DRAFT – 30/04/2021

A Compendium Report - Good Practices in the Council of Europe to Promote Voluntary Measures in Mental Health Services

Piers Gooding

Appendix A – Questionnaire

COUNCIL OF EUROPE

CONSEIL DE L'EUROPE

Strasbourg, 3 July 2020

DH-BIO/INF (2020) 5
Addendum

COMMITTEE ON BIOETHICS (DH-BIO)

ADDENDUM

to the Compendium of good practices in mental health care

- how to promote voluntary care and treatment practices -

Collection of examples

July 2020 – December 2020

Filling form for the Collection of proposals of examples of good practices for the inclusion in the Compendium (July 2020 – December 2020)

Replies to be submitted using the form below by e-mail
to the Secretariat of the Committee on Bioethics

Person responsible within the Secretariat:
Ms Katrin Uerpmann, tel. +33 (0) 390 21 43 25

a) Essential information (necessary for inclusion in the compendium)

Name of the practice:

Address of the place where the practice is carried out:

1. **In which areas is the practice implemented** (healthcare, employment, housing, training/education, social policies…)?

2. **If the practice is linked to healthcare, at which stage of the health care path is it implemented** (general health care, admission, follow up…)?

3. **What is the aim of the practice?**

4. **Does the practice address a specific situation** (crisis situation, follow-up to hospitalisation, homelessness...)?

5. **Individuals concerned** (persons with specific mental health needs, specific groups such as adolescents/young adults, elderly persons, health care professionals…)?

6. **Scope or area of the practice:** national/regional/local?

7. **Detailed description of the practice and how it is carried out,** including length and frequency, if applicable.

8. **Indicator of the impact of the practice** (feedback from service users/family members/service providers/health professionals; decrease of recourse to involuntary measures…), including any available information on the medium- or long-term impact of the practice.

b) Additional useful information (to be submitted only if available)

9. Factors which have **facilitated the implementation of the practice.**

10. Information on the **barriers to the implementation of the practice**, if any.

11. Which **other options** were available?

12. Which factors are considered essential for **transferability of the practice** into a different setting?

13. **Formal assessment of the impact of the practice** (external or self-evaluation)

14. **Cost evaluation** (costs/saving analysis)

15. How were the **service users involved** in the decision-making process leading to the implementation of the practice?

16. Any additional **feedback from stakeholders** (service users, family members, health professionals, social workers etc.)

17. Any **additional statistical information** relating to the short-, medium- or long-term impact of the practice

18. Information on any **on-line or other resources** (tool kits, guides, reports…)

19. **Detail of a contact person** who could be contacted to request further information, if needed.

Appendix B – Table of English-Language Research from COE Member States

This Section provides a brief annotated bibliography of formal papers published in peer reviewed journals that align with the broad aims of the compendium. The journal articles are listed first, followed by a table that provides information on the country, aim, methods and findings of each study.

These materials were adapted for this report after being gathered as part of the following study:

> Gooding, P, McSherry, B, and Roper, C (2020). 'Preventing and Reducing "Coercion" in Mental Health Services: An International Scoping Review of English-Language Studies' *Acta Psychiatrica Scandinavica* 142(1) pp.27-39. https://onlinelibrary.wiley.com/doi/full/10.1111/acps.13152

A limit was placed on the date range for the search, from 1990 and 31 September 2018. A language filter was applied to focus on English-language results. This English-language bias is a clear limitation. The authors acknowledged that the solely English-language focus of the survey impoverished the findings. They recommended a comprehensive study of non-English language materials.

Another limitation is that the review considers scholarly literature alone, which may overlook much of the research and practical implementation work concerning reduction and prevention initiatives may well have occurred in 'grey literature', including policy documents, service reports, advocacy news, and so on.

For a detailed account of the method, including limitations of the study, please refer to the original (open access) report (Gooding et al. 2020).

Bibliography of Relevant Studies from Council of Europe Countries (as surveyed in Gooding et al, 2020)

Aagaard, J., Tuszewski, B., & Kølbæk, P. (2017). Does Assertive Community Treatment Reduce the Use of Compulsory Admissions? *Archives Of Psychiatric Nursing*, *31*(6), 641–646. mnh. https://doi.org/10.1016/j.apnu.2017.07.008

Aaltonen, J., Seikkula, J., & Lehtinen, K. (2011). The Comprehensive Open-Dialogue Approach in Western Lapland: I. The incidence of non-affective psychosis and prodromal states. *Psychosis*, *3*(3), 179–191. https://doi.org/10.1080/17522439.2011.601750

Andersen, K., & Nielsen, B. (2016). Coercion in psychiatry: The importance of extramural factors. *Nordic Journal Of Psychiatry*, *70*(8), 606–610. mnh. https://doi.org/10.1080/08039488.2016.1190401

Bak, J., Zoffmann, V., Sestoft, D. M., Almvik, R., & Brandt-Christensen, M. (2014). Mechanical restraint in psychiatry: Preventive factors in theory and practice. A Danish-Norwegian association study. *Perspectives In Psychiatric Care*, *50*(3), 155–166. mnh. https://doi.org/10.1111/ppc.12036

Bak, J., Zoffmann, V., Sestoft, D. M., Almvik, R., Siersma, V. D., & Brandt-Christensen, M. (2015). Comparing the effect of non-medical mechanical restraint preventive factors between psychiatric units in Denmark and Norway. *Nordic Journal Of Psychiatry*, *69*(6), 433–443. mnh. https://doi.org/10.3109/08039488.2014.996600

Barrett, B., Waheed, W., Farrelly, S., Birchwood, M., Dunn, G., Flach, C., Henderson, C., Leese, M., Helen Lester †, Marshall, M., Rose, D., Kim Sutherby, Szmukler, G., Thornicroft, G., & Byford, S. (2013). Randomised Controlled Trial of Joint Crisis Plans to Reduce Compulsory Treatment for People with Psychosis: Economic Outcomes. *PLoS One*, *8*(11). Health & Medical Collection. https://doi.org/10.1371/journal.pone.0074210

Boumans, C. E., Egger, J. I. M., Souren, P. M., & Hutschemaekers, G. J. M. (2014). Reduction in the use of seclusion by the methodical work approach. *International Journal of Mental Health Nursing*, *23*(2), 161–170. https://doi.org/10.1111/inm.12037

Boumans, C. E., Walvoort, S. J. W., Egger, J. I. M., & Hutschemaekers, G. J. M. (2015). The Methodical Work Approach and the Reduction in the Use of Seclusion: How did it Work? *Psychiatric Quarterly*, *86*(1), 1–17. Health & Medical Collection; Psychology Database. https://doi.org/10.1007/s11126-014-9321-7

Bowers, L, Haglund, K., Muir-Cochrane, E., Nijman, H., Simpson, A., & Van Der Merwe, M. (2010). Locked doors: A survey of patients, staff and visitors. *Journal Of Psychiatric And Mental Health Nursing*, *17*(10), 873–880. mnh. https://doi.org/10.1111/j.1365-2850.2010.01614.x

Bowers, Len, James, K., Quirk, A., Simpson, A., Stewart, D., & Hodsoll, J. (2015). Reducing conflict and containment rates on acute psychiatric wards: The Safewards cluster randomised controlled trial. *International Journal of Nursing Studies*, *52*(9), 1412–1422. https://doi.org/10.1016/j.ijnurstu.2015.05.001

Bowers, Len, Stewart, D., Papadopoulos, C., & Iennaco, J. D. (2013). Correlation between levels of conflict and containment on acute psychiatric wards: The city-128 study. *Psychiatric Services (Washington, D.C.)*, *64*(5), 423–430. mnh. https://doi.org/10.1176/appi.ps.201200328

Chambers, M., Gallagher, A., Borschmann, R., Gillard, S., Turner, K., & Kantaris, X. (2014). The experiences of detained mental health service users: Issues of dignity in care. *BMC Medical Ethics*, *15*, 50–50. mnh. https://doi.org/10.1186/1472-6939-15-50

