint practices in forensic psychiatric hospital settings and reports the results from empirical studies. The chapter also discusses the provisions for involuntary treatment in mental health legislation, specialty courts, and compulsory community based treatment and supervision models.

10.1 Operationalising Coercion

The Mental Health Commission of Canada (2009) prescribes adherence to the principle of "least restrictive care" for mental health professionals; "*the provision of safe, competent, and ethical care which respects individual rights, dignity, and autonomy with the least possible recourse to mechanical, chemical, environmental,*

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or physical measures to limit the activity or control the behaviour of a person or a portion of their body" (p. 121). Within these boundaries, a continuum of coercive practices exists in psychiatric services that vary in intensity from overt coercion (e.g. use of force), over legal leverage, to cause-effect relations in treatment (Link et al. 2008).

We consider coercive measures to be temporary management techniques, not primary forms of treatment. It is within these directives that our definitions of coercive measures are understood.

10.1.1 Seclusion

Seclusion, also referred to in the literature as solitary confinement, segregation, or environmental restraint, is best defined as a temporary management technique that involves environmental containment of a patient who is perceived to be in psychiatric crisis in a room "*from which free exit is denied*" (Mayers et al. 2010; Stewart et al. 2010; BC Ministry of Health 2012). Often the room is especially designed for that purpose, providing a safe, stimulus-poor environment (Stewart et al. 2010). Depending on the facility where seclusion is used, patients may be guided into an isolation cell, safe room, or comfort room, and different protocols may be enforced depending on the therapeutic environment and the imminence of threat to safety for the patient or others (e.g. open-door seclusion, closed-door seclusion). For the scope of this chapter, all of these practices will be considered under the common denominator "seclusion".

10.1.2 Physical Restraint

Physical restraints are temporary management techniques that restrict patient movement. Use of physical restraint can precede seclusion, occur during seclusion, or be used as a temporary alternative to seclusion. When a patient's behaviour escalates or the risk for harm increases rapidly, two or more staff members may manually immobilise the patient to facilitate medication administration or help the patient regain control of his behaviour prior to moving him into seclusion (Macpherson et al. 2005). Mechanical restraint is a different type of physical restraint whereby a patient is (partially) restricted in the use of two to four limbs (e.g. hands, legs) and/or other body parts (e.g. neck, torso) by securing them with soft restraint material such as straps, belts, or other equipment approved to do so (Stewart et al. 2009).

10.1.3 Chemical Restraint

Medication-induced sedation, or chemical restraint, is another temporary management technique (Stewart et al. 2009). It is often used simultaneously with other

forms of restraint (e.g. seclusion) or as an alternative to restraint to help contain patient behaviours before they reach the critical point where seclusion or physical restraint is deemed necessary. The administration of oral or parenteral psychotropic medication has been recommended as a rapid tranquilisation technique in case of agitation or aggression in individuals with mental illness. Best-practice recommendation for the use of this technique is "*to reduce patient suffering, allow improved communication, reduce risks to the patient and others, and to do no harm*" (Macpherson et al. 2005, p. 407). Use of PRN medication (pro re nata; as necessity arises) is not considered a form of chemical restraint. Currier (2003) has described cogent PRN as part of a "least restrictive" form of medication "*in the context of a symptom-based, but not necessarily a disorder-based, plan of care*" (p. 68).

10.1.4 Passive Coercion and Perceived Coercion

We define passive coercion as a consequence of the legal framework surrounding individuals with mental illness. Involuntary commitment, community treatment orders, probation orders, criminal responsibility, peace bonds, no contact orders are sometimes perceived as forms of passive coercion into behavioural compliance within a legal framework. Although they may be perceived as coercive, these measures leave room for individual agency in the choice to comply with the legal conditions (and return to a previously held level of autonomy) or defect and be considered for worse outcomes (e.g. longer deprivation of autonomy or freedom, financial burden, punishment). Perceived coercion thus is akin to the concept of passive coercion, although it exists primarily in the interpersonal and intrapersonal domain; it is a more elusive concept than the latter. It focuses on the experience of the patient in treatment, and the factors that influence the perception of being coerced in different aspects of psychiatric contact. Although we recognise "perceived coercion" as an important consideration in individual treatment of different patient groups, it falls beyond the scope of this chapter (see Link et al. 2008).

10.2 North American Statistics on the Use of Seclusion and Restraint

The extant North American literature on the use of seclusion and restraint (SR) in forensic psychiatric populations is scant. The relative absence of recent scholarship on seclusion and restraint in forensic psychiatry does not indicate the absence of coercive practices. Another major influence in the debate surrounding SR use is the relative lack of uniform legislations across Canada and America (see Sect. 10.2 in this chapter); within the framework of the *Canadian Charter of Rights and Freedom,* the measurement and regulation of SR use is left to local government and often to individual institutions (Larue et al. 2009; Chaimowitz 2011). The current census among governmental, healthcare, and patient rights organisations is to minimise or abolish existing SR practices (BC Ministry of Health 2012;

Chaimowitz 2011; Maguire et al. 2012). This initiative has grown concurrent with the understanding of the many negative and unintended consequences of SR practices for all parties involved [e.g. fear, loss of trust, deaths, staff injury (Huckshorn 2006)]. Other countries such as Finland, Australia, and the United Kingdom have a more long standing tradition of researching SR use with forensic patients (for a review, see Hui et al. 2013).

There is a dearth of research on seclusion and restraint practices in North American forensic psychiatric settings. We have identified only ten articles since 1989 that examine the topic of SR use in forensic psychiatry in North America. In a forensic hospital in Alberta, 27.7 % ($N = 183$) of all mentally ill offenders were managed with seclusion on 306 occasions over a 2.5-year period (Ahmed and Lepnurm 2001). A large-scale retrospective audit in Quebec revealed that 40.7 % of 2721 patients admitted to an adult psychiatric hospital experienced seclusion with or without restraint, and 77.2 % of seclusions were accompanied by mechanical restraints (Dumais et al. 2011). A 1-year retrospective file review in a sample of 527 forensic inpatients indicated that violence risk was managed with PRN in 40.8 % of male aggressors and in 22.2 % of female aggressors (Nicholls et al. 2009). Seclusion with and without restraint was used to manage male patients in 77.8 % of the cases and 63.3 % of female aggressive incidents. Additionally, male inpatients received increases in environmental restraint (2.6 %) by transferring them to a higher security level within the hospital and consequently limiting privilege levels. Reimann and Nussbaum (2011) reported SR use in 42 % of a group of 130 not criminally responsible (NCR) patients in Ontario. Five per cent had three or more SR episodes recorded over a 2-year study period. Another study indicated that approximately 36 % of the entire population ($N = 806$) of a New York forensic psychiatric centre had experienced restraint, and 42.8 % had experienced seclusion over a 7-year study period (Benford Price et al. 2004). A comparative review of 243 patients (forensic $N = 119$ and civil $N = 124$) who had been subjected to physical control (seclusion and/or restraint) in a 1000-bed public psychiatric hospital found that this sample was responsible for 870 physical control incidents during a 1-year study period (Heilbrun et al. 1995). Interestingly, civil patients were more violent than forensic patients, required seclusion more often and required longer episodes of seclusion and restraint (Heilbrun et al. 1995). Beck et al. (2008) conducted a longitudinal study in a state psychiatric hospital with a substantial number of forensic clients that focused on SR trends in this population ($N = 622$). The majority of their sample (71 %) had an overall rate of 2.55 SR incidents per 1000 patient days; a moderate SR trajectory group (22 %) was responsible for 30.29 SR incidents per 1000 patient days and 41 patients (7 %) made up the high SR group, having an average of 149.84 SR episodes per 1000 patient days.

These data indicate that SR use in forensic psychiatry in North America falls within the range of reported SR use in Europe and the UK (0.03–35.6 %) and an international review on SR use in forensic settings (27.7–44 %; Hui et al. 2013; Steinert et al. 2010). These data are more favourable than those described in correctional settings. A recent report by Correctional Investigator Canada (2015) reveals that 63.2 % of federal inmates with SR incidents have mental illness.

In sum, data indicate that the use of seclusion and restraint (SR) is still prevalent in North America. However, recent efforts have been made to address and reduce the use of physical control in civil and forensic psychiatry. A research group in Pennsylvania documented a state-wide reduction of SR use in psychiatric, including forensic, hospitals over a 10-year time period (Smith et al. 2005). Specifically, mechanical restraint use decreased from 6.4 to 1.2 incidents per 1000 patient days, and seclusion use decreased from 7.2 to 0.3 incidents per 1000 patient days.

10.2.1 Precipitants of Seclusion and Restraint

Results from Canadian studies on patient-related precipitants of SR use have largely replicated international findings. Overall, seclusion with or without restraint is more commonly used to manage agitated patients, with a more severe clinical presentation.

10.2.1.1 Patient-Related Factors

A retrospective file review on aggressive incidents in a forensic psychiatric hospital in British Columbia indicates that seclusion with or without restraint and the use of PRN were the primary interventions (63.3–77.8 %) used to manage serious incidents of physical violence, and/or inappropriate sexual behaviours (Nicholls et al. 2009). Further examination of the sample revealed that a small subset (10 %) of the population ($N = 527$) was responsible for 60 % of all perpetrated aggression (Lussier et al. 2010). An analysis of patients who were responsible for 15 or more violent episodes, and thus had more SR incidents, revealed that they were more likely to be female, have a prior criminal record for violent crime and have been found unfit or NCR on previous occasions. Furthermore, they had more prior hospitalisation and were more likely to present with brain damage or cognitive impairment. Lussier et al. (2010) and Nicholls et al. (2009) did not primarily focus on seclusion and restraint; however, as such, their evidence speaks more to the profile of chronic perpetrators of inpatient aggression. Similarly, the SR interventions in Heilbrun et al. (1995) were targeted toward 20 % of the entire forensic population, and for this subgroup psychopathy correlated significantly with SR incidence. Reimann and Nussbaum (2011) found that behavioural impulsivity (Factor 2 in the Hare psychopathy construct; Hare 2003) was most predictive of SR episodes in a Canadian sample of NCR-accused. Suicidal threats and self-harm have also been documented as primary motivators for a seclusion episode in more than one in five mentally disordered offenders (Ahmed and Lepnurm 2001); female gender, psychotic spectrum disorders, and substance abuse were more common in secluded patients. Dumais et al. (2011) found that younger age, male gender, a psychotic spectrum disorder, bipolar disorder, personality disorder, and longer hospital stay were important factors. Similarly, high-frequency SR was associated with gender, young age, borderline personality disorder, and mental retardation in Beck et al.'s (2008) high-SR group. As racial minorities are overrepresented in some correctional and forensic regimes, it is surprising that only one study has

examined the association between ethnicity and SR incidents. Interestingly, Benford Price et al. (2004) found that Caucasian, African-American, Asian, and Hispanic forensic patients all endured similar types, rates, and durations of seclusion and restraint.

Not all motivators for SR use may be equal; for example, in the case of suicidality and self-harm, an argument can be made against the therapeutic value of seclusion. The initiation of SR after disclosure of suicidal ideation or a desire to self-harm may be perceived as punitive and disrupt therapeutic alliance. Future research efforts may lie in the exploration of the motivation of disruptive patient behaviour. Emerging research in forensic psychiatric populations has indicated that therapeutic management techniques attuned to the origin of violent episodes are more effective than SR use; social learning and Dialectical Behavioural Therapy are two promising alternatives (Evershed et al. 2003; Goodness and Renfro 2002). Future research needs to categorise the index events eliciting an SR episode and the (intended) victim; currently, the definition of "aggression", the presence of (intended) victims or targets and the clarification of the proportion of SR incidents due to actual, attempted, or threatened verbal or physical assault are missing pieces of the puzzle. Empirical data on the effectiveness of SR practices are lacking, as are forensic perspectives on the impact of SR events on patients' sense of self and therapeutic alliance.

10.2.1.2 Staff-Related Factors

We do not contend that mental health staff knowingly and willingly uses SR to contain patients when other interventions may be more suitable. Staff working in mental health are at risk for work-related injuries, due to accidents, targeted assaults, or impulsive aggression from patients in their care. Forensic psychiatry is no different. Actual or perceived (un)safety may play a central role in staff hesitance towards the move towards a SR-free environment (Curran 2007). Regardless of observable patient behaviour, staff may decide to initiate or follow-through with SR protocols out of fear not to disrupt the therapeutic milieu (e.g. losing credibility, deviating from unit or organisational regulations; Curran 2007). It is concerning that some teams underuse alternatives and relational interventions once SR protocols have been initiated (Larue et al. 2009, 2013). Larue et al. (2013), furthermore, found that the underlying causes of patient behaviour warranting an SR incident were often unexplored or attributed to a single cause. One American study by Klinge (1994) investigated differences in staff attitudes towards SR use ($N = 109$); she found that gender and education were important factors in deciding to use SR with acutely psychotic forensic patients. Male staff opined that SR had a more negative impact on patients than female staff, and higher educated clinical staff thought that SR use was overused.

Little research has been done on the influence of ward culture and staff-related factors in SR incidents in a forensic population. It stands to reason that risk assessment is central to rehabilitation in forensic psychiatry; inadvertently, staff may be more prone to perceive patients as violent and be more oriented towards aggression management and less oriented towards therapeutic intervention in day-

to-day patient interaction. This "forensic bias" has been noticed by Benford Price et al. (2004); although 11, 152 SR incidents were recorded over a 7-year time period, there were only 4538 episodes of violence. Furthermore, "risk" for inpatient violence is not a concept primarily linked to forensic psychiatry. It may surprise some that institutional violence is *less* common in forensic psychiatric populations than in civil psychiatric populations (Linhorst and Scott 2004). Furthermore, a relatively small subgroup of forensic inpatients is often responsible for the majority of violent incidents in an institution (Lussier et al. 2010; Nicholls et al. 2009; Heilbrun et al. 1995; Quanbeck et al. 2007). Future merit lies in investigating the impact of ward climate (e.g. perceived safety, group dynamics), the impact of SR use on staff, and staff training in other de-escalation techniques.

10.2.1.3 Ecological Factors

Recommendations to minimise or abolish SR practices consistently emphasise the role of the organisation (Chaimowitz 2011; Knox and Holloman 2012; BC Ministry of Health 2012). This is unsurprising as a large number of non-clinical factors, among which hospital culture, impact SR incidence (Fisher 1994; Borckardt et al. 2011). Even seemingly trivial ecological factors such as day of the week and time of day have been found to impact the rate and duration of SR use (Nicholls et al. 2009; Heilbrun et al. 1995). The mandate of forensic psychiatric hospitals may be more conducive to SR practices than that in other mental health facilities. Shuman and Zervopoulos (2010) have made the argument that forensic psychiatry is likely the only psychiatric environment where empathy is sometimes seen as an impediment to service provision. Staffing levels are a long standing and an important concern in some forensic psychiatric hospitals (Arboleda-Flórez 2006; Livingston 2006; Way et al. 1990). Increasing staff-to-patient ratios, and investing in staff education on alternative behavioural management techniques, decreased violent incidents, and SR use; attention to staff-to-patient ratio may help some forensic regimes reduce their SR incidence (Donat 2003; Donovan et al. 2003; Morrison et al. 2002). Like clinicians have a *parens patriae* duty towards their patients and clients, so do organisations towards their staff members. Staff injuries when engaged in SR protocols are common, and the toll it takes on staff members and patients is likely underestimated. The likely starting point of investigating SR in forensic psychiatry lies with the larger therapeutic environment. Mandatory reporting, adequate risk assessment, and diverse training in risk management techniques and clear therapeutic directives are the likely pillars of SR reduction in forensic psychiatry.

10.3 Mental Health Acts

In general terms, mental health acts (MHAs) in North America (Canada and the USA) utilise either narrow criteria that limit admissions only to those who pose an imminent safety to risk self or others or broad criteria that include financial, occupational, family, and social harms as well (Browne 2010; Gray et al. 2010;

Gray and O'Reilly 2005). In Canadian jurisdictions, narrow criteria are used in Alberta, the Northwest Territories, Nunavut, and Ontario while the remaining provinces and territories use broad criteria. Some provinces also include a "deterioration condition" to allow for the involuntary admission of individuals with a mental disorder, who are not currently a risk to self or others, but are deemed to be at imminent risk to become such with British Columbia, Saskatchewan, Manitoba, Ontario, Nova Scotia, and Newfoundland and Labrador having such a provision. British Columbia, Saskatchewan, and Newfoundland and Labrador do not allow treatment refusal; while other provinces do allow treatment refusal, it can be overruled. Most Canadian jurisdictions also now include a deterioration criterion as an alternative to the harm criterion (Gray et al. 2010; BC Ministry of Health 2005; Kaiser 2009).

These MHA provisions apply also to court-ordered inpatient assessments of fitness to stand trial and criminal responsibility; a remanded patient may receive involuntary treatment in hospital during the assessment period provided the accused satisfies criteria for committal and lacks capacity. In British Columbia, where the court has made a disposition of the accused being unfit to stand trial or NCR and issues an order for hospital treatment, the MHA states that such a person shall receive the necessary treatment and is deemed to have consented to such treatment (BC Ministry of Health 2005; Gray et al. 2010). In contrast, a number of Canadian provincial jurisdictions do allow involuntary patients to refuse the treatment necessary for them to regain their liberty. For example, in Ontario, a patient found to be capable may refuse treatment. Treatment may even be refused if the person is incapable, and the patient's substitute decision maker must refuse treatment if the incapable person has a prior capable wish applicable to the circumstance to refuse treatment (Gray et al. 2010).

10.4 Treatment Refusal

Canadian and USA jurisdictions are significantly different concerning the refusal of treatment necessary to restore an involuntary patient's liberty, whether through capability definitions or advance directives. In Canada, some provinces allow an override of a capable person's wishes by a review panel (Alberta, New Brunswick) or by the admission authorising treatment (British Columbia, Newfoundland and Labrador) or by requiring a previous expressed wish to be followed except if serious harm to the person or others is likely (Manitoba, Nova Scotia). Saskatchewan, Nova Scotia, and Newfoundland and Labrador do not admit a person involuntarily who is able to understand and make an informed decision about treatment. The federal *Criminal Code* (Canadian Criminal Code 1985) does not permit a person found unfit to stand trial, capable or not, to refuse treatment, despite refusal being allowed under a provincial Act (see Gray and O'Reilly 2005).

Starson v. Swayze (2003) was the Supreme Court of Canada's (SCC) first case involving capacity and the refusal of involuntary psychiatric treatment. The case

involved a self-described "professor" who had attained international recognition as co-author of a scientific publication on physics and who had been found NCR on account of mental disorder for uttering death threats. While considered incapable of making a treatment decision by psychiatrists and the Ontario Criminal Code Review Board, the provincial and Ontario Supreme Court and the Supreme Court of Canada found him to be capable. "Professor" Starson continued to refuse treatment for his psychosis, characterised by grandiose, bizarre, and paranoid delusions, as well as threatening harm and as a result of the hospital's inability to mitigate risk to others to the extent that he could be released to the community, he spent over 7 years detained in a forensic psychiatric hospital. This refusal of treatment is permitted under Ontario law, although it is not permitted in some other Canadian provinces, and in many other countries. "Professor" Starson remained untreated for 7 years until mental illness had eroded his capacity to make treatment decisions to such an extent that the court deemed him incapable and the high court refused to hear a further appeal by him of the finding. He improved on treatment and was able to return to the community.

Starson's situation is illustrative of several issues central to coercion, legal leverage, and treatment capacity in Canada and in the broader North American context. In a detailed discussion of the legal, ethical, and clinical implications of the Starson case, Gray and O'Reilly (2005) discuss Ontario's law with respect to consent to treatment and relevant Canadian constitutional and criminal law, the Ontario Consent and Capacity Board decision, and the court appeals. Implications from the Starson case are analysed in relation to what happened to Starson, human rights and comparative law pertaining to involuntary patients' refusal of treatment, especially their relevance to the *Canadian Charter of Rights and Freedoms* and laws in some other countries. As Gray and O'Reilly (2009) point out, several Canadian and foreign jurisdictions where laws are believed to align with human rights codes do not allow treatment refusal where such treatment is required to restore their liberty and conclude that legislation permitting a person with a mental illness to be incarcerated indefinitely in a "hospital" because needed psychiatric treatment cannot, by law, be provided is not justifiable in a caring democratic jurisdiction.

In the American context, the right to refuse psychiatric medication is explicitly enshrined in law in several jurisdictions. Several scholars and psychiatrists have documented the legal implications for, and impact on, general psychiatry and forensic mental health (Appelbaum 1994, 2004; Bassman 2005; Caplan 2006; Cherry 2010; Heilbrun and Kramer 2005; Herbel and Stelmach 2006; Monahan et al. 2005; Swanson et al. 2007; Swartz et al. 2004; Baker et al. 2009; Bowers et al. 2012; Glod 2010; Owiti and Bowers 2011; Skipworth et al. 2012). This debate gained further impetus after the 1983 Massachusetts case of *Rogers v. Commissioner* (1983) where the court separated mental illness and capacity to make treatment decisions and held supreme the person's constitutional right of autonomy. The influence on psychiatric practice of subsequent rulings such as *Winters v. Miller* (1971), *Hargrave v. Vermont* (2003), *Rennie v. Klein* (1981), *Washington v. Harper* (1990), *Riggins v. Nevada* (1992), and *Sell v. U.S* (2003), all

representing seminal cases that delineated further the limits of the psychiatrist's ability to direct, prescribe, and enforce treatment, has been extensive. In the *Sell* case, pertinent for forensic mental healthcare, the United States Supreme Court held that a defendant who is hospitalised as incompetent to stand trial may be involuntarily medicated under some circumstances but not others, thus striking a balance between the defendant's autonomy and right to be free from unwarranted treatment and the state's interest in restoring an incompetent defendant to fitness for trial (Heilbrun and Kramer 2005). Some scholars also have made recommendations for clinicians working with defendants such as Sell to optimise patient engagement, maximise autonomy in treatment, and restore the person to fitness (Heilbrun and Kramer 2005).

10.4.1 Psychiatric Advance Directives

Psychiatric advance directives (PADs) have been debated intensely since the 1980s. Over the past few years, a growing number of articles have focused not only on general ethical questions but also on matters of implementation, as advance directives have become increasingly widespread in institutions such as hospitals, including forensic psychiatric settings, and nursing homes (Lack et al. 2014; Appelbaum 2004). The issues arising depend on various contextual factors, such as the legal framework and the attitudes of health professionals regarding patient autonomy and its limits. Psychiatric advance directives attempt to strike a balance between paternalism and autonomy, allowing patients to identify and appoint another person to make decisions regarding treatment; all to take effect should patients later become incompetent to make decisions for themselves. Advance directives are intended to facilitate, in the event of future incapacity, discussion, and negotiation between clinicians and treatment providers regarding treatment options (Srebnik et al. 2005; Swanson et al. 2008; Elbogen et al. 2006). All US states presently have statutes that govern the use of advance directives which can be applied to general medical and psychiatric care, and many states now have special provisions for advance directives for psychiatric care per se (Appelbaum 2004).

Empirical studies demonstrate that PADs most frequently concern issues pertaining to preferred medications and unwanted medications, preferred alternatives to hospitalisation, psychiatric crises de-escalating preferred strategies and refusal of Electroconvulsive therapy (Srebnik et al. 2005). In addition to the advance directive, 57 % of the participants explicitly stated that they wished their directive to be irrevocable during periods of incapacity.

In the same study, and in contrast to the frequently expressed reservations of European psychiatrists towards advance directives, empirical studies from the USA paint a more positive picture: for 95 % of PADs, the patients' treatment preferences were rated by psychiatrists as feasible, useful, and consistent with practice standards (Srebnik et al. 2005).

Another US study that demonstrated success in treatment can be achieved by educating and informing patients about psychiatric advance directives. Swanson et

al. (2007) found that facilitated sessions increased the number of advance directives completed by patients. The specific information on treatment preferences given in the directives was rated by psychiatrists as consistent with standards of community practice and indicated the acceptance by a majority of patients and physicians alike of PADs as valuable and ethical vehicles to promote patient engagement and autonomy in treatment decisions (Swanson et al. 2006).

However, as Swanson et al. (2006) have pointed out, PADs are embedded in larger structures of mental health law and policy "*that protect the interests of parties other than the patient, and which, in situations of conflict involving the treatment of incapacitated patients, tend to favour the clinician's professional judgment over the patient's manifest wishes to avoid standard treatment*" (p. 392). Thus, PADs are superseded by civil commitment law in the USA and may also be legally overridden by clinicians. Psychiatrists who believe that they are acting in good faith may consider PADs to be ethically problematic since the person may not, when signing the legally binding PAD, have considered the specific affliction and treatment options for the condition that now has resulted in incapacity and for which effective treatment is available. Barriers to implementation, compliance and acceptance include ethical, clinical, fiscal and, in some jurisdictions, judicial ones with respect to the legal status of certain patients, and these barriers have been discussed in the general as well as forensic mental field (Mautner et al. 2014; Mossman and Luddington 2012; Srebnik and Russo 2008; Swanson et al. 2008; Van Dorn et al. 2008; Vuckovich 2003). Some commentators also have recommended strategies to reduce barriers to implementation (Van Dorn et al. 2008) and guidance regarding the legal requirements and circumstances when PADs may be ignored (Mossman and Luddington 2012).

Ambrosini and Crocker (2007) reviewed the scientific literature on involuntary treatment and PADs in the Canadian context. Having reviewed the sparse literature and the respective provincial legislation, the authors concluded that before PADs can be embedded fully and widely in Canada, empirical research is needed on the perceptions of various stakeholders in the legal and mental health profession. It is possible that disparate views among patients, clinicians, and the legal profession regarding PADs are related to provincial mental health legislation, discordant opinions that may present a barrier to more widespread acceptance. Society's view of people with mental illness has, however, changed dramatically in Canada over the years and the courts have since the 1990s moved away from a more traditional paternalistic stance regarding consent for treatment issues towards greater emphasis on personal autonomy, despite the presence of mental illness. The further introduction of PADs may generate a respectful attitude and greater legal protection for the autonomous rights of people with mental illness while recognising that individual rights must be balanced with the obligations of mental health professionals to deliver appropriate medical treatment. Legal limitations to PADs, like in the USA, are a reality. For example, the *Criminal Code of Canada* requires that all persons found unfit to stand trial receive the necessary treatment to restore fitness, thus rendering moot the patient's opinion regarding the need for treatment (Canadian Criminal Code 1985). While this section of the Criminal Code

does not apply to those designated NCR, in British Columbia, the mental health act includes a "deemed consent" provision for all those ordered by a court into hospital for treatment (i.e. those found unfit or NCR), thus avoiding potential accusations of "warehousing" persons with mental illness (BC Ministry of Health 2005). As discussed earlier, all provinces have legal mechanisms for the review of treatment refusal and the Canadian judiciary, similar to the USA context, is receptive to the views and recommendations of physicians whose intentions are grounded in ethical and person centred models of care.

10.5 Coercion, Legal Leverage, and Treatment Pressures in the Community

The debate concerning non-consensual community based mental health treatment continues to engage clinicians, scholars, lawyers, decision makers, bio-ethicists, and the judiciary. Apart from a growing emphasis on human rights, public safety concerns regarding community treatment and the evolving nature of the clinician–patient relationship represent two major drivers of this discourse (Szmukler and Appelbaum 2008).

Public safety concerns relate to whether mental health services can be provided in the community in a manner that considers and accommodates community interests, while safeguarding as far as is possible, the civil liberty interests of the person living with psychiatric illness. In the North American context, as elsewhere, the movement towards community based treatment has sought to integrate clinical excellence and public security in models that also aim at maximising the patient's degree of autonomy and freedom from coercion. Part of this debate has been linguistic and informed by moral philosophy, seeking to find language that is sufficiently nuanced so as to reflect the aspirational, person centred, altruistic, and yet, ultimately paternalistic and coercive nature of this movement (Anestis and Carbonell 2014; Backlar et al. 2002; McKenzie 2008; Moser and Bond 2009; Szmukler and Appelbaum 2008; Mullen et al. 2006; Newton-Howes and Mullen 2011; O'Reilly 2004; Pouncey and Lukens 2010; Simpson and Penney 2011; Swanson et al. 2001; Vuckovich and Artinian 2005; Wynn 2006; Livingston 2012; Pinfold 2001).

These provisions are changing the nature of the relationship between clinicians and patients. Assertive community treatment, compulsory community treatment (CCT), community treatment orders (CTO), conditional release dispositions, and the extended leave provisions of MHAs bring care to the patient at home or to a community clinic and aim to ensure that engagement is maintained even when the patient's desire to continue treatment falters.

Especially in the context of the latter, we propose use of the more neutral term, "treatment pressures", instead of "coercion"; this covers a (Szmukler and Appelbaum 2008) range of interventions aimed at inducing reluctant patients to accept treatment, with "coercion" reserved for specific types of pressure (i.e. with

limited regard for patient wishes). Pressures to accept treatment occur in the context of complex and ever-changing relationships between clinicians and patients, and the inherent influence of the clinician on the patient may further be quantified in terms of, for example, purposeful intensity, where the safety of the patient or others is urgent or significant. Szmukler and Appelbaum (2008) proposed a spectrum of pressures in mental health that would be applicable also to forensic psychiatric settings:

1. Persuasion, i.e. an appeal to reason and the emotions involving a discussion with the patient that revolves around an arguably realistic appraisal of the benefits and risks of treatment. There is a respect for the patient's arguments, and the treatment is discussed in the context of his or her value system.
2. Interpersonal leverage: The clinician utilises his or her relationship with the patient that is broader and more intimate than the traditional one and uses "interpersonal pressure" to secure the patient's agreement or consent. The patient may wish to please someone who has proved helpful or react to signs of disappointment in the clinician when a treatment suggestion is rejected.
3. Inducements: the offer of benefits, gains, or advantages should the patient agree or consent.
4. Threats: inducements and threats both involve biconditional propositions. *If* the patient accepts treatment A, *then* the clinician will do X; or *if* the patient does not accept treatment A, *then* the clinician will not do X (or do Y). As Szmukler and Appelbaum (2008) suggest, the term *coercion* is best considered and reserved to action of this nature.

This is a useful frame within which to articulate the philosophical, ethical, clinical, and legal components of the debate; however, a detailed treatment of these issues in the North American context is beyond the scope of this chapter. In terms of brief commentary, scholars have argued that while many philosophers regard "coercion" as "lexically normative", this understanding of "coercion" is overly restrictive and that a non-evaluative, "*descriptive account allows the separation of the normative judgment from the identification of the phenomenon thereby described*" (Rhodes 2000). Even in forensic psychiatric contexts where the person's decisions often are described as being the result of "coercion", the person/patient/coercee contemplates alternatives prior to acting, even if the alternatives consist only of doing something or not doing it. The notion that coercion does not involve a choice being made by the coerced person is nonsensical, yet pervasive in clinical, ethical, and legal discourse. Philosophers who maintain that coercion involves forcing persons against their will to perform or refrain from actions and deny that a choice was made, have to provide a comprehensible notion of a forced choice (Rhodes 2000). It therefore has been argued that what should count as "coercive" is the perceived threat entailed in a proposal regardless of the pre-proposal situation (Rhodes 2000) and that it is the person's "*belief about what is the case that motivates his choice of action or non-action rather than what actually is the case*". At issue is the extent to which such autonomous agency can be said to

have found new or meaningful (personally satisfying) expression within the context of legally sanctioned containment or compulsory community treatment.

10.5.1 Community Treatment Orders

Community treatment orders (CTOs) or Compulsory community treatments (CCTs) refer to compulsory psychiatric treatment delivered in the community and may be clinician-generated or court ordered. CTOs and CCTs, whether court ordered or physician generated, constitute an important aspect of the legal regulation of psychiatric practice. They may be perceived as a form of coerced compliance with treatment and supervision requirements since they enable community tenure in preference to enforced hospitalisation. While CCTs and CTOs constitute arrangements that are broader than what typically is deemed "forensic", the diminution of the person's ability to exercise freedom of choice as an autonomous agent renders relevant here the issues of coercion and consent (Kisely and Campbell 2014; Newton-Howes and Mullen 2011; Chaimowitz 2004; Hiday 1992; Monahan et al. 2005; Moser and Bond 2009; Stefan 1987; Swartz and Swanson 2004; Swartz et al. 2006).