Corlett, S. (2013). Policy watch: A steady erosion of rights. *Mental Health & Social Inclusion*, *17*(2), 60–63. ccm. https://doi.org/10.1108/20428301311330090

Cullberg, J., Levander, S., Holmqvist, R., Mattsson, M., & Wieselgren, I.-M. (2002). One-year outcome in first episode psychosis patients in the Swedish Parachute project. *Acta Psychiatrica Scandinavica*, *106*(4), 276–285. https://doi.org/10.1034/j.1600-0447.2002.02376.x

Cullberg, J., Mattsson, M., Levander, S., Holmqvist, R., Tomsmark, L., Elingfors, C., & Wieselgren, I.-M. (2006). Treatment costs and clinical outcome for first episode schizophrenia patients: A 3-year follow-up of the Swedish 'Parachute Project' and Two Comparison Groups. *Acta Psychiatrica Scandinavica*, *114*(4), 274–281. https://doi.org/10.1111/j.1600-0447.2006.00788.x

de Jong, G., & Schout, G. (2013). Researching the Applicability of Family Group Conferencing in Public Mental Health Care. *British Journal of Social Work*, *43*(4), 796–802. ccm. https://doi.org/10.1093/bjsw/bcs006

Eytan, A., Chatton, A., Safran, E., & Khazaal, Y. (2013). Impact of Psychiatrists' Qualifications on the Rate of Compulsory Admissions. *Psychiatric Quarterly*, *84*(1), 73–80. Health & Medical Collection; Psychology Database. https://doi.org/10.1007/s11126-012-9228-0

Flammer, E., & Steinert, T. (2016). Association Between Restriction of Involuntary Medication and Frequency of Coercive Measures and Violent Incidents. *Psychiatric Services (Washington, D.C.)*, *67*(12), 1315–1320. mnh.

Gilburt, H., Slade, M., Rose, D., Lloyd-Evans, B., Johnson, S., & Osborn, D. P. J. (2010). Service users' experiences of residential alternatives to standard acute wards: Qualitative study of similarities and differences. *The British Journal Of Psychiatry. Supplement*, *53*, s26–s31. mnh. https://doi.org/10.1192/bjp.bp.110.081075

Gjerberg, E., Hem, M. H., Førde, R., & Pedersen, R. (2013). How to avoid and prevent coercion in nursing homes: A qualitative study. *Nursing Ethics*, *20*(6), 632–644. https://doi.org/10.1177/0969733012473012

Groot, P. C., & Os, J. van. (2018). Antidepressant tapering strips to help people come off medication more safely. *Psychosis*, *10*(2), 142–145. https://doi.org/10.1080/17522439.2018.1469163

Hackett, R., Nicholson, J., Mullins, S., Farrington, T., Ward, S., Pritchard, G., Miller, E., & Mahmood, N. (2009). Enhancing Pathways Into Care (EPIC): Community development working with the Pakistani community to improve patient pathways within a crisis resolution and home treatment service. *International Review of Psychiatry*, *21*(5), 465. Health & Medical Collection; Psychology Database.

Henderson, C., Farrelly, S., Flach, C., Borschmann, R., Birchwood, M., Thornicroft, G., Waheed, W., & Szmukler, G. (2017). Informed, advance refusals of treatment by people with severe mental illness in a randomised controlled trial of joint crisis plans: Demand, content and correlates. *BMC Psychiatry*, *17*(1), 376–376. mnh. https://doi.org/10.1186/s12888-017-1542-5

Henderson, C., Flood, C., Leese, M., Thornicroft, G., Sutherby, K., & Szmukler, G. (2004). Effect of joint crisis plans on use of compulsory treatment in psychiatry: Single blind randomised controlled trial. *BMJ (Clinical Research Ed.)*, *329*(7458), 136. https://doi.org/10.1136/bmj.38155.585046.63

Henderson, C., Flood, C., Leese, M., Thornicroft, G., Sutherby, K., & Szmukler, G. (2009). Views of service users and providers on joint crisis plans. *Social Psychiatry and Psychiatric Epidemiology*, *44*(5), 369–376. Health & Medical Collection; Psychology Database. https://doi.org/10.1007/s00127-008-0442-x

Heumann, K., Bock, T., & Lincoln, T. M. (2017). [Please do Something—No Matter what! A Nationwide Online Survey of Mental Health Service Users About the Use of Alternatives to Coercive Measures]. *Psychiatrische Praxis*, *44*(2), 85–92. https://doi.org/10.1055/s-0041-109033

Højlund Mikkel, Høgh Lene, Bojesen, A. B., Munk-Jørgensen Povl, & Stenager Elsebeth. (2018). Use of antipsychotics and benzodiazepines in connection to minimising coercion and mechanical restraint in a general psychiatric ward. *The International Journal of Social Psychiatry*, *64*(3), 258–265. Health &

Medical Collection; Psychology Database. https://doi.org/10.1177/0020764018760650

Høyer, G., Kjellin, L., Engberg, M., Kaltiala-Heino, R., Nilstun, T., Sigurjónsdóttir, M., & Syse, A. (2002). Paternalism and autonomy: A presentation of a Nordic study on the use of coercion in the mental health care system. *International Journal Of Law And Psychiatry*, *25*(2), 93–108. mnh.

Huber, C. G., Schneeberger, A. R., Kowalinski, E., Fröhlich, D., Felten, S. von, Walter, M., Zinkler, M., Beine, K., Heinz, A., Borgwardt, S., & Lang, U. E. (2016). Suicide risk and absconding in psychiatric hospitals with and without open door policies: A 15 year, observational study. *The Lancet Psychiatry*, *3*(9), 842–849. https://doi.org/10.1016/S2215-0366(16)30168-7

Hustoft, K., Larsen, T. K., Brønnick, K., Joa, I., Johannessen, J. O., & Ruud, T. (2018). Voluntary or involuntary acute psychiatric hospitalization in Norway: A 24h follow up study. *International Journal of Law and Psychiatry*, *56*, 27–34. https://doi.org/10.1016/j.ijlp.2017.10.011

Husum, T. L., Bjørngaard, J. H., Finset, A., & Ruud, T. (2010). A cross-sectional prospective study of seclusion, restraint and involuntary medication in acute psychiatric wards: Patient, staff and ward characteristics. *BMC Health Services Research*, *10*, 89–89. mnh. https://doi.org/10.1186/1472-6963-10-89

Jaeger, M., Ketteler, D., Rabenschlag, F., & Theodoridou, A. (2014). Informal coercion in acute inpatient setting—Knowledge and attitudes held by mental health professionals. *Psychiatry Research*, *220*(3), 1007–1011. https://doi.org/10.1016/j.psychres.2014.08.014

Jaeger, M., Konrad, A., Rueegg, S., & Rabenschlag, F. (2015). Patients' subjective perspective on recovery orientation on an acute psychiatric unit. *Nordic Journal Of Psychiatry*, *69*(3), 188–195. mnh. https://doi.org/10.3109/08039488.2014.959561

Janssen, W. A., Noorthoorn, E. O., Nijman, H. L. I., Bowers, L., Hoogendoorn, A. W., Smit, A., & Widdershoven, G. A. M. (2013). Differences in seclusion rates between admission wards: Does patient compilation explain? *The Psychiatric Quarterly*, *84*(1), 39–52. mnh. https://doi.org/10.1007/s11126-012-9225-3

Janssen, W. A., van de Sande, R., Noorthoorn, E. O., Nijman, H. L. I., Bowers, L., Mulder, C. L., Smit, A., Widdershoven, G. A. M., & Steinert, T. (2011). Methodological issues in monitoring the use of coercive measures. *International Journal of Law and Psychiatry*, *34*(6), 429–438. https://doi.org/10.1016/j.ijlp.2011.10.008

Johnson, S., Nolan, F., Pilling, S., Sandor, A., Hoult, J., McKenzie, N., White, I. R., Thompson, M., & Bebbington, P. (2005). Randomised controlled trial of acute mental health care by a crisis resolution team: The north Islington crisis study. *BMJ : British Medical Journal*, *331*(7517), 599. Health & Medical Collection. https://doi.org/10.1136/bmj.38519.678148.8F

Kalisova, L., Raboch, J., Nawka, A., Sampogna, G., Cihal, L., Kallert, T. W., Onchev, G., Karastergiou, A., Del Vecchio, V., Kiejna, A., Adamowski, T., Torres-Gonzales, F., Cervilla, J. A., Priebe, S., Giacco, D., Kjellin, L., Dembinskas, A., & Fiorillo, A. (2014). Do patient and ward-related characteristics influence the use of coercive measures? Results from the EUNOMIA international study. *Social Psychiatry And Psychiatric*

Epidemiology, *49*(10), 1619–1629. mnh. https://doi.org/10.1007/s00127-014-0872-6

Keski-Valkama, A., Sailas, E., Eronen, M., Koivisto, A.-M., Lönnqvist, J., & Kaltiala-Heino, R. (2007). A 15-year national follow-up: Legislation is not enough to reduce the use of seclusion and restraint. *Social Psychiatry And Psychiatric Epidemiology*, *42*(9), 747–752. mnh.

Kogstad, R. E. (2009). Protecting mental health clients' dignity—The importance of legal control. *International Journal Of Law And Psychiatry*, *32*(6), 383–391. mnh. https://doi.org/10.1016/j.ijlp.2009.09.008

Kontio, R., Välimäki, M., Putkonen, H., Kuosmanen, L., Scott, A., & Joffe, G. (2010). Patient restrictions: Are there ethical alternatives to seclusion and restraint? *Nursing Ethics*, *17*(1), 65–76. https://doi.org/10.1177/0969733009350140

Lawlor, C., Johnson, S., Cole, L., & Howard, L. M. (2012). Ethnic variations in pathways to acute care and compulsory detention for women experiencing a mental health crisis. *The International Journal Of Social Psychiatry*, *58*(1), 3–15. mnh. https://doi.org/10.1177/0020764010382369

Lay, B., Kawohl, W., & Rössler, W. (2018). Outcomes of a psycho-education and monitoring programme to prevent compulsory admission to psychiatric inpatient care: A randomised controlled trial. *Psychological Medicine*, *48*(5), 849–860. https://doi.org/10.1017/S0033291717002239

Lay, B, Nordt, C., & Rössler, W. (2011). Variation in use of coercive measures in psychiatric hospitals. *European Psychiatry: The Journal Of The Association Of European Psychiatrists*, *26*(4), 244–251. mnh. https://doi.org/10.1016/j.eurpsy.2010.11.007

Lay, Barbara, Blank, C., Lengler, S., Drack, T., Bleiker, M., & Rössler, W. (2015). Preventing compulsory admission to psychiatric inpatient care using psycho-education and monitoring: Feasibility and outcomes after 12 months. *European Archives of Psychiatry and Clinical Neuroscience*, *265*(3), 209–217. Health & Medical Collection; Psychology Database. https://doi.org/10.1007/s00406-014-0553-1

Lindgren, I., Falk Hogstedt, M., & Cullberg, J. (2006). Outpatient vs. Comprehensive first-episode psychosis services, a 5-year follow-up of Soteria Nacka. *Nordic Journal of Psychiatry*, *60*(5), 405–409. https://doi.org/10.1080/08039480600937686

Long, C. G., West, R., Afford, M., Collins, L., & Dolley, O. (2015). Reducing the use of seclusion in a secure service for women. *Journal of Psychiatric Intensive Care*, *11*(2), 84–94. Health & Medical Collection; Psychology Database. https://doi.org/10.1017/S174264641400017X

Looi, G.-M. E., Engström, Å., & Sävenstedt, S. (2015). A Self-Destructive Care: Self-Reports of People Who Experienced Coercive Measures and their Suggestions for Alternatives. *Issues in Mental Health Nursing*, *36*(2), 96–103. https://doi.org/10.3109/01612840.2014.951134

Lyons, C., Hopley, P., Burton, C. R., & Horrocks, J. (n.d.). Mental health crisis and respite services: Service user and carer aspirations. *Journal of Psychiatric and Mental Health Nursing*, *16*(5), 424–433. https://doi.org/10.1111/j.1365-2850.2009.01393.x

Mann-Poll, P. S., Smit, A., Noorthoorn, E. O., Janssen, W. A., Koekkoek, B., & Hutschemaekers, G. J. M. (2018). Long-Term Impact of a Tailored Seclusion

Reduction Program: Evidence for Change? *Psychiatric Quarterly*, 1–14. Health & Medical Collection; Psychology Database. https://doi.org/10.1007/s11126-018-9571-x

Meijer, E., Schout, G., de Jong, G., & Abma, T. (2017). Regaining ownership and restoring belongingness: Impact of family group conferences in coercive psychiatry. *Journal Of Advanced Nursing*, *73*(8), 1862–1872. https://doi.org/10.1111/jan.13270

Mezzina, R., & Vidoni, D. (1995). Beyond the Mental Hospital: Crisis Intervention and Continuity of Care in Trieste. A Four Year Follow-Up Study in a Community Mental Health Centre. *International Journal of Social Psychiatry*, *41*(1), 1–20. https://doi.org/10.1177/002076409504100101

Morrison, A. P., Turkington, D., Pyle, M., Spencer, H., Brabban, A., Dunn, G., Christodoulides, T., Dudley, R., Chapman, N., Callcott, P., Grace, T., Lumley, V., Drage, L., Tully, S., Irving, K., Cummings, A., Byrne, R., Davies, L. M., & Hutton, P. (2014). Cognitive therapy for people with schizophrenia spectrum disorders not taking antipsychotic drugs: A single-blind randomised controlled trial. *Lancet (London, England)*, *383*(9926), 1395–1403. https://doi.org/10.1016/S0140-6736(13)62246-1

Noorthoorn, E. O., Voskes, Y., Janssen, W. A., Mulder, C. L., van de Sande, R., Nijman, H. L. I., Smit, A., Hoogendoorn, A. W., Bousardt, A., & Widdershoven, G. A. M. (2016). Seclusion Reduction in Dutch Mental Health Care: Did Hospitals Meet Goals? *Psychiatric Services (Washington, D.C.)*, *67*(12), 1321–1327. mnh.

Norredam, M., Garcia-Lopez, A., Keiding, N., & Krasnik, A. (2010). Excess use of coercive measures in psychiatry among migrants compared with native Danes. *Acta Psychiatrica Scandinavica*, *121*(2), 143–151. mnh. https://doi.org/10.1111/j.1600-0447.2009.01418.x

Norvoll, R., Hem, M. H., & Pedersen, R. (2017). The Role of Ethics in Reducing and Improving the Quality of Coercion in Mental Health Care. *HEC Forum: An Interdisciplinary Journal On Hospitals' Ethical And Legal Issues*, *29*(1), 59–74. https://doi.org/10.1007/s10730-016-9312-1

Olsson, H., & Schön, U.-K. (2016). Reducing violence in forensic care—How does it resemble the domains of a recovery-oriented care? *Journal of Mental Health*, *25*(6), 506–511. Health & Medical Collection; Psychology Database. https://doi.org/10.3109/09638237.2016.1139075

Osborn, D. P. J., Lloyd-Evans, B., Johnson, S., Gilburt, H., Byford, S., Leese, M., & Slade, M. (2010). Residential alternatives to acute in-patient care in England: Satisfaction, ward atmosphere and service user experiences. *The British Journal Of Psychiatry. Supplement*, *53*, s41–s45. https://doi.org/10.1192/bjp.bp.110.081109

Papageorgiou, A., King, M., Janmohamed, A., Davidson, O., & Dawson, J. (2002). Advance directives for patients compulsorily admitted to hospital with serious mental illness. Randomised controlled trial. *The British Journal of Psychiatry: The Journal of Mental Science*, *181*, 513–519.