The policies and institutional practices developed to care for people with mental illnesses, especially those whose compliance is compelled by statute, have critical relevance to the generation, minimisation, or avoidance of coercion and stigma (Torrey and Zdanowicz 2001; Torrey and Kaplan 1995). Similarly, judicious use of coercion may reduce stigma in the longer term because it facilitates treatment engagement and aides in symptom reduction. Others argue to the contrary that coercion enhances stigmatisation resulting in lowered self-esteem, a compromised quality of life and increased symptoms. In a North American study that examined these competing perspectives in a longitudinal study of 184 people with serious mental illness, 76 of whom were court ordered to outpatient treatment and 108 who were not, Link et al. (2008) found that improvements in symptoms led to improvements in social functioning. Also consistent with this perspective, assignment to mandated outpatient treatment was associated with better functioning and enhanced quality of life. Nevertheless, the study also found that self-reported coercion increased stigma (perceived devaluation–discrimination), that eroded quality of life and resulted in lower self-esteem. In order for involuntary community based treatment to achieve maximum benefit, while reducing or avoiding the detrimental effects of such services, the authors recommend that future policy needs to find ways to insure that people who need treatment receive it and in a manner that minimises circumstances that induce perceptions of coercion (Link et al. 2008, 2011).

Unsurprisingly, compulsory psychiatric treatment in the community continues to be a major topic of study, debate, and legislative activity in many countries, including in the USA and in Canada. In New Zealand and some Australian states, compulsory treatment in the community has been in place for decades and some jurisdictions, including Canada, require that all psychiatric treatment be delivered

in the least restrictive setting, that is, in the community, with involuntary hospital treatment reserved for exceptional circumstances (McIvor 1998). While the clinical intent of CCTs is to relieve suffering and reduce relapses and re-hospitalisations, CCTs also exemplify the moral and legal principle of the least restrictive setting, a principle enshrined in the *Canadian Charter of Rights and Freedoms*. This principle suggests that people should not have their decision making rights unduly curtailed and be detained in a hospital to receive treatment that can be safely provided in the community. The respective Canadian provincial CCT provisions, however, all require a previous in-patient detention and thus honour only in part the principle of the least restrictive setting. As Gray and O'Reilly (2005) correctly assert, provisions that do not require a previous in-patient detention (e.g. Australasia) are more aligned with this fundamental principle. Canada, with 12 different mental health acts (ten provinces, three territories with two using the same act) and a population of 34 million, provides considerable diversity in its approaches to compulsory community treatment (CCT) (Gray and O'Reilly 2005). Most Canadian jurisdictions have incorporated community treatment provisions into their MHAs, with legal support available to the person and safeguards to ensure due and transparent process with opportunity for appeal (Mfoafo-M'Carthy and Williams 2010). Given the continuing changes from an institutional model to a community model of service delivery that is occurring in Canada, it seems likely that all jurisdictions will develop some form of compulsory community treatment provision. Canadian compulsory community treatment, at present, cannot be accessed unless there is a history of at least one in-patient admission. Thus, a person with a first episode of psychosis in need of involuntary services can only receive these services in hospital. In contrast, in Australia, New Zealand, and some US states, a less restrictive approach enables a clinically informed decision whether community or hospital based treatment is most appropriate. As Gray and O'Reilly (2005) state, given the broad admission criteria in a number of Canadian jurisdictions, including likelihood of significant mental or physical deterioration, the possibility of permitting a criterion to initiate compulsory community treatment directly would seem easily addressed in mental health act legislation (Gray and O'Reilly 2005).

Consequences of non-adherence to the conditions of the compulsory community treatment provisions varies widely across North America. In some US states, there are no consequences (Torrey and Kaplan 1995) while in Canada non-adherence may result in apprehension of the person who is then examined involuntarily to determine if certification and involuntary admission are warranted (e.g. *Ontario Mental Health Act,* s. 33.3) or a direct return to hospital without a re-examination of their admissibility.

In a review of the Ontario experience with CCTs, Hunt et al. (2007) compared the impact of a CTOs on individuals. On exit from the intensive case management program, individuals with a CTO were compared to individuals without a CTO on sociodemographic and clinical variables, hospital use, and continued health service engagement (immediately post admission and 6 months post admission). Although reduction in hospital use was noted for both groups, the CTO group displayed a

significantly higher reduction in cumulative inpatient days per hospital admission. This same group also had a significantly greater reduction in hospital admissions during the 6-month post admission follow-up, and was significantly more likely to continue with ongoing medical supervision when their CTO had expired, than the comparison group. This study demonstrated that CTOs are helpful in assisting individuals who historically refused services to remain engaged with treatment and support services (Hunt et al. 2007).

10.5.2 Specialty Courts

An increasingly widespread approach to reducing criminal justice involvement of persons with mental disorders and/or substance use difficulties is mental health courts (MHCs), drug courts (DCs), and community courts (CCs) (Redlich et al. 2012; Castellano and Anderson 2013; Desmond and Lenz 2010). The aim of these rapidly expanding therapeutic jurisprudential institutions is to reduce criminal behaviour, prevent recidivism, and additionally promote personal well-being through judicially facilitated social services support and treatment (Almquist et al. 2009). The number of MHCs across the United States of America and Canada has expanded significantly with more than 400 (including more than 50 juvenile MHCs) across the United States alone (Goodale et al. 2013). MHCs initially targeted only those charged with minor, misdemeanour offences; however, recent trends have included inclusion of more serious, felony offences (Steadman et al. 2005). Participation in the specialty courts is voluntary; however, as discussed above, the degree of personal agency in being able to make a decision free from actual or perceived coercion is a relevant question. Participants agree to follow a judicially supervised treatment plan, with the expectation of a reduction in charges or mitigation in sentence severity, understanding that non-adherence to the provided treatment plan may result in more severe legal consequences than the initial outcome (i.e. regular court proceedings).

Although the structure and functional operations of specialty courts, including MHCs, vary across jurisdictions, three guiding principles underpin the philosophy: a problem-solving orientation, collaboration between and across legal, clinical, and social disciplines, and a focus on accountability (Porter et al. 2010). Shared characteristics typically include having a designated judge (and usually designated prosecution and defence attorneys), adopting a non-adversarial team approach in which criminal justice and mental health professionals share decision making (Almquist et al. 2009).

An important study, albeit with a relatively small sample size (Munetz et al. 2014), examined levels of perceived coercion, procedural justice and the impact of MHC or assisted outpatient treatment (AOT) among participants in a community treatment service in Ohio, USA. Results indicated that MHC participants ($N = 35$) felt more respected and had more positive feelings about the program than did AOT participants ($N = 17$). No significant difference was found between MHC and AOT participants in perceptions of procedural justice in

interactions with their case managers. MHC participants felt more respected and had more positive feelings about the program than did AOT participants. The findings suggest that judges and case managers can affect participants' perceptions of these programs by the degree to which they demonstrate procedural justice, a process that may affect the long-term effects of the programs on individuals. Important research is awaited regarding the extent to which participants feel that their decision to participate in MHCs was voluntary and free from overt or perceived coercion (Munetz et al. 2014).

A major concern of advocates for justice-involved persons with mental illness is that enrolment in MHCs entails elements of coercion with limited information or understanding by participants of the voluntary nature of the court. An earlier examination of the perception of voluntariness, knowingness, and legal competence among 200 newly enrolled MHC participants indicated that most participants reported that enrolment was a choice, but most were unaware of the voluntary nature or requirements of the MHC (Redlich et al. 2010a).

While results are uneven regarding the effectiveness of individual MHCs in reducing recidivism (Cross 2011; Anestis and Carbonell 2014; Sarteschi et al. 2011; Greene 2014; Hiday et al. 2013), a recent review of over 400 MHCs indicated that the specialty courts are indeed meeting the stated goal of reducing recidivism (Goodale et al. 2013).

The MacArthur Mental Health Court Study is a prospective, longitudinal, quasi-experimental four-site study that compares behavioural health and public safety outcomes for MHC ($N = 447$) participants with a "treatment as usual" (TAU = 600) jail sample; final results are awaited (Details available at http://gainscenter.samhsa.gov/judgescourts/courtsjudges.asp). A comparison of the MHC and TAU group in the MacArthur Mental Health Court Study was completed on a number of outcome variables including annualised arrests, jail days, amount, or "dose" of treatment, time to community treatment, and use of incentives and sanctions. Findings strongly endorse the conclusion that MHCs lower post-enrolment recidivism, even after court supervision has ended (Steadman et al. 2011; Redlich et al. 2010b, 2012; Goodale et al. 2013) with significantly fewer post-enrolment jail days than in the comparison group (Steadman et al. 2011; Redlich et al. 2010b, 2012; Goodale et al. 2013). Participants charged with more serious crimes such as those involving a victim are less likely to be rearrested than those charged with less serious crimes such as drug offences.

Regarding treatment engagement, 1-year post engagement, MHC, participants have more intensive and therapeutic treatment episodes and access community treatment more quickly than do the comparison group. This strongly supports one of the major goals of MHCs. The study found no relationship between the type of treatment intervention received (or not) and rearrest.

With respect to cost efficiency, the MacArthur Mental Health Court Study examined the treatment and criminal justice costs of MHCs in comparison to usual criminal justice processing of persons with mental illness. Results indicated that MHC participants are more costly both before and after MHC enrolment than

the comparison group, but also found that higher costs correlated positively with higher service and treatment needs.

These results provide early, positive indications that the implementation of specialty courts, especially MHCs, constitutes a viable and effective way to engage participants without the use of overt coercive measures, in a voluntary, problem solving based alternative to traditional court systems. Because the number of MHCs that include individuals with histories of felony charges or violence is expanding, further research is needed on whether courts that accept higher-risk participants (and thus with greater incentive for participation) can operate without compromising public safety.

10.6 Conclusion

The nature and challenges of coercive practices in forensic mental healthcare in North American parallel largely those in Europe, with advocates for the interests of those with mental illness expressing concern regarding paternalism and the erosion of personal autonomy. Such concerns traditionally focused on hospital practices of involuntary admission, forced medication, seclusion, and restraint. The evolution of community based judicial and clinical interventions treatment such as MHCs and compulsory community treatment orders has brought appropriate attention to the degree that societal preferences have sought to balance the individual's right to be free from coercion and public safety concerns. It is entirely proper that societies that proclaim to be free, fair, and just in their treatment of their citizens require rigorous oversight mechanisms to protect the individual's right to due process, safe, and effective treatment and that involuntary and restrictive treatment measures be employed only when less coercive interventions have failed. A review of the research of these issues in the North American context suggests that while more can always be done and that some degree of perceived coercion is an inevitable aspect of forensic mental healthcare, much has been achieved to mitigate concerns and assist patients and clients in their recovery.

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The Use of Coercion in Prison Settings

11

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Abstract

Coercive measures are widely used in general psychiatry as well as in forensic and prison psychiatry. In this chapter, we describe the use of coercive measures in prison psychiatry, focusing on restrictive measures (restraint and seclusion) and forced medication as opposed to involuntary admission. We recommend some implementation principles as well as how to prevent some complications (side effects of use of restrictive measures). We also discuss prevention of the misuse of coercive measures. These recommendations have the aim of giving a practical approach that could be applied in most countries, especially those with a less developed prison health service. A limitation of our recommendations is

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that the authors' opinions could be influenced (clinically and legally) by the authors' countries (Spain and the Netherlands). Finally, some general conclusions are given about coercive measures, mainly training and implementation of projects to reduce these kinds of measures and reduce stigma of patients and protect human rights.

11.1 Introduction

The high prevalence of mental disorder in prison has been widely described in the last few years (Fazel and Danesh 2002; Fazel and Seewald 2012; Arboleda-Flórez 2009), and there is a gradual increase in interest, both by psychiatrists and managers in prisons to provide adequate mental healthcare provision for prisoners. The services provided to prisoners vary depending on each country's healthcare system and range from mental health consultations (by psychiatrists or nurses) and in-reach teams to prison psychiatry services (with clinics and hospitals).

Prison itself is a coercive measure used by society to detain people who offend (mainly serious offences) in all the countries. There is a wide variation of penal laws, and services are as varied as the respective countries. This means that it is difficult to find many similarities in these services. This also applies to the health services in general and psychiatric services in particular. The clinical and legal framework regarding the implementation of coercive measures in Europe also varies widely (Kallert et al. 2007). Raboch et al. (2010), in the EUNOMIA (European Evaluation of Coercion in Psychiatry and Harmonisation of Best Clinical Practise) study, found that the percentage of patients subject to coercive measures varies between 21 and 59 % with the most frequently used coercive measure being forced medication.

In Western countries, there are some recommendations for mental health in the prison system (provided by the health organizations and mental health professional associations) in an effort to protect mentally ill offenders housed in prison. Principles of equivalent care with community services are, however, more an aspiration than a reality, despite an increase of provision of mental health services to prisoners in recent years. For instance, in the Netherlands, as in most of the developed countries, much effort is made to deliver psychiatric care comparable to psychiatric care in society within the prison. One of the leading principles is to offer detainees psychiatric care in general psychiatric services unless this proves impossible for some reason, for example a sentence that has to be served in prison or the inability of general psychiatry to offer adequate facilities, for example due to extreme violent or disruptive behavior. Similar principles apply to most European countries.

Despite many recommendations regarding care to prisoners with mental disorders (Konrad et al. 2006; Konrad 2013), these guidelines do not address the use of restrictive measures. Coercive measures used are hardly described in the main prison psychiatry books (Wilson and Cumming 2010; Fagan and Ax 2011). In fact, only in the last few years restrictive measures have been a topic described in the medical literature though mainly related to human rights and ethical issues than

from a medical point of view. Despite the wide use in medicine, there are therefore not many national or international recommendations/procedures addressing this topic. The procedures are more described on a local/regional basis (for instance Padros et al. 2013).

In prison, the topic of coercive measures is of paramount importance not least because of the obligations of governments with regard to custodial settings. Some procedures governing these measures are, however, more focused on terms of safeguarding the prison services than directed towards patient's rights and needs. Furthermore, as noted above, the medical literature about coercive measures in general and forensic psychiatric settings is scarce (Steinert et al. 2010) and in prison settings nearly absent. In some countries such as the Netherlands or Spain, psychiatric care in prison is organized in the so-called penitentiary psychiatric centers (PPC), located within prison facilities and in prison mental health clinics. The PPCs can be compared to a psychiatric unit but within a prison. Because it is part of the prison system, penitentiary law applies but psychiatric care is also subject to the same laws and rules that apply in general psychiatry.

Probably the lack of relevant publications on the use of coercive measures has several explanations. Firstly, coercive measures are not a fashionable topic between psychiatrists. Secondly, prison governors tend to avoid publishing data regarding coercive measures, and hence these data are not easily available. Lastly, the publication of such data could worsen the stigma of offenders with mental illness. From our point of view, however, studying such data could help to prevent and reduce the application of these measures. On the other hand, the prevention and reduction of the use of coercive measures is a much debated subject in some countries (for instance in the Netherlands or UK, both in general psychiatry and forensic psychiatry). Much effort is made to achieve this goal. It is interesting to know that in the Netherlands, e.g., all data concerning the use of coercive measures are available to the Ministry of Justice and to the regulatory health institutions. They are used by the PPCs to evaluate on a regular basis the effect of measures and to reduce coercive measures in forensic psychiatry.

In this chapter, we will focus on coercive measures related to prison psychiatric settings, rather than the coercive measures used to manage behavioral problems in inmates who have no mental illness. Frequently in prison psychiatric units, interventions are used that may lead to the implementation of measures and procedures to restrict the movement of people we serve. Of course, psychiatric care in prison has to be delivered literally and figuratively speaking within the prison walls. This, however, does not prevent the application of the same best practice as is used in general and forensic psychiatry settings. Restrictive procedures are included as standard of care more based on consensus though than evidence-based proof. On the whole, the benefits must exceed the iatrogenic consequences such as potential and severe physical, psychological, ethical, and legal impact.

Undoubtedly, the restriction of movement represents a confrontation between the ethical principles of autonomy (limiting the freedom of a patient against their will) and beneficence (well-intentioned desire to protect patient health, the

environment, and the safety of others). An application based solely on coercive authoritarianism violates also the principle of non-maleficence.

The isolation or physical/mechanical restraint of a patient is a last resort that should be used only when all other measures have failed to control the situation, that must prioritize the protection of patients, due to the emergence of risks to himself, to others, or to the physical environment. These clinical situations increase workload and require a large investment of time and personnel, given that these are situations in which the patient is highly vulnerable and highly dependent. The use of restrictive measures can be seen as the equivalent of intensive care in the general health system.

In Spain, the application of restrictive measures in the prison environment is governed by the articles of the Prison Regulations; they must be governed by the principles of necessity, proportionality, and least restrictive intervention according to Articles 71 and 72: "The security measures shall be governed by the principles of necessity and proportionality and must always be carried out with due respect for the dignity and fundamental rights of the person and shall apply only when there is no other way to achieve the purpose of security and only for as long as time strictly necessary." Furthermore, the characteristics of the population assisted in psychiatric units, and the use of these measures is directly linked to the implementation of Article 188.3 which states: "The use of coercive means is an exception which can only be accepted by the physician for the minimum time necessary before the effect of pharmacological treatment is realized, and the dignity of the person must be respected at all times." Even assuming that from a medical point of view, it is considered that there is no alternative to the application of the coercive measure; the measure must be reported promptly to the judicial authority.

11.2 Coercive Measures

In prison, there are a variety of coercive measures in use that are similar to those applied in general and forensic psychiatry. These include:

- Seclusion
- Mechanical/physical restraint
- Administering medication against a patient's will (forced medication)
- Involuntary/compulsory admission

There are some issues that are specific to prison settings to be considered, such as hunger strike, death row prisoners, and self-injuries (no related mental illness).

Other coercive measures, such as forced feeding, are not considered in this chapter, however, as they are mainly relevant to prison medical officers rather than psychiatrists. Forced feeding will be considered only if it is related to cases when people stop eating due to psychiatric symptoms such as delusional thinking or suicidal ideation.

11.2.1 Definitions

11.2.1.1 Restrictive Measures

Generally by "restrictive measures," we mean procedures that reduce or limit the freedom of movement of the patient: Seclusion and physical or mechanical restraint.

11.2.1.2 Seclusion

Placement of a person alone in a room or space, particularly with additional protective measures, for a period of time. In some countries, e.g., in the Netherlands, seclusion is defined as remaining in a specially designed seclusion room.

11.2.1.3 Segregation (E.g., Time-Out)

The restriction of mobility of patients within a defined space (room, special areas, etc.) with opportunities for observation. This is used if the mental state is unstable and integration with the peer group is not feasible. It is a restrictive measure that will be applied when the level of disorganization, agitation, or aggression does not require physical/mechanical restraint, but the patient has to be prevented from living with the rest of their peer group. The measure allows control of the patient in an environment of minimal risk. In the Netherlands, time-out is defined as remaining in one's own cell for a limited period of time.

11.2.1.4 Physical Restraint

Using physical processes aimed at limiting the movements of part or all of the person's body in order to monitor their physical activity and protecting them from injury while there is a risk that may result in harm to others, to themselves, or to the environment.

11.2.1.5 Mechanical Restraint

Procedure that restrains the patient by using a mechanical device, while there is a risk that may result in harm to others, to themselves, or to the environment.

11.2.2 Use and Misuse

In the Netherlands, mechanical restraint is subject to strict regulations such as regular observations, evaluations, and, arguably the most important of all, the application of the four eyes principle, i.e., two professionals advice to use and to continue mechanical restraint independently. The director of the facility decides on the measure. The decision to continue the use of mechanical restraint can be taken for no longer than 24 h so has to be decided on again after that period. In Spain,

mechanical restraint is also subject to regular observations and should be stopped as soon as possible after the physician has assessed that the risk has ceased.

Physical and/or mechanical restraint is the last resource used in extreme situations to ensure the safety of the patient or others. It is an exceptional procedure subject to clinical indications.

Restrictive measures will be used prioritizing the benefit of the patient and not by lack of resources or professional comfort. Besides prioritizing the benefit of the patient, the safety of other patients, staff, and the environment has to be considered.

Sailas and Fenton (2008), in a Cochrane Review, found there were no control studies that assess the value of seclusion or restraint in people with a severe mental disorder. However, reports using qualitative research methods of these techniques describe severe side effects. They recommend the development of alternative ways of treating undesirable behavior. The authors suggest that due to the lack of controlled studies, no recommendation about effectiveness, the benefits, or harm of coercive measures can be made. The only recommendation was to reduce the use of these measures as much as possible for ethical reasons. They also recommend randomized studies to evaluate the benefits or harm and to compare to pharmacological and non-pharmacological procedures to control behavioral disturbance. Although unpleasant, pharmacological methods could be a safe and practical procedure. It could also be helpful to ask the opinion of the patient regarding what their intervention of choice would be if their mental state deteriorated.

One of the problems of coercive measures is their potential misuse. In order to not misuse these measures, we must not use coercive measures in the situations outlined in Table 11.1.

Table 11.1 Misuse of coercive measures

These measures must not be used in the following situations
• As an answer to inadequate behavior
• As a punishment for a transgression
• As an answer to medication refusal while other alternatives can be used
• As a treatment substitute
• If there is a therapeutic alternative of similar efficacy
• At patients' demand if not indicated
• If nothing is known about the physical condition of the patient
• If there is organic etiology of the disturbance
• For convenience or staff comfort

11.2.3 Coercive Measures: Side Effects

11.2.3.1 Associated with Seclusion

Risk of self-harm Cuts, bites, burns, shock.

Risk of suicide Hanging, suffocation with a pillow, or objects obstructing airways, phlebotomy, or arteriotomy.

Preventive measures:

Room layout and furnishing
- Ensure absence of ligature points (curtain rails, etc.).
- Remove obstacles or any material that could be used as dangerous objects: nails, fixtures, wiring, etc.
- Furniture without corners or pronounced edges and, if necessary, fixed to the ground.
- Have the bed as low as possible and set to the ground.
- Bathrooms locked.
- Doors to open outwards.
- Shatter proof glass.
- If medical devices (O_2, suction, etc.) are needed, they should be well protected.
- Monitor sheets, curtains, and other fabric as they can be used for choking.

Patient
- Make sure patient does not have any dangerous objects on them (lighters, blades, belts, glasses, dentures, etc.).
- Monitor clothes as they can be used for choking.

Procedures
- Appropriate environmental temperature: It is very important that the temperature of the room is adequate because the thermoregulatory body system can be affected by antipsychotic drugs.
- Ensure that windows remain locked.
- If you need sharp objects for cleaning (scissors for cutting nails, razor blades, etc.), use them under direct supervision of nursing staff.
- In the case of eating implements offer disposable trays, knife and fork, and paper or plastic cups.
- Consider the use of surveillance cameras.

In the Netherlands and other countries, specific soft material furniture is used in seclusion rooms. Patients in seclusion have to wear clothing considered safe for tearing (“protective clothing”).

11.2.3.2 Associated with Mechanical Restraint

Given the potential of complications, a doctor must immediately be notified so he or she can assess the patient, and this assessment will be recorded in the medical record frequent observations and keeping records should be mandatory.

Risk of injury Fractures, dislocations, swelling, bruising, nerve compression.

Preventive measures
- Evaluate the mechanical factors: pressure and fasteners.
- Ensure proper placement of fasteners: the degree of compression (neither excessive nor insufficient pressure). It should not hurt.

Respiratory risk Bronchial aspiration: strangulation, respiratory infection.

Preventive measures
- Maintain body alignment
- Patient should be in supine position with the head at 30° and no obstruction to breathing.
- Raise upper body for 1 h after a meal.

Vascular risk Pulmonary embolism (PE), deep vein thrombosis, peripheral ischemia, stroke, myocardial infarction, pulmonary edema.

Preventive measures
- Free one end of device for 30 min at each time, especially in older people.
- Prophylaxis with low molecular weight heparin (LMWH) once mechanical fastening is initiated.

Risk of damage to skin integrity Pressure ulcers, skin wounds.

Preventive measures
- Observe extremities.
- Allow, as much as possible, postural changes.
- Use a pillow or other soft surface at the points of support, protecting areas of risk.
- Change wet or stained fasteners to prevent lacerations of the skin.
- Apply moisturizing.

Risk of constipation Pain and fecal impaction.

Preventive measures
- Control.
- Hygienic measures.
- Facilitate normal defecation.

Urinary risk Dysuria, retention,

Preventive measures
– Control.
– Facilitate the use of the toilet to the extent possible.

Psychological risk Fear/panic, shame, anger, depression, aggressiveness, apathy.

Preventive measures
Close contact with mental health workers and psychological support.

11.3 Coercive Measures in Prison Psychiatry

As said above, there is scarce literature regarding the use of coercive measures in prison settings. It is easy to forget that some mentally ill offenders are difficult to treat in the community (general hospitals, forensic settings, etc.) and are sent back to prison for treatment by prison psychiatrists because therapeutic options have failed (for several reasons such as lack of cooperation of the patient, lack of efficacy of therapeutic approaches, etc.).

In prison psychiatry, the use of the coercive measures should follow the same indications as in general or forensic psychiatric hospitals, but some pressure exists because prisoners are also individuals under the care of penitentiary services. This is a classical confrontation between prison (security culture) and health services (health culture).

Sometimes, the psychiatric proceedings when applying these kinds of measures overlap with prison regulations. For instance, in Spain, inmates for whom mechanical restraint is used are dealt with through medical regulations as well as security prison proceedings, and the prison governors have to be informed of an inmate requiring coercive measures. The prison governor has to inform a Magistrate who has the duty to ensure that the rights of the prisoners are fulfilled. Another example comes from the Netherlands where it is not the psychiatrist who decides about the use of involuntary medication but the prison governor, after being advised to do so by one or two psychiatrists, depending on the specific procedure. The regulatory health authorities as well as the Ministry of Justice are informed about the application of forced medication.

The use of forced medication in the Netherlands is regulated in penitentiary law but closely mirrors rulings in general psychiatry. Avoiding too many details, two procedures can, however, be discerned. In very urgent cases, the decision to use forced medication can be taken by the prison governor, advised by the psychiatrist, if necessary to avoid serious harm to the prisoner or others, even if there is no clear relation between danger and psychiatric disorder; this is regulated in penitentiary law. In all other cases, a relationship between psychiatric disorder and the danger to

be managed by the coercive measure has to be established. In less urgent cases, the so-called a-procedure has to be used; in more urgent cases, the so-called b-procedure can be used, both regulated in health law. The most important differences between the two procedures are the obligation of a second opinion of an independent psychiatrist and the obligation to inform a lawyer and supervising council in case of the a-procedure, and the time frame, which can amount up to 2 weeks between the first decision and the application of forced medication in this less urgent procedure. This is to guarantee the patient the possibility to object to the decision. In the case of the b-procedure, the advice of the treating psychiatrist suffices and forced medication can be applied instantly.

In both procedures, the decision has to comply with the principles of subsidiarity (is there a less intrusive option available?), proportionality (is the measure justified by and in proportion to the danger to be avoided?), and efficacy (can it be expected that it serves to avoid or reduce the danger?). In all cases, the use of forced medication has to be supervised by skilled medical personal at all times. All use of forced medication has to be reported to the Ministry of Justice as well as regulatory health authorities which can decide to investigate the case further.

Forced medication in the penal environment must be set in the same context as any involuntary treatment including the importance of the degree of capacity of the patient at the time of decision making of the administration of the therapeutic measure, in this case a psychotropic drug. Therefore, once the decision is made by the professional (always a physician, where medication is concerned), two questions have to be evaluated:

1. The degree of the patient's mental competence to decide about the medication.
2. The prevention of possible serious risk to the physical or mental health of the patient or others.

In Spain, there are three types of situations in the daily practice of psychiatrists where *forced medication* could be used:

Case 1 The patient is not mentally competent at the time, and administration of medication is considered urgent to prevent serious risk to the physical or mental health of the patient or others.

For this decision, consent from the patient is not required, because that would contradict the very essence of consent that is based on the mental competence of the subject to decision making. Psychiatrists must therefore still explain the measure to the patient, but if no collaboration can be established, the measure will be applied nevertheless using minimum physical force. Patients should therefore be treated with drugs if possible with the ethical and legal principle of not causing harm observed, i.e., that the benefit is greater than the harm.

Treatment should be properly recorded in medical files, including all the circumstances, such as administration against the will of the patient and recording the psychopathological examination and mental competence of the service user, which has led to the decision of the involuntary drug administration. The duration

of this measure should be the duration of the incapacity to consent of the patient only. Mental capacity of the patient should be evaluated periodically, because at the time that the patient regains capacity it is obligatory to ask for consent to continue treatment, and if the patient does not wish to continue, psychiatrists should suspend the treatment, again recording all relevant assessments and decisions comprehensively in the medical records. If the patient withdraws consent, it is recommended that the patient signs a form indicating their refusal of treatment, as this document, along with the comprehensively completed medical file, guarantees the legality of the practice.

In the event of any doubt about the consent of the patient, or in the case of high-risk drug treatments (for instance, clozapine), the body responsible for protecting the rights and guarantees of a non-competent patient is the appropriate court to consider treatment decisions. In the case of Spain, this is the Prison Supervision Court, and it would be appropriate to inform the court in writing of the administration of this drug and its risk; the court itself can request more information if needed. This is regulated in Spanish penal law in the General Penitentiary Law and Royal Act Prison Rules.

Case 2 The patient is not mentally competent at the time, and administration of medication is NOT considered urgent to prevent serious risk to the physical or mental health of the patient or others.

In this case, psychiatrists must ask for a magistrate's authorization to allow the administration of the medication from the appropriate court, in the Spanish case the Prison Supervision Court. After the psychiatric report (advice), the magistrate helped by a forensic doctor (who is different doctor from who writes the report, could review the patient) authorizes or denies such treatment.

Case 3 Patients undergo a security measure (in Spain, forensic patients with serious offences are admitted to prison psychiatric facilities).

In the criminal environment, we must address the issue, perhaps more controversial and not specifically regulated, of the obligation of treatment set out in a security measure imposed on those acquitted for not being criminally responsible at the time of having committed a crime (not guilty for reasons of insanity). The very essence of the imposition of the measure, in addition to reducing the risk, is to "submit to treatment," and "no submission" might be a cause to impose more stringent environmental measures. It can therefore be inferred, though not explicitly stated, that there is, de facto, an obligation to drug treatment if this is considered essential to comply with the provisions of the security measure. However, and ensuring guaranteed maximum patient rights, the same rules, for patients not under a security measure, apply in the event of a nonurgent treatment, i.e., authorization can be requested from the Prison Supervision Court in case of a non-consenting patient.

A situation that always requires informed consent by the patient is the use of hormonal treatment in the case of paraphilia in sex offenders, though one has to

consider that informal coercion may consist in those cases (Cosyns and Goethals 2013).

11.3.1 User's and Caregiver's Views

There are few studies that look at the experience of applying these measures from the user's and carer's point of view in prison psychiatry settings. Soinien et al. (2014) described the methodological and ethical challenges aiming to describe patients' perspectives of coercive measures. Study design, reasons for nonparticipation, difficulties in recruiting, and ethical challenges were described as the potentially confounding factors.

Katsakou et al. (2010) found that satisfaction with treatment among involuntary patients was associated with perceptions of coercions during admission and treatment, rather than with the documented (objective) extent of coercive measures. Interventions to reduce patients' perceived coercion might increase overall treatment satisfaction.

Runte-Giedel et al. (2014) described the views of inmates and caregivers but they did not reach clear consistent conclusions except that forced medication was the most frequent coercive measures, and sometimes these were accompanied by physical and verbal violence as the patient felt angry about these actions. They also concluded the need of protocols to manage patients presenting with behavioral problems. Nurse et al. (2003) also found that inmates were unhappy about verbal ill-treatment received from some staff.

11.4 Ethical Concerns

The application of restrictive measures can extend to a violation of people's rights, especially in prison settings, and this is the reason why we should make use of all protective mechanisms.