Paterson, B., Bennet, L., & Bradley, P. (2014). Positive and Proactive Care: Could new guidance lead to more problems. *British Journal of Nursing*, *23*(17), 939–941. ccm. https://doi.org/10.12968/bjon.2014.23.17.939

Poulsen, H. D. (2002). The prevalence of extralegal deprivation of liberty in a psychiatric hospital population. *International Journal Of Law And Psychiatry*, *25*(1), 29–36. mnh.

Putkonen, A., Kuivalainen, S., Louheranta, O., Repo-Tiihonen, E., Ryynänen, O.-P., Kautiainen, H., & Tiihonen, J. (2013). Cluster-Randomized Controlled Trial of Reducing Seclusion and Restraint in Secured Care of Men With Schizophrenia. *Psychiatric Services*, *64*(9), 850–855. Health & Medical Collection; Psychology Database.

Robertson, J. P., & Collinson, C. (2011). Positive risk taking: Whose risk is it? An exploration in community outreach teams in adult mental health and learning disability services. *Health, Risk & Society*, *13*(2), 147–164. ccm. https://doi.org/10.1080/13698575.2011.556185

Russo, J., & Rose, D. (2013). "But what if nobody's going to sit down and have a real conversation with you?" Service user/survivor perspectives on human rights. *Journal of Public Mental Health*, *12*(4), 184–192. Health & Medical Collection; Psychology Database. https://doi.org/10.1108/JPMH-05-2013-0030

Schneeberger, A. R., Kowalinski, E., Fröhlich, D., Schröder, K., von Felten, S., Zinkler, M., Beine, K. H., Heinz, A., Borgwardt, S., Lang, U. E., Bux, D. A., & Huber, C. G. (2017). Aggression and violence in psychiatric hospitals with and without open door policies: A 15-year naturalistic observational study. *Journal of Psychiatric Research*, *95*, 189–195. https://doi.org/10.1016/j.jpsychires.2017.08.017

Schout, G., Meijer, E., & de Jong, G. (2017). Family Group Conferencing—Its Added Value in Mental Health Care. *Issues in Mental Health Nursing*, *38*(6), 480–485. https://doi.org/10.1080/01612840.2017.1282996

Schout, G., van Dijk, M., Meijer, E., Landeweer, E., & de Jong, G. (2017). The use of family group conferences in mental health: Barriers for implementation. *Journal of Social Work*, *17*(1), 52–70. https://doi.org/10.1177/1468017316637227

Seikkula, J., Alakare, B., Aaltonen, J., Holma, J., Rasinkangas, A., & Lehtinen, V. (2003). Open Dialogue Approach: Treatment Principles and Preliminary Results of a Two-Year Follow-Up on First Episode Schizophrenia. *Ethical Human Sciences and Services*, *5*(3). https://www.ingentaconnect.com/content/springer/ehss/2003/00000005/00000003/art00001

Siponen, U., Välimäki, M., Kaivosoja, M., Marttunen, M., & Kaltiala-Heino, R. (2011). A comparison of two hospital districts with low and high figures in the compulsory care of minors: An ecological study. *Social Psychiatry And Psychiatric Epidemiology*, *46*(8), 661–670. mnh. https://doi.org/10.1007/s00127-010-0233-z

Slade, M., Byford, S., Barrett, B., Lloyd-Evans, B., Gilburt, H., Osborn, D. P. J., Skinner, R., Leese, M., Thornicroft, G., & Johnson, S. (2010). Alternatives to standard acute in-patient care in England: Short-term clinical outcomes and cost-effectiveness. *The British Journal of Psychiatry*, *197*(S53), s14–s19. https://doi.org/10.1192/bjp.bp.110.081059

Thomsen, C., Starkopf, L., Hastrup, L. H., Andersen, P. K., Nordentoft, M., & Benros, M. E. (2017). Risk factors of coercion among psychiatric inpatients: A

nationwide register-based cohort study. *Social Psychiatry and Psychiatric Epidemiology*, *52*(8), 979–987. Health & Medical Collection; Psychology Database. https://doi.org/10.1007/s00127-017-1363-3

Thomsen, C. T., Benros, M. E., Maltesen, T., Hastrup, L. H., Andersen, P. K., Giacco, D., & Nordentoft, M. (2018). Patient-controlled hospital admission for patients with severe mental disorders: A nationwide prospective multicentre study. *Acta Psychiatrica Scandinavica*, *137*(4), 355–363. Health & Medical Collection. https://doi.org/10.1111/acps.12868

Thornicroft, G., Farrelly, S., Szmukler, G., Birchwood, M., Waheed, W., Flach, C., Barrett, B., Byford, S., Henderson, C., Sutherby, K., Lester, H., Rose, D., Dunn, G., Leese, M., & Marshall, M. (2013). Clinical outcomes of Joint Crisis Plans to reduce compulsory treatment for people with psychosis: A randomised controlled trial. *The Lancet*, *381*(9878), 1634–1641. https://doi.org/10.1016/S0140-6736(13)60105-1

van der Post, L. F., Peen, J., Visch, I., Mulder, C. L., Beekman, A. T., & Dekker, J. J. (2014). Patient perspectives and the risk of compulsory admission: The Amsterdam Study of Acute Psychiatry V. *The International Journal of Social Psychiatry*, *60*(2), 125. Health & Medical Collection; Psychology Database.

van der Schaaf, P. S., Dusseldorp, E., Keuning, F. M., Janssen, W. A., & Noorthoorn, E. O. (2013). Impact of the physical environment of psychiatric wards on the use of seclusion. *The British Journal Of Psychiatry: The Journal Of Mental Science*, *202*, 142–149. mnh. https://doi.org/10.1192/bjp.bp.112.118422

Vruwink, F. J., Mulder, C. L., Noorthoorn, E. O., Uitenbroek, D., & Nijman, H. L. I. (2012). The effects of a nationwide program to reduce seclusion in the Netherlands. *BMC Psychiatry*, *12*, 231–231. https://doi.org/10.1186/1471-244X-12-231

Zinkler, M. (2016). Germany without Coercive Treatment in Psychiatry—A 15 Month Real World Experience. *Laws*, *5*(1), 15. https://doi.org/10.3390/laws5010015

END. Annotated bibliography starts on the next page.

AUTHOR & YEAR	COUNTRY	POPULATION SAMPLE	AIM	TYPE OF STUDY	MAIN FINDINGS
Aagaard, J; Tuszewski, B; Kølbæk, P (2017)	Denmark	240 men and women starting as recipients of Assertive Community Treatment during a five-year period.	To see whether Assertive Community Treatment (ACT) may have the quality to reduce the use of several types of coercion including compulsory admissions.	Quantitative - analysis of service data from the Danish National Case Register at three psychiatric hospitals.	An assertive approach appears to reduce hospitalisation including some involuntary admissions. ACT is preferable from both team and patient perspectives. The researchers recommend revision of the criterion of 'severe mental illness' to facilitate ACT to be offered to a larger group of patients. In addition, the researchers recommend that the introduction of Crisis Intervention Teams should be considered and allocated to psychiatric emergency rooms.
Aaltonen, J; Seikkulaa, J; and Lehtinen, V (2011)	Finland	Mental health service data concerning a health district in Finland with a population of 72,000.	To analyse the changes in the incidence of first-contact non-affective psychoses and prodromal states in two cities of the District following the introduction of the 'Open Dialogue Approach', including considering the five-year periods before and after the system was fully established	Quantitative – analysis of service data.	The mean annual incidence of schizophrenia decreased, brief psychotic reactions increased, and the incidence of schizophreniform psychoses and prodromal states did not change. The number of new long-stay schizophrenic hospital patients fell to zero. It can be argued that the ODA has been helpful, at least in moving the commencement of treatment in a less chronic direction. It may have even increased social capital in the entire psychiatric catchment area, and promote mutual trust between the general population and the psychiatric services.
Andersen, K; Nielsen, B (2016)	Denmark	235 men and women admitted to a closed ward during 2011-2013 were randomly selected.	To identify possible external (extramural) factors that may increase the risk of coercion during admission to a closed psychiatric ward.	Quantitative - retrospective analysis of case report data.	66 people (28% of the sample) were subject to coercion. The time of forced procedures was predominately during the first hours after admission. The risk of forced measures being applied was sig-nificantly higher if patients were involuntarily admitted (OR = 6.4 (3.4- 11.9)), or were acutely intoxicated by substances at the time of admission (OR = 3.7 (1.7-8.2)). The researchers recommend that extramural factors should be considered when seeking to reduce coercion, and suggest better integrated efforts between mental health and substance abuse services as a way to reduce coercion.

Bak, J, et al (2014)	Denmark, Norway	Survey data from all psychiatric hospital units in Denmark (87) and Norway (96) that treated adult inpatients.	To examine how potential mechanical restraint preventive factors in hospitals are associated with the frequency of mechanical restraint episodes.	Quantitative - cross-sectional survey of psychiatric units.	Three mechanical restraint preventive factors were significantly associated with low rates of mechanical restraint use: 'mandatory review' (exp[B]=.36, p < .01), 'patient involvement' (exp[B]=.42, p < .01), and 'no crowding' (exp[B] = .54, p < .01). None of the three restraint preventive factors presented any adverse effects. Authors recommend implementing the measures.
Bak, J, et al (2015)	Denmark, Norway	Survey data from all psychiatric hospital units in Denmark (87) and Norway (96) that treated adult inpatients.	To test the hypothesis that 'factors of nonmedical origin' may explain the differing number of mechanical restraint (MR) episodes between Denmark and Norway. An earlier study found MR was used twice as frequently in Denmark than Norway.	Quantitative - cross-sectional survey of psychiatric units.	Six MR preventive factors confounded [Aexp(B)> 10%] the difference in MR use between Denmark and Norway, including staff education (- 51%), substitute staff (- 17%), acceptable work environment (- 15%), separation of acutely disturbed patients (13%), patient- staff ratio (- 11%), and the identification of the patient's crisis triggers (- 10%). Researchers suggest these preventive factors might partially explain the difference in the frequency of MR episodes observed in the two countries. None of the six MR preventive factors presents any adverse effects.
Barrett, B, et al (2013)	England	569 participants were chosen from four English mental health trusts.	To test the effectiveness of 'Joint Crisis Plans' (JCP), a form of (non-statutory) advance planning, in reducing rates of compulsory treatment. They compared JCP plus treatment as usual (TAU) to TAU alone for patients aged over 16, with at least one psychiatric hospital admission in the previous two years.	Quantitative - economic evaluation within a multi-centre randomised control trial.	The addition of JCPs to TAU had no significant effect on compulsory admissions or total societal cost per participant over 18-months follow-up. From the service cost perspective, however, evidence suggests a higher probability (80%) of JCPs being the more cost-effective option. Exploration by ethnic group highlights distinct patterns of costs and effects. Whilst the evidence does not support the cost-effectiveness of JCPs for White or Asian ethnic groups, there is at least a 90% probability of the JCP intervention being the more cost-effective option in the Black ethnic group. The researchers argue that the results by ethnic group are sufficiently striking to warrant further investigation into the potential for patient gain from JCPs among Black patient groups.

Boumans, CE, et al (2015)	Netherlands	4 detailed case examples, involving 4 adults in the South East of the Netherlands.	To examine how the 'methodical work approach' worked to reduce seclusion, by providing a detailed case study. The study complemented a quantitative study on the approach (see below), which reportedly led to a reduction in the use of seclusion in a ward with a high seclusion rate.	Case Study - the team of this ward implemented the methodical work approach.	The 'methodical work approach', which has been adopted largely in Dutch and Flemish settings, appears to have provided guidance for the multidisciplinary team, the patient and the family to work together in a systematic and goal-directed way to reduce seclusion. Positive changes were reported in the team process: increased interdisciplinary collaboration, team cohesion, and 'professionalization'. It is argued that the implicit or non-specific effects of an intervention to prevent seclusion may constitute a major contribution to the results and therefore merit further research. This study follows from a study to test whether reductions in rates of seclusion occur (see below).
Boumans, CE, et al (2014)	Netherlands	134 adults admitted to an experimental ward and 544 adults in control wards for the intensive treatment of adults with psychosis and substance use disorders in the South-East of the Netherlands.	To test effectiveness of an intervention, the 'methodical work approach', designed to reduce seclusion. This is a 'systematic, transparent and goal- directed way' of working, characterised by 'an emphasis on cyclic evaluation and readjustment of the working process'.	Quantitative - analysis of case report data (before and after introduction of the methodical work approach).	The methodical work approach has five phases: (i) translation of problems into goals; (ii) search for means to realise the goals; (iii) formulation of an individualised plan; (iv) implementation of the plan; and (v) evaluation and readjustment. Compared to control wards within the same hospital, at the ward where the methodical work approach was implemented, a more pronounced reduction was achieved in the number of incidents and in the total hours of seclusion. The authors conclude that the methodical work approach can contribute to a reduction in the use of seclusion.

Bowers, L, et al (2010)	England	A total of 1227 responses were obtained, with the highest number coming from staff, and the smallest from visitors.	To survey the beliefs and attitudes of patients, staff and visitors to the practice of door locking in acute psychiatry. Locking doors in psychiatric wards has increased in the UK in recent years, but has received little attention by researchers.	Quantitative - cross-sectional questionnaire of staff, patients and visitors at psychiatric units.	Analysis identified five factors (adverse effects, staff benefits, patient safety benefits, patient comforts and cold milieu). Patients were more negative about door locking than the staff, and more likely to express such negative judgments if they were residing in a locked ward. For staff, being on a locked ward was associated with more positive judgments about the practice. There were significant age, gender and ethnicity effects for staff only. Patients registered more anger, irritation and depression as a consequence of locked doors than staff or visitors thought they experienced.
Bowers, L; Stewart, D; Papadopoulos, C; lennaco, JD (2013)	England	Secondary analysis of cross-sectional data collected from 136 acute psychiatric wards across England in 2004-2005.	To investigate wards with the counterintuitive combination of 'low containment and high conflict' or 'high containment and low conflict'.	Quantitative - secondary analysis of cross-sectional service data collected from 136 psychiatric wards.	Safe, calm inpatient psychiatric wards that are conducive to positive therapeutic care have thought to have lower rates of coerced medication, seclusion, manual restraint and other types of containment, and, usually, rates of conflict - for example, aggression, substance use, and absconding - are also low. Sometimes, however, wards maintain low rates of containment even when conflict rates are high. This study wanted to understand these anomalies. The researchers created a typology of different ward characteristics (e.g. high/low conflict, high/low containment, socio-economic disadvantage in the area). Among the variables significantly associated with the various typologies, some, such as environmental quality, were changeable, and others - such as social deprivation of the area served - were fixed. High-conflict, low-containment wards had higher rates of male staff and lower-quality environments than other wards. Low-conflict, high-containment wards had higher numbers of beds. High-conflict, high-containment wards utilised more temporary staff as well as more unqualified staff. No overall differences were associated with low-conflict, low-containment wards. Wards can make positive changes to achieve a low-