In 1983, Beauchamp and Childress published a text book on the principles of biomedical ethics in which they adopted the three principles of the Belmont Report and added a fourth principle, that of non-maleficence (Beauchamp and Childress, 1994). The four basic ethical principles that must be considered in the case of having to make use of restrictive measures are:

1. Autonomy: Respecting the decision-making capacities of autonomous persons; enabling individuals to make reasoned informed choices. "Everyone is an autonomous moral agent, has the right to make decisions about their lives and their health." So anyone who could be subject to a restrictive measure must be informed of this action and their consent, wherever possible, has to be sought, and their decision respected. If that person is not in a position to make decisions

for themselves, the information will be given go to their immediate next of kin (e.g., family) and/or guardian.

2. Justice: Distributing benefits, risks, and costs fairly; the notion that patients in similar positions should be treated in a similar manner.

   The application of a restrictive measure cannot ever be applied on a discriminatory basis by professionals and measures of care and protection have to be applied in accordance to the applicable laws.

3. Beneficence: This considers the balancing of benefits of treatment against the risks and costs; the healthcare professional should act in a way that benefits the patient.

   When it is decided to apply a restrictive measure, one must ensure that the benefits are greater than the harm and ensure the welfare of the person.

4. Non-maleficence: avoiding harm; the healthcare professional should not harm the patient. All treatments potentially involve some harm, even if minimal, but the harm should not be disproportionate to the benefits of treatment.

The indications of the practice of a restrictive measure must be clear, and they must only be applied when all the alternatives are exhausted. Of particular importance is the consideration of the issue of vulnerability. People who suffer any kind of restrictive measure have a high vulnerability and dependence, more than other patients. Their basic needs must be covered by healthcare professionals, and they must be given help in protecting their rights.

We may, in conclusion, sum up the ethic-deontological requirements to be met by an institution applying any restrictive coercive measure:

Indication
- Ensure the principle of necessity and therapeutic indication.
- Always consider less restrictive measure.
- Always has to be prescribed by a doctor.
- Documenting the indication.
- Benefit to the patient.
- Families or legal representatives of patients are informed of the procedure and, if possible, informed beforehand.

Method
- Ensuring respect for the dignity of patients.
- Respecting the privacy of individuals.
- Avoid authoritarian attitude.

Follow-up
- Ensure comprehensive review as to the proportionality of the measure.
- Limit it to the shortest period of time possible.
- Documenting the actions taken.
- Maximum patient's comfort.

Table 11.2 Implementation principles for coercive measures (Barrios-Flores 2003, 2007)

• Need • Care • Congruency • Respect Personal dignity • Respect for intimacy/privacy • Lawfulness	• Temporality • Prohibit abuse/excess • Recording of actions • Supervision/audit • Suitability of means

There are many colleagues that have highlighted the ethical problems within prison psychiatry (Pollähne 2013). Some principles specifically relevant to coercive measures are recommended by Barrios-Flores (2003, 2007), see Table 11.2.

From a medical point of view, an ethical concern not often described but nevertheless of importance is taking the decision by psychiatrists to apply coercive measures to a mentally ill patient: What is the best decision to take? An often difficult consideration in an urgent situation with only a few minutes to take a decision. The question is: If I order the application of coercive measures, is it going to benefit or harm the patient's condition? If I do not: What might be the consequences (harm to the patient or others)? All these questions have no simple answer.

11.5 Practical Approach

In cases where coercive measures are applied to a mentally ill inmate, some basic principles should be implemented (Richmond et al. 2012):

- Introduce yourself to initiate the contact.
- Use first names to initiate the interaction (if culturally appropriate and not objected to by the patient).
- Establish a therapeutic relationship and trust.
- Never speak with the patient alone; there should be at least two people present during any coercive action.
- Use an approach that is calm and provides security.
- Re-orientation in time, space, and person.
- Use clear and simple language, avoiding discussions. Give time to process information and repeat if necessary.
- Avoid defensiveness, maintain and show a calm and controlled attitude.
- Be aware of own feelings and reactions.
- Do not take the situation as a threat to you personally.
- Find out what the reasons are for any anxiety and try to address it with alternative means.
- Establish clear and precise limits to the physical or verbal aggression.
- Increase monitoring in a protective environment (restricted/safer) if you expect increased potential (auto-) _aggression.
- Explain the actions that will be performed to avoid potential aggression and fear.
- Communicate the risk to other staff members, especially security staff.

11.5.1 Nursing Care of Patients in Restrictive Measures

During the duration of the measure, the status of the person subject to the restrictive measure should be reviewed, the general physical and mental state as well as the circumstances surrounding the implementations of the measure. Monitoring will also take place in order to make a clinical decision whether to continue it or end the measure.

11.5.1.1 Guarantees Regarding the Care of the Person

1. Ensure before implementation of these measures that other valid alternatives have been tried.
2. If restraint is applied, use the least restrictive way to do so.
3. Ensure patients have all their basic needs met and receive care to prevent or minimize negative effects.
4. Ensure that the person is not isolated or marginalized as a result of the implementation of these measures.
5. Ensure termination of the measure as soon as is possible.

11.5.1.2 Individualized Evaluation of Care

The nursing staff—in a situation where coercive measures are used—has extreme control and must ensure continuous monitoring of the patient. Observations should be performed with predefined interval variables according to the clinical evolution (For instance, every 15–30 min during the first hour depending on the state of the patient, then at least every hour).

Nurses must undertake an assessment of individual needs and patient care once the procedure has been carried out and control the measures that will be implemented through a register of restrictive measures (in addition to the medical file).

The nurse must also assess and record the following:

- Vital signs: Register regularly, noting the day and time.
- Drug Administration: According to medical prescription from the doctor.
- Psychopathology: level of consciousness (an agitated patient may be administered sedative medication that can decrease their level of consciousness), orientation, attention, behavior, psychomotor coordination, language, thoughts, emotions.
- Apply and document all preventive measures described previously to avoid side effects.

Both in the Netherlands and Spain, the physician, assisted by the nurse, is responsible for the somatic health of the patient. The nursing team must complete the registration of restrictive measures.

11.5.1.3 Recording of Restrictive Measures

The restrictive measures should be, during each shift, specifying the number of hours of seclusion, the number of hours of fasteners, and the number of activities/treatments performed, always ensuring that the mechanical restraints are well placed and in perfect condition of use and maintenance.

We suggest that, when coercive measures are applied by prison wardens, nursing and medical staff should be present (because of the difference between prison and health cultures) in order to avoid any misuse. In the Netherlands, the application of coercive measures in forensic psychiatry is supervised by medical personnel, at least on an hourly base or as often as is necessary.

11.6 Conclusions

The main conclusions are summarized in Table 11.3.

The use of restrictive measures is a practice that involves ethical, clinical, and social dilemmas (Padros et al. 2013). Despite international controversies, the complete abolition of these measures has not been achieved by any country, and it seems that currently it is impossible to renounce it totally. However, there are factors that contribute to the continuation of the use of these measures, e.g., there is a belief that they cannot be eliminated unless there is a significant increase in staff; there is also a lack of knowledge of alternatives by some professionals and the fear that patients or others may suffer injuries if these measures are not applied as usual.

As outlined in this chapter, mechanical/physical restraint and seclusion should be used only in extreme cases and by applying the least restrictive interventions possible. If used, it should be done by involving both the patient personally and the patient's family or guardian in each case.

It is essential that the staff who implement these measures have proper training and know the procedures and protocols available to the institution. Training has to be directed towards mental health professionals as well as prison officers (when they are the ones who apply these measures). In some prisons, when restricting

Table 11.3 Conclusions

• Avoid stigmatization and respect human rights of the patients
• Regulations (need for national and international guidelines)
• Research (need for more research on both the application and consequences of coercive measures)
• Training (for both mental health professionals and prison wardens)
Implementation of projects to decrease or avoid the application of coercive measures

measures are implemented by prison officers, the presence of mental health staff helps to assure the respect and dignity of patients and avoid excess.

Restraints always have to be ordered by a psychiatrist or a medical officer. Only for a short time and in situations of emergency can restraints be ordered by nursing staff until the doctor can reassess the situation and continue with or terminate the measure. Forced medication has to be prescribed by a psychiatrist or a medical officer (with training in mental health).

Also, it has to be taken into account that the use of restrictive measures could worsen the stigmatization both in prison and in the community, in addition to the stigma associated with being a prisoner and a person with a mental disorder jeopardizing their social rehabilitation.

It is important to understand that there are alternatives to the use of coercive measures (Scanlan 2010) and that the scientific evidence to support their use is slim. Muralidharan and Fenton (2006), in a Cochrane review, found no evidence to support non-pharmacological alternatives to contain disturbed or violent behavior. However, we should thrive towards reducing mechanical restraint and always think of less aggressive alternatives for the patient.

There are some issues that need further attention in future discussions and research. Firstly, international basic guidelines about the use of restrictive measures ought to be developed. Because of the divergent judicial systems and rulings, this will partly depend on the introduction of new international regulations. More important still though is the development of international guidelines by the international forensic psychiatric community. Secondly, research related to the use (or misuse) of coercive measures from a clinical point of view is urgently required. Training courses of quality about the implementation of coercive measures have to be developed and implemented and should be addressed at all staff involved in the implementation of coercive measures.

We have to implement projects focusing on reducing the implementation of coercive measures in prison psychiatry (like the Beta project—Richmond et al. 2012). This project recommends ten domains to approach agitated patients and reduce coercive measures including involuntary medication.

To be acceptable from an ethical point of view, the implementation of coercive measures must meet certain requirements including:

- The least restrictive measure is used.
- The measure is not prolonged beyond what is necessary.
- The patient's dignity is respected in the proceedings, privacy, adequacy of physical and human resources.
- The patient's relatives or guardians are informed.
- Established national and local protocols are followed.

Finally, we need to remember the need of clear legislation to avoid excess and stigmatization and to preserve the dignity and human rights of these patients.

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Part III

The Experience of Coercion

Staff Attitudes Towards Seclusion and Restraint in Forensic Settings

12

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Abstract

Aggression on forensic wards occurs commonly, as 82 % of staff and 46 % of patients report having been targets of aggression (Pulsford et al. 2013). This high incidence of violence, the constant threat of violence and the knowledge of a patient's criminal history affect nursing staff. Nurses therefore have to deal with fear on a daily basis; it affects nursing care, as nurses have to deal with both fear and situations in which they must maintain control. In such situations, seclusion and restraint serve as a means to control threatening and dangerous situations.

Although the use of seclusion and restraint in forensic psychiatric settings is quite well researched, there seems to be a gap in the knowledge of the staff's attitudes towards seclusion and restraint. Personal opinions on interventions seem to be a major factor when choosing one method or the other. Regardless of the actual measure in question, the measure that is most familiar to the staff is also judged to be the safest and most preferable in clinical practice.

12.1 Forensic Psychiatry: Treatment and Protection?

Nursing in forensic psychiatry is a global and culturally bound profession. Caring processes are intertwined with the criminal justice system, and staff deal with the most vulnerable psychiatric patients. Personal maturity and interpersonal skills are

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as important as the special knowledge and tasks inherent in forensic nursing (Bowring-Lossock 2006). Empirically, this duality—to care for and to exert control over patients—is complex in the socio-professional domain. Nurses have a duty to report and punish patients' reprehensible acts (Holmes 2005). Forensic psychiatrists, whose role also includes tasks different from typical treatment settings (e.g. giving testimonies in court), require ethical precepts to guide their work: truth-telling and respect for individuals (Appelbaum 1997). In medicine, medical professionals learn to respect common prima facie moral commitments—respect for autonomy, beneficence, non-maleficence and justice—as well as an understanding for the scope of their application. These commitments offer a common moral analytical framework and language (Gillon 1995). If the basic medico-moral objective of psychiatric treatment is to benefit patients with the least harm, then, arguably, forensic psychiatry must sometimes part company from medicine, as the forensic medico-moral objective is said, primarily, to protect (benefit) the public by controlling patient behaviour (Sen et al. 2007). This complexity further complicates discussions whether to use or not to use coercive measures in forensic settings.

12.2 Seclude or Not, That's the Question

In psychiatric inpatient settings, seclusion and restraint serve as risk management strategies for controlling agitated, disturbed and violent behaviour. These practices are considered the most controlling, restrictive and coercive interventions of last resort, for use only after excluding or employing other less restrictive forms of treatment (Cleary et al. 2010). Some authors have called to commit to policies that seek to eliminate their use altogether (Glover 2005). In many organisations, reducing the use of seclusion and restraint serves as a quality-of-care indicator for hospital-based inpatient psychiatric services (Sacks and Walton 2014). Nonetheless, seclusion continues to exist in the complex environment of contemporary mental health care (Cleary et al. 2010).

Earlier studies indicate that nurses consider seclusion to be necessary, non-punitive and highly therapeutic, an opinion that differed substantially from patients' views (Meehan et al. 2004). However, recent debates and research have shifted these opinions towards a more critical view of the restrictive measures or punitive uses of coercion. Bowers et al. (2007) compared the attitudes towards containment measures of psychiatric professionals in the United Kingdom, the Netherlands, Finland and Australia. The countries showed important differences: staff in Finland expressed the highest level of approval of more restrictive measures, staff in the UK the least and those in the Netherlands occupied an in-between position. Regardless of the actual measure in question, those measures that staff considered to be good were also presumed to be safe for patients, to prevent them harming themselves or others and to quickly calm the patients. When choosing a measure to use, staff safety and patient dignity were considered less important than the expected effectiveness of the measure. In Finland, the sample

consisted entirely of professionals from forensic psychiatric hospitals, which may explain some of the findings. However, the Australian sample included both forensic and non-forensic staff, yet researchers found no differences between them. It seems therefore that the use and approval of seclusion and restraint in forensic mental health varies widely between countries. Staff gender influenced the approval of seclusion and restraint, but age did not. Women expressed approval of the use of seclusion and restraint less often than did men.

When selecting the containment method to use, national cultural values and customs may be more important than the national psychiatric system itself. Nurses' attitudes towards the causes and management of aggressive behaviour may affect their selection of interventions more than their attitude towards a particular containment measure (Berg et al. 2013; Dickens et al. 2013). In clinical practice, staff must believe in certain strategies regarding how to behave in order to achieve what one wants, and presumed efficacy and patient safety are important factors in their selection and use. Several studies have found that staff experience discomfort and conflicting feelings when using seclusion and restraint (Bowers et al. 2007). Previous studies (e.g. Bowers et al. 2004) have found that these attitudes stem from national rather than from psychiatric culture.

Despite the cultural differences, both patients and staff in forensic psychiatric wards find the use of seclusion and restraint justifiable and acceptable in managing violence or the threat of violence (Rose et al. 2011). Because these most restrictive interventions are considered acceptable, the nurses' attitudes towards the causes and management of aggressive behaviour might inhibit the selection of situational interventions (Berg et al. 2013; Dickens et al. 2013). Although nurses' attitudes towards the use of seclusion and restraint in forensic psychiatry are crucial in reducing their use (Happell and Harrow 2010), the research in general psychiatry has found other notable factors that are also related to the use of seclusion and restraint, including staffing characteristics (Donat 2002), male–female staff ratio and education level (Janssen et al. 2007).

12.3 Forensic Psychiatry Is All About Trust and Safety

Aggression in forensic wards is common, as 82 % of staff and 46 % of patients report having been the target of aggression (Pulsford et al. 2013). These high frequencies of violence, the constant threat of violence and knowing a patient's criminal history impact upon nursing staff. In clinical practice, forensic nurses are described as balancing "fear related to threats, emotional and physical distress, utilised defence and coping mechanisms to maintain [their own] mental health" (Tema et al. 2011). In the forensic literature, the staff's fear is considered as one of the major emotions that influence nurses and nursing care. Nurses have to deal with fear on a daily basis, which affects nursing care, as they must handle both fear and situations in which they must maintain control (Jacob and Holmes 2011). Colleagues' ability and experience in handling difficult situations as well as their interpersonal styles and attitudes reportedly affect their sense of safety and

confidence and are thus a major factor in minimising fear in clinical work (Martin and Daffern 2006).

Fear, the need for control or the feeling of control, and the patient population all affect ward culture. The constant exposure to threats and fear seems to strengthen the emphasis on security and security-related concepts on forensic wards. This results in distrust of patients and distances staff from patients especially in a forensic setting. Sometimes this goes to extremes when seeing a patient as a "normal person" becomes difficult and daily tasks are described as "*to control, contain and avoid*" (Jacob and Holmes 2011). Jacob et al. (2009) ruminate about the idea that, "*as a result [of distancing], mentally ill offenders who evoke feelings of disgust, repulsion, and fear represent a greater threat to nurses' integrity and are likely to be treated with less trust, less commitment, or neglected all together*", and present the idea that forensic staff use abjection or othering as the main coping mechanism for delivering good care to patients. As a result, the ward culture on forensic wards leads to settings built on the basis of custodial care and distrust of patients (Rose et al. 2011), and new nurses are socialised into this culture; new nurses are considered naïve before growing into the role of forensic psychiatric nurse (Jacob and Holmes 2011). The role of experienced forensic nurses is one in which the nurse can respect patients without trusting them. Unfortunately, this culture of distrust and fear ultimately seems to distance staff from patients and from concepts of good care (Jacob and Holmes 2011).

Recent research notes that, in addition to mental distancing, the actual physical distance between nurses and patients is also growing. This is partly due to fear and partly to the use of modern surveillance technology such as surveillance cameras (Jacob and Holmes 2011), which enable nurses to relocate from common spaces to the office; as a result, informal meetings are becoming infrequent, and interaction between staff and patients is decreasing. This could result in a rise in the use of seclusion and restraint, as staff do not know patients, measures that are intended to de-escalate situations are not applied promptly or staff are unable to choose patient-specific de-escalation measures (Wright et al. 2014). Staff describe informal talks with patients as one of the major tasks of nursing staff and an important tool in assessing patients' mental states; however, unfortunately, this does not always appear noted in patient records, which tend to focus on observations of patient behaviour and compliance (Martin and Street 2003).

12.4 How Do We See Forensic Patients?

Stigma is an overarching term that includes problems of knowledge (ignorance or misinformation), attitudes (prejudice) and behaviour (discrimination) (Link and Phelan 2001). Stigma can determine how others view a person belonging to a stigmatised group. One possible consequence of stigmatisation is the internalisation of stigma (i.e. believing that stereotypes are actually true). People with schizophrenia typically experience negative discrimination in making or keeping friends, from family members, in both finding and keeping jobs and in intimate or sexual

relationships (Thornicroft et al. 2009). Half of patients with schizophrenia report alienation (shame) as the most common aspect of self-stigmatisation (Gerlinger et al. 2013). There is also evidence of the stigmatisation of people with criminal offense histories; ex-offenders are often seen as dangerous and dishonest (Hirschfield and Piquero 2010).

People who belong to multiple stigmatised groups may face unique struggles in developing a positive self-concept, thereby placing them at particular risk for compromised outcomes. People with both a mental illness and a criminal history—namely forensic psychiatric patients—are particularly accustomed to the experience of multiple stigmas (West et al. 2014). Forensic patients and patients with substance abuse problems are often stigmatised in both general health care and forensic care, whereas patients with major psychiatric problems are stigmatised only in general health care (Rao et al. 2009). Studies have shown mental health professionals to have as many negative stereotypes of people with mental illness as the general public has; thus, greater knowledge of mental health does not prevent or even ease stigma. Surprisingly, psychiatrists seem to harbour even more negative stereotypes than the general population (Nordt et al. 2006).

Even in a recent study reporting that mental health professionals harbour significantly more positive attitudes toward people with mental health problems than the general public, healthcare providers maintained conceptions concerning the dangerousness of people with schizophrenia and of providers' desire for social distance from clients in work and personal situations (Stuber et al. 2014).

12.5 Attitudes Matter

Attitudes towards patients affect their treatment. When nurses respect patients, but at the same time do not trust them, compliance becomes a major factor in how psychiatric professionals view patients. Rose et al. (2011) present the concept of "not-untrustworthy", which describes compliant patients who receive more respect, whereas "untrustworthy" describes less compliant patients who are responded to with less flexibility and stricter rules. In addition to compliance, patients with less functional deficits or a more likeable physical appearance enjoy more respect and favourable treatment. Patients who do not comply may receive less respect and therefore probably do not enjoy sufficient care. Sometimes this discrepancy leads to power games between staff and patients, as patients feel intimidated by the inappropriate use of punishment, the rigid application of rules or threats of seclusion and respond with successful counter-intimidation strategies that aim to intimidate nurses (Rose et al. 2011).

In a study by Laiho et al. (2014), the Attitudes Towards Aggression Scale (Jansen et al. 2005) served to measure attitudes towards aggression in staff. The study was conducted as a cross-sectional questionnaire study. According to that study, the attitudes towards aggression seemed to stem from individual opinion and personal life experiences, not from culture or attitude at the ward level. Yet the patient population and specialty of the ward appear to have some impact on the

staff's views of the causes of aggression. In this study, staff in forensic units saw aggression as more planned and reliant on the aggressor than on the environment or situations. This view differs considerably from the view of staff working on acute admission wards or rehabilitation wards, where aggression is considered to be the result of environmental and situational motives, such as self-defence or a lack of privacy in the ward.

Although the use of seclusion and restraint in forensic psychiatry is well researched, staff attitudes towards the use of seclusion or restraint are not. These attitudes towards aggression appear to impact which interventions they are willing to use to manage aggression and violence (Pulsford et al. 2013; Dickens et al. 2013). The impact of attitudes on the use of seclusion and restraint is also evident in general psychiatry (Nakahira et al. 2009). According to studies of forensic psychiatric wards, staff do not believe that an aggressive patient would calm down without staff intervention, although patients themselves believe that leaving an aggressive patient alone would in most cases de-escalate the situation. This might partly be the result of staff's need to maintain control on both the ward and patient levels. Therefore, the incident of aggression is handled immediately with interventions that staff believe in and that had previously been used with success. Additionally, since staff do not believe in leaving a patient alone to calm down by him or herself, they do not learn that self-calming could be an effective intervention for dealing with aggression.

Patient and staff perceptions collide on judging a patient's own responsibility and capability of dealing with his or her own aggressive emotions. In a study by Pulsford et al. (2013), patients more than staff maintain that the individual patient has a responsibility to manage his or her own feelings of aggression. Staff feel that patients are over-reliant on staff interventions in situations of aggression or anger management (Wright et al. 2014).

Part of the violence that occurs on a ward is believed to stem from staff attitudes towards patients, problems in care delivery and poorly implemented strategies to deal with aggression (Wright et al. 2014). The environment itself, with its rules and restrictions, is considered as one of the major causes of violence (Pulsford et al. 2013), but a positive attitude towards patients seems to reduce the incidence of violence, and knowing the patient improves predictions of violent incidents and the de-escalation of aggression (Wright et al. 2014). This sufficient knowledge of a patient is achieved through formal and informal interaction with patients (Martin and Street 2003). This balance between a "good attitude", fear and distrust, and custodial care seems to be a burden, especially to nursing staff, which arguably mostly impacts on the care delivered in wards.

Violence is also a great challenge in adolescent forensic psychiatric units. In adolescent psychiatry, some violence may stem from the fact that disturbed adolescents may have fewer ways to control themselves than do adults. In such situations, physically aggressive behaviour may be the greatest risk to staff and other adolescents. In contrast to adult psychiatry, Berg (2012) found that staff describe violence and aggression as an understandable phenomenon in adolescent forensic psychiatry.

12.6 The Need for Continuing Education

Staff culture of safety is the product of individual and group values, attitudes, perceptions, competencies and patterns of behaviour (Health and Safety Commission 1993). Education is an important factor in developing and improving attitudes that influence safety culture. Registered Nurses are considered able to master the core of their jobs better than less educated nursing staff. Therefore, cultural differences between groups of different professional staff should be taken into account when devising plans for staff education. In the development and planning of continuous education programmes, patient safety surveys are considered an effective means of assessing the strengths and weaknesses of cultures of safety—attitudes among other things—in forensic hospitals. Kuosmanen et al. (2013) found that the prevailing cultural norms of their organisations and work groups partly influence the safety practices of forensic hospital staff.

Forensic nurses themselves report that they lack the knowledge and advanced skills needed to care for forensic patients. This lack is partly due to the dearth of continuous education programmes and specialised education programmes for forensic nursing (Tema et al. 2011). Continuous, advanced-level training should be on the agenda both nationally and institutionally, as training has been shown to increase forensic nurses' self-confidence and morale (Brennan 2006; Koskinen et al. 2014). Because the competencies required in forensic nursing change with cultural shifts in the field (Koskinen et al. 2014), continuing education should address the changes taking place in society, those demanded by national supervising authorities and the cultural changes in forensic nursing, which is moving from a custodial culture to a more humanistic and interpersonal one (Gillespie and Flowers 2009; Timmons 2010). There is also a need to define more effective standards and procedures for handling seclusion and restraint in forensic settings (Kallert 2008).

Bowring-Lossock (2006) has clarified the competencies needed in forensic nursing within a four-dimensional competence framework. These dimensions of competence are: Task-oriented skills, Knowledge, Interpersonal skills and Personal traits. Task-oriented skills include competencies to assess and manage safety, security and risk; awareness of therapies; practical reporting skills; first aid and escorting and searching patients. This area of knowledge comprises competencies related to the criminal justice system, litigation procedures and relevant legislation. Interpersonal skills entail the skillful and therapeutic use of the self, including self-awareness, reflection and honesty. Personal traits include a person's maturity and ability to use common sense. A personally competent nurse demonstrates respect for the humanity of the patient regardless of his or her background.

Still the main weakness in forensic nurses appears to be their inability to engage in or to resolve conflict (Bowen and Mason 2012). Some have also suggested that training for the prevention and management of aggression should emphasise the modifiability of aggressive behaviour in the forensic setting (Dickens et al. 2013). In adolescent forensic wards, it has been shown that a shared understanding of adolescents' aggressive behaviour enables staff to implement safe, ethically sound

and more consistent aggression management (Berg et al. 2013). This could also be true for adult forensic psychiatry.

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Mental Health Workers' Experiences of Using Coercive Measures: "You can't tell people who don't understand"

13

Ada Hui

Abstract

This chapter explores healthcare workers' experiences of using coercive measures within a high security hospital in England. High security hospitals represent those with the greatest restrictions placed upon patients. Security levels within these hospitals are the equivalent of Category A prisons, yet the employees working in the hospital are healthcare professionals and those accommodated in the hospital are patients, not prisoners. The challenges in balancing care and containment within these restrictive environments are frequently cited in the literature. Healthcare workers' experiences of working within these environments, however, are rarely explored. Narrative interviews were conducted with 28 members of staff exploring their experiences of working, and of using coercive measures, in a high security hospital. The interviews were analysed using an iterative-comparative approach, whereby the processes through which mental health workers manage their feelings, roles and actions became apparent. Participants frequently spoke of the challenges they experience in reconciling security measures with their roles as healthcare practitioners. Tensions were frequently expressed between mental health workers' professional expectations, personal feelings and perceptions of responsibility towards their work. Mental health workers describe degrees of detachment and desensitisation as ways of coping with such tensions, conflicts and challenges. All of these factors ultimately influence the decisions made, the practices conducted and care provided within high security hospitals.

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13.1 Background

Forensic psychiatry poses many challenges for mental health practitioners, not least in the context of high security hospitals, where balances between care and containment are imperative, yet frequently in contention (Alty and Mason 1994). The uses of coercive measures have been increasingly viewed with controversy over recent years. Indeed questions have been raised as to whether these practices are ethical, moral or indeed necessary at all (Alty and Mason 1994; American Psychiatric Association et al. 2003; Gunn and Taylor 1993; National Mental Health Working Group 2005; NICE 2015; Queensland Government 2008; Soloff 1979; Tardiff 1984). Where coercive measures are used in secure hospitals, healthcare workers are expected to conduct such practices. Juxtapositions are therefore apparent between the roles of healthcare workers as person-centred, recovery-orientated practitioners, in contrast with their roles as agents of security and restriction. Few studies have examined the uses of coercive measures specifically within high security hospitals and even fewer have explored staff experiences of working in this environment (see Chapter 9: The Uses of Coercive Measures in Forensic Psychiatry: A Literature Review). In order to understand the attitudes, cultures and practices within these institutions, it is important to i) explore the processes through which staff decide upon conducting coercive measures, ii) examine workers' thoughts and feelings towards such methods, and iii) consider the implications upon workers as individuals, as well as their roles as mental health practitioners.

13.2 Methods

This chapter reports on the findings of part of a doctoral thesis, examining staff experiences of conducting coercive measures within Rampton Hospital (Hui 2015). Rampton is one of three high security hospitals, located in the Nottinghamshire countryside. The hospital accommodates approximately 350 patients and is comprised of five directorates, namely, mental health, learning disabilities, personality disorder, dangerous and severe personality disorder and women's services. The hospital provides the only national high secure hospital provisions for women, patients with learning disabilities and patients who are deaf. The mental health directorate is the largest within the hospital, having 110 beds. It is this directorate in which the interviews were conducted.

During the time of the interviews, the mental health directorate was divided into eight wards; two admission wards, three treatment wards, two pre-discharge wards and one intensive care ward. The study took place on four of the wards (admission, treatment, pre-discharge and intensive care), so that staff experiences could be compared in accordance with the functions of each of the wards and assessments of patients' 'risks and dangerousness'. Twenty-eight interviews were conducted in total. These were with 9 staff nurses and 11 healthcare assistants, who make up the majority of the hospital's workforce, along with one ward manager, one team leader, two responsible clinicians, one social worker and one psychologist. The

numbers of practitioners interviewed from each of these professional roles were in proportion to those found on each ward. The majority of staff who chose to participate in the interviews were from the intensive care unit (18). This perhaps reflects the higher rates and frequencies of coercive measures being used within this particular ward.

The interviews were conducted using a narrative approach, enabling participants to share their experiences of using coercive measures. Participants were encouraged to talk about their experiences, thoughts and feelings surrounding the uses of restraint, seclusion and segregation within the context of working in a high secure hospital. A semi-structured approach was adopted, using an open-ended style of questioning. Prompts were used to encourage further exploration and understanding. Thus, participants' thoughts and feelings were made accessible through narratives of the processes of using coercive measures, descriptions of isolated incidents that have stood out for individuals, as well as through sharing personal and professional experiences more broadly.

Throughout the interview process, interview findings were constantly compared and questions framed to deepen the understanding of practitioners' experiences. Through these comparisons, data were analysed and grouped into themes and further subthemes. Findings indicated that practitioners experienced coercive measures through a series of processes, pertaining to three main themes; (1) decision-making, (2) thoughts and feelings, (3) personal implications and professional implications. These will each be presented and discussed in turn.

13.3 Results

13.3.1 Decision-Making

Each of the practitioners spoke of the challenges faced in making, often difficult, decisions to conduct coercive measures. Practitioners spoke of every situation being different, and therefore of the accompanying challenges and difficulties in describing and quantifying specific situations when coercive measures might be used. Decisions to use coercive measures, however, seemed to centre around three main junctures; (1) accountability, (2) safety and (3) having "no other option".

13.3.1.1 Accountability

In England, high security hospitals are governed by both the NHS and the Ministry of Justice, a ministerial department of the UK government that has a role in managing and authorising the containment, restriction and discharge of patients under forensic mental health care. The friction resulting from being employed by the NHS whilst remaining answerable to the Ministry of Justice clearly created anxieties amongst staff with regards to their roles and responsibilities:

> We are answerable to more people than prisons are, the Home Office[1] and that sort of thing, and people are really wary because you're answerable, whereas in prison, you serve your sentence and you go, if you reoffend, people aren't going to be asking questions about the prison officers or wardens, because you will be arrested and you will go back to prison. Whereas here, if people reoffend, questions are asked about us and our practice and what we are doing... we have to answer for those things... it's not a light thing, it's a very serious thing (Staff Nurse—male)

> [The] legal requirement of your detention, that's very much driven by the dictates of the Home office and the security practices that the home office tell us that we have to adhere to (Team Leader—male)

The prospect of accountability and levels of responsibility seemingly resulted in conflict between the competing principles of healthcare (NHS) and prison (Home Office) services. Where such conflicts arose, security measures ultimately preceded that of care:

> That's the strange thing, when I first came here, Rampton was its own authority directed under the Home Office. They then got drawn into the Trust, which really tried to put across that the nature of the hospital is care and treatment and then all of a sudden as they've tried to do that, you've got this massive increase in assessments, risk assessments, big fences, personal alarm systems (Team Leader—male)

> The security sometimes governs the nursing, if you know what I mean, so things that you might do in other hospitals, you have to do differently here because of the security measures (Nursing Assistant—male)

> As a nurse, when you come to the field of forensics, one of the hardest things that you have to try and balance out is the security aspect of the job that you do, along with the nursing side of how you were trained. It's something quite different, and the two, I don't think, ever sit totally comfortably with each other (Team Leader—male)

> How you go about putting across your nursing care isn't always that easy a job within a contained area, a place with massive security practices, but you've just got to stay true to yourself (Team Leader—male)

The onus of security appeared not only to be driven by clinicians' fear and anxieties surrounding accountability but also as a result of their acute sense of responsibilities, particularly surrounding safety. Safety was spoken about through the language of safety, security and protection as will be presented in the following.