Bowers, L, et al (2015)	England	Staff and patients in 31 randomly chosen wards at 15 randomly chosen hospitals.	To test the efficacy of the Safewards model in reducing the frequency of 'conflict' and 'containment'.	A pragmatic cluster randomised controlled trial with psychiatric hospitals and wards as the units of randomisation. The main outcomes were rates of conflict and containment.	The Safewards model enabled the identification of ten interventions to reduce the frequency of both. For shifts with conflict or containment incidents, the experimental condition reduced the rate of conflict events by 15% (95% CI 5.6-23.7%) relative to the control intervention. The rate of containment events for the experimental intervention was reduced by 26.4% (95% CI 9.9-34.3%). Simple interventions aiming to improve staff relationships with patients can reduce the frequency of conflict and containment.
Chambers, M, et al (2014)	England	19 adult service users detained under mental health legislation.	This paper reports on the experiences of 19 adults detained under mental health legislation. These service users had experienced coercive interventions and they gave their account of how they considered their dignity to be protected (or not), and their sense of self being respected (or not).	Qualitative - in-depth interviews with thematic analysis.	The service users considered their dignity and respect compromised by 1) not being 'heard' by staff members, 2) a lack of involvement in decision-making regarding their care, 3) a lack of information about their treatment plans particularly medication, 4) lack of access to more talking therapies and therapeutic engagement, and 5) the physical setting/environment and lack of daily activities to alleviate their boredom. Dignity and respect are important values in recovery and practitioners need time to engage with service user narratives and to reflect on the ethics of their practice. Respecting the dignity of others is a key element of the code of conduct for health professionals. Often from the service user perspective this is ignored.

Corlett, S (2013)	England	N/A	To review recent trends in detention under the Mental Health Act 1983 in England and the relationship to trends in access to mental health services.	Qualitative - policy research review based on Care Quality Commission, which monitors the Mental Health Act and regulates health and social care.	The paper suggests that a steady increase in coercion is related to tightening access to mental health care and that these form a toxic relationship that undermines people's mental health, recovery and rights. These trends might be reversed by a combination of rights-based measures, shared decision-making and commissioning a better level and mix of mental health services. The paper updates and discusses knowledge on trends and cites recent evidence from the Care Quality Commission and from Mind.
Cullberg, J, et al (2002)	Sweden	253 adults with first episode psychosis (FEP) from a catchment with a population of 1.5 million.	To evaluate one-year outcomes in first episode psychosis patients in the Swedish Parachute project. Research participants were asked to participate in this 5-year project.	Quantitative - analysis of case report data, using historical (control (n=71)) and prospective (experimental (n=64)) populations.	A total of 175 patients (69%) were followed up through the first year of treatment. Global Assessment of Functioning (GAF) values were significantly higher than in the historical comparison group but similar to the prospective group. Psychiatric in-patient care was lower as was prescription of neuroleptic medication. Satisfaction with care was generally high in the Parachute group. Access to a small overnight crisis home was associated with higher GAF. The researchers argued that it is possible to successfully treat FEP patients with fewer in-patient days and less neuroleptic medication than is usually recommended, when combined with intensive psychosocial treatment and support.

Cullberg, J (2006)	Sweden	61 consecutive first episode schizophrenia patients were followed over 3 years, and compared to 66 service users from 'treatment as usual' and high quality service groups.	To undertake a three-year follow- up of the Swedish 'Parachute Project', which uses 'need- specific treatments', considering treatment costs and clinical outcomes for first episode schizophrenia patients.	Quantitative - analysis of case report data comparing Parachute Project group with 'treatment as usual' (n=41) and prospective group from a high quality psychiatric centre (n = 25).	Symptomatic and functional outcome was significantly better compared with the Historical group and equal with the Prospective group. During the first year, the direct costs for in- and out-patient care per patient in the Parachute project were less than half of those in the Prospective group. The researchers conclude that the evidence supports the feasibility, clinically and economically, of a largescale application of 'need- specific treatments' for first episode psychotic patients.
De Jong, G; Schout, GG (2013)	Netherlands	N/A	The aim of the study is to answer the question of whether Family Group Conferencing (FGC) is an effective tool to generate social support, to prevent coercion and to promote social integration in public mental health care (PMHC).	Qualitative - policy analysis, and study design.	The paper merely sets out the proposed study, which is reported upon in the 2017 paper by the same authors, led by Schout (see below). The paper sketches the context for using FGC in the Netherlands, in which there has been a steady growth in conferences being organised each year. An amendment in the Dutch Civil Code designates FGC as good practice. Clients in PMHC often have a limited network. The authors proposed that they will research the applicability of FGCs in PMHC over the following two years by evaluating forty case studies.

Eytan, A; Chatton, A; Safran, E; Khazaal, Y (2013)	Switzerland	This search retrieved data on a total of 2,227 hospitalisations for 1,584 patients in a single hospital in Geneva, Switzerland.	From October 2006, only certified psychiatrists were authorised to require a compulsory admission to this facility, while before all physicians were, including residents. This study sought to assess the impact of this change of procedure on the proportion of compulsory admissions.	Quantitative - analysis of case report data (before/ after new requirement). All medical records of patients admitted respectively 4 months before and 4 month after the implementation of the procedure were	The overall proportions of compulsory and voluntary admissions were 63.9 % and 36.1 % respectively. The average length of stay was 32 days (SD ± 64.4). During the study period, 25% of patients experienced two hospitalisations or more. Compared with the period before October 2006, patients hospitalised from October 2006 up were less likely to be hospitalised on a compulsory basis (OR = 0.745, 95 % CI: 0.596-0.930). Factors associated with involuntary admission were young age (20 years or less), female gender, a diagnosis of psychotic disorder and being hospitalised for the first time. The authors argue that their results 'strongly suggest that limiting the right to require compulsory admissions to fully certified psychiatrists can reduce the rate of compulsory versus voluntary admissions'.
Flammer, E; Steinert, T (2016)	Germany	2,071 adults diagnosed with psychotic disorders and at least one admission during at least one of the three time periods were included, for a total of 3,482 admissions.	In one German state, 'involuntary medication of psychiatric inpatients was illegal during eight months from July 2012 until February 2013'. The authors examined whether the number and duration of mechanical coercive measures (seclusion and restraint) and the number and severity of violent incidents changed in this period.	Quantitative - A cross-sectional analysis was conducted of admission-related routine data collected in seven psychiatric hospitals.	Data was collected in three time periods (period 1, July 2011 -February 2012; period 2, July 2012-February 2013; and period 3, July 2013-February 2014). The mean number of mechanical coercive measures and violent incidents per admission increased significantly during period 2, when involuntary medication was not possible, and decreased significantly during period 3. They also differed significantly between periods 1 and 3. The percentage of admissions involving seclusion increased during period 2 significantly and was significantly different during period 1 compared with period 3. The severity of illness and the length of hospitalizsation did not change over the three periods. The authors note that '[Restriction of involuntary medication was associated with a significant increase in use of mechanical coercive measures and violent incidents'.

Gilburt. H, et al (2010)	England	40 adults living in residential alternative services who had previously experienced hospital inpatient stays.	To explore patients' subjective experiences of traditional hospital services and residential alternatives to hospital. To address gap in research on the 'preferences and experiences of people with mental illness in relation to residential alternatives to hospital'.	Qualitative - purposive sampling, thematic analysis of interview data.	Patients reported an overall preference for residential alternatives. These were identified as treating patients with lower levels of disturbance, being safer, having more freedom and decreased coercion, and having less paternalistic staff compared with traditional in-patient services. However, patients identified no substantial difference between their relationships with staff overall and the care provided between the two types of services. The authors conclude that 'for patients who have acute mental illness but lower levels of disturbance, residential alternatives offer a preferable environment to traditional hospital services: they minimise coercion and maximise freedom, safety and opportunities for peer support'.
Gjerberg, E; Hem, MH; Forde, R; Pedersen, R (2013)	Norway	11 interdisciplinary focus group interviews consisting of nurses, auxiliary nurses and some members of staff without formal qualifications, (N = 60).	This article examines what kinds of strategies or alternative interventions nursing staff in Norway used when patients resist care and treatment and what conditions the staff considered as necessary to succeed in avoiding the use of coercion.	Qualitative - inter-disciplinary focus group interviews with nursing home staff.	In many Western countries, studies have demonstrated extensive use of coercion in nursing homes, especially towards patients suffering from dementia. The study indicated that the nursing home staff usually spent a lot of time trying a wide range of approaches to avoid the use of coercion. The most common strategies were deflecting and persuasive strategies, limiting choices by conscious use of language, different kinds of flexibility and one-to-one care. According to the staff, their opportunities to use alternative strategies effectively are greatly affected by the nursing home's resources, by the organisation of care and by the staff's competence.

Groot, P; van Os J (2018)	Netherlands	1194 adult users of tapering strips	To observe the use of 'tapering strips', which allow gradual dosage reduction and minimise the potential for withdrawal effects. A tapering strip consists of antidepressant medication, packaged in a roll of small daily pouches, each with the same or slightly lower dose than the one before it.	Quantitative - observational and survey study of 1194 users.	Of 1194 users of tapering strips, 895 (75%) wished to discontinue their antidepressant medication. In these 895, median length of antidepressant use was 2-5 years (IQR: 1-2 years- > 10 years). Nearly two-thirds (62%) had unsuccessfully attempted withdrawal before (median = 2 times before, IQR 1-3). Almost all of these (97%) had experienced some degree of withdrawal, with 49% experiencing severe withdrawal (7 on a scale of 1-7, IQR 6-7). Tapering strips represent a simple and effective method of achieving a gradual dosage reduction.
Hackett, R, et al (2009)	England	Access data was analysed for 200-300 adults.	The project aimed to empower the Pakistani community to seek mental health support earlier within their own community, build up trust in mainstream services and enhance the clinical pathways within services to provide more culturally appropriate care.	Mixed methods - qualitative report from 'link worker' (see Main Findings) and quantitative service data on access rates.	Black and Minority Ethnic (BME) communities receive different pathways into mental health care with BME service users often presenting in crisis. The Sheffield Crisis Resolution Home Treatment joined with the local Pakistani Muslim Centre (PMC) to work in partnership. The PMC had existing links with the Pakistani community and provided a range of social, respite and occupational opportunities. The partnership created an innovative new role: the Pakistani link worker. The EPIC partnership strengthened the PMC's influence and raised awareness of mental health issues in the community. Through integration of the link worker within the everyday practice of clinicians, pathways of care showed evidence of positive change including more referrals to the PMC from psychiatric services. The EPIC project piloted a model of partnership working that is effective and transferable.

Henderson, C, et al (2017)	England and Wales	221 Joint Crisis Plans, which are plans formulated by service users and their clinical team with involvement from an external facilitator, compared to 424 'baseline routine care plans'.	The authors aimed to estimate the demand for an informed advance treatment refusal under the Mental Capacity Act 2005 (England and Wales) within a sample of service users who had had a recent hospital admission, and to examine the relationship between refusals and service user characteristics.	Mixed methods - content analysis of Joint Crisis Plans, and routine care plans in subsamples from a multi-centre randomised controlled trial of Joint Crisis Plans (plus routine mental health care) versus routine care alone (CRIMSON) in England.	99 of 221 (45%) of the Joint Crisis Plans contained a treatment refusal compared to 10 of 424 (2.4%) baseline routine care plans. No Joint Crisis Plans recorded disagreement with refusals on the part of clinicians. Among those with completed Joint Crisis Plans, adjusted analyses indicated a significant association between treatment refusals and perceived coercion at baseline (odds ratio = 1.21, 95% CI 1.02-1.43), but not with baseline working alliance or a past history of involuntary admission. They demonstrated significant demand for written treatment refusals in line with the Mental Capacity Act 2005, which had not previously been elicited by the process of treatment planning. Future treatment/crisis plans should incorporate the opportunity for service users to record a treatment refusal during the drafting of such plans

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

Heumann, K; Bock, T; Lincoln, TM (2017)	Germany	83 service users	In recent years the legal basis in Germany for the use of coercive measures in psychiatry has changed, yet there is no regulation of the type or amount of 'milder measures', which must now be used. The authors investigated which and how many 'milder measures' were experienced by service users before coercion was used and which measures they value as potentially helpful to avoid it.	Quantitative - online survey of 83 service users. Their experience with 21 milder measures and their evaluation of whether the measures were helpful were assessed by self-reporting.	On average, participants reported 5.4 experienced milder measures. The most frequent reason provided for why measures failed were structural factors, followed by staff behaviour, and reasons caused by the participants themselves. The only milder measure rated by less than 50% as potentially helpful in avoiding coercive measures was being persuaded to take medication. Although many milder measures are perceived as potentially helpful, only few seem to be made use of in routine clinical practice. The authors conclude that in order to prevent coercion staff members should apply a wider range of milder measures.
Højlund M, et al (2018)	Denmark	Data from 101 admissions after implementation of interventions were compared with data from 85 admissions in a historical reference cohort.	To quantify and compare the use of antipsychotic and anxiolytic medications in connection with the implementation of a programme to reduce coercion and restraint.	Mixed methods - quantitative analysis of service data combined with observational study in a general psychiatric ward.	Mean defined daily doses of antipsychotics, benzodiazepines or the total amount of both showed no difference before and after implementation of the programme. The data showed that neither total dose of antipsychotics (adjusted 0: .05, 95% confidence interval (CI): -0.20 to 0.31), total dose of benzodiazepines (adjusted 0: -.13, 95%CI: -.42 to 0.16) nor total amount of both drugs (adjusted 0: .00, 95%CI: -.26 to 0.21) increased after implementation. A decrease in coercive measures from 2013 to 2016 has not lead to significant increases in the use of antipsychotic medication or benzodiazepines. The interventions are useful in establishing restraint-free wards, and careful monitoring of the psychopharmacological treatment is important for patient safety.

Høyer, G, et al (2002)	Denmark, Finland, Iceland, Norway, and Sweden (Northern Europe)	Not stated	Study called 'Paternalism and Autonomy—A Nordic Study on the Use of Coercion in the Mental Health Care System,' is a joint study involving all the five Nordic countries (Denmark, Finland, Iceland, Norway, and Sweden).	Mixed methods - textual analysis and interviews with ethicists, lawyers, and physicians, 'core interview' with service users, data from medical records and related documents	Preliminary data from all Nordic countries suggest that perceived coercion tends to be a 'dichotomized phenomenon', measured both by the 'MPCS' and the 'Coercion Ladder', and this dichotomized pattern remains even when formally voluntarily and involuntarily admitted patients are studied separately. The authors report being 'unable to produce a good explanation for the bimodal distribution of perceived coercion' and raise 'questions about flaws in the instruments used to measure perceived coercion' and 'if perceived coercion really is a dichotomized phenomenon and, in this way, more resembles the concept of "integrity."'
Huber, CG, et al (2016)	Germany	349 574 admissions to 21 German psychiatric inpatient hospitals from Jan 1, 1998, to Dec 31, 2012.	To compare hospitals without locked wards and hospitals with locked wards and to establish whether hospital type has an effect on these outcomes.	Quantitative - naturalistic observational study with linear mixed-effects models to analyse the data.	Patients at risk are often admitted to locked wards in psychiatric hospitals to prevent absconding, suicide attempts, and death by suicide. However, there is insufficient evidence that treatment on locked wards can effectively prevent these outcomes. In the 145 738 propensity score-matched cases, suicide (OR T326, 95% CI 0- 803-2-113; p=0-24), suicide attempts (1-057, 0-787- 1- 412; p=0-71), and absconding with return (1-288, 0-874-1 -929; p=0-21) and without return (1 -090, 0-722- 1 -659; p=0-69) were not increased in hospitals with an open door policy. Compared with treatment on locked wards, treatment on open wards was associated with a decreased probability of suicide attempts (OR 0-658, 95% CI 0-504-0-864; p=0-003), absconding with return (0-629, 0-524-0-764; p<0-0001), and absconding without return (0-707, 0-546-0-925; p=0■ 01), but not completed suicide (0-823, 0-376-1-766; p=0-63). Lock-ed doors might not be able to prevent suicide and absconding.