13.3.1.2 Safety

While security aspects of practitioners' roles seemingly dictate the care they are able to provide, the practitioners spoke of the great levels of responsibility they feel towards maintaining safety. These responsibilities seemed to emerge not only from those governing bodies outside of the hospital, but from protecting patients and colleagues, as well as the public:

[1] The Ministry of Justice was formed in 2007, taking over what was previously known as the Home Office.

> You have to bear in mind that we are providing a service to the public and keeping them safe as well... so you've got to be very mindful of that, very careful, it's the reason it's high secure, the big fences around it is because these people may pose a risk, so while trying to maintain a therapeutic environment for the patients, it's making sure everybody's safe as well. Which can be tricky (Nursing Assistant—male)

> You come into work every day knowing that there's a chance you might be assaulted or that you might have to restrain a patient... you don't get to Rampton hospital as a psychiatric patient really without having been violent and aggressive in some way or form, so with regard to violence and aggression, we're always aware that there's a possibility of that (Nursing Assistant—male)

> I suppose in a hospital like this you have to cover eventualities... trying to keep people safe, (Nursing Assistant—male)

13.3.1.3 "No Other Option"

Finally, the decisions of whether or not to employ coercive measures seemed to rest upon whether the risks, or breaches of safety and security, were great enough to warrant such restrictive practices. Practitioners spoke of coercive measures being as used as a last resort when left with no other option:

> They're a last option, it's something that you're going to avoid if you can help it because it's not good for [the] patient is it, you know, it can't be good for anybody's mental state, you know, we're trying to help them get better, it can't be good for anybody's mental state (Nursing Assistant—male)

> As far as I'm concerned, you know, obviously none of us want that to happen, it's a last resort so to speak, you know (Staff Nurse—male)

> If there's nothing you can do to calm them down or talk them down or anything like that, then it's got to be done (Team Leader—male)

> We try and avoid it as best we can but sometimes we have no option (Nursing Assistant—male)

> Sometimes there is no other alternative. How else do you deal with somebody who wants to stand up in the middle of the day room and fight everybody, you know, I don't really know another, I can't really see another option at that time (Nursing Assistant—male)

In exploring the decisions surrounding the use of coercive measures, it became apparent that safety and security are paramount to the ethos of working within a high secure hospital and that clinicians feel under great pressure to maintain a safe environment where they feel both responsible and accountable towards the safety of all patients, colleagues and the public. From the findings presented so far, there is the suggestion of unease surrounding some of the ethos and practices of the high secure environment from clinicians. While accountability, safety and having no other option each contribute towards the decisions made as to whether or not coercive measures are used, they fall short of exploring the thoughts and feelings of practitioners towards conducting such actions. These will be examined in the following sections.

13.3.2 Thoughts and Feelings Towards the Use of Coercive Measures

The thoughts and feelings of practitioners towards the use of coercive measures appeared to be strongly influenced by their attitudes and philosophies of working within a high secure hospital, as well as towards the patients contained within. The practitioners identified subtle differences in "tolerance" and "boundaries" between members of a team. However, the overarching attitudes were that those contained are patients not prisoners, that the uses of coercive measures are a necessary evil and that where practitioners feel at unease, they tend to mask or manage their feelings through aversion or bravado.

13.3.2.1 Patients Not Prisoners

Practitioners were adamant and keen to point out that the environment in which they work is 'a hospital and not a prison', despite the conflicts and tensions between care and safety regimes being frequently apparent, and in spite of the aforementioned practices of security often preceding that of care:

> Even though lots of the nursing staff are members of the Prison Officers Association, that's their union rather than Unison or something like that. . .they're not prison officers, they're nurses, you know, so the patients are not inmates, they are patients, I think that's important (Responsible Clinician—male)

> We're nurses, we're not bouncers, we're not soldiers, you know, we're nurses. . . it's a very different role, but we're not prison guards Staff Nurse—male)

> I think the thing is with Rampton, you look at prisons and you can sort of think it's a prison, it isn't a prison, it's a hospital and that's the difference, these people are poorly, you know, and we have to remember that (Staff Nurse—male)

> Prisons are supposed to be about rehabilitation. . . we're a hospital which means we're about treatment (Social Worker—female)

13.3.2.2 "A Necessary Evil"

Of all the practitioners who were interviewed, each person viewed the use of coercive measures as a last resort, secondary to attempts at de-escalating potentially violent situations via verbal means. Practitioners generally voiced negative feelings towards using coercive measures, viewing these as a necessity to prevent injury and to minimise harm, but preferred not to have to undertake these measures as part of their role and duty, given the choice:

> It's not a nice experience but it is a necessary evil (Nursing Assistant—male)

> It's not something that you relish, you know, it's a needs must, you have to step in for whatever reason to lessen the harm that they're doing, it's really for their safety, the safety of the victim that they're attacking be that another staff or another patient, it's that part of the job that sometimes is necessary but not that you like, and then you do it to the best of your ability (Team Leader—male)

> It's not something either party enjoys, I don't think, obviously, you know, it's an invasion of their privacy, you know, nobody likes it (Nursing Assistant—male)

> I think it's a necessary part of the job, I think it's a necessary evil. It's not the most pleasant part of my job but it is so necessary, especially when you're talking about risk to other people. When you've seen violence and experienced violence and been at the receiving end of violence, you would wish somebody to be involved, and manage them, in a safe way, and when people are put at risk, you know, you have to do something. . . the alternative is not acceptable, it is not acceptable that people can be subject to or victim of violence, not just staff but other patients and there be no consequence and there be no management of that. I've seen patients who have been on the receiving end of an unprovoked attack, brutal unprovoked attack, and you have to manage that, you know, you have to manage that. We have a duty of care (Staff Nurse—male)

13.3.2.3 Banter and Bravado Versus Aversion and Avoidance

Staff support was an important feature identified by practitioners throughout the process of conducting coercive measures. Mutual trust and support were key factors in establishing good team relations and in conducting coercive measures safely. There is an implied sense of dependency between staff, while trust appears to be a major factor in working as part of a team. Indeed, some staff have felt 'let down' and angry when colleagues have not responded to incidents in ways that would be expected or have not supported colleagues in a manner felt appropriate. Teamwork, esteem and respect for colleagues were therefore not only associated with levels of training and experience, but also staff willingness to be involved when colleagues are placed in vulnerable situations. Practitioners frequently spoke of the reinforcement of team closeness fostered through camaraderie and banter following serious incidents. Displays of confidence and bravado earned respect between colleagues, whilst those who demonstrated fear and aversion were ostracised through being seen as unreliable, untrustworthy and undependable:

> I think it creates stronger bonds between people when you've been involved in them sort of incidents together. . . I mean, I've got some friends that are in the army and they say. . . friends, you know, mates that they've made when they've been in war zones together, I mean, they say it's a relationship that other people can't understand. . . you know, I suppose it's like that but on a much [less] extreme scale, isn't it? (Nursing Assistant—male)

> You've got to support each other otherwise it just wouldn't work, you just wouldn't be able to work with each other (Nursing Assistant—male)

> You are conscious of how dangerous it can be and how much you rely on other people to keep you safe, but then again, they rely on you as well (Team Leader—male)

> You've got to be there for each other (Team Leader—male)

> I've seen people with a negative attitude involved in restraint, and it's a very dangerous mix because your personal feelings always come into it, so you always have to be detached about how you feel about it and just do the job in hand, you know, you've got to think about people's safety, the patient's safety, other people's safety, you know, they are paramount (Staff Nurse—male)

> I know people, I personally know people that are fearful, fearful of restraint, fearful of that, "Can I?", and when those incidents happen, they shy away from being involved. . . some people sometimes develop an aversion, I know quite a few people here that have, and it's not healthy, it's not healthy, you're in the wrong environment to be here to develop an aversion to that (Staff Nurse—male)

The ways in which practitioners act and react towards the uses of coercive measures implies some bearing upon the individual both at a personal and professional level. Whilst so far, the findings have alluded towards collective impacts upon the practitioners as a team, such as through trust, team building and support, the implications of conducting coercive measures upon individual practitioners will be explored in greater detail. A focus will be given towards the influences and interrelations between the practices of coercive measures and practitioners' personal and professional values.

13.3.3 Personal Implications

Practitioners spoke of the challenges and tensions of working within an institution that "outsiders" know little about and where personal and professional values often conflict. The lack of knowledge and awareness from those outside of the hospital seemingly reinforces an insular community of support and understanding, albeit resulting in feelings of isolation where personal and professional roles and values are misaligned. Clinicians spoke of their inability to tell friends and family about their work, of having to "make peace with" the decisions and actions required of them within a high secure hospital and the challenges faced in attempting to reconcile and consolidate both their personal and professional values so that they could continue working in their roles.

13.3.3.1 You Can't Tell People Who Don't Understand

Practitioners spoke of feeling unable to talk to friends or family who work outside of the institution, since they do not understand:

> We are detached from the rest of the world. We're in our own little bubble, so I'm an expert at Rampton but out there I'm a novice, I wouldn't know, I wouldn't cope out there, but in here I'm an expert, but out there... no (SN - male)

> You can't really tell people that don't understand, so you can't take it home with you, because they don't understand the process, they don't understand the things that you're going through and that you're dealing with (Staff Nurse—male)

> I think it's something that only people that work here can understand (Nursing Assistant—male)

13.3.3.2 Peace and Reconciliation

Clinicians described a sudden lull in their emotions, following the heightened tensions in managing incidents, such that staff require time to manage their own emotions before continuing with their usual work. The outlet of emotions associated with the challenges of working within a high secure hospital were described by clinicians as 'making peace with' their personal and professional roles and identities:

> You're working with people at the end of the day, you're dealing with people. Patients are people and it's violent at the worst, it's a violent act, it's a violent process and you have to wade through the mist, the red mist and process it, and do things professionally and all of those things. The adrenaline's going, you know, your senses are heightened and then afterwards you almost crash, you know, yeah, you almost crash (Staff Nurse—male)

> What always plays on your mind is just to make sure you are doing things right, you know, it's a volatile situation whereby emotions are running high, up and down, but still as staff, you just keep on reminding yourself that, you know what, you have to do things right (Staff Nurse—female)

> Everybody is a little bit pumped up, so there is almost a little bit of post seclusion sort of, not blues, but phew, that was phew, what happened then, but then you sort of take off, evaluate it (Nursing Assistant—male)

> You have to deal with the fear, you know, fear sets in and it's fear of there being another incident, what if the worst incident, what if I can't help, what if, you know, could I have got there quicker... you're working with, you're dealing with those things, those thoughts of could I have got there quicker, what if, what if, I should have got there quicker, you know, what could I have done, I should have been more attentive and all those sorts of things, you know, and it's what ifs that you're dealing with, and that sense that you've let somebody down... the fear of should it happen again, can I be relied upon, am I dependable, you know, am I good at this and all that kind of stuff, so it's a range of things you're battling and dealing with... I remember for weeks, carrying this, you know, and you have to make your peace with it, I tried my best, I did my best, there was nothing more I could have done, you know (Staff Nurse—male)

13.3.3.3 Consolidating Personal and Professional Values

Practitioners describe their attitudes and outlooks as having to change in order to manage and accommodate the institutional and emotional demands of their working environment and the coercive practices they are called upon to conduct:

> I found my attitude towards it changed, when I experienced it first-hand, when I witnessed it first-hand, my attitude towards it, the necessity of it changed...It's not easy when you see it for the first time, and then when you see violence against staff, you know, people that you work with, colleagues, friends, especially some of the attacks I've seen, quite brutal attacks on staff, that can be quite disturbing. You have to contend with that, you've got to put it in the right context and you have to process and deal with it (Staff Nurse—male)

> It's not the easiest of jobs, sometimes, it's very difficult to, when you have to be physically involved in restraining patients, that doesn't initially sit very easily with how you're first educated to what nursing is, it doesn't, you know, they don't sit comfortably together (Team Leader—male)

> I think you've got to sort of, you've got to stay true to yourself as to what brought you into nursing and then how you go about putting across your nursing care isn't always that easy a job within a contained area, a place with massive security practices, but you've just got to stay true to yourself (Team Leader—male)

Through examining workers' experiences of working in a high secure hospital, the tensions between organisational expectations, professional practices and personal values become apparent. These will be considered with a specific focus upon the uses of coercive measures.

13.3.4 Implications for Practice

The implications of using coercive measures upon workers' roles and practices were discussed as a sequence of processes related to 1) preparedness, 2) confidence and 3) routine. Practitioners spoke of their anxieties of conducting coercive measures for the first time, the confidence they feel in knowing what to expect and finally, confidence in their capabilities of conducting coercive measures. The paradox of becoming confident in their every day practices, however, were the rituals, routines and emotional detachments towards such practices over time. The processes of becoming institutionally embedded and emotionally detached will therefore be explored in the following.

13.3.4.1 Nothing Prepares You

Frequent distinctions were made between training, on the one hand, and the intensity of experiencing and enacting approved holds within the ward environment during actual incidents on the other. Staff attributed these distinctions, in part, to the lack of resistance that staff put up against their colleagues during training, as well as to the speed, intensity and potential for injury with which real-life incidents occur:

> It's nothing the same at all, it's nowhere near... when you're practicing, you're just practicing with each other and nobody ever puts up any resistance or anything, so you've got time to do it all properly whereas in a restraint, a patient never stands there and lets you grab them, they're trying to fight you, so it's totally, totally different, totally different... most of the time, you just have to do it, you just have to try and do what you're trained to do, and just do it as quickly as you can but you haven't got time to think about it... if a patient comes at you swinging his arms and trying to punch you, you just have to, you can't think, hang on a minute, I need to put my hands there, you just get on with it (Nursing Assistant—male)

> In a way, what you're taught down there is never the same, you never get the reality of it, there's no, because nobody really struggles when you're doing the training, if you do the shield training that's slightly different because when you do the shield training, the instructor's there, they really make you have it, they do, metal batons and baseball bats and it's quite difficult, it is, quite scary as well when they're whacking you with a baseball bat on a plastic shield (Nursing Assistant—male)

> You can talk about approved holds and how you should take people, but when limbs are flying everywhere and people are scrapping or somebody's just been hit and they've hit the floor, especially if the patient's putting up a struggle, sometimes it's just grabbing onto something and holding it still and when everything's stopped moving, then, one at a time, get them into the appropriate holds (Staff Nurse—female)

13.3.4.2 Confidence and/or Desensitisation?

Practitioners spoke of the challenges in not knowing how they might react when initially faced with an incident requiring the use of coercive measures. They often spoke of the relief they felt after experiencing their first encounter of using coercive measures, of knowing what to expect and having an increased confidence in their abilities. These experiences, however, were frequently coupled with detachment

and desensitisation in coping with the traumas of witnessing and managing such situations:

> Once you've done the first one, it's kind of a relief, you know, the procedure, if anything, it makes you feel more confident (Nursing Assistant—male)
>
> You have to get to a point where you get over it because the next one is just going to be the same again (Staff Nurse—male)
>
> I think with time, you get used to it, you get used to it (Staff Nurse—female)

13.3.4.3 Rituals and Routines

In managing and coping with both personal and professional values, staff regularly refer to individual rituals that they undertake in preparing themselves for working within the high secure hospital organisation. The routines and rituals that staff identify are seemingly associated with detaching themselves from the patients that they work with, the crimes they have committed and the personal judgements that staff hold in relation to each of these:

> It's another hat that I've got on, that I have to wear when I come to work so I can put all my morals, or most of my morals and beliefs to one side and in a box because I have to put my work hat on, which means that I have to deal with these patients and I know that patients come to Rampton because they've done horrendous offences (Staff Nurse—male)
>
> You learn to deal with situations and not let them affect you. . . if a patient died in hospital, I've got no love, feelings or emotions for that person, so it's easier for me to do all those things (Staff Nurse—male)
>
> You have to put all that sort of stuff in a box, I'm not saying it's easy or that it doesn't affect you or anything. . . it is hard, I think you just have to be aware of it and try and manage it to the best of your capabilities whether it be through supported supervision or, you know, it's not easy (Staff Nurse—male)

13.3.4.4 It's Just a Job

Coupled with, and related to, practitioners' routinising of their actions, were their descriptions of using coercive measures as simply being "part of their job". This distinction and separation of their personal values from that of their work perhaps indicates degrees of detachment with the actions that they feel most uncomfortable with conducting, thus shifting the responsibility onto their role, rather than themselves as individuals:

> You do kind of get used to it, it is part of the job, you don't enjoy it but you know it's there and you deal with it, try and make a bit of light of it afterwards, as a coping mechanism more than anything (Nursing Assistant—male)
>
> It's just my job, I'm not here to criticise, society needs somewhere to put people who have done this and I just work in that environment (Nursing Assistant—male)
>
> A lot of the time it's just part of the job and you respond to what you need to do at the time, so apart from the particularly violent ones or ones that are completely out of the ordinary, it just gets to be one of those things, you just do it (Staff Nurse—female)
>
> I think you have to remind yourself that you're here to do a job and you have to do the best job (Social Worker—female)

13.4 Discussion and Conclusions

From examining findings from the interviews, several key themes emerge. First, the decisions made surrounding the uses of coercive measures were greatly influenced by workers' perceptions of accountability, responsibility and assessments of risk and safety in the workplace. Second, inherent in these decisions and actions were practitioners' thoughts, feelings and personal values. These were articulated in relation to the uses of coercive measures, the patients accommodated within high secure hospitals, their roles as healthcare professionals and the secure environments in which they work. Third, the processes by which staff negotiate their personal values, professional roles and organisational expectations are particularly noteworthy in gaining greater understandings of practitioners' experiences of working in this environment.

Each of the practitioners were adament that although working in a high secure environment, their roles were of healthcare and those they work with are patients, not prisoners. However, discrepancies were revealed between the language used and the security and containment measures practiced wthin. Workers within forensic hospitals are accountable to both healthcare and legal governing bodies. These dual obligations frequently place workers in contention with their personal values and professional roles.

Findings from the interviews alluded to the marginalisation of those who have an aversion to conducting coercive measures. To avoid such marginalisation, workers tend to adopt a mask of confidence and bravado in order to be accepted by others, whilst displaying an appearance of coping. Workers' feelings towards their work seemingly resulted in either (1) clinicians taking ownership of their fears and anxieties at the expense of being outcast by their colleagues or (2) masking their fears and anxieties through banter and bravado in the hope of being accepted. Each of these rely on elements of deception, either towards the self or others, both of which are considered unhealthy responses, with the potential for toxic consequences as practitioners become increasingly detached and isolated (Hochschild 1983).

The interviews with practitioners uncovered their changing emotions towards their work through a series of processes: from the fear and anxieties of anticipating their first experiences of conducting coercive measures to gaining confidence and eventually routinising such actions as being "part of their job". Each of these experiences contributed to the clinicians' detachment from their work, perhaps as coping strategies in shielding themselves from the uncomfortable situations they are tasked with managing. These processes may have profound implications not only for the individual practitioners involved but also in terms of care delivery. Studies have previously found that clinicians develop "fear and abjection" towards patients within secure settings and thus view patients as objects rather than people (Jacob et al. 2009; 2011a & 2011b). This raises important questions as to 1) the quality of care being delivered under such circumstances, 2) how such negative cycles of detachment and objectivised care can be broken and 3) whether it is possible to provide humanistic, person-centred, recovery-orientated care within these challenging environments and conditions. These questions are particularly important given the conflicts between

the values and practices of healthcare workers and in light of the national and international guidelines towards the reduction of coercive measures.

Such revelations lead to questions of how clinicians can be supported through these challenges, how such support might be accessed without fear of judgment from fellow colleagues, and, moreover, how cultures of openness and honesty can be fostered within environments where circles of fear often lead to masking, aversion and feelings of isolation. These questions and associated answers may be key to preventing staff fatigue, improving the retention of staff working in these environments, while encouraging cultures of support in place of fear and apprehension. Workers must learn to look after themselves by changing the internal cultures of secure environments, by supporting colleagues to take ownership of their fears, anxieties and apprehensions and by extending this approach towards those in their care. Through such changes, emotional isolation may be replaced with acceptance and emphases on containment replaced with care.

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Patient Experience of Coercive Measures

14

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Abstract

Coercive situations are complicated and stressful for both the one being forced as well as the one forcing the other. Patients' experiences of coercion have been studied since the end of the 1970s, and interest in this theme has increased since about 2000. It seems that involuntary treatment as a general concept is more accepted than individual, specific coercive measures, such as forced medication, seclusion or restraint, which patients usually deem unnecessary. Patients' views on seclusion and restraint have been mostly but not always negative. For instance, patients have expressed seclusion- or restraint-related feelings of safety and security, protection, trust, helpfulness and a decrease of stimulation. Moreover, perceptions vary according to, for example, patients' age and gender and their adaptation to the illness and treatment system. The importance of patients' perspective and service user involvement in the development of services has been officially recognised. Indeed, taking patients' experience into proper consideration is a matter of the services' quality. In this chapter, we also discuss these future challenges.

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14.1 Patients' Perception of Coercion

One would think, offhand, that a person's perception of coercion is quite a simple issue; no one likes to be coerced. Yet, human beings are complex and being forced provokes a myriad of reactions. Coercive situations are stressful for both the one being forced as well as the one forcing the other. They are never simple situations—all the emotions and thoughts, all the actions before, during and after. In the worst situations, there may be objects thrown, hitting, wrestling, yelling—a significant commotion. Anyone who has been involved in or witnessed a patient being carried into seclusion knows that everyone involved is hyped up. If one has an ounce of empathy, there is bound to be adrenaline flowing. Even at the lower end of merely being unable to leave the ward, there are still the emotions of frustration, disappointment, perhaps sadness of not being able to choose for oneself.

Patients' experiences of coercion, mostly involuntary treatment, have been studied since the end of the 1970s (e.g. Wadeson and Carpenter 1976; Spensley et al. 1980). With increasing awareness of patients' rights, research on patients' perspectives has increasingly emerged (e.g. Soininen et al. 2014). Katsakou and Priebe (2006) reviewed five qualitative articles on patients' experience of involuntary admission and treatment. Patients mentioned both negative and positive consequences from involuntary admission in regards to three main areas: (1) perceived autonomy and participation in decisions for themselves, (2) feelings of whether or not they are being cared for, and (3) sense of identity. In their earlier review, Katsakou and Priebe (2006) found that, retrospectively, between 33 and 81 % of involuntarily admitted patients regarded their admission as justified and/or the treatment as beneficial. This wide percentage range portrays the complexity of the issue.

Wallsten et al. (2006) interviewed a total of 233 involuntarily as well as voluntarily admitted patients first within 5 days from admission and then at discharge or after 3 weeks of care. Outcomes were measured as reported by the patients and by change in Global Assessment of Functioning (GAF) scores. The aim was to find out if subjective and assessed outcomes of brief psychiatric inpatient care are related to patient characteristics, coercion at admission or during treatment or to other treatment characteristics. The authors found that a positive subjective outcome was more probable if the patients reported that they had been well treated by the staff and had contact persons at the ward. However, coercion was not related to outcome (Wallsten et al. 2006).

Not surprisingly the experience of coercion and reactions to it are not the same for patients and others involved. Bowers et al. (2010) investigated how patients, staff and visitors feel about locking the doors of adult acute psychiatric wards. Patients were more negative about door locking than staff. Patients reported more anger, irritation and depression as a consequence of locked doors than the staff or visitors thought they had experienced (Bowers et al. 2010).

Perceived coercion is not always congruent with legally defined coercion. A Swedish study in 1995 found that two thirds of committed and about one third of voluntarily admitted patients reported coercive measures during their index period

of care (Eriksson and Westrin 1995). The committed patients justified 19 % of the coercive measures reported while the voluntarily admitted justified 38 %. In Norway, Sørgaard (2007) found that about half of the patients (51 % of the committed patients and 38 % of the voluntarily admitted patients) stated at follow-up interviews that they had been violated as a person during the index period of care. Many patients reported restrictions on movement, forced medication and patronising communication. Sørgaard also found that a substantial proportion of patients didn't know their legal status while admitted to inpatient care.

A more recent review on the prevalence of perceived coercion among psychiatric patients found, unsurprisingly, that legally detained patients are more likely to report coercion than those voluntarily admitted (Newton-Howes and Stanley 2012). What is important to note, however, is that one in four voluntarily admitted in-patients experienced coercion in management. As the authors of the study noted, this has ethical implications for practice.

The way patients are treated logically affects how they perceive their treatment. Patients who believe they have been allowed 'a voice' and are treated with respect, concern and good faith in the process of hospital admission report experiencing significantly less coercion than patients not so treated (Hoge et al. 2004). This holds true even for legally involuntary patients and for patients who report being pressured into hospitalisation. Satisfaction studies have reported similar findings; patients were on the whole quite satisfied with inpatient care, but expressed dissatisfaction towards specific coercive measures (Kuosmanen et al. 2006; Iversen et al. 2007). It seems that involuntary treatment as a general concept is more accepted than individual, specific coercive measures, such as forced medication, seclusion or restraint, which patients usually deem unnecessary (Katsakou and Priebe 2006; Priebe et al. 2009; Sibitz et al. 2011). Nevertheless, experiences of involuntary treatment and of coercive measures are likely to influence the total burden of being coerced (Kjellin and Wallsten 2010).

It is obvious that we still need more clarity in psychiatric practice, riddance of the grey areas, to ensure explicit consent for treatment. The laws are quite explicit on this matter. We need to offer in-patient treatment by multi-disciplinary teams, on-going education and discussion of treatments and patients need to be involved. 'Unofficial coercion' should not exist; definite action is needed to ensure the reduction of coercion—both official and unofficial.

14.2 Patients' Perception of Seclusion and Restraint

Even though there are studies on patients' experiences of seclusion dating back to the 1970s and 1980s (Wadeson and Carpenter 1976; Binder and McCoy 1983; Soliday 1985; Hamill et al. 1989; Mann et al. 1993), interest in this theme has increased since about 2000 (Meehan et al. 2000; Hoekstra et al. 2004; Holmes et al. 2004; Meehan et al. 2004; Sørgaard 2004; Wynn 2005; Chien et al. 2005; Stolker et al. 2006; Steinert et al. 2007; El-Badri and Mellsop 2008; Keski-Valkama et al. 2010a; Kontio et al. 2012).

Not entirely surprisingly, seclusion and restraint seem to be on a continuum of traumatic events in a patient's life. Traumatic events in a patient's personal history seem to increase the likelihood of being subjected to seclusion and restraint (Steinert et al. 2007). Furthermore, secluded and restrained patients are at risk of retraumatisation and revictimatisation (Frueh et al. 2005; Steinert et al. 2007). Sexually abused women have perceived restraint extremely unnecessary and terrifying; they felt they were not being heard, believed or even considered human (Gallop et al. 1999). Indeed, seclusion and restraint may remind patients of previous abuse.

Patients' views on seclusion and restraint have been, predominantly, but not exclusively, negative. Negative feelings raised by seclusion and restraint include anger, fear, loneliness, anxiety, hostility, sadness, misery, rejection, betrayal, guilt and embarrassment (Meehan et al. 2000; Holmes et al. 2004; Wynn 2005; El-Badri and Mellsop 2008; Kontio et al. 2012). Patients have reported they felt powerless and that they were being subjected to punishment rather than to treatment (Gallop et al. 1999; Meehan et al. 2004; El-Badri and Mellsop 2008; Keski-Valkama et al. 2010a; Kontio et al. 2012).

Patients' negative perceptions of seclusion and restraint have been found to be associated with a lack of information on the reason as to why it was decided to seclude or restrain them (Meehan et al. 2004; Sibitz et al. 2011; Kontio et al. 2012). Patients have reported problems during seclusion ranging from maintaining their basic needs such as hygiene to a lack of meaningful activities (El-Badri and Mellsop 2008; Keski-Valkama et al. 2010a; Kontio et al. 2012). Patients also said they would have needed more communication and human presence during seclusion or restraint (Meehan et al. 2000; Chien et al. 2005; Mayers et al. 2010; Kontio et al. 2012).

In current clinical practice, patients' individual seclusion/restraint-related needs often remain unmet, and service user involvement is insufficient. In a study by Kontio et al. (2014), the service users' delayed (i.e. years after the event) perceptions of not having received sufficient attention brought to their mind feelings of loneliness, boredom, oppressive control and rules, fear and insecurity, as well as a lack of clarity about their current situation, their treatment plan and the reasons for seclusion or restraint. These delayed perceptions were, in fact, strikingly similar to those reported by patients immediately after the violent and seclusion/restraint episodes in earlier studies (Duxbury and Whittington 2005; Hottinen et al. 2012; Kontio et al. 2012; Stenhouse 2011).

Nevertheless, patients do not always perceive seclusion and restraint merely negatively. For instance, patients have expressed seclusion- or restraint-related feelings of safety and security, protection, trust, helpfulness, and a decrease of stimulation (Binder and McCoy 1983; Mann et al. 1993; Kennedy et al. 1994; Chien et al. 2005; Kuosmanen et al. 2007; Kontio et al. 2012). Information on the reasons for seclusion and restraint helped patients to understand these restrictions (Meehan et al. 2004; Chien et al. 2005; Kontio et al. 2012). In particular, the delayed descriptions—unlike most of those in the reports on immediate perceptions—were enriched with positive examples of professional and humane,

readily available and attentive nurses able to create an atmosphere of safety (Kontio et al. 2014).

Even physical restraint has sometimes been considered to be therapeutic and protective (Chien et al. 2005), and mechanically restrained patients have felt less fear than secluded patients (Bergk et al. 2011). Furthermore, Keski-Valkama et al. (2010a, b) found that of those patients who regarded seclusion as at least partly beneficial, 83 % were able to give a reason for their opinions which included: to learn to control one's own behaviour (38 %), positive effect on psychiatric condition (30 %), and own privacy (21 %). Essentially, patients need privacy on the ward and may ask to spend some time in seclusion rooms with open or closed doors, if no other facilities are offered.

Patients' views of seclusion have been found to be associated with the lack of privacy on the ward. Many wards still offer shared rooms although the general aim is to offer patients single rooms. To get some privacy in these situations, patients may wish to be placed in a seclusion room (Stolker et al. 2006). A patient-friendly environment on the ward has been reported to be helpful in managing aggression (Keski-Valkama et al. 2010a; Kontio et al. 2012). The environment on the wards needs regular improvements to ensure privacy and peacefulness; private rooms as well as therapeutic furnishing should be guaranteed.

Finnish studies have shown that patients treated on forensic wards are more dissatisfied with seclusion and restraint and consider these measures to be more punitive than their counterparts in a general psychiatric setting (Keski-Valkama et al. 2010a, b; Soininen et al. 2013a, b). Earlier studies revealed that a forensic setting is a more stressful environment than a non-forensic one. Furthermore, in risk factor research forensic nurses perceived secluded patients more often at risk of causing harm to themselves or others (Whitehead and Mason 2006). This may be associated with patients' critical perceptions in forensic settings. Nurses are alert and feel stressed due to the threat of violence and this, in turn, may affect their relationship with patients. What's more, patients' negative feelings during coercive interventions are also likely to affect the therapeutic relationship and patients' self-esteem in the future (El-Badri and Mellsop 2008). Tenkanen et al. (2011) found that in a forensic setting, nurses need more specific education and training, even in basic clinical knowledge and skills such as basic life support skills, needs-led treatment, the theory and practice of therapeutic relationship, de-escalation skills, risk assessment skills and debriefing techniques after a violent episode or a near miss event.

Seclusion studies have explored patients' suggestions for better seclusion and restraint-related nursing practices. Suggestions have included an external evaluator in the decision-making situation, up-to-date information on how long the seclusion or restraint will last, and written agreements on alternative interventions (Keski-Valkama et al. 2010a; Kontio et al. 2012). Furthermore, patients have suggested alternatives to seclusion such as constant observation, medication, a time-out programme, resting in one's own room, verbal de-escalation, activities, music, and an opportunity for interaction (Meehan et al. 2000; Keski-Valkama et al. 2010a). Other suggestions have included more interaction, caring behaviour

and a calm manner on behalf of staff as well as more medication (Binder and McCoy 1983; Kennedy et al. 1994; Meehan et al. 2000, 2004; Chien et al. 2005).

After seclusion or restraint is over, ventilation and discussion are needed to process all the feelings experienced, to provide psychological and emotional support, to accept the reasons for seclusion and to discuss treatment plans for the future (Mann et al. 1993; Kennedy et al. 1994; Meehan et al. 2000; El-Badri and Mellsop 2008; Ryan and Happell 2009; Keski-Valkama et al. 2010a; Larue et al. 2010; Needham and Sands 2010; Kontio et al. 2012). The importance of being respected as a unique fellow human being cannot be emphasised enough (Välimäki 1998; Chien et al. 2005).

14.3 Coerced Patients' Perceptions of Their Overall Treatment

One could argue that coercion, especially seclusion and restraint, is fraught with overall dissatisfaction with treatment and thereby poor treatment adherence and worse outcome. Soininen et al. (2013a, b) studied the perceptions on the overall treatment of patients who had been secluded or restrained. Yet again, unsurprisingly, the authors found that the patients' perceptions of cooperation with staff and especially their perceptions of seclusion and restraint were negative. On the contrary, perhaps unexpectedly, the patients' perceptions of the benefit of these measures (seclusion and restraint) were more positive than the perceptions of their necessity. Yet, both were very low. That is, on the whole, seclusion or restraint were deemed neither necessary nor beneficial.

It is uncertain whether the patients' age is associated with how patients perceive their treatment. In the aforementioned study, older patients were more critical of the use of seclusion and restraint than younger ones (Soininen et al. 2013a, b). Contrarily, Whittington et al. (2009) found that older patients were more accepting of coercive methods than younger ones. Differences in samples may explain this discrepancy: Soininen et al. (2013a, b) included participants from both acute and forensic settings, whereas the study by Whittington et al. (2009) only examined the views of patients on acute general psychiatric wards. Another reason could be the use of specific coercive measures. Mechanical restraint or both seclusion and restraint were used more frequently in the Finnish setting, but in the UK, mechanical restraint is not used at all. Another potential reason for this dissimilarity could be different study design and outcome measures making direct comparisons difficult. Further, cultural factors, including patient expectations, legislation and psychiatric practices are likely to be important variables explaining differences among countries (Newton-Howes and Stanley 2012). Patients meet non-statutory pressure and coercion, although they are in voluntary in- or out-patient care. Burns et al. (2011) studied social pressure and leverage in USA and UK and found that some measures of social pressure vary by country. Using non-statutory pressure is associated with the severity of mental illness and substance use (Burns et al. 2011).

Gender also seems to be associated with how patients perceive treatment and coercive measures. Nawka et al. (2013) studied gender differences among coerced

patients with schizophrenia in 12 European countries. They found that coerced women were more likely to show aggressive behaviours but with a lesser intensity than their male counterparts, while aggression in men was more severe. Men were more often secluded or restrained, while women were more likely to receive forced medication. The authors suggest that gender issues should be taken into account when making national or international recommendations (Nawka et al. 2013).

Finnish women have been found more critical than men of the degree of cooperation with staff and the use of seclusion and restraint (Soininen et al. 2013a, b; Kuosmanen et al. 2006). A Dutch study reported gender to be associated with patients' preferences as to whether they want to be secluded or medicated when needed: Women preferred medication while men chose seclusion (Veltkamp et al. 2008). On the whole, women more often prefer interpersonal interventions and seek help earlier (Seeman 2006). Men more often suffer from schizophrenia and bipolar disorders than women, whereas women suffer more often from depression. Compared with depression, schizophrenia and bipolar disorder more likely present with symptoms, which may lead to the use of coercion (Andreasen 2005) and this may be associated with the differential rates of coercive measures in the two genders as well as with perceptions by men and women of the coercive measures used.

In general, coerced patients suffer from a lack of proper communication with personnel, and their opinions are not taken into account, the opportunities to voice their opinions are inadequate and staff members' understanding of patients' concerns is poor (Soininen et al. 2013a, b; Meehan et al. 2004; Keski-Valkama et al. 2010a, b; Kontio et al. 2010; Mayers et al. 2010). These are not results the psychiatric services can be proud of. It should be obvious that patients' opinions need to be taken into account when making treatment decisions, even those concerning restriction (Bergk et al. 2011; Georgieva et al. 2012). We need to listen to patients in a similar way we listen to others. Respectful rapport surely prevents coercion and influences patients' perceptions in a positive way.

In a Finnish study, those patients who had experienced seclusion or restraint during their current hospitalisation reported significantly better self-rated quality of life just before discharge than did their not secluded or restrained counterparts (Soininen et al. 2013b). The patients were often secluded just after admission, and their hospital duration was quite long (mean ca. 2.5 months). Although patients consider seclusion/restraint unnecessary (Soininen et al. 2013a) and more of a punishment than treatment (Meehan et al. 2004), this study showed that experiencing seclusion/restraint was associated with improved quality of life. This positive relationship between the experienced seclusion/restraint and higher subjectively perceived quality of life was hardly causal. Neither was it explained by gender, age nor diagnosis, which were all controlled in the analyses. The authors argued that the long hospitalisation time of their patients and other—more positive—elements of the treatment could just make the seclusion/restraint episode relatively unimportant in the entire context of the overall, positively perceived treatment. Maybe the contrast between the seclusion/restraint experience and the

freedom of the upcoming end of hospitalisation brought such joy that the quality of life assessment was affected by this elation. This, of course, remains speculative.

Adaptation to the illness and treatment system as well as experiences of earlier coercive measures have been shown to influence patients' perception of coercive measures (Hoekstra et al. 2004; Georgieva et al. 2012). Patients hospitalised more than once might be more familiar with the treatment system, adapted to their symptoms to some extent and had lowered their expectations of their living conditions and well-being (Kahneman et al. 2004). Hoekstra et al. (2004) concluded that the reasons for earlier secluded/restrained patients' positive experiences of coercion were associated with adaptation; learning to live with the experience rather than assimilation, active coping and control. Other factors during hospitalisation may also have impacted upon results: patients' recovery (Ristner et al. 2011), psychoeducation received (Pitkänen et al. 2011; Michalak et al. 2005), therapeutic relationships between patients and nurses (Michalak et al. 2005), or characteristics of the wards.

14.4 Preventing Coercion

Based on the current knowledge of patients' perceptions on coercion, it seems safe to say that the best way to take them into serious consideration is to prevent coercion altogether. Coercion is most often used to control violent behaviour. Thus, to prevent coercion, one has to consider what prevents violence. In preventing violence, risk assessment is widely used. Its use as sole determinant of detention, punitive measures or release is not supported by current evidence, however (Fazel et al. 2012). Of course, if patients' distress is noticed and treated so that it never amounts to violence, coercion is also prevented. If the process leading to violence is halted early on, it will never end in violence nor coercion. If risk scenarios are assessed, their climax will never happen providing treatment is administered effectively. To our knowledge there is no research on patient experience of risk assessment and its usefulness though.

During the past decade, many countries have announced the objective of reducing the use of coercive measures, shortening their duration and ultimately finding alternatives for coercion. Many countries have given up straitjackets and shackling to the wall, for example. In line with this, it should not be impossible to fathom a future without mechanical restraint, even decreasing seclusion to the bare minimum. Obviously, this would mean major changes in treatment culture and therapeutic models on the wards.

Reducing coercion is the aim in psychiatric care at national and international level (Bowers et al. 2011). Globally, there are many programmes to diminish the use of coercion, for example in Finland (National Institute for Health and Welfare 2011), the Netherlands (Abma and Widdershoven 2006; Janssen et al. 2008; Vruwink et al. 2012), USA (American Psychiatry Association [APA] 2003), and Australia (Australian Government 2008) and Japan (Noda et al 2013). The programmes include as their main elements state-level support, policies and

regulations, leadership and culture, educating staff on assessment, treatment planning, documentation, management and early intervention, debriefing, and guidance on restraint and seclusion (APA 2003; Huckshorn 2004; Smith et al. 2005; Gaskin et al. 2007). Service users are also involved in these programmes, for example in Finland (National Institute for Health and Welfare 2011).

Culture and attitudes of psychiatric staff have been found to be associated with the use of coercive measures (Meehan et al. 2004; Bowers et al. 2007; Mann-Poll et al. 2013). In psychiatric hospital care, the aim is to ensure a safe environment for all patients by preventing violent behaviour and by offering the best treatment to help patients to deal with their symptoms. In order to develop ward culture and a non-restrictive atmosphere, patients' individual situations and therapeutic interventions need to be considered, not organisational structures or routines. We need a shift from mass production to individual handicraft.

Patients and their relatives have demanded more information on treatment alternatives and to be more active participants in the treatment and care. There seems to be strong evidence for psychiatric advanced directives (PAD) leading to a better treatment alliance (Swanson et al. 2006). PAD, among other things, means patients provide written instructions to the medical personnel on their treatment preferences in a situation when they are incapable. Patients' preferences and suggestions should be elicited when their condition is settled, mainly in outpatient care, and this information should be transferred to the treating hospital (Swanson et al. 2003; Srebnik and Russo 2007). It should urgently be studied how PADs reduce the use of coercion, particularly seclusion and restraint, and what the patients' perspectives on them are.

14.5 Patients' Experiences and Clinical Practice: Future Challenges

In the past decade, patients have been increasingly encouraged to take a more active role in the planning and delivery of health care (Council of Europe 2000). In psychiatry, too, a number of measures have been undertaken to strengthen the position of patients (European Commission 2005). Patients' personal experience-based expert knowledge of health services provides new information that challenges traditional assumptions, highlights key priorities and prompts professionals to re-evaluate their work (Rutter et al. 2004).

In Finland, among other countries, the importance of patients' perspective and service user involvement in the development of inpatient aggression management programmes has been officially recognised (Ministry of Social Affairs and Health 2009). It is understood that patients' experiences and practical suggestions on the improvement of coercive measures, especially seclusion and restraint practices and their alternatives, are essential to ensure evidence-based patient-centred psychiatric services (Hyde et al. 2009; Kuosmanen 2009; Keski-Valkama et al. 2010a, b; Kontio et al. 2012, 2014).

It is of concern that even a long time after the event perceived as traumatic, salient perceptions, recollections and feelings of the service users may remain in their minds (Kontio et al. 2014). For example, suicides witnessed on the ward many years ago still are experienced as extremely taxing memories and the same seems to be true for aggressive or violent incidents experienced or witnessed.

The (mostly negative) perceptions of poorly handled aggression and coercion-related incidents have an unwanted impact on patients' adherence to services (Jenkins et al. 2002), and this effect may be long-lasting (Kuosmanen et al. 2006). Therefore, from the very beginning of treatment contact, a humane nursing style must be applied and the therapeutic relationship between patient and staff established.

The quality and substance of the interaction between patients and personnel are crucial in how patients' perspectives evolve. Patients have been found to feel alienated from the staff in in-patient settings, which makes communication more difficult and hinders or prevents sharing information between patients and staff (Jeffs et al. 2012). Nurses' absence from the wards may result in feelings of loneliness (Duxbury 2002; Kontio et al. 2014). In the absence of staff, patients tend to withdraw from situations and take a passive observer role with consequent or worsened suspiciousness. The perceived loneliness is frightening, and the patients may feel insecure (Koller and Hantikainen 2002). This kind of negative staff and patient relationship can lead to patient aggression (Duxbury 2002; Kontio et al. 2014). When patients spend a lot of time together, they seek therapeutic interaction between each other and may carry each other's burdens. Without professional guidance, this is a somewhat counterproductive constellation (Stenhouse 2011). Patients' experience of restrictive rules, inappropriate control or use of power and strength on the part of authoritarian staff can precipitate aggression and violence (Kontio et al. 2010; Shattell et al. 2008). This, in turn, launches a vicious circle of ever growing restrictions that are common, for example, in Finland (Raboch et al. 2010).

It seems clear that it is not the lack of data on service users' views that is the most challenging issue. Indeed, patients' experiences have been extensively studied, yet the research data have insufficiently penetrated into clinical practice in many countries. Remaining with the example of Finland, service users' actual involvement has been unsatisfactory and restricted mostly to participation in working groups focused on limited specific issues (Kuosmanen 2009). This is peculiar, because the importance of service user involvement in the development of psychiatric inpatient aggression management programmes has long been recognised by Finnish health care authorities and legislation, and all professional guidelines emphasise service user involvement in the course of treatment (Amendment to the Mental Health Act, 1423/2001 2001; Ministry of Social Affairs and Health 2009).

Patient-centred care, that is co-working with patients and their relatives, is fundamental. A paradigm of dialogue and basic psychiatric nursing skills, such as communication skills and an empathic rapport, should be self-evident in nursing practice. When a patient unexpectedly behaves aggressively, has threatening

psychotic ideations, cognitive deficits or her/his competence is temporarily impaired, this may be acutely challenging for nursing staff to negotiate. Situations may demand quick decisions to ensure the safety for all patients and staff. During these abrupt situations, the patients may feel that their voice has not been heard. Therefore, it is crucial to prevent such escalated situations altogether.

By respectful and sympathetic cooperation, the staff should seek appropriate de-escalating interventions. Even more important than making quick decisions is to concentrate on dialogue with patients, to observe their symptoms, for example, anxiety, and then help them cope with these symptoms before building up to heated situations. After all, psychiatric staff exist to treat, not to police. Building a therapeutic alliance in every situation has shown promising evidence in reducing the use of seclusion as well as emotional exhaustion of nurses (Happell and Koehn 2011).

Reviewing the international research proves that this is obviously a global issue. For a Nordic reader, it is easy to nod in agreement with the Indian perspective of Shah and Basu (2010). They highlight the importance of skilled communication that is two-way, open, repeated, empathic and accommodative. Furthermore, advanced planning for the possibility of future incapacity, by use of joint crisis plans, reduces compulsory admissions and treatment in patients with severe mental illness, and it may affect the amount of perceived coercion. The authors continue that one should be explicit about what one is doing and why, allow patients to tell their side of the story, and seriously take this information into account. This is a matter for the whole of psychiatry.

We have proceeded beyond the notion of staff telling the patients what is best for them. We have to listen to patients and work together to ever improve their experiences of their treatment, even if seclusion or restraint had to be used. Today, we acknowledge that patients' experience is a matter of the services' quality. And people with psychiatric problems do deserve high quality services. We have to treat people in a way that we would wish our children to be treated.

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Service User: Coercion Concern

15

Peter Andrew Staves

Abstract

In this short chapter, I discuss coercive practice by calling on personal experiences of over 20 years being treated for manic depression to give a patients' perspective. This is of course a biased and somewhat anecdotal view of coercion that focuses on negative aspects, but reflects a patient's experience of these techniques. In the context of this book, it is hoped that this account of coercion provides an alternate view to what readers may have already gained from previous chapters. I utilise treatment experiences over my time as a patient to emphasise my arguments. The chapter aims to question the rational of using coercive methods and questions the benefit to a patient over time. After defining what I think coercion is, I conclude by questioning why it is used and if it is at all an effective way of treating people with a mental health condition.

15.1 Introduction

I begin by a dull and formal introduction of myself. Unfortunately, I hold a 20-year plus history as a patient, I don't like the term service user. I also state what we are really talking about when considering coercive practice, which equates to the torture, in a socially unsupported and persecuted demographic of people. When patients with mental health problems are ill they exist in a vulnerable mental state and because of this are open to coercion, but just because you can doesn't mean that you should. Mostly, this treatment is due to a lack of understanding and compassion. I write this with no knowledge of what others in this book have said. I do this to introduce my conceptual concern as to how coercive practises are seen from a

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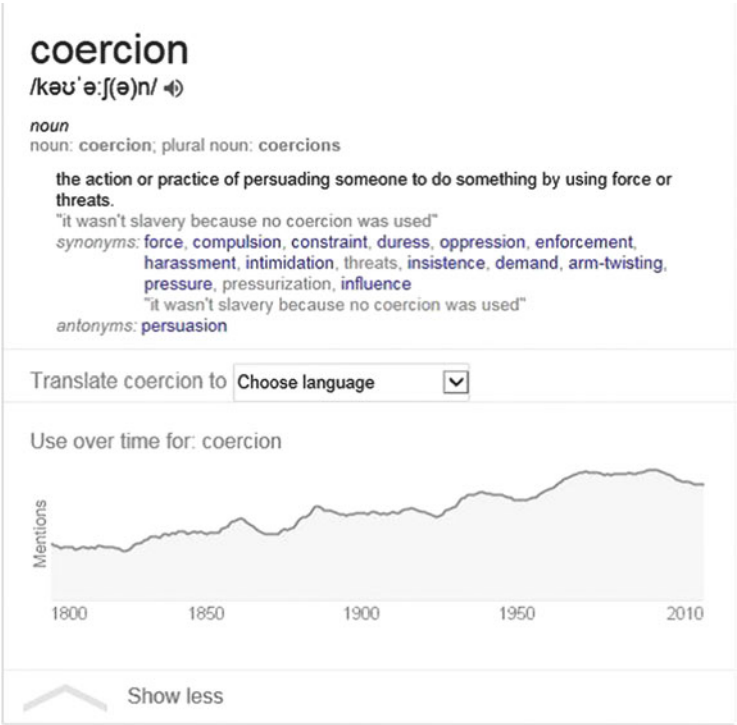
patient's perspective now, in 2015. I don't like to use the term 'service user' and in the same vein usage of 'coercion', as the word holds and instils negative connotations in how to regard and treat people with a mental health disorders.

15.1.1 Peter: The Rock; Andrew: The Strong; St' aves: Demi-God (THOR), Magical Nordic (See Staves), Myth Around Here, Myhr'andeer, Merlin, Muse and Singer or Just a Crazy Man

Diagnosed as a manic depressive in 1998 at the age of 17–18. I have spent approximately 10 % of my life since as a sectioned patient in hospital that equates to a total of approximately 3 years. My diagnosis and type of treatments have also changed over time, and temporal themes will weave through my chapter. But to clarify, I have been diagnosed as a manic depressive, bi-polar 1, bi-polar 1 with psychosis (see above in title) and now I am officially BAD (bi-polar affective disorder), nothing like a good acronym, or complex renaming of a condition to make Joe Public understand less. Have I changed, or my condition? I would say both, in understanding, treatment and time. I have had close to nine admissions and begin to lose count. I am a patient but also attempt to lead a normal life and fit in with society. I consider myself a learned man holding three higher degrees cumulating in a doctorate from the School of Biological Sciences, Queen Mary University of London, on Mixed infection dynamics and competition. Currently, I work for the Public Health England (PHE) as an infection control healthcare scientist/informatician at Colindale's Centre for Infections. I come from both a religious and farming background, one grandfather theologian (Durham Cox) and Reverand for the Church of England and on the other side a farming family, all with Lincolnshire roots, although I was born, miraculously, at Doncaster Royal infirmary in the 70's, so a Yorkie. I say miraculously due to the maternity ward scandals around the time and introductions of choice during pregnancy. Luckily for me, my mother worked for the hospital, as a nurse, so it was a room full of professionals and my dad, so not at the pub. But let's get back on topic and talk about NHS practice today, although as mentioned above, the past is always important for perspective.

15.1.2 What Are Coercive Techniques?

If you google "coercion definition" this is the first hit on google books:

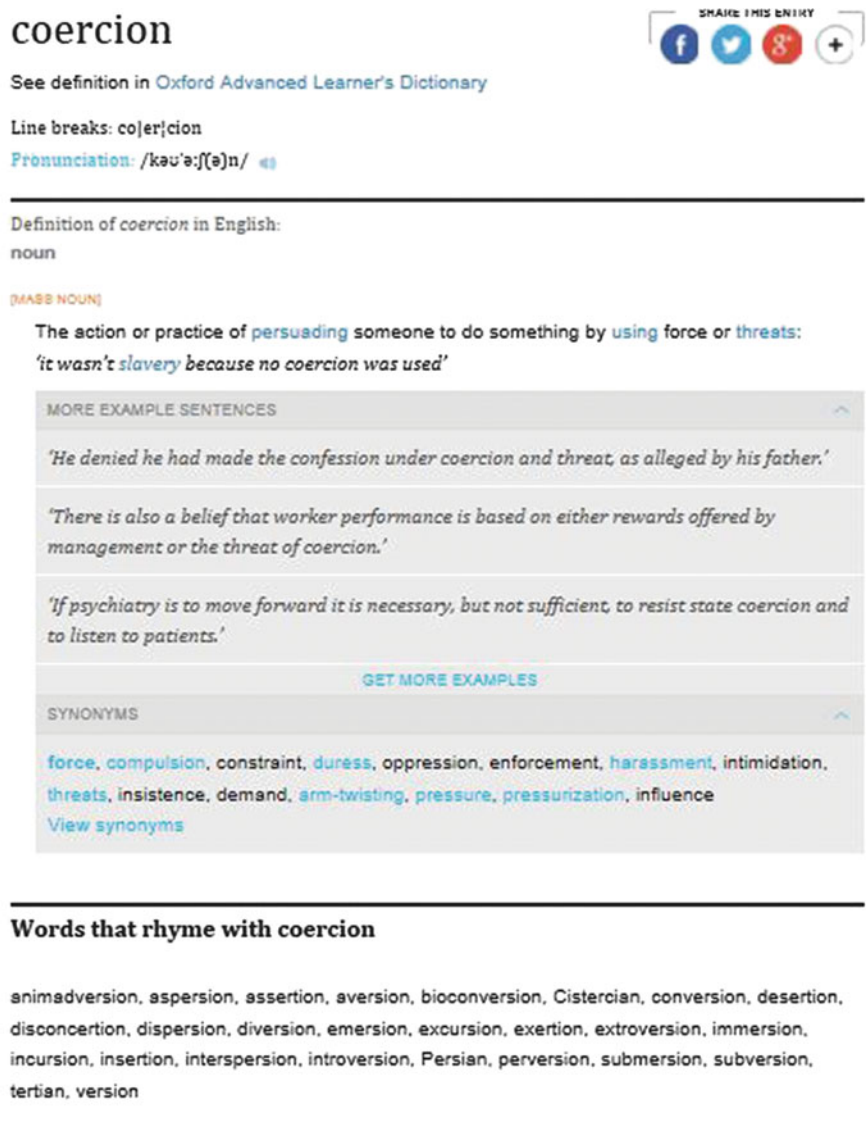


Now, none of the above sounds good to me, as a patient. Force, duress and **not slavery if no coercions are used**, and we are treated like them, "**slaves**" that is. Unfortunately, a William Wilberforce is yet to be in our generation/demographic, so in his absence I will hope to fill a void and display why coercion is the wrong path for modern nursing and doctoring, I say modern in a loose sense since this hasn't always been my treatment, in the late 1990s, for example, when nurses were nurses first and specialised and doctors still held reason and, more importantly, wisdom.

Perhaps when I was younger, I questioned such professionals less and had more faith in them, again time changes perspective. But in reflection it is fair to say that training methods, staffing and funds have taken their toll on the service I used to receive as a patient. These days, I have found younger doctors and consultants far too overly impressed with themselves, their self-importance, forgetting their main purpose to above all care and do no harm. This attitude, I hate to say, comes from three main sources:

1. A reliance on medication making up for lower staffing levels and an overriding belief in science and its answers.
2. A doctor's power, the use and misuse of the section, coupled with a consultant's reliance on their juniors, rather than getting to know patients personally.
3. The policy dictating mental health provision and how it is now entrenched as a business model.

But back to those lovely definitions of coercion:
The Oxford dictionary web page (2015) states, with examples:



coercion

SHARE THIS ENTRY

See definition in Oxford Advanced Learner's Dictionary

Line breaks: co|er¦cion

Pronunciation: /kəʊˈəːʃ(ə)n/

Definition of *coercion* in English:

noun

[MASS NOUN]

The action or practice of persuading someone to do something by using force or threats:

'it wasn't slavery because no coercion was used'

MORE EXAMPLE SENTENCES

'He denied he had made the confession under coercion and threat, as alleged by his father.'

'There is also a belief that worker performance is based on either rewards offered by management or the threat of coercion.'

'If psychiatry is to move forward it is necessary, but not sufficient, to resist state coercion and to listen to patients.'

GET MORE EXAMPLES

SYNONYMS

force, compulsion, constraint, duress, oppression, enforcement, harassment, intimidation, threats, insistence, demand, arm-twisting, pressure, pressurization, influence

View synonyms

Words that rhyme with coercion

animadversion, aspersion, assertion, aversion, bioconversion, Cistercian, conversion, desertion, disconcertion, dispersion, diversion, emersion, excursion, exertion, extroversion, immersion, incursion, insertion, interspersion, introversion, Persian, perversion, submersion, subversion, tertian, version

Interestingly, coerce rhymes with nurse—but that's quite a tenuous link for a wholeheartedly supported treatment path/system for people who can only be described globally as sensitive, hence coercible. I say with irony, "how is it that, given time, aggression and an unwillingness to comply to health treatments results in sectioning and, unfortunately, deaths". Often this scenario is in a very short time frame and due to coercion. I will end my section with a poem using the above

rhyming words, and in doing so hope again to capture my concerns and that of my people/kin (i.e. those who suffer society in the West).

15.1.3 So Why Are Patients Coerced?

This is not a hard question to answer from a patient's perspective in 2015. Put simply, it is viewed to be easier than caring, given a changing health service now hell bent on meeting government set budgetary targets that limit patient–staff time. Patients have less beds and nurses available to treat them, what does this mean for a patient when ill? Well, it means to be admitted into hospital you can't just be unwell you have to be in a section-able or severely ill state, and when you are in hospital the care you receive is limited, with hospitals struggling to meet best practice with the resources they have. Nowadays, the nurses must also fill out endless reams of paper work and meet their obligatory mandatory online training, whilst the OTs (Occupational Therapists) who also have administrative demands are left to pick up the caring slack—but on a lower salary grade, yet at higher personal risk. This mirrors the system in place in the police where community support officers patrol the street, so not always with a full constable. The highest paid mental health staff, the consultants, are often allowed to go to work in other private practices and actually see the patient once or twice a week, relying on inexperienced junior doctors and their online nurses to fill them in on happenings of ward life (officially called a management round). I liken this management round to a giant game of Chinese whispers, where the patient rarely gets a say and like Chinese whispers the truth disappears. Individual care, so vital for treatment success, is lost and states to me that caring and therapy are low on the hospital consultant's agenda. Patient control and not care are now the goals, but does this approach display greater efficacy? Value for money is measured by economic models that only look at the short-term goal of freeing up a bed. I will go into this in more detail giving my personal experience to this short sighted approach. And a patient's quality of care is often overlooked and measured simply as their time spent on the ward although new guidance advocates a patient centred approach to quality metrics in a mental health setting (NICE NG10 2015). The goal of coercive practice is to ensure that the patient is controlled whilst cared for, and unfortunately the two aims are at odds with one another when considering the patient's perspective.

Coercion over the weak and mentally infirm is employed in a hope to reduce incidences of challenging behaviour and to make the patient compliant. However, this becomes a negative feedback loop, as by our very nature humans respond poorly to threats and intimidation. This is no different within the mental health patient demographic. In fact, for those with mental health conditions, we react very poorly to manipulators making the outcome and negative impact worse, increasing our likelihood of displaying challenging behaviour and, in my opinion, lengthen the stay as an inpatient. The medical professionals working in the field of mental health know that the patients, when well, are not a mentally weak demographic; in fact we are more creative, articulate and, in many cases when older, wiser than our captors.

It is this fact, more than any other, that results in failures of coercion and in some cases brutal treatment of patients who resist.

15.2 Personal Accounts

15.2.1 Money

Apparently, this makes the world go around. I am sure that Newton would disagree and as a biologist, a religious one, I would say it is love and/or reproduction. In the NHS, monetary decisions are often based on 5–10 year economic models, where bed availability and patient well-being metrics are optimised based on the cost of the possible treatments over time. This model can result in the exclusion of the best treatment based on the number of patients an expensive treatment covers. I could go into this more but it would bore me and you and I think this is enough, to explain it in the most simple terms. The medication for mental health conditions is nearly an infinite list with doses, release mechanisms, blood levels and targets all specifically designed to treat the patient's mind state at the time and maintenance doses in the future. New medications are developed and then tested clinically; often these come into mental health because they are found to have beneficial side effects and so are not used for their primary or intended (designed) purpose, so a welcome accident. Some of the best scientific discoveries happen this way, penicillin, to mention one.

From the age of 17, I was put onto Olanzapine, Lilly Zyprexa. I used to call them my "Lilly Savage's"; he was a cross dressing comedian in the UK at the time. This was the original patented drug's trade name. I took this with only minor side effects for over 15 years. But a new "pine" became available, so a similar chemical species called Quetiapine or Seroquel (first trade name, UK). When this came out it was cheaper and boasted less side effects, in particular less weight gain, thus reducing the chances of developing diabetes. Since taking Seroquel in place of Lilly's which was the economic drive, I have been ill much more frequently, in fact four times in 5 years. I have tried different doses, different release mechanisms and different combinations with other drugs, semi-sodium valproate (Depakote) and Sodium valproate (Epilim), and tried taking meds at different times of the day. But I still haven't had the length of wellness I had when I was on Olanzapine. So, it was obviously always the best drug for me, in combination with Epilim. I have asked to be put back on it as it is no longer in patent and again economic.

Just as an aside—the patented or original drugs are best. They are made with greater quality. I currently get Accord versions of my Quetiapine, from Boots the Chemist; these are not enteric coated, they are film coated and this leads to a cracked tongue, metallic tasting scum in the mouth every morning and kidney pain. I have to request Seroquel from my GP as the patient's choice of brand is no longer considered important to these older meds or health conditions. I used to have the right to choose branded tablets, and this has changed in line with policy. This account of the economics is important to emphasise—how patient quality of life

can be governed by so called “best practice”, and this also applies to coercive techniques and the local policies in practice.

15.2.2 A Broken Family

I am currently a married man of 10 years with two children, ages 5 and 2, a girl and boy, respectively. However, due to the frequency of my illnesses over the last 5 years and the resulting hospital stays I have endured during the time I have had a family, I now live alone. The plan was a trial separation, space to help get love back, it would seem this is working. But the result of my mutual separation status and living circumstances I don’t have my children over to stay with me. My wife can treat me as an ill person, even though I am well and working. She herself has been treated with medication for depression, so you would think she would have a better insight. Do I blame her entirely? No. My wife behaves often with affection to me but not when I come out of hospital and into the community, an in-between phase of too ill to work (mild mania) but not ill enough to be in hospital. It is at these times when our relationship has been tested and the arguments during these times which have led to trial separation. I am under monetary stress, running two houses—a flat in my dad’s name and the family home, a three-bed in London with a mortgage—not a cheap place to live. Before my latest health relapse and after, I have been racing between two houses to take my children to school, at first 3 days a week and now 2, before heading off to work on an hour’s commute, I also try to get home for the children’s bath time. Currently, I am phasing back into work, 3 days a week but will soon be back to full time. This means, of course, multiple stressors for me but I refuse to just give in, stop work and take benefits like many of my mental health afflicted peers. My wife and I have had couples’ counselling with the South Hackney CMHT team in the past to help her and us work together to understand the condition and me when I am ill. We have tried hard to resolve things but I still remember feeling controlled by my wife, who, like many staff in the hospital, uses my condition as a weapon. She is a very bright women, working as an editor and knows naturally how to coerce me and more than any NHS staff member ever could. She knows exactly what buttons to press, common in any marriage of length, I know her buttons too. Where did she see this happening to me with greatest effect? In hospital, when I am weak. And it has resulted in my current living situation being less than ideal. I am currently seeing a psychologist and discussing these issues with a professional. Unfortunately, as a patient in Hackney, you often need to fight to get such help, post-hospital.

15.2.3 Why Have My Illnesses Occurred Recently

Triggers due to stressors, changes in medication and treatments, changes in policy leading to situations where I have not been treated humanely. The short answer.

15.3 Methods and Results

In this section, I will try to give some suggestions. How a change in ethos helps reduce the level of coercion used in mental health settings with the aim of improving patient centred care and also the money spent per patient. Some of what I am about to say has such intuitive sense; it is quite embarrassing that it must be pointed out.

15.3.1 What Can Be Done?

Promote happiness and a relaxed approach in mental health settings. A good book to read is called "The Happiness Project", take note of the suggested further reading at the back (Rubin 2009). It was a New York Times best seller and details the life of the author who for 12 months tried to use all wisdom, both old and modern, and to become happier in life. When similar wisdom is applied to hospital ward life, you can really see a change in both the patient experience and that of the staff. If staff and patient alike all work as one team with a nursing and caring focus, then life in hospital at least can improve. East London's Homerton hospital East Wing is now running with a very happy ethos, and this is proving to be both cost-effective and beneficial for all, from my manic standpoint it is like the old adage, "If you can't beat them join them". This is in part due to the nursing led approach and the willingness to scientifically test new policy and staff led initiatives. The approach is in line with new NHS quality standards. Jane Kelly, currently the lead Nurse at the East Wing, is driving this forward and I am amazed by the results. These results of patient experience and cost were shared very recently with international delegates from the quality complaints commission and held at a local OT charity, Core Arts. The delegation toured both the OT charity centre in the community and visited Joshua Ward in the hospital to view a photography exhibition. My understanding was that the initiatives being trialled utilised both NICE guidance and best local practice:

1. Women's health questionnaires, as a patient experience metric to steer treatment.
2. Rapid tranquillisation (RT) measures to reduce instances of repeated frequent doses.

The evidence presented was extremely well received and to date this acute hospital stands as a beacon of what can be done with hard work on both sides, patient and staff and how to promote a healthy vibrant life on acute wards.

15.3.2 Postcode Lottery

This is the reality, not all Trusts support such innovation, are unwilling to break with doing what they know and local policies are overriding best practice. Recently, I was part of an NHS policy guidance board, working for the UK's National Institute of Clinical Excellence (NICE GDG). This guidance was a 2-year process

where a group of experts in conjunction with lay members (service users and carers) reviewed and updated best practice for the management of challenging behaviour when mentally ill. I was astonished at the final meeting of my NICE GDG, the consultation, to see that many interested parties had no comment. My question was, have they bothered to read it and do they even care? My advice to other patients is: only be treated in hospital if you are happy that they know you personally and know what works best for you. Homerton know me well now and I benefit from this. I have always had concerns that, if guidance is not adopted, what happens to both new patients and those with no family or carer support? Advocacy services such as Mind and Florid help here massively, I normally utilise this resource when in hospital.

15.3.3 The Past, the Present, the Future

15.3.3.1 Past Learning

Like any historian, we can always learn from past initiatives and adopt back those schemes that worked. This may be specific to the hospital and the demographic it covers. London's population is, for example, much different to a Northern mining town. Sometimes a good understanding of this can help with local variation in policy. Did any level of coercion work? If so, what people, when in their treatment/admission and to what degree was acceptable? What ward types, environment and how best to monitor its use for the good of patient care.

15.3.3.2 Present Needs

The reality is mental health provision has to work with the resources they have now. Can everything be done? Short answer, no. Changing the ethos of staff who wish to control their patients, however, should be possible. What are the best economic decisions long term? Acute mental health conditions don't just disappear, is "release a bed as early as possible" a working model over more than 5 years? In my opinion, if true and effective, treatment is promoted and that this treatment ensured a patient's life both in and out of hospital was in balance following an episode of illness, then in the long term the patient would need less help over time from health services. Short-term investment would lead to long-term gain. Imagine economics models that were patient focussed, economics based on lifespan of condition and treatment aimed at the longevity of health, not to simply free up a bed. In such models over longer time frame, money could be saved. With funding in the UK for mental health provision spread across inpatient care and community care, more should be done to ensure a fluid dynamic between the two sets of patient resource. If communication and the working dynamic between both in- and out-patient services is poor, then longevity of health to the individual patient is unlikely.

To come back to coercion, I see very little point in its application if the above was a reality. Why force a patient to act a certain way rather than treat humanely. If the goal is a healthy life for your patient then this approach seems absurd.

Coercion has in my mind only one role: short-term gain within a particular circumstance and can only have a long-term negative effect on a patient's perception of their healthcare treatment.

15.3.3.3 Future Hopes

Patients already suffer the stigma of having mental illness, and such stigma is compounded by the people that are meant to treat them when coercive practice is used. Mental health professionals should understand that if their attitude is to control people who have done nothing wrong in life but have a health condition, then their efforts aren't good enough. Wasting time controlling people instead of treating them is not only counterproductive for health, it wastes money and incites the need for a patient to rebel.

If we can save money by utilising best caring practice and applying it correctly to the patient demographic but ensuring that this money isn't lost on overly controlling patients, a negative feedback loop. Then this approach goes on to fuel further best practice over a patient's lifespan. By the healthcare system in itself, we can promote positive feelings amongst patients across the course of their life and remove a layer of societal stigma that exists. Patients remember the times they have been coerced, and this affects future treatment. If we lost the emphasis to control ill patients, the resulting negative feelings would also be lost. For each patient, this could only lead to an improvement in their perception of mental healthcare provision, leading to continual improvement when treated over time.

15.4 Discussion and Conclusions

What should be the aim of acute mental health services? From my perspective, I would say patient happiness and continued well-being. Can this be achieved via coercion? I would say "no", I am not even sure if coercion should be used even when it is deemed appropriate. What should all staff be? Patient—when staff rush to treat within an acute patient setting, mistakes happen. This fact is evident in restraint death records (Duxbury et al. 2011; Paterson and Duxbury 2007) and when harm comes to NHS staff in multiple settings, so policy should reflect this and not rush staff members when applying dangerous techniques, including coercive practice. Am I happy now? No, but I aim to be. I continue to fight in life because I am optimistic and refuse to break because of my mental health condition. Everyone has a cross to bear in life and this is mine so I cope with it. Find what love is to you and hold onto it. For me, it is my family life I am losing here right now but I hope to have a better situation eventually. If we can make patients happier to go into hospital, treat them humanly and with respect they will again trust in their health service and the treatment it provides. To gain the trust of patients is a much better way to make them compliant with treatment than trying to control via coercive practices. There is light at the end of the tunnel for both staff and patients; together with true nursing led care, we can all be happier, but old habits die hard and—I hate to say it—but some staff enjoy the control too much.

To quote/paraphrase Winston Churchill who was reported to suffer with manic depression. “For me, I am the eternal optimist, I see no point in being anything else”. That quote serves me well to this day.

My Poem (as promised):

Alone with my mind
I immerse myself in life,
All creatures of habit,
We are so diverse, biodiverse,
No one solution for all.

My nurse knows me, yes me,
I can be happy it’s allowed,
I am not perverse or bad,
Sometimes terse and sad.

But life reimburses me,
I traverse time with joy,
In my heart I am free,
To wander the world.

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Part IV

Practical Challenges

Best Practices for Reducing the Use of Coercive Measures

16

Jacqueline Ewington

Abstract

Coercive measures in forensic metal health settings are utilised in the management of disturbed, aggressive or violent behaviour and there are always moral issues, even when these types of intervention are legitimised. Although coercive measures are routinely utilised when all other intervention options fail, it is important to acknowledge that occasionally patients with predisposing factors for violence do not always respond positively to de-escalation attempts, and the violence that nurses and other professionals face is sometimes instantaneous, extreme and intense; so it is unrealistic to believe that coercive measures are totally unnecessary or uncalled for. Therefore, while we strive to reduce their use to a minimum, they will continue to be considered as planned or unplanned intervention options.

In 2014, the United Kingdom Government guidance 'Positive and Proactive Care; reducing the need for restrictive interventions' (Department of Health (DH). Positive and Proactive Care: Reducing the need for restrictive interventions. http://www.tinyurl.com/o2h8rxs, 2014) was published to ensure that care providers implemented least restrictive practices in their services. This initiative was further supported by the Mental Health Act (Code of Practice. TSO, Norwich, 2015) and the National Institute for Clinical Excellence [NICE] (Violence and aggression: Short-term management in mental health, health and community settings. http://www.nice.org.uk/guidance/ng10, 2015). These drivers inspire positive changes as all NHS Trusts must evidence a Restrictive Intervention Reduction Programme. Prevention and early intervention strategies rely on promoting least restrictive ways of managing a patient's behaviour by reducing risk factors for violence and aggression. To achieve this and reduce the use of coercive measures, protective factors that promote the safety and

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well-being of patients must be implemented, and individuals should be treated with understanding and acceptance.

To begin to reduce coercive measures such as physical restraint, seclusion and chemical restraint, and identify and introduce best practice initiatives, healthcare professionals should gain insight into the theories around causes of violence and aggression and understand factors that may pre-empt or exacerbate violent episodes. A review of the background of violence and aggression management and staff training in forensic mental health settings clearly shows how practices have evolved and developed so far. An evaluation of staff training and practice models gives insight into progress and development. Change management models and methods are identified to help leaders drive best practice changes. Current drivers and guidance for healthcare providers within the NHS and the Private Sector are highlighted with best practices and innovative projects aimed at reducing the use of coercive measures in response to the guidance.

16.1 Introduction

This chapter examines the use of coercive measures in forensic mental health settings with particular regard to measures currently in place in high secure services, such as physical restraint, seclusion and chemical restraint, in order to ascertain methods to reduce their use. The Cambridge dictionary defines coercive practices as '*using force to persuade people to do things they are unwilling to do*'. By the nature of the definition, these types of practices in healthcare are not always regarded as ethically sound or acceptable and the use of coercive measures continues to be very controversial, although these practices can be inherently ingrained in the culture of some organisations. In forensic mental health settings there are sometimes extreme and mixed views towards using means to force someone to comply with societal or institutional values.

Szmulkler and Appelbaum (2008) define coercive measures as '*the action or practice of persuading someone to do something by using force or threats*'. These measures can be objective or subjective but aim to prevent harm towards self or others in a situation where there is a high likelihood of aggression or violence. Within forensic healthcare environments, care and treatment in the UK is Recovery model focussed and, although promoting these principles is sometimes complex, there should be collaboration between healthcare professionals and the patient as the model is based around patient experiences and the need for hope, opportunity and control (Repper and Perkins 2003).

Drivers to change current practices have gained momentum and guidance from the Department of Health's (DH) attempts to ensure that coercive measures are never misused. Therefore it is crucial for all mental health care providers to evidence robust programmes to reduce restrictive and coercive practices. The Oxford Dictionary defines best practices as '*Commercial or professional procedures that are accepted or prescribed as being correct or most effective*'.

In order to adopt best practices for reducing the use of coercive measures, organisations need to understand the risks and complexities of the patients in their care and consider innovative ways to change the culture of their workforce, in order to drive forward the changes necessary to adopt best and least restrictive measures to manage patients' behaviour and allow for therapeutic interventions to take place, while maintaining safety and security for all.

Mental health legislation and government guidance in many countries may include specific directions for managing risks and protecting the public. Local policies are developed by the care provider for the management of coercive measures such as physical restraint, seclusion and chemical restraint. But there are also blanket restrictions, based on level of security that must be monitored and cannot be adjusted for safety, security and commissioning purposes; other restrictions that should be more fluid and based on individual risk assessments. It is important to consider the safety implications of reducing the use of coercive measures in forensic settings as the dangerousness of individuals does not always reduce with admission to a secure hospital. Therefore the aim of this chapter is to motivate leaders to scrutinise their departments and care provision and find innovative ways to reduce the use of coercive measures by ensuring that patient care is individualised, robust and, effective and aids the recovery process.

The Arizona Department of Education (2014) states that seclusion is often used in conjunction with physical restraint and rapid tranquilisation and has the potential to increase the level of stress experienced by a disturbed and distressed person. Therefore careful consideration should be given in order to safeguard the safety, rights and welfare of the individual. Seclusion involves the patient being contained alone in an isolation room that they cannot freely exit until staff decide to allow them to do so (Mental Health Act Commission 2004). It is often described as the solitary confinement of psychiatric patients in a bare room but it can be argued that the use of seclusion can have therapeutic benefit and value (Cotton 1995). Fisher (1994), e.g. stated that the use of seclusion can prevent injuries and reduce agitation. Morrall and Muir-Cochrane (2002) on the other hand, described seclusion as a form of social control over people who are already excluded from the community. The Mental Welfare Commission (2013) in the UK advocate that seclusion is a coercive measure that requires careful control by agreed decision-making processes and monitoring by staff who are trained in the management of violence and aggression as they are concerned that locking someone alone in a room could have serious consequences.

Patients who experience acute behavioural disturbances, resulting, e.g. from psychotic symptoms or high levels of anxiety, may require urgent treatment (Atakan and Davis 1997). When all means of de-escalation and minimisation of risk have been exhausted, then rapid tranquilisation with intra-muscular or intravenous antipsychotics may be indicated. NICE (2015) clinical guidance advises that oral medication should be offered for tranquilisation whenever possible and that chemical restraint should be used as a last resort to reduce any risk to the patients themselves or others, and to allow them to receive any medical care that they need. The person must be kept safe and treated with dignity and respect.

In order to identify best practice initiatives, we should first consider why coercive measures are necessary as current practice guidelines advocate that the least restrictive option should always be sought and physical restraint, seclusion or chemical restraint must be the last resort. Therefore, while it is understood that not all patients respond well to de-escalation or distraction techniques, all measures must be exhausted before we can justify any of these coercive measures. If organisations identify and introduce best practice principles to attempt to reduce frustrations that cause anger, aggression or violence, this alone will lead to a reduction in the use of coercive measures.

16.2 History of the Development of Training Courses to Manage Violence and Aggression

Wright (1999) acknowledged that the physical management of violence and aggression continues to be a controversial and emotive topic, as since the late 1950s mental health care has been criticised for being inherently harmful and oppressive although, in the recommendations from a review of forensic care settings, Blom-Cooper et al. (1992) were clear that physical restraint should only be used as a last resort. Nelsop et al. (2006) systematically reviewed the effectiveness of physical techniques but found insufficient evidence to support its effectiveness. Hopton (1995) considered the ethical justifications and objections to the physical management of violence and aggression and concluded that there are grounds for justification for this coercive practice where failure to use physical restraint might result in actual harm to be caused to the disturbed person, any bystander or property, as long as the method of restraint employed minimises the harm done to the restrained person and does not involve inhumane or degrading treatment. However, the gross infringement of civil liberties and human rights continues to be one of the most powerful arguments in the ethics of using coercive practices in care settings (Middlewick 2000). Beech (2001) felt that legal and ethical considerations should have a positive effect on the quality of care offered, on the therapeutic environment and the satisfaction of clients and their families. This will improve the morale, recruitment and retention of staff and decrease sickness/absence rates. Therefore these factors can have major implications for organisations.

Blofeld (2003) explored the implications associated with managing aggression surrounding the death of an in-patient whilst being restrained; there was no evidence that staff had attempted to de-escalate prior to restraint and the patient was held face down for approximately 25 min without his head or airway being managed or monitored. The incident that preceded the physical restraint was incited by racial abuse from another in-patient. Blofield (1994) concluded that there is a great need to explore this practice and its effect; this report also had significant implications for the care of patients from ethnic minorities as it was found that this patient with a mental illness was placed in a predominantly white environment, isolated from his family with no consideration of his cultural, social or religious

needs. Therefore he had feelings of oppression; he was acutely sensitive to racist remarks and had a desire to retaliate. Although this report noted that the racism was not deliberate it may have had a corrosive and cumulative effect on the patient's mood and aggression. This case was high profile and the findings were used to improve violence reduction training content.

In 2011 the World Health Organisation (WHO 2011) continued to evidence that violence is a problem that places a large burden on the national economy each year through healthcare costs, law enforcement and lost productivity and NHS Protect (2014) data recorded 68,683 incidences of violence in the NHS in 2013/2014. National Policy, Guidance and Legislation set mandatory standards for violence reduction training and this underpins how organisations approach the management of violence and aggression, health care professionals are also regulated by professional codes of practice. Wright (1999) found the law regarding self-defence during an assault to be complicated and inconsistent and state that healthcare professionals are at risk of facing disciplinary action due to breaching a code of professional practice, even though their response to an assault may be legally acceptable; this is despite the Department of Health and Welsh Office (1983) and the Mental Health Act (1983) endorsing the exercise of statutory powers and duties as legitimate reasons for the use of physical force or restriction of behaviour. In British Law, there is a clear distinction between the act (*actus reus*) and the intent (*mens rea* [guilty mind]), and action can be taken against individuals who are violent towards NHS staff under the Criminal Law Act although in order to prove intent (*mens rea*) the perpetrator must have understood their actions and intended to harm the victim. If this action is unsuccessful, then Civil Law may be utilised in order to seek compensation.

The UK Criminal Law Act (1967) section 3(1) states that in order to prevent a criminal act, an individual can use 'such force as is reasonable', and in forensic mental health this was been interpreted to mean that psychiatric nurses have the legal authority to physically restrain clients under circumstances of physical assault, dangerous, destructive or threatening behaviour (Jones 1994). Although this Act is relatively old and there have been some changes to criminal law, it continues to be operational today.

The Health and Safety at Work Act (1974) imposes a duty on managers to take reasonable steps to safeguard their employees against foreseeable risk of injury and the Mental Health Act (1983) Code of Practice specifies that staff who are likely to find themselves in situations where restraint of patients may be necessary should attend appropriate courses run by qualified instructors. However, Paterson and Leadbetter (1999) stated that with no regulatory body, anyone can provide training courses with no qualification.

The importance of staff training in restraint methods has long been recognised; e.g. Dietz and Rada (1982), studying assault in a forensic psychiatric setting, implied that there was a lack of skill, and this was resulting in patients and staff being injured during the restraint process. During the past 30 years, the management of violence and aggression training in the UK has changed dramatically. The first courses implemented in secure health settings were derived from the Prison Service Model (1981) of control and restraint following recommendations from the

Richie Report (1985) that all mental health nursing staff working in high secure environments must receive training in the control and restraint of patients. However, reviews such as one by The Royal College of Psychiatrists (1998) highlighted that this training advocated reacting to violence, and there was a lack of evidence or theory on the impact of the techniques used. Through the 1990s training continued to focus on crisis management; it was still only provided to the three high secure hospitals and was based on health and safety initiatives and fear of litigation. Miller et al. (2007) stated that during that time little was taught about prevention or reduction of violence, and this could have reinforced negative attitudes in both trainers and learners. However, audits and reviews of both training and incident management began to identify weaknesses in the effectiveness of the management of violence and aggression.

In 2005, changes in drivers, legislation and the evidence base resulted in a refocusing of courses from the *management* of violence and aggression to a *reduction* of the same with the introduction of a theory element called 'promoting safe and therapeutic services' (PSTS). Approaches to violence reduction training still varied throughout the country, and some models were outdated but still continued to be utilised by some care providers. Whittington et al. (2006) reviewed former research into the effectiveness of physical interventions and found the studies inappropriate and lacking in sound evidence. Therefore, more robust studies should be carried out to gather meaningful data that can be compared and measured.

In 2005, NICE Clinical Guideline (CG) 25 'Violence and Aggression: The Short Term Management in Mental Health, Health and Community Settings' began to drive changes in staff training by insisting that measures to reduce disturbed or violent behaviour must be based on risk assessment and risk management strategies, staff must receive competency training in recognising and anticipating antecedents, risk factors and signs of anger and be able to monitor their own verbal and non-verbal behaviour and staff should be trained in de-escalation and techniques of coping with disturbed or violent behaviour. Nevertheless, NICE CG 25 noted caveats in that there were no studies that specifically addressed the issues described, so the Guideline Development Group used 'formal consensus techniques' to develop their recommendations. This demonstrated the lack of research and evidence around the prevention and management of violence and aggression. The National Institute for Mental Health in England (NIMHE 2004) who gives Mental Health Policy implementation guidance concurred that the use of physical restraint should be regulated, and standardised guidelines and training should be paramount for the future of these practices.

A review of research surrounding patients' and nursing staff's views about physical restraint by Duxbury and Paterson (2005) revealed that nursing staff had mixed feelings about using this type of coercive intervention, and patients often perceived these strategies as punishment; therefore, organisations should make positive moves to find common therapeutic goals. Whittington and Wykes (1994) advocate that violence and aggression should not be treated by coercive measures alone, and therefore the care plan for every patient who has an identified risk of violence should include a range of interventions aimed at de-escalating potentially

violent situations. All healthcare professionals have a duty of care towards patients, and when planning effective care to reduce the risk of violence in mental health settings, they must also consider and risk assess the added complexities of paranoid ideas, emotional states, medication side effects and possible restrictions due to loss of liberty which can all lead to breakdowns in communication and subsequent outbursts of violence or aggression.

The DH (2008) and NICE (2015) guidance state that policies and practices to control socially undesirable behaviour are shaped more by the values and attitudes of the public and professionals than by the application of scientific evidence. They state that care and coercion are linked, and while there may be different considerations for forensic patients where the disorder may be linked to dangerousness and a lack of treatment could result in longer detention, we must take care not to misuse coercion.

16.3 Understanding Violence and Aggression

Epidemiological research suggests an association between mental health problems and violence, but interestingly Whittington and Wykes (1996) found that immediate antecedents to violence are often not symptoms of these disorders but rather conflict between service users and staff, and Richter and Whittington (2007) agreed that violence may result from indirect consequences of being in a restricted environment, feeling disempowered and as though being treated unfairly. Miller et al. (2009) also remind us that there are pre-conceptions and stigma surrounding people with mental health problems regarding the risk of violence and aggression, and symptoms, such as paranoid ideas and unstable emotional states, can lead to breakdown in communication and confrontation. Duxbury and Whittington (2005) advocate that staff should make every effort to engage positively with service users and gain understanding of when and why their emotional state has altered.

In order to formulate best practices to reduce the use of coercive measures, it is essential to understand theories around the causes of violence and aggression. The main theories of the causation of violence are psychological, social and biological. Early psychological theories were based on Freud's views on instinct and human behaviour; his theories were based on the concept that instincts are located in the subconscious mind; traumatic experiences in childhood could result in problems with a person's behaviour in adult life. In support of these theories, McDougal (1947) developed his hydraulic model to examine the way emotions build up to a point where they must be released; however, this model did not attempt to explain why some people are more aggressive than others. Due to Freud's work being based mainly on his own clinical experience of people displaying extreme distress and supported insufficiently by objective evidence according to modern science, his theories have been afforded little attention by researchers and academics in recent years (Turnbull and Paterson 1999).

Behaviourists, such as Pavlov, Watson and Skinner, developed social learning theories around Classical and Operant conditioning (described in Scales 2008); they

believed that behaviour could be changed through a process of stimuli, responses and reinforcement. However, these theorists did not take biological factors into account, and most of their studies were conducted on animals.

Other theorists considered the effects of the environment on aggressive behaviour. Dollard et al. (1939) believed that aggression was a direct result of frustration caused by environmental factors and Sheridon et al. (1990) supported this view as their evidence showed that a substantial amount of aggression in mental health services occurred as a result of staff enforcing the rules of the service. This could be interpreted to mean that coercive measures increase patient aggression.

Biological theorists studied genetic contributions to violence and gathered evidence from family, adoption and twin studies; this was initiated following the discovery that men with an extra Y chromosome were over represented in secure psychiatric hospitals. However, Casey et al. (1973) found that, although residents of secure facilities were 30 times more likely to have an extra Y chromosome, there were also considerable numbers of people with an extra Y chromosome living as law-abiding citizens in the community, and therefore the presence of an extra Y chromosome in itself was not sufficient to explain why an individual behaved violently. Bevilacqua and Goldman (2013) studied the genetics of impulsive behaviour and found that dopamine and serotonin releasing neurons are prominent in brain regions that regulate impulse control.

Research further points to the involvement of multiple neurotransmitters in the modulation of aggressive behaviour (for a review, see Völlm 2006). Of these serotonin (5-HT) is the most widely studied with multiple reports indicating that central nervous system 5-HT function may be altered in suicidal and aggressive/impulsive behaviour. 5-HT appears to show an inverse relationship to aggression and/or impulsivity across a broad range of population samples. Linnoila et al. (1983) found that cerebrospinal fluid 5-hydroxyindoleacetic acid (5-HIAA—a breakdown product of serotonin) was reduced in individuals whose aggressive behaviour and violence was impulsive, but it was not reduced in those for whom it was premeditated. Other biological arguments include the observation that men have a higher rate of violence than women (Turnbull and Paterson 1999) and the possible explanation of an effect of testosterone levels although some argue that testosterone is more related to dominance than aggression (Kedenbury 1979).

Evidence from lesion studies also indicates a role of biological factors in aggression. This evidence started to emerge first with the now famous case of Phineas Gage (e.g. Damasio et al. 1994), an American construction worker in the mid nineteenth century who sustained significant brain injuries in an accident during which a 3 cm thick iron rod was hurled through his skull and brain. His speech, intelligence and memory were unaffected but contemporary accounts suggest that as a result of the accident his personality changed considerably and he became irresponsible, impulsive and aggressive. Later case series have also suggested that brain lesions, in particular of the orbitofrontal regions, can result in an increase of aggressive behaviour (e.g. Pondsford 1996). Furthermore, in the early 1970s, a study of the effects of electrical stimulation on the amygdala area of the brain showed an increase in rage and escape responses (Hitchcock and Cairns 1973), but although these

studies seemed to evidence the connection between neurological problems and violence, the evidence is not fully consistent.

Swartz et al. (1998) studied the role of substance abuse and medication non-compliance in the occurrence of violence among severely mentally ill people and found that the combination of these factors was a strong predictor of serious violent behaviour. In forensic hospitals, especially in the personality disorder directorates, a high number of patients were under the influence of drugs or alcohol when they committed violent offences. Tardiff (1996) also found alcohol and drugs to be important factors in violence as they cause a pharmacological effect of disinhibition, excitement, disorganisation and delusional thinking. Kroll and McKenzie (1983) agreed that drugs and alcohol are often implicated in the occurrence of violent offences; however, it is still unclear whether these substances initiate or impact on violent behaviour, if environmental conditions at the time cause the violence or if the violence is due to psychological or social influences.

Many studies have attempted to dissect the factors surrounding race, culture and economics of violence in society and Tardiff (1996) found that the social determinants of violence are linked in a cycle that includes poverty, marriage breakdowns, single-parent families, unemployment and difficulty with maintaining family structures, interpersonal ties and social control.

It may be presumed that mental health nurses and therapists have sufficient knowledge and experience to understand these issues; however, a number of staff, both qualified and unqualified, who work with these types of detained patients, do not understand how to respond pro-actively to mental disorder, substance misuse and violence and aggression. Knowledge and understanding of the factors described will help to improve services for people with the complexities of a mental illness such as schizophrenia or personality disorder with a pre-disposition for violence. If clinical teams can be trained, not only to deal with a violent episode that presents itself in front of them, but to gain in depth knowledge of the person, their preferences, likes, dislikes, triggers, etc. then there will be mutual respect, an emphasis on preventing violence and a greater quality of care. This type of training could be undertaken through multi-disciplinary collaborative working in conjunction with de-escalation and violence reduction training.

16.4 Drivers to Implement Best Practices

Healthcare organisations have a duty to comply with drivers to change. Within the NHS, there are multiple drivers and best practice guidelines that place an emphasis on professional responsibilities and accountability. In order for an organisation to be resilient and robust, it must have a commitment to the change process and provide leaders who are knowledgeable, skilled and committed. With regard to reducing the use of coercive measures, there have been multiple changes in recent years and these are ongoing. The Health Service Advisory Committee (HSAC 1997) in the UK advised that training should include theory, interaction and post-incident

action with an emphasis on prevention by understanding the cause of aggression, assessing danger and taking adequate precautions. The Royal College of Psychiatrists (1998) audit of the management of violence in institutions agrees and states that an indicator of good practice is when training emphasises prevention, calming and negotiating skills rather than confrontation, looking at causes of aggression, reducing violence and resolving conflict. There are many models for evaluating training, assessing needs and to structure the change process. These help the change to move forward by identifying resistors and therefore providing opportunities to analyse cultures and values in order to motivate and inspire the workforce to embrace the changes. Involving people leads to ownership of the changes leading to willingness and commitment to see the change succeed. If people feel valued, essential and integral to the change, the possibility of conflict and resistance is reduced (Smith and Preston 1996). Curtiss and White (2002) advocate that change should not be viewed as a threat but as a challenge to undertake something new. Factors around organisational change in the use of coercive measures have been examined and, within forensic healthcare, training evaluation and organisational change continue to be an integral part of these reduction strategies.

The UK Department of Health documents *Positive and Proactive Care* (*2014*) and *A Positive and Proactive workforce* (DH 2014) provide a framework to transform culture, leadership and professional practice in order to deliver care and support which keeps people safe and promotes recovery. The documents identify levers to action changes which include improving staff training and issues around developing person-centred organisational cultures, staff recruitment and retention, support, supervision, development of skills and knowledge and how to commission high quality training. Services where restrictive interventions may be used must have restrictive intervention reduction programmes which are based on the principles of effective leadership, data informed practice, workforce development, the use of specific coercive intervention reduction tools, service user empowerment and a commitment to effective models of post-incident review. In response to these requirements, Nottinghamshire healthcare (NHS) Foundation Trust, e.g. has improved systems to allow meaningful data to be collected weekly and for findings to be fed back into practice. There is a heavy investment in distributed leadership programmes and treatment of all patients on an individual basis, including formulation of advance statements and post-incident reviews. For these programmes to be effective, there must be robust governance arrangements, a clear understanding of the legal context for applying restrictions and effective training and development for staff.

The Department of Health (2015) also insists on a stronger focus on positive and proactive care as well as additional safeguards around the application of coercive interventions. NHS England and Local Government Association (2014) highlights the importance of a relentless person centred focus on outcomes, with all decisions being based on the best interests of the individual and a full recognition that family carers are most often those who know what the ‘best interests’ are. Rigorous adherence to the core principles will improve individuals’ quality of life and reduce the prevalence and incidence of behaviour that challenges.

NHS Protect (2013) emphasises the importance of positive engagement, communication between staff and de-escalation approaches. They advocate that staff must identify, assess, understand, prevent and manage clinically related 'challenging behaviour' by preventing or minimising a person's distress, meeting their needs and ensuring that high quality personalised care is delivered within a safe environment. NICE (2015) guidance on safeguarding NHS staff from violent and aggressive patients includes a number of recommendations with regard to physical restraint and seclusion, stating that these measures should only be used as a last resort, once all other methods have failed. The guidance asks for training for health and social care workers in de-escalation techniques for difficult situations and an understanding of the impact that restrictive and unhelpful environments have on people with mental health problems.

There should also be consideration of appropriate staffing ratios, skill and gender mix during roster planning. Gournay et al. (1998) suggested that increased violence is strongly associated with increased use of temporary nursing staff, and Lanza et al. (1994) agrees that the frequency of assault is related to the number of staff and patients in a unit. Low staffing numbers or unfamiliar staff can lead to patients becoming aggressive or violent as their needs cannot always be met in a timely fashion; they may feel ignored or neglected or their initial frustrations or anxieties that precede the violent episode go unnoticed or are ignored. The patient is also more likely to respond positively to someone in their clinical team whom they trust and who understands their needs and wishes. Problems with frustration and anxiety leading to violent episodes resulting in physical restraint and seclusion have occurred when the patient does not know the staff on duty due to bank cover, or their care team has changed significantly due to ward moves with insufficient handover periods. During post-incident reviews, patients have stated that this led to them feeling insecure, isolated and in some cases abandoned.

Within forensic healthcare, there is a great need to drive changes in order to improve standards, meet targets and embrace best practice initiatives. In forensic mental health settings, there have been many changes implemented successfully and changes in legislation with regard to violence reduction and training have begun to be initiated. Reports and investigations into incidents and events have been scrutinised to identify lessons and failings that had severe consequences such as the Bennett Inquiry (Norfolk, Suffolk and Cambridgeshire Strategic Health Authority 2003) which found that staff had an 'unconscious misunderstanding' about how to safely restrain a person in a prone position, and therefore the restraint was mishandled, highlighting a serious failure of training. HSE (1996) developed legislation to ensure that organisations conduct risk assessments to identify workplace hazards in order to provide a safe working environment. These hazards include the risk of violence and aggression; therefore, organisations have a duty to ensure that risk assessments take predictable violence into account and put plans into place to reduce this risk, such as staff awareness and training in de-escalation, breakaways and physical interventions.

16.5 Leading Organisational Changes

The key changes in strategy (DH 2014; MHA 2015; NICE 2015) have been developed through a review of healthcare provision taking into account complaints, audits, incident reporting, serious untoward incident reviews, risk assessment and management strategies, statistics around workplace violence, patient to patient assaults, restraint, seclusion and chemical restraints. As the Care Quality Commission (CQC) will audit compliance with changes such as evidence of de-escalation (detailed documentation), appropriateness of physical restraint, seclusion and chemical restraint being a last resort, methods of physical restraint, duration of seclusion, etc., organisations have a lot at stake if the changes are not implemented in a timely and acceptable manner; therefore, the change process needs to be effectively governed, managed, evidenced and structured.

There are various models to structure organisational change, as in order for change to take place a model will aid a successful process and outcome. In order to achieve change, one cannot simply change a system; the bigger picture needs to be considered along with the process and management in order to succeed and make a change in practice. In order to manage change, it is necessary to analyse local influences; these are identified through good networks where information can be gathered and exchanged, although Upton and Brooks (1995) warn that sometimes these networks are resistant to change rather than promoting it—so knowledge of who, how and why will avoid stumbling into potential conflict. Kurt Lewin's (1951) Force Field Analysis and his Model for change are based on the assumption that any social situation is held in a state of balance by opposing forces, some are driving forces and some are opposing and change will occur if resisting forces are removed. This is a simple best practice model that is a good guide for taking stock of what considerations need to be made in order to effect change. It looks at the Current State, the Desired Future State and in the centre is the Transition. The Force Field Analysis works alongside the Model for Change with Drivers listed on one side and Resistors listed on the other. However, Lewin (1951) found that if more driving forces were added in order to influence or to change the balance, more opposing forces were generated to compensate. Therefore, it is simpler to deal with the existing resisting forces. Within forensic services, many staff may unexpectedly become the resistors although Marquis and Huston (2000) warn that resistance should always be expected. Maurer (2010) pinpointed trust issues, being afraid and lack of understanding as the reasons for this resistance to change; therefore, strong leadership skills such as respect, communication, support and guidance are essential components of change management. Mahoney (2001) describes an effective leader as visionary, equipped with strategies, a plan and desire to direct their teams and services to a future goal. Frankel (2008) agrees but adds that they should also be dynamic, passionate, have motivational influence and be solution focussed.

Colton (2004) suggests an approach to reduce the occurrence of restraint and the use of seclusion. This approach not only promotes effective leadership, but it also challenges values, cultures and behaviour and guides individuals to acknowledge and embrace the need for change. If individuals and groups 'buy in' to the need for

change, any resistance will reduce, and the change can be implemented more effectively. Anderson (2010) agrees and suggests that in order to ensure staff engagement and ownership of the changes, they could be asked to come up with workable ideas themselves. This change process was utilised in Nottinghamshire Healthcare (NHS) Foundation Trust in order to implement new de-escalation training that was to be provided by violence reduction instructors as part of the violence reduction induction and yearly updates for direct care staff. The course was based on visual media to show a variety of situations where patients were becoming agitated, angry or violent and to demonstrate how staff's verbal and non-verbal interactions could either exacerbate the situation or de-escalate and avoid an incident. Initially, some instructors were reluctant to get involved in providing this classroom based training; so in order to reduce resistance, all instructors across the Trust (including colleagues in Retford, Nottingham, Rotherham and Leicester) were invited by the core group to take part in the filming of the scenarios. Three filming days were planned and most instructors got involved; they also put peer pressure on those who were more reluctant to join in, which began to reduce their opposition. As time went on the feedback from instructors was really positive, stating that because they had been involved from the beginning and allowed opportunities to have their say and felt that their contributions were appreciated and valued, they felt that they had ownership of the project, and this enabled them to present it to the groups of staff with confidence and enthusiasm.

The NHS (2008) provides innovation and improvement Leaders Guides and these support the implementation of change management with the application of theory and models. Kerridge (2012) identified key points to leading change management projects including identifying what needs to change through root cause analysis, process mapping and assessing stakeholder power, influence and impact. However, Ammerman (1998) found that engaging in these processes may mean that valuable time could be wasted focussing on the symptoms without resolving the problem. Therefore in order to effect a change to reduce the use of coercive measures, it is essential to evaluate not only the external drivers but also internal factors including the content and effectiveness of current training provision. Kirkpatrick's (1959) model of evaluation continues to be the most influential and commonly used. It is structured around four levels—Reaction, Learning, Behaviour and Results. However, Thackwray (1997) argued that as Reactions (subjective opinions of participants on a course) are easy to measure, they tend to be the only level of evaluation of a course. Kraiger et al. (1993) and Quinones (1997) agree and add that this level only measures what participants liked or disliked; it does not measure any learning that has taken place. Although the model becomes more effective if all four levels are worked through, critics such as Kraiger and Jung (1997) suggest that it has restricted value for helping decisions on how to convert evaluation results into decisions about changes to future training. However, Thackwray (1997) advocates that billions of pounds would be saved in the UK if all organisations at least followed Kirkpatrick's model as training provision is not always evaluated effectively so it may not be fit for the purpose it is intended,

necessitating more money to be spent on releasing staff for other training. Subsequently, the model has been developed to include skills based learning and aspects of attitudes and motivation training to overcome identified deficits and offer clear direction to manage and measure change, although it offers no guidance for determining financial value or cost-effectiveness of training as other models do (Kraiger et al. 1993). Therefore, an amalgamation of best practice models aimed at supporting training to arm staff with the necessary knowledge and skills to change the culture of the workforce should be considered.

16.6 Best Practice Models and Innovative Projects

In order to reduce the use of coercive measures, there are many Best Practice models and initiatives, but throughout this chapter, through examination of the causes of violence and aggression and the background of interventions for the management of aggressive or violent episodes in forensic healthcare, it has become apparent that the best outcomes will be achieved if several principles are taken into account to avoid or reduce an aggressive or violent episode at the earliest stage. These principles have been highlighted by drivers to change and include consideration of:

- Service user and staff conflict
- Engagement in meaningful activity/therapeutic environment
- Frustration due to environmental factors—restricted environment/disempowerment/unfair treatment
- Quality of care offered
- Satisfaction of patients and their families
- Staff morale
- Low staffing, lack of named nurse provision, recruitment, retention, sickness/absence, staff moves with no handover period

An amalgamation of best practice models that could be implemented simultaneously to complement each other would greatly improve patient experiences of their healthcare setting. If they receive individualised, well informed care, with adequate staffing levels for provision of meaningful activities and therapies, dedicated staff that are well trained and insightful, highly skilled, with high morale and satisfaction, staff and patient frustrations would decrease and the quality of care improves significantly, impacting positively on the satisfaction of patients and their families. This can only be achieved through significant investment in training, sound leadership and a whole organisational approach.

16.7 The Public Health Model

A teaching strategy for prevention of aggression and violence is highlighted in the Public Health Model (Krug et al. 2002) which has a visual triangular format (see Appendix 1) with 'Primary Prevention' being the main emphasis and taking up the largest dimension at the base of the triangle; this promotes the strategy of identifying triggers and addressing root causes to prevent violence and aggression occurring. Primary interventions include prevention planning, identifying the causes of the violence or aggression, antecedents and the individual's antagonists that increase or reduce these feelings or actions. In order to achieve this, evidence based risk assessments should include both static (historical) and dynamic factors as risk can increase or decrease through effective treatment programmes, increased knowledge and insight, and it is important that the patient is involved as much as possible in their own treatment programmes for them to be effective. 'Secondary Prevention' indicates the first reactive responses such as de-escalation techniques. Infantino and Musingo (1985) compared staff who had received training in verbal interventions with staff who had not over a 24 month period and found that during that period only one of the 31 staff who had received training had been assaulted compared to 24 assaults towards staff out of the 65 staff who had not been trained. Although the exact reasons for this difference are unclear, it is of note that staff who had been trained reported that they felt more comfortable, relaxed and confident to manage violent incidents. At the top of the Public Health Model, the smallest dimension is 'Tertiary Prevention'—this includes physical interventions and seclusion. This model has a good visual impact and should be used pro-actively as organisational and policy initiatives for healthcare providers continue to focus mainly on de-escalation and physical restraint methods.

16.8 Colton's Best Practice Model to Reduce the Incidence of Violence and Aggression

Colton's (2004) model promotes best practice by analysing causes of violence and aggression in order to inform practice and minimise daily stressors for restricted patients. It focuses on leadership, orientation and training, staffing, environmental factors and programme structure, treatment planning that is timely and responsive, processing after the event, communication and consumer involvement, system evaluation and quality improvement. Although there would be an initial cost to fund research and train staff, the benefits of changing attitudes towards coercive practices would soon outweigh this initial cost as patients' treatment programmes would be more effective, risk of violence and aggression would reduce, relational security would become more robust, staff sickness levels as well as staff and patient injuries would decrease, as would incidents on the whole and staff seeking compensation for injuries. This in turn would improve staff morale, and patients'

experience of in-patient forensic care would be less traumatic and recovery time and rate would improve.

16.8.1 Value Centred Approach

Miller et al. (2007) introduced a Value Centred Approach towards reducing incidences of violence and aggression, based on three rings of considerations around a central core of values. The considerations are '**Caring**' aspects such as recovery focus, respect, engagement, empathy, inclusion, needs for care and therapeutic safety. '**Professional**' aspects are legal and ethical frameworks, professional self-respect and self-regulation, evaluation and defined roles and responsibilities, solution focus, multi-disciplinary team (MDT) working and robust record keeping. '**Educational and Developmental**' includes transfer of skills into practice, post-training supervision and professional development plans. Hopton (1995) also states that if mental health services are to be client centred, they should be committed to therapeutic interventions that are orientated towards exploring clients' experiences of invasion of privacy and oppression and therefore assist them to use their anger, resentment and frustration more productively. Colton (2004) found consistent themes in a Restraint Reduction Analysis in America; the highest level of staff within an organisation must lead on violence prevention, staff must be equipped with skills to keep themselves and others safe and understand proactive prevention; there should be adequate skill mixed staff to promote a therapeutic environment; consideration must be given to match the physical environment with the needs of the patient; balanced therapies and activities must be offered; there must be structured, individualised monitored care plans, structured reviews of incidents, patient involvement in crisis management planning, systematic analysis of service provision and regular reviews of staff members practice. Although these measures are supported in English forensic care settings, there could be more emphasis placed on the importance of proactive reduction of coercive practices.

16.9 Post-incident Review or Debrief

When violence or aggression has occurred, the post-incident review or debrief is an excellent starting point for identifying the root cause or antecedence for the episode. The patient should be included so their thoughts and opinions can be heard and taken into account. When the review or debrief takes place, it should identify the causes as well as individualised primary strategies for future prevention of violence and aggression. If this opportunity is utilised to its full capacity it would enable individualised prevention strategies to be put in place, reducing risk of harm or distress to the patient, the staff and others.

16.10 Positive Behaviour Support

Positive Behavioural Support (PBS) originated in Learning Disability (LD) services and is based on reflection, mindfulness and professional ethics. It is advocated by the British Institute of Learning disabilities (BILD) as an approach for use when working with people with LD who exhibit challenging behaviour as it is rooted in person centred values and aims to increase personal skills and competence with an emphasis on respect for the individual. However, this model has been criticised as over simplistic and open to corruption through poor interpretation, lack of training and effective leadership (Farquharson 2004). Paterson et al. (2014) state that this approach attempts to modify behaviour, and there is a long history of concerns about applying purely behaviourally derived approaches in mental health. Deveau and McGill (2013) advocate that PBS alone is not sufficient, and safe services should include integrated perspectives although Rimland (2011) and Williams and Grossett (2011) suggest that the evidence base does support the use of PBS in LD services to reduce the use of coercive measures.

16.11 Trauma Informed Care

Trauma informed Care (TIC) is an evidenced based theory that fits with recovery model principles in mental health. TIC attempts to understand the impact of historical adversity and trauma on the patient's current emotional well-being, functioning and relationships. This best practice model aims to explore each patient as a unique individual with sensitivities to the influence of their past trauma and how this affects their current experience of care, especially with regard to the use of coercive measures, as physical restraint, such as placing a person in a prone position, secluding and undressing or pulling down clothing to administer chemical restraint, could inadvertently re-enact past trauma.

16.12 High Secure Services Positive and Safe Violence Reduction Manual

The Mental Health Act Code of Practice (2015), NICE (2015) and DH (2014) guidance ask that some interventions, especially prone restraint, should not be used unless there are cogent reasons to do so. They also advocate that best practice principles are adhered to at all times in mental health and social care settings. With regard to these principles, the high secure services (HSS) in England, Ashworth, Broadmoor and Rampton Hospital, and the State Hospital in Scotland (Carstairs) have co-produced an instructors manual for training staff the skills to manage disturbed, aggressive or violent behaviour, taking into account all current best practice guidelines. In order to produce the HSS Positive and Safe Violence

Reduction Manual (2015), the expert group shared experiences and reviewed current and historical practices and completed an extensive literature review on the use of restraint in all services including complaints, injuries, death in custody, legal, ethical and practical issues. The manual is based around the Positive and Proactive Care and NICE guidelines, least restrictive practice principles, and aims to reduce physical restraint in these organisations through robust training for Violence Reduction Instructors which is transferred throughout the workforce beginning during the induction process and reinforced during annual updates. The underlying principles originate from the hierarchical approach of the Public Health Model and the Assault Cycle that advocates early recognition and primary intervention as essential to prevent behaviour escalating. The models combined for this training manual emphasise that each patient must be treated as an individual. De-escalation must continue throughout the episode, and touching the subject should be avoided if possible by allowing them alternatives to being held in restraint, such as clear space, the opportunity to choose to walk to seclusion or ask for medication. Continual assessment of the level of threat utilising The National Decision Making Model (NDM) (Association of Chief Police Officers 2010) (see Appendix 2) must take place so that if secondary (passive/supportive) or tertiary (full restraint/restrictive) holds have been applied, the threat analysis will be reviewed to ensure that holds are relaxed at the earliest opportunity. The manual is based on well-established principles; it describes core holds and offers a range of risk assessed interventions that are adequate, robust and suitable for the extreme levels of violence that may be presented in order to ensure the safety of all while maintaining the emphasis of justification of all interventions and accurate documentation.

An example of the content of the HSS Positive and Safe Violence Reduction manual is that it takes account of specialist services and considerations for training staff to raise awareness of specific difficulties that may present due to sensory differences. For example, if a physical restraint cannot be avoided, the restraining staff must ensure that deaf patients are held in a way that offers some freedom of movement in order to allow them to communicate via British sign language (BSL), if their presentation is such that it is safe to do this. In the case of a deaf patient, there should be staff in the vicinity that are trained in BSL and can sign instructions. Communication can prove difficult with some individuals who are deaf as they may avoid eye contact. This may be because the person wants to shut themselves off from external stimuli in order to internalise their thoughts without interruption. This can be problematic for de-escalation purposes and also when attempting to give instructions to the person during physical restraint. Deaf support workers or BSL interpreters and staff with ‘deaf awareness’ can be helpful in these situations. In addition, it is more difficult to monitor the individual’s physical condition without communication. For patients that do not speak English, realistically there may be no staff in the area that can speak their language so verbal instructions should be kept short and clear. At the earliest opportunity, an interpreter should be sought. It is the patient’s legal right to have access to an interpreter for seclusion reviews.

The Positive and Safe Violence Reduction and Management Programme (2015) has been medically, legally and professionally reviewed, and comments from service user and expert reviewers were shared and actioned. In England, the manual is being piloted within Nottinghamshire Healthcare (NHS) Trust, West London Mental Health Trust and Mersey care Trust. The manual is fluid and will evolve and develop in accordance with emerging guidance, research, analysis and annual review. While the manual has initially been developed with regard to clinical issues and risk profiles of individuals nursed in high secure forensic services, there will also be adaptations to allow these best practices to be adapted to guide instructors that teach staff based in other forensic units and also in local and specialist services, including elderly and child and adolescent care. This manual is the first of its kind as it aims to change the culture of responding staff by insisting that de-escalation and distraction are the first interventions, and any type of physical restraint really is a last resort that has to be robustly justified. The collaboration of professional experts, the openness, transparency and enthusiasm of the core group have given the manual the potential to become the national best practice model for violence reduction.

16.13 National Accreditation for Violence Reduction Instructors

For the past ten years, since NICE guideline 25 (2005) was published, there has been a drive to have a National Accreditation for Violence Reduction Instructors. Although there is a related BSc degree programme relating to violence reduction, it would be unrealistic to expect all current Violence Reduction Instructors to achieve this level of academic qualification, although in order to professionalise this area of healthcare, this may be something to aspire to in the future. However, Violence Reduction Instructors need more than academic work. In order to equip staff with the skills to reduce episodes of violence, which ultimately will reduce the use of coercive practices such as physical restraint, seclusion and chemical restraint, they should also have sound clinical experience. In order to begin to address the deficit in national accreditation, Nottinghamshire Healthcare (NHS) Foundation Trust in collaboration with relevant partners has developed a Level 3 certificate course (equivalent to A Level) academic modules accredited by The Office of Qualifications, Examinations and Assessments (Ofqual) to accompany and complement the physical aspects of instructor courses (Train the Trainers). This has been rolled out for the past 2 years with positive outcomes. Following the first year of success, a Level 4 diploma (equivalent to undergraduate) course was developed for existing instructors; this takes into account the professionalism, skills and knowledge already gained and expands on this to ensure that the instructors are up to date with research, current practices and guidance. There has already been interest in accessing these professional courses from other NHS Trusts, so this could prove to bridge the gap towards National accreditation. National regulation by a governing body would set standards and further professionalise this highly specialised and skilled group.

16.14 Positive Leadership

Miller et al. (2007) discussed proactive ways in which South London and Maudsley Trust changed practice and implemented safer services in mental health services by establishing senior posts and specialist nurses to improve the safety of patients and staff by implementing a change strategy. Training promoted professional values and collaborative working to raise standards of care, and service users were empowered through involvement and collaboration in their care programme. This promoted positive leadership to drive best practice strategies and to ensure that staff are provided the necessary skills and training to meet the needs of the service.

16.15 Improving Space

The Positive and Safe Champions Network (DH 2015) share best practice initiatives to reduce the use of coercive measures by improving the ward environment. These have been implemented by Cambridge and Peterborough NHS Foundation Trust and are based around the concepts of healing space, dignified space, creative space, shared space and reflective space. These range from large-scale structural changes to low cost small changes that aim to enhance the physical environment and reduce the feeling of institutionalisation by breaking down barriers between staff and patients, promoting personalised activities that develop new skills and creativity, while maintaining safety. While this is not a Trust with high secure forensic provision, the principles of having a motivated team with an individualised and flexible approach is a good start to reducing the use of coercive measures.

16.16 De-escalation and Communication

Insightful and innovative de-escalation training should be developed and provided by organisations as sometimes nursing, occupational, therapeutic and medical staff are unaware that their actions or in-actions may be escalating a problem. This rigorous training should emphasise the importance of primary interventions to all staff as in forensic institutions some experienced members of staff become reluctant to accept change as they think they are being criticised and become defensive. Infantino and Musingo (1985) studied the effects of verbal intervention training on NHS staff and found a noticeable reduction in physical assaults on trained staff. The staff reported that they felt confident, relaxed and comfortable to utilise de-escalation techniques.

16.17 Using Visual Media to Develop Awareness of Communication and De-escalation Skills

A joint group of professionals throughout Nottinghamshire Healthcare (NHS) Foundation Trust, including speech and language therapy, security and violence reduction staff have co-worked towards a de-escalation project by developing visual media resources that show patients in a variety of situations and looking at how poor verbal and non-verbal communication skills can either escalate or de-escalate a patient's anxiety or anger. This project was undertaken following a literature review around de-escalation that showed that although there is a lot written about communication skills, there is no specific research based best practice model to inform training in this field. The project has been running for direct care staff since January 2015, and data has been collated from evaluation forms which show that staff found the training helpful as it made them consider and question their own approach to patients who appear agitated or feel angry; the overall aim is to reduce the occurrence of physical restraint, seclusion and chemical restraint, but while 99 % of staff stated that their communication skills would improve following the training, however, how this will relate into practice is currently unclear. The training also generated discussions around de-escalation and showed that this is so much part of staff's day to day working that it is not always documented ('Using Visual Media to Develop Awareness of Communication and de-escalation Skills in Staff within Forensic Mental Health Services', presented at the International Association of Forensic Mental Health Services Conference [IAFMHS] May 2015). The project is evolving rapidly and is being refreshed for 2016, and a best practice de-escalation training model is currently being developed.

16.18 Additional Considerations for Best Practice

When searching for innovative ways to reduce the use of coercive measures, consideration should be given to current initiatives that strive for best practices as the projects described have been developed by professionals with the best intentions to aid a reduction in all restrictive and coercive practices, not only to comply with legislation but also because organisations strive to improve service provision and offer bespoke care that is patient- and recovery focussed. It is important to share good practices and initiatives between organisations, not for financial gain but because patients' safety and welfare is at the heart of what we aim to achieve. Roberts et al. (2008) believes that the therapeutic purpose of detaining a person and treating them against their will is a process of gradual handing back of choice, control and responsibility. While we understand that seclusion is a coercive measure sometimes used for the management of violence and aggression, it could be presumed that this measure always follows a violent incident and is preceded by physical restraint. However, seclusion can also be requested by a patient who understands their own distress and would like to go into the seclusion room in

order to allow them time away from peers, to give them time to reflect and reduce their own anxiety. If the patient was refused this request with no suitable alternative offered, then their behaviour may escalate and they might carry out a violent act in order to achieve their goal. This may be written into their advance statement, so the organisation needs to decide if they accept seclusion as a de-escalation method and, if so, how this would be managed. The patient should be given the opportunity to discuss their own care and be empowered to make decisions. There are opportunities for organisations to manage the seclusion differently if the patient has chosen it, rather than been coerced into going in. Documentation should also be considered, as this event is a choice rather than an 'incident'.

Best practice initiatives to reduce the use of seclusion based on an analysis of successful restraint and seclusion reduction practices include national direction, committed and active organisational leadership, organisational culture that embraces trauma informed care and recovery approaches, service user participation, provision of meaningful activities, an atmosphere of listening and respect, crisis intervention planning, de-escalation and effective debriefing. Staff satisfaction should be taken into account including education, supervision, recruitment and retention.

Rights, Risks and Limits to Freedom (2013) notes that best practices for reducing the use of seclusion must include a clear local and external monitoring framework and that an evaluation of the benefit to the individual should be carried out following each episode. Staff involved should have access to regular reflective supervision sessions. Gaskin et al. (2007) reviewed best practice interventions for reducing the use of seclusion in psychiatric facilities. They identified regulations, policies, staff support, increased staff to patient ratios, emergency response teams, staff education, pharmacological interventions as well as improving treatment and seclusion reduction plans by involving patients, changing the therapeutic environment and improving staff safety and welfare as effective practices. They found that a systematic use of several of these interventions (and possibly others) is more likely to reduce rates of seclusion as on their own none of these interventions would be sufficiently powerful.

Best practice guidelines state that, as chemical restraint has a sedating effect, the patient should be informed of the period of time that this is expected to last. They may also wish for a relative to be informed as they may be concerned for their autonomy and dignity. Chemical restraint is a very restrictive coercive measure that may only lawfully be applied when absolutely necessary. Wherever possible alternative, less restrictive interventions should be used. The Mental Health Act (2007) and the Mental Capacity Act (2005) advocate that collaborative advance safety plans should be in place for patients that are at high risk of needing chemical restraint or have been chemically restrained in the past. This should include a thorough review of the patient's history, treatments attempted, doses and the patient's responses, any concerns raised by the patient or vulnerabilities. A second opinion may also be sought as a best practice measure. Authority to administer the chemical restraint must be gained taking into account the patient's preferences and

the consequences of not using chemical restraint, such as prolonged physical restraint or mechanical restraint.

The evidence suggests that the key to reducing use of coercive measures is to minimise the stress and anxiety associated with being detained in hospital. Initiatives such as pat dogs, time out, talking therapies, distraction activities such as art, aromatherapy, gym and swimming and other meaningful occupational activities chosen by the patient are tried and tested best practices to reduce levels of aggression and violence. Environmental factors such as ward dynamics should be risk assessed, monitored and discussed regularly. Individualised programmes should be structured to ensure that each patient is occupied in meaningful activity for at least 25 h/week. According to the terms of the Care Programme Approach (CPA) model, treatment should be assessed, planned, coordinated and reviewed in multi-disciplinary team (MDT) meetings, and the patient should be involved in the assessment of needs and in developing the plan to meet those needs. Lanza et al. (1994) agree that social and recreational activity for patients are important factors for reducing violence and aggression. When violence or aggression has occurred, risk management plans are put in place; however, although there is discussion with the patient regarding the incident, there is no set format, training or model for nurses to identify the cause of the problem. Patients should be involved as much as possible in care planning and be given choices for their management if they become anxious, aggressive or violent—these could be written in advance statements. Family contact and involvement can be very important to detained patients and play a big part in the recovery process. Good communication skills are paramount for effective care and patient recovery. Standards are evaluated for quality improvement both internally and externally through audits by the Care Quality Commission (CQC) and the Prison Service Audit Team and through Peer Audit from the two other high secure hospitals.

Within Nottinghamshire Healthcare (NHS) Foundation Trust, there have been large investments in leadership training as the importance of sound leadership within the Recovery focus for patients is recognised. The quality of all staff training is scrutinised for evidence of its effectiveness, but there should be national standards for accredited training packages that are regulated and audited based on legal, ethical and professional standards and trainers should be nationally accredited for their level of competency. The purpose of providing training in the management of violence and aggression is primarily to minimise harm to the subject or to others during a crisis. If we get the training right, this will ultimately reduce the need for the use of coercive measures. Training for forensic healthcare professionals has improved standards for maintaining a safe environment for staff, patients and visitors, and incidents of violence and aggression have already reduced. This has been achieved by education for staff regarding equality and diversity, promoting safe and therapeutic services (PSTS) and relational security which has given staff increased knowledge, enabled clear and effective communication and increased confidence in their role as care providers.

16.19 Conclusion

Many common themes have been identified, and it is evident that using best practices to reduce the occurrence of violence and aggression in forensic healthcare settings will reduce the use of coercive measures. Forensic care providers have a responsibility to offer services that are fit for the purpose they are intended, and in the NHS many are well established institutions that are proud of their standards and the quality of care provided, but there is no room for complacency and standards should never become stagnant. Lessons are identified from audits, quality reviews and revelations of abuse in some services leading to new legislation and guidance. Expectations change and services must continually strive to review and improve. There must be an organisational approach to adopting and implementing best practices for reducing the use of coercive measures as implementing these initiatives requires investment in ensuring adequate staffing levels, and high quality, best practice based training packages to equip staff with the necessary skills to work in the challenging environment, sound leadership to drive development of services and influence the culture of the whole workforce. There must be a commitment to change and a proactive approach. Baseline measures in the use of physical restraint, seclusion or chemical restraint will offer a starting point in order to evidence a reduction when best practices are adopted. Bespoke training packages may be necessary as changing attitudes and culture is not an easy task, but investment in the improvement of services with patient and staff well-being and safety at the forefront has to be worthwhile and ultimately cost-effective as there will be an increase in service quality and job satisfaction, with a reduction in sickness levels and litigation costs.

Relational security is paramount as is a multi-disciplinary approach to reducing coercive measures as we need to understand the causes of violence and aggression and gather as much information as we can about each individual to understand the cause of their frustration and how this can be eased or exacerbated. Staff should be educated in issues associated with mental health diagnosis, substance misuse and the impact from histories of abuse. Regular clinical supervision must be undertaken to check the well-being of staff working with these patient groups in order to discuss issues, assess well-being of staff and look for symptoms of burnout. De-escalation skills should be taught and monitored in practice as one cannot presume that everyone has these skills at the level required to work with people with complex needs.

Patients and their carers should play an integral part in their care programme as they understand their own (or their relatives') needs and anxieties better than anyone else. Advance statements ensure that the patient is understood as an individual and if this information is communicated to staff involved in the patient's care, individualised distraction and de-escalation can be implemented so that conflict will be reduced.

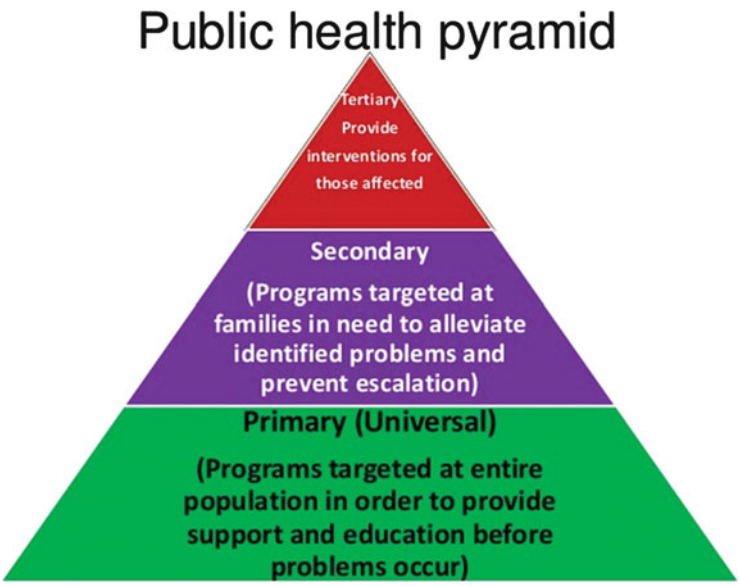
Appropriate staffing levels and staff that are familiar to the patient are more likely to achieve a positive outcome for de-escalation when the patient becomes

anxious. In order for de-briefs and post-incident reviews to be effective, findings must be shared and actioned to inform future practice.

Regulatory bodies set standards for healthcare providers but as professionals we should strive to, not only achieve, but to exceed these standards by providing modern recovery focussed services, with patients' well-being at the heart of care provision. Organisations should be open to change and constantly scrutinising current practices and the culture of the workforce in order to ensure that evidence based best practice models are being implemented and their services are honest, open, transparent and open to audit and external scrutiny.

While some best practice models and new initiatives to reduce the use of coercive measures have been discussed, these are by no means exhaustive. However, if the general principles are addressed while organisations work towards compliance in reducing restrictive practices, many new best practice initiatives will emerge. These should be piloted for effectiveness, the results measured and success shared between organisations.

Appendix 1: Public Health Model



Appendix 2: National Decision Making Model (NDM)

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Mechanical Restraint: Legal, Ethical and Clinical Issues

17

Susan Elcock and Jessica Lewis

Abstract

The use of mechanical restraint as a means to manage the violent and/or self-injurious behaviour of psychiatric patients remains controversial, due primarily to this practice restricting freedom, and often being implemented against the patients will (Georgieva et al. BMC Psychiatry 12:54, 2012). The thought of mechanical restraint conjures up cruel and often barbaric interventions, confined to historical ideas about how to treat and manage the mentally ill. With modern advances in psychiatry, particularly in relation to an increased understanding of mental illness, and more effective psychotropic medication, there was hope that interventions of this nature were no longer required. Policies on the use of mechanical restraint vary significantly from country to country and depend greatly, although not consistently, on the prevailing culture and legal framework (Steinert and Lepping. European Psychiatry 24:135–141, 2009). Within the United Kingdom (UK), mechanical restraint is relatively uncommon, compared to other countries (Stewart et al. Mechanical restraint of adult psychiatric inpatients: A literature review. Report from the Conflict and Containment Reduction Research Programme. City University, London, 2009), and it attracts the highest levels of disapproval of all the containment methods by UK student psychiatric nurses (Bowers et al. Nurse Education Today 24:435–442, 2004; Whittington et al. Psychiatric Services 60:792–798, 2009). However, there remains a small group of patients, whose severe mental disorder, combined with "grave and immediate" violence and life-threatening self-injury, has deemed it necessary to consider restrictive interventions of this nature. Within

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the UK, these patients will most likely reside in "Special Hospitals", which offer high secure hospital accommodation for mentally disordered offenders. Thus, the clinical teams who attempt to treat patients who present with these challenges face an ethical conflict between patients' autonomy and physical and mental integrity on the one hand and the requirement to prevent harm on the other (Bergk et al. Psychiatric Services 62:1310–1317, 2011). Within this chapter, we consider the legal, ethical and practical considerations to exploring the implementation of mechanical restraint in a secure psychiatric setting.

17.1 Introduction

The use of mechanical restraint devices is a contentious issue but one that is becoming increasingly topical. The term mechanical restraint in itself can conjure up all sorts of images and responses based on individuals' experiences, beliefs and socio cultural factors. It is often an emotive topic which can remind professionals of previous scandals in various institutional settings and inquiries into hospital care.

In the UK, mechanical restraints such as the strait jacket were routinely in use in the old psychiatric asylums into the twentieth century. In 1814, a patient at Bethlem Hospital was found to have been kept in chains for 14 years which triggered the start of a movement called the "non-restraint approach". An article about Robert Gardiner Hill (1811–1878) in *Madness to Mental Illness* gives an insight into this movement. Robert Hill was believed to be the first doctor to run a public asylum, the Lincoln Lunatic Asylum, without the use of mechanical restraint for treating insanity. His obituary noted that the non-restraint method was "a procedure fraught with momentous results to the insane". In 1836, he first advocated all restraint be stopped and his best known work was *A Concise History of the Entire Abolition of Mechanical Restraint in the Treatment of the Insane* (Bewley 2008).

Historically, there have been limited publications in the UK about mechanical restraint, and the literature has been broad, incorporating a range of settings and populations and often combining the use of seclusion and other forms of restraint. Mechanical restraint mainly started to appear within the Learning Disability literature and the American, Australian and European psychiatric literature (e.g. Raboch et al. 2010; Steinert et al. 2009). Mechanical restraint in the UK has rarely been used compared to other countries (Stewart et al. 2009). Over recent years, a number of guidelines and discursive papers have been published, and reference is now more openly being made to mechanical restraint both within a legal context, e.g. Mental Health Act (MHA) Code of Practice (Department of Health 2015) and within a clinical context, e.g. National Institute of Health and Care Excellence (NICE) guidance on management of violence and aggression (NICE 2015), Care Quality Commission (CQC) monitoring of practice (CQC 2014) and guidance on reducing restrictive interventions (Department of Health 2014). The British Institute of Learning Disabilities (BILD) Guidance by Paley in 2008 is probably one of the clearest guidelines available about mechanical restraint.

Our recent literature review found in excess of 260 articles and there is a clear move towards professionals wanting to share their experiences of using mechanical restraint within clinical settings; however, there are significant flaws in the research base to date. Much of the literature joins together seclusion and restraint with the various forms of restraint, physical, mechanical and chemical, not being individually considered. Indeed, a Cochrane systematic review of the literature on seclusion and restraint for people with serious mental illness (Sailas and Fenton 2000) excluded all studies due to their research limitations and felt that "*the complete lack of trial-derived evidence regarding the effects of seclusion and restraint is surprising given the invasiveness of the intervention and its continued use over time. This dearth may highlight a belief that they are such effective, satisfactory interventions that there is not the need for evaluation in randomised trials*". It has also been acknowledged that carrying out randomisation to either seclusion or mechanical restraint would prove ethically challenging (Soininen et al. 2014).

An important consideration is also that different cultures assess the forms of restraint differently regarding what is deemed the most restrictive practice (Ward 2000). In 2010, an opinion piece on the Nursing Times website by an American nurse about the use of mechanical restraint devices in America, as compared to the UK, generated huge feedback and divergence of opinion. The author responded, "*In the US, nurses and doctors were pragmatic about this and we happily used whatever tools we could get our hands on to stop confused patients from getting out of bed without help. Yes, this included restraints*" (Morgan 2010). Some further argue that chemical and physical restraint are more restrictive and less safe than mechanical restraint (Gordon et al. 1999; Batty 2005; Winship 2006).

The Report from the Conflict and Containment Reduction Research Programme, "Mechanical restraint of adult psychiatric inpatients: a literature review" (Stewart et al. 2009) identified 69 studies where mechanical restraint was used as an intervention, and of these, 50 were from the USA. Interpretation of the research findings was marred by the diversity; thus, it was not clear how transferable research findings were. The review reported on some studies where patient experience had been considered. There were different findings, with some reporting that restraint is deeply traumatic and can trigger memories of previous abuse and flashbacks, effectively re-traumatising the patient (Smith 1995). Nevertheless, one study found that 2/3rds of a group of 30 patients who had experienced mechanical restraint for the first time expressed warm feeling towards staff who had shown concern for their needs afterwards (Chien et al. 2005). The same study also found a difference in the perspective based on diagnosis, with patients with "psychopathic personalities" tending to be more supportive of restraint as a means of controlling their violent behaviour whilst patients with schizophrenia indicated more negative aspects of restraint. A survey of 54 patients with schizophrenia and a history of serious offences in Croatia found that even though 63 % of the patients had been mechanically restrained, 64.8 % felt that if a patient was intentionally being aggressive, mechanical restraint was an acceptable form of "punishment". In addition, 61 % also felt that if a patient requested mechanical restraint they should be placed in it immediately (Margetić et al. 2014).

Although more research is coming out about the impact on patients, ultimately this debate often seems to have hinged mainly on ethical views and legal precedents rather than on patient opinion.

Our experiences mirrored those described by Carr in "The use of mechanical restraint in mental health: a catalyst for change?" (2012) where the author shares the experience of exploring mechanical restraint in the management of a female patient, carrying out life-threatening acts of self-injury, within a secure mental health setting. We followed the same journey as Carr, exploring the legal, ethical and practical (clinical and organisational) aspects of mechanical restraint to enable us to come to a conclusion as to whether there was a role for mechanical restraint in clinical care in our high secure setting.

17.2 What Do We Mean by Mechanical Restraint?

Restraint is defined in the *New Shorter Oxford English Dictionary* (Oxford Dictionaries 2007) as the "deprivation or restriction of liberty or freedom of action or movement". When considering mechanical restraint, this has been defined by Georgieva et al. (2012) as "*the application of any mechanical device which limits the patient's movement, physical activity, or normal access to his or her body*". However, these definitions, in our view, do not capture the breadth or scope of devices used in mechanical restraint. The Positive and Proactive initiative (Department of Health 2014) highlights "*the use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control*" whilst Paley (2008), in the BILD Guidance, identifies management of self-injury as key to her definition: "*As a last resort, the application and use of materials or therapeutic aids such as: belts, helmets, clothing, straps, cuffs, splints, specialized equipment designed to significantly restrict the free movement of an individual, with the intention of preventing injury; as a result of behaviour that poses significant and proportionate risk to the individual of serious long term harm or immediate injury*". Paley further notes that mechanical restraint may be partial, in that it significantly impairs the free movement of a limb, or total, in that the person may be unable to freely walk or stand as a result of the application of the restraint. Whilst this was written within the context of providing care in a learning disability setting, the principles seem to be applicable to all clinical settings.

17.3 What Are the Legal Frameworks in England and Wales?

Within England and Wales, there are a range of laws which must be considered in developing appropriate policy framework:

- Criminal Law Act 1967 3 (1)
- Mental Health Act 1983 and Code of Practice (Department of Health 2015)
- Human Rights Act 1998

- Common Law: "Cases of Necessity" (Card and English 2015)
- Mental Capacity Act 2005 and Code of Practice (Department of Constitutional Affairs 2007)

The Human Rights Act 1998 (which implements the rights and freedoms guaranteed under the European Convention on Human Rights into English law) enshrines an individual's right to freedom of movement, provided that they are not harming others in exercising that right. If this is to be impeded, then the use of restraint must be justified by a clear rationale as to what are the considerations believed to override this individual freedom of action.

Therefore, in considering whether the use of mechanical restraint could be seen as assault, it is important for staff to understand the criminal law framework. The Criminal Law Act 1967, s 3 provides "*that it is lawful to use such force as is reasonable in the circumstances in the prevention of crime or in effecting (or assisting in) the lawful arrest of offenders, suspected offenders or persons unlawfully at large. Where the accused acts under a mistake as to the circumstances, this provision is applied to the circumstances as he believed them to be. The effecting of an arrest will almost always involve some form of restraint, even if it is symbolic, and this would be a battery but for the present defence. It must be emphasised that, if the force used to prevent a crime or to make an arrest is unreasonable in the circumstances, it will be unlawful and the person using it will not have a defence to a charge of battery or of another offense against the person. A person has no defence, even though he uses reasonable force, if he is acting in furtherance of an unlawful arrest*".

Therefore, if it is deemed necessary to use any form of mechanical restraint, it must be used within the legal frame work of "reasonable force" as described in The Criminal Law Act 1967, s 3. Thus, its use must be **P**roportionate, **L**egal, **A**cceptable and **N**ecessary, and its use must be **B**ased on the facts as known at the time of use (PLAN B). PLAN B is a system for identifying the legal use of force by Metropolitan Police Officers (cited in Equality and Human Rights Commission 2010) and is a system that can be useful to all staff involved in any use of force whether this is mechanical or physical.

The Council of Europe (2004) further stated that the benefits of using physical restraint and seclusion should be in proportion to the risks entailed: "*persons with mental disorder should have the right to be cared for in the least restrictive environment available with least restrictive or intrusive treatment available, taking into account their health needs and the need to protect the safety of others*". Those working within forensic psychiatry are well used to applying the least restrictive principle, but again, current practice in England and Wales is based on the perception that mechanical restraint is the "most restrictive" practice.

Further consideration must be made when deciding on any interventions for an individual who lacks capacity, in that it must meet the "best interests principle" within the meaning of the Mental Capacity Act 2005. It defines this as "*An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests*". One of the exceptions to this principle

is, however, if an individual has made an Advanced Decision in respect of their care. Furthermore, the interplay between the Mental Capacity Act 2005 and the Mental Health Act 1983 for those who lack capacity but are also detained under the Mental Health Act is complex.

The Royal College of Psychiatrists notes in "The Short-term Management of Disturbed/Violent Behaviour in Psychiatric In-patient Settings and Emergency Departments" (2005) that "*in the UK the physical intervention primarily used in the short-term management of disturbed/violent behaviour is manual holding, rather than the use of mechanical devices such as belts, body vests or handcuffs. These devices are rarely and only used in exceptional circumstances usually within high security settings*". This understanding has further developed over the past 10 years, and The Mental Health Act Code of Practice was revised in 2015 (Department of Health 2015), offering clearer practice guidance on managing disturbed behaviour. The revised Code of Practice makes specific mention of mechanical restraint noting that if mechanical restraint is to be used then there needs to be a clear policy in place and emphasises the importance of de-escalation. Mechanical restraint should then only be used exceptionally, where other forms of restriction cannot be safely employed. The code stresses that it should be used in line with the principle of "least restrictive option" and should not be an unplanned response to an emergency situation. Mechanical restraint further should never be used instead of adequate staffing, neither should restraints ever be tied to some part of a building nor its fixtures. In the new Code of Practice, Chapter 26 "Safe and therapeutic responses to behavioural disturbance" replaced the previously titled chapter "Patients presenting particular management problems", reflecting a greater awareness of the impact of restrictive interventions, and the code encourages the use of advance statements by patients in how to deal with episodes of particularly disturbed behaviour.

Whilst Clinical Guidelines are exactly that—guidelines—it is vital that they are taken into consideration and any deviation explained. The 2015 NICE clinical guideline on managing violent/aggressive behaviour covers how people in the National Health Service (NHS) should try to prevent violent situations from happening, and what they should do if someone becomes violent. This latest review of the guidelines notes that mechanical restraint should consist of authorised equipment, be applied in a skilled manner by designated healthcare staff. It also states the importance of its use in high secure settings only, as a "last resort" and for the purpose of managing extreme violence directed at other people or limiting self-injurious behaviour of extremely high frequency or intensity. The Guidance Development Group (GDG) also saw that mechanical restraint may have a place when transferring service users at risk of violence between healthcare settings (medium to high). In all cases, the GDG agreed that the use of mechanical restraint should be planned in advance and reported to the Trust Board. Again, this is indicative that mechanical restraint is becoming more widely used and explored within England and Wales.

However, national concern following an inquiry into extensive abuse of people with learning disabilities (Department of Health 2012) has prompted further

guidance from the Department of Health in "Positive and Proactive Care: Reducing the need for restrictive interventions" (2014). In this document, which clearly states its goal to work towards stopping all restrictive interventions, clear reference to mechanical restraint is made: "*Mechanical restraints should never be a first line means of managing disturbed behaviour. The use of mechanical restraint to manage extreme violence directed towards others should be exceptional, and seldom used in this or other contexts outside of high secure settings. It is recognised that following rigorous assessment there may be exceptional circumstances where mechanical restraints need to be used to limit self-injurious behaviour of extremely high frequency and intensity*". It offers further advice on the practicalities of implementation, namely: "*Wherever mechanical restraint is used as a planned contingency it must be identified within a broad ranging, robust behaviour support plan which aims to bring about the circumstances where continued use of mechanical restraint will no longer be required*".

The legal and guidance framework is therefore extensive, although there is considerable overlap, and some common guiding principles. However, although an intervention can be legal, and considered to conform to clinical practice guidelines, the ethics of any restrictive interventions must also be of concern.

17.4 What Ethical Issues Arise?

The question of whether mechanical restraint is ethical is an important consideration prior to its implementation; however, the necessary management of extreme violent and/or self-injurious behaviours, often against an individual's will, makes this a complex ethical minefield. The ethical issues around the use of mechanical restraint are regularly debated within the literature (Jones and Allen 2009; Whittington et al. 2006; Mohr 2010), which can help us to start to structure our thinking. The starting point has to be the highest ethical principle of all: that is an individual clinicians' duty to maintain life (of the individual and others) (Sen et al. 2007). Within England and Wales, legislation also offers fundamental requirements when considering coercive interventions, such as "least restrictive" (Department of Health 2014), "proportionate" (NICE 2015) and "last resort" (Care Quality Commission 2014); therefore, clinical teams must determine that all other possible interventions have been considered first, and that mechanical restraint is really the only option left. However, is mechanical restraint always the "most restrictive"? It could be argued that, for some, mechanical restraint is less restrictive than long-term seclusion, for example. Attempts to assess the relative restrictiveness of interventions, based on patient self-report, have not been able to demonstrate evidence for a preference of one method over another (Bergk et al. 2011); in addition, Paterson (2005) argues that mechanical restraint may be preferable to some patients as it does not rely on pain compliance, unlike physical restraint.

The complexity of ethical issues around mechanical restraint means that it is not just enough to consider: is it legal? And is any harm outweighed by the good it might do? The question of whether it is "fair" and "right" needs to be also

considered, and a wider ethical framework within which mechanical restraint may be explored is needed. The "four principles plus scope" approach (Gillon 1994), which considers the concepts of "respect for autonomy", "beneficence", "non maleficence" and "justice", offers a basic moral analytic framework (Gillon 2015), and this is a good starting point. Although this approach can be viewed as having specific limitations in relation to ethical dilemmas in forensic psychiatry, especially when considering mechanical interventions (Sen et al. 2007), it can still allow clinical teams to systematically consider the broader range of ethical issues, prior to making clinical decisions.

The principle of "respect for autonomy" is concerned with respecting the decision-making capacities of autonomous persons, enabling individuals to make reasoned informed choices. The initial challenge faced by this concept, for those in forensic psychiatry, is that the patient is unlikely to have capacity to act in a truly autonomous way, particularly as they are often detained against their will, and moreover: Can patients meaningfully consent to coercive measures (Sen et al. 2007)? NICE (2015) guidelines stress the importance of including patient preference when identifying an intervention, and studies suggest that there is a trend towards service user involvement, even when the decision involves coercive measures (Soininen et al. 2014). Therefore, notwithstanding issues of capacity, it can be possible for patients to be included in decisions of this nature, through open and transparent discussion with their team, which provide the patient with a clear outline of the clinical dilemma and rationale for treatment options. Decisions about mechanical restraint may form part of advance decisions, and active care planning, which take patient preference into account. Care plans can then be reviewed regularly and modified in light of patient feedback and experience. Planned intervention has other benefits, in that it is safer for the staff than emergency use; indeed planned use of mechanical restraint can lead to fewer staff injuries than physical restraint (Hill and Spreat 1987). It is important to note that, although patient involvement is sought, for the detained patient mechanical restraint is neither dependent on consent nor invalidated based on advance decisions (Gordon et al. 1999). However, patient involvement in the decision process allows this to be a more predictable intervention.

Gillon (1994) further notes that "respect for autonomy" can be viewed as "equal respect for the autonomy of all potentially affected". This is particularly salient in forensic psychiatry where the duty of care has to extend beyond the individual, to include other patients, staff, family and the general public and it is likely that the duty to the patient conflicts with duties towards third parties (Sen et al. 2007). This highlights the extent of "the scope" to which the principles apply. In other branches of medicine, scope might solely be "the patient" (Gillon 1994); however, clearly in forensic psychiatry scope must extend beyond the individual to those who may be at risk due to the patient's behaviour. This can be "local" in relation to other patients and staff on the ward or wider to encompass family and society at large (Sen et al. 2007).

The principle of "beneficence" balances the benefits of treatment against the risks and costs, ensuring that the healthcare professional acts in a way which

benefits the patient. Is it enough that the self-injurious patient is prevented from further harm? Or the violent patient is prevented from harming others? More importantly, any intervention should also lead to an improvement in the individual so that the intervention can be terminated. The clinical team therefore needs to establish whether the intervention will "work" or at least improve the situation to the benefit of the patient. There is an international, albeit limited, literature base in this area; however, this can lead to wide variations in the type of mechanical restraint referred to, thresholds for implementation and cultural interpretations of its usefulness. For clinical teams, this can make it difficult to assess the effectiveness and find appropriate "norm" groups for comparison. There is a need for more evidence of effectiveness (Nelstrop et al. 2006); however, the particular ethical issues surrounding completing research of this nature make it a difficult area to investigate (Soininen et al. 2014). Single case studies can demonstrate that mechanical restraint can have positive outcomes for patients (Carr 2012); however, comparability can be difficult. This reminds us that when we consider extreme behaviours, and our responses to them, it is important to consider that, although this intervention may benefit one patient, it will not necessarily benefit another, or more likely what is beneficial on one occasion, may or may not be beneficial on subsequent occasions. It can also be difficult to establish whether "beneficence" applies to "behaving better", rather than just feeling better, as these two dimensions can be mutually exclusive, e.g.: Are we justified in interventions that improve behaviour, even if they make the individual feel worse? Although it could be argued that if a patient's behaviour improves, it can have benefits for the wider community (such as increased acceptance), which can then benefit the patient in the end (Sen et al. 2007).

The principle of non-maleficence has its roots in the Hippocratic Oath "first, do no harm". Gunn and Taylor (2014) express this concept as "*given an existing problem, it may be better not to do a particular thing, or even to do nothing, than to risk causing more harm than good*". Mechanical restraint can be viewed negatively, but does it cause harm? The answer has to be "yes", in that it can cause harm to the patient both through physical injuries and in rare cases death (Paterson et al. 2003), and it also has the potential to cause psychological distress (Bergk et al. 2011; Gallop et al. 1999). Bergk et al. (2011) attempted to assess the level of psychological distress caused by mechanical restraint using the Coercion Experiences Scale (CES) (Bergk et al. 2010). This scale was developed to assess both the level of restriction on human rights and the resultant stressors, when comparing seclusion and restraint, and has shown that some forms of mechanical restraint can impact on patients' sense of autonomy, subsequent traumatisation and cause them to develop negative attitudes towards psychiatric services which, for some, are still present 18 months after the incident (Steinert et al. 2013). Coercive interventions can also have significant negative impact on the nurses who implement them, e.g. experience of, and suppression of, emotional distress which can further impact on their connectedness with the patient (Moran et al. 2009). This is concerning for the clinician, as there is a risk of mechanical restraint contributing to a vicious cycle of behaviour, where the patient's emotional state deteriorates, and

the care staff's ability to contain and respond positively to this diminishes due to the intervention thereby, paradoxically, increasing the risk of distress-based self-injury and violence.

It is therefore beholden for any clinical team when considering if mechanical restraint offers the best chance of managing life-threatening behaviours to attempt to reduce the potential negative impact on the patient, if at all possible. Strategies considered to reduce the risk of physical harm should be employed, such as use of the correct equipment, implementation by trained staff, constant observations whilst being restrained, regular reviews and active attempts to remove the restraint as soon as it is safe to do so (Whittington et al. 2006; Paley 2008). These criteria should form part of the guidelines/procedures of the organisation to ensure the safety of the patient and the consistency of the intervention and guard against potential misuse. In fact, factors such as mandatory reviews and patient involvement can be found to be preventative factors, associated with lower rates of use of mechanical restraint (Bak et al. 2014). The CES can also be considered as a useful screening measure, prior to the application of mechanical restraint, to identify possible levels of trauma and as such can help inform decision making. In fact, research suggests that patients' choice and feelings of being in control appear to reduce their perceptions of the restrictiveness of the intervention and their feelings of helplessness (Bergk et al. 2011). This can be established if patients are actively involved in the process of decision making; some patients do report experiencing it as being less restrictive than other practices such as physical restraint (Carr 2012). Steinert et al. (2013) also found in their 18-month follow-up study that, although mechanical restraint can be traumatising for some patients, other patients acknowledged that the length of time which they were subjected to mechanical restraint in their case was justified.

The principle of Justice can be broadly viewed as "fairness", particularly in relation to competing claims on limited resources, respect for peoples' rights and respect for morally acceptable laws (Gillon 1994). However, Sen et al. (2007) argue that "justice" is a particularly difficult concept in forensic psychiatry as patients already experience less justice in relation to liberty and personal autonomy, as well as access to care than the general public. In addition "fairness for the patient" necessarily needs to compete with "fairness for the public" and that justice is for every individual, not just for the patient but society's needs too. They therefore propose that "justice" within the forensic setting needs to be more "communitarian", whilst still preventing exploitation of the vulnerable patient. This is often a difficult balance to strike, particularly when we need an individualised approach to patient care, almost taking us full circle to the primary ethical consideration of preservation of life.

Therefore, the issue might be "Is it right to mechanically restrain a vulnerable patient, against their will, if this is protecting their life and/or the rights of others (to safety)?" Additionally, any decision must take into account the full range of ethical principles, in essence trying to balance conflicting concerns of respect for autonomy, benefits and costs to reach a solution which is "fair and just".

17.5 Practical Issues

17.5.1 Developing a Mechanical Restraint Policy: Putting It All into Practice

Over the past 8 years, the authors have had experience of developing a policy for the safe and exceptional use of mechanical restraint and approved mechanical restraint devices have become an accepted intervention for the management of self-injury, risk of injury to others and damage to property "*when its use is absolutely necessary to achieve the required objective and has been approved in accordance with the procedure*" (Nottinghamshire Healthcare NHS Trust 2013). The process of developing a policy of this nature, from concept to implementation, was lengthy and will always be "ongoing".

For us, the process began in 2007 within the National High Secure Healthcare Service for Women, at Rampton Hospital, England, and was driven by clinical need and the wish to consider all forms of management strategies. There were two main clinical scenarios which prompted this journey. The first was that there remained a very small number of patients being nursed within seclusion for long periods of time, due to their high levels of unpredictable violence, for whom it had not proved possible to safely reintegrate into ward areas. There were concerns that the process of reintegration to the main ward was a significant challenge and that sustained, risk free periods of time were rarely seen. It was postulated that mechanical restraint might provide a means to safely reintegrate such patients, allowing them to mix safely with both staff and patients, and start to acclimatise them to life outside of seclusion, whilst reducing the life-threatening risks to others, primarily direct care staff.

The second clinical risk scenario was life-threatening acts of self-injury which a small number of patients were regularly carrying out, with little success in our attempts to manage these collaboratively. The most serious, and anxiety provoking, acts included severe head banging, "bloodletting" and exsanguination by exposing veins and arteries, e.g. the brachial artery. It was felt that existing interventions, namely seclusion, physical restraint and chemical restraint, did not adequately balance the risks to self and others, with our duty of care to patients and staff to preserve life.

For most staff, mechanical restraint was a new intervention, and it was felt that it would potentially signal a departure from "tried and tested" methods to something which historically had very negative connotations in the UK. It therefore felt important to approach this in an as sensitive and inclusive a way as possible.

We found it helpful in the first instance to form a "working group" which consisted of a range of professionals from a broad variety of disciplines including: Psychology, Psychiatry, Social Work, Nurse Management, Practitioner Nursing, Security Liaison and Managing Violence Trainers. The group represented a variety of views on mechanical restraint, in that some were broadly in favour of it, and others were passionately against it. As a working group, we met regularly to discuss, initially, the clinical challenges facing us, namely impulsive violence,

long-term seclusion and life-threatening self-injury. In the early phase of the process staff were most concerned with exploring whether mechanical restraint would offer a way to allow severely disturbed patients, who need to be nursed in seclusion for long periods of time to manage risk, opportunities to safely reintegrate into the ward (much like the case discussed by Gordon et al. 1999). We were particularly concerned with issues around quality of life, safe reintegration and managing violence. A literature search was carried out in order to both inform our discussions around mechanical restraint, and to establish what other alternative interventions might be helpful with the clinical issues. Examination of the literature considered key areas such as clinical effectiveness, existing guidance, legal and ethical issues.

The working group could then provide a forum in which we could examine, and explore, evidence and opinion. It became an important space where individuals could freely express possibilities, reservations, practicalities and cautions. Often, staff reflected that their opinion changed from week to week, moving between different positions, which highlighted the complexity of the issue, and the difficulties in reaching an "absolute decision". It was apparent early on that the literature would not provide us with any definitive answers; however, a number of papers helped us with clinical and ethical dilemmas (in particular Gordon et al. 1999; Paterson 2005). Alongside the working group meetings, a number of focus groups were carried out to capture nursing opinion. This was felt to be particularly important as it would be nursing staff who would be actually applying the restraint. Staff were able to articulate the clinical challenges which they faced, offer alternative interventions as well as recognise a range of issues pertinent to mechanical restraint. Most staff identified the ethical issues involved, and although they were cautious about the impact of an intervention of this nature, they were also keen to try things which might improve patients' quality of life.

The staff focus groups explored the clinical pros and cons regarding the use of mechanical restraint, admittedly from a staff perspective, but the groups were encouraged to also consider patient perspectives. The repeated tension that arose was the need to manage life-threatening risks to self and the life-threatening risk of violence to others. This, at times, conflicted with staff's own ethical standpoints; however, the reduction of life-threatening self-injury, to the point of maintaining life, was felt to be the most important clinical factor. Staff were also keen to ensure that all legal issues would be considered, and any use of mechanical restraint would be fully compliant. Additional positive points included a reduction on the reliance of chemical and physical restraints and the associated effects on staff and patients. In particular, having an alternative to the situations where long-term physical restraint was required was felt to be very valuable as physical restraint, in our experience, can be damaging, place staff directly at risk as well as also being perceived as intrusive by patients. The option of using advance statements to facilitate empowering patients to make planned informed decisions about restraint was also considered. Some of the concerns raised included one of perception and the historical image of mechanical restraint, in particular issues regarding negative publicity and the potential for mechanical restraint to be seen as a punishment. The

risk of "the slippery slope" was also of concern, and it was clear that the governance of any use would need to be stringent. The potential for re-traumatising effects for the patient was identified, although this was balanced with the fact that ultimately, we were discussing an "alternate form of restraint" in an extreme clinical situation, in which some form of restraint would ultimately be required.

Much thought was given as to how to include patient opinion; however, this proved difficult as it was felt to be not in the patients' best interest to ask them their views about a "possible" intervention, thereby potentially raising their expectations, when it was by no means certain that this approach would be implemented. We acknowledged this was a gap, and the lack of the "patient voice" felt difficult at times in the group.

The group often reflected on their concerns that mechanical restraint, if reintroduced, might be overused or even abused. Sharon Paley's (2008) paper, which outlined the principles for practice when using mechanical restraint, offered clear guidance in relation to the implementation of the intervention. Although her paper is written with a learning disabled population in mind, it outlines important areas such as "Principles of Good Practice" and encourages high levels of team discussion and planning prior to implementation, which felt essential for our service too. This helped us form a framework for ethical, legal and effective intervention, which was agreed by the group.

The hospital had an existing policy for the use of handcuffs, for patients when they are outside of the hospital, and this was being reviewed by the Violence Reduction Team. In addition, they had identified a possible piece of equipment, namely a waist belt with cuffs, which would restrain a patient by holding their wrists next to their body. It was agreed that our working group and the trust wide policy development group would jointly work on a mechanical restraint policy which met the needs of all patients. The policy group was therefore multi-disciplinary and was able to incorporate much of the working groups' clinical, legal and ethical thinking.

The developed policy included clear reference to the importance of adherence to legislation and guidance within documents such as the Mental Health Act 1983, respective Code of Practice and relevant NICE guidance in relation to the management of disturbed/violent behaviour, making reference to concepts such as "last resort" and "least restrictive". It stressed the importance of making every effort to avoid the use of mechanical restraint, by trying other interventions first. There were strict instructions about gaining senior management permission and the patient needing to be under constant observation once in the restraint. Review periods were clearly outlined, as well as the need for staff to actively work with the patient to be able to remove the restraint as soon as possible.

Since the policy has been in place within our hospital, it has been used primarily for the management of life-threatening self-injury (such as severe head injury, "bloodletting", choking, disembowelling and self-mutilation near major arteries) and less for managing violence than had been originally planned or predicted. It is also used to facilitate the safe transfer of patients who are presenting a high risk to others, for example to seclusion areas. It remains a rarely used intervention and

although staff have gained confidence in implementing it, they remain uncomfortable, at times, about its use. The use of the restraint is formally monitored and regularly reviewed at team level, as well as at senior management level. The CQC also monitors it closely and receives regular reports on its use. The policy has also been reviewed in order to accommodate feedback both from staff who are using it and clinicians concerned about the potential for misuse. It remains a very "live" topic, with staff and patients challenging its use at times and this feels both appropriate and necessary given the seriousness of this restrictive intervention.

17.6 So What Does All This Mean?

Having been involved in the development of the Safe and Exceptional Use of Mechanical Restraint Policy within Rampton Hospital, we have spent many hours discussing the various dilemmas that we hope we have presented in this chapter. This is not to say that we have arrived at conclusive answers but we at least feel that we have a good understanding of the issues and perhaps can identify some important ways to move forward.

There is no doubt that clinicians in the UK need to keep sharing their practices so that we can all learn from each other. We also need to be open to reflect on practices elsewhere in the world, noting that a vast amount of the literature on mechanical restraint is European and American. Whilst it may be a difficult and contentious issue, the need to discuss, and be open about, the use and individual services' clinical experience is vital, as it could be viewed that without consideration of mechanical restraint patients are not being offered all available treatment options in extreme clinical situations.

In our view, we have experienced clinical scenarios where we feel that mechanical restraint has been the preferred management strategy and, interestingly, some of the anecdotal feedback suggests that we need to be more proactively involving patients in advance decision making to explore the variety of options available to manage violence and life-threatening self-injury. After all, one of the key principles we all work with is trying to promote patient choice, which is often at odds with being detained under the Mental Health Act in a secure psychiatric hospital. On a personal note, we also shared the reflections that Carr (2012) expressed in his case study in terms of having many anxieties about starting to explore this option and finding that, actually, some of the findings and dilemmas challenged some of our preconceived views. In our opinion, one of the most important aspects moving forwards is to explore how the research base can be made more meaningful and how patients' views and outcomes can be central to this.

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