Hustoft, K. et al. (2018)	Norway	3338 patients referred for admission in 20 Norwegian acute psychiatric units across 3 months in 2005-06 (about 75% of national acute units).	The aim of this study was to investigate the extent to which Involuntarily Hospitalised (IH) patients were converted to a Voluntary Hospitalisation (VH), and to identify predictive factors leading to this conversion.	Quantitative - analysis of service data using generalized linear mixed modelling.	The incident of conversion from involuntarily hospitalisation (IH) to voluntary hospitalisation (VH) was analysed. Out of 3338 patients referred for admission, 1468 were IH (44%) and 1870 were VH. After re- evaluation, 1148 (78.2%) remained on involuntary hos-pitalisation, while 320 patients (21.8%) were converted to voluntary hospitalisation. The predictors of conversion from involuntary to voluntary hospitalisation after re-evaluation of a specialist included patients wanting admission, better scores on Global Assessment of Symptom scale, fewer hallucinations and delusions and higher alcohol intake. The 24h re- evaluation period for patients referred for involuntary hospitalisation, as stipulated by the Norwegian *Mental Health Care Act,* appeared to give adequate opportunity to reduce unnecessary involuntary hospitalisation, while safeguarding the patient's right to VH.
Husum, TL, et al (2010)	Norway	The study includes data from 32 acute psychiatric wards and 1214 involuntarily admitted persons.	This study investigates to what extent use of seclusion, restraint and involuntary medication for involuntary admitted patients in Norwegian acute psychiatric wards is associated with patient, staff and ward characteristics.	Quantitative - multilevel logistic regression using Stata was applied with service data from patients that were linked to data about wards.	The total number of involuntary admitted patients was 1214 (35% of total sample). The percentage of patients who were exposed to coercive measures ranged from 0-88% across wards. Of the involuntary admitted patients, 424 (35%) had been secluded, 117 (10%) had been restrained and 113 (9%) had received involuntary depot medication at discharge. Data from 1016 patients could be linked in the multilevel analysis. The authors conclude that the substantial between- ward variance, even when adjusting for patients' individual psychopathology, indicates that ward factors influence the use of seclusion, restraint and involuntary medication and that some wards have the potential for quality improvement. They conclude that interventions to reduce the use of seclusion, restraint and involuntary medication should take into account organisational and environmental factors.

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

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

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

Keski-Valkama, A (2007)	Finland	National survey of psychiatric hospitals	To evaluate the nationwide trends in the use of seclusion and restraint were investigated in Finland over a 15- year span which was characterised by legislative changes aiming to clarify and restrict the use of these measures.	Quantitative - structured postal survey of Finnish psychiatric hospitals, using data from the National Hospital Discharge Register.	The total number of the secluded and restrained patients declined as did the number of all inpatients during the study weeks, but the risk of being secluded or restrained remained the same over time when compared to the first study year. The duration of the restraint incidents did not change, but the duration of seclusion increased. The authors conclude that legislative changes solely cannot reduce the use of seclusion and restraint or change the prevailing treatment cultures connected with these measures, and argue that the use of seclusion and restraint should be vigilantly monitored and ethical questions should be under continuous scrutiny.
Kogstad, RE (2009)	Norway	335 adult service users	To investigate violations of dignity considered from the clients' points of view, and to suggest actions that may ensure that practice is brought in line with human rights values.	Qualitative - interviews with thematic content analysis.	The authors conclude that '[mjental health clients experience infringements that cannot be explained without reference to their status as clients in a system which, based on judgments from medical experts, has a legitimate right to ignore clients' voices as well as their fundamental human rights'. They argue that 'recommendations and practices should be harmonized with the new UN Convention on the Rights of Persons with Disabilities (2006)'.
Kontio, R, et al (2010)	Finland	22 nurses and 5 physicians	To explore nurses' and physicians' perceptions of what actually happens when an aggressive behaviour episode occurs on the ward and what alternatives to seclusion and restraint are actually in use as normal standard practice in acute psychiatric care.	Qualitative - focus group interview with thematic content analysis.	The participants believed that the decision-making process for managing patients' aggressive behaviour contains some in-built ethical dilemmas. They thought that patients' subjective perspective received little attention. Nevertheless, the staff proposed and appeared to use a number of alternatives to minimise or replace the use of seclusion and restraint. The authors conclude that '[mjedical and nursing staff need to be encouraged and taught to: (1) tune in more deeply to reasons for patients' aggressive behaviour; and (2) use alternatives to seclusion and restraint in order to humanize patient care to a greater extent.'

Lawlor, C, et al (2012)	England	287 women admitted to an acute psychiatric inpatient ward or a women's crisis house in four London boroughs during a 12-week period were included.	To explore ethnic variations in compulsory detentions of women, and to explore the potential role of immediate pathways to admission and clinician-rated reasons for admission as mediators of these differences.	Quantitative - descriptive data drawn from health services.	287 women from White British, White Other, Back Caribbean, Black African and black other groups were included. Adjusting for social and clinical characteristics, all groups of Black patients and White other patients were significantly more likely to have been compulsorily admitted than White British patients; White British patients were more likely than other groups to be admitted to a crisis house and more likely than all the Black groups to be admitted because of perceived suicide risk. Immediate pathways to care differed: White Other, Black African and Black Other groups were less likely to have referred themselves in a crisis and more likely to have been in contact with the police. When adjustment was made for differences in pathways to care, the ethnic differences in compulsory admission were considerably reduced. There are marked ethnic inequities not only between White British and Black women, but also between White British and White Other women in experiences of acute admission. Differences between groups in help-seeking behaviours in a crisis may contribute to explaining differences in rates of compulsory admission.

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

Lay, B; Kawohl, W; Rössler, W (2018)	Switzerland	238 inpatients who had at least one compulsory admission during the past 24 months.	The aim of this study was to evaluate an intervention programme for people with severe mental illness that targets the reduction in compulsory psychiatric admissions. In the current study, the researchers examine the feasibility of retaining patients in this programme and compare outcomes over the 24 months to those after treatment as usual (TAU).	Quantitative - randomised controlled intervention study conducted currently at four psychiatric hospitals in the Canton of Zurich.	Fewer participants who completed the 24-month programme were compulsorily readmitted to psychiatry (28%), compared with those receiving TAU (43%). Likewise, the number of compulsory réadmissions per patient was significantly lower (0.6 v. 1.0) and involuntary episodes were shorter (15 v. 31 days), compared with TAU. A negative binomial regression model showed a significant intervention effect (RR 0.6; 95% confidence interval 0.3-0.9); further factors linked to the risk of compulsory readmission were the number of compulsory admissions in the patient's history (RR 2.8), the diagnosis of a personality disorder (RR 2.8), or a psychotic disorder (RR 1.9). Dropouts (37% intervention group; 22% TAU) were characterised by a high number of compulsory admissions prior to the trial, younger age and foreign nationality. This study suggests that this intervention is a feasible and valuable option to prevent compulsory re-hospitalisation in a 'high-risk group of people with severe mental health problems, social disabilities, and a history of
Lindgren, I, et al (2006)	Sweden	24 first-episode psychosis patients diagnosed between 1990-92 and 32 between 1993-96.	The aim of the present study was to follow the patients in the two groups for 5 years, comparing the outcome.	Quantitative analysis using Soteria Nacka recovery scale.	The results showed that easily accessible need-adapted treatment with integrated overnight care might be advantageous for first-episode psychotic patients. The duration of untreated psychosis was shorter and the outcome better

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

Meijer, E, et al (2017)	Netherlands	41 family group conferences were studied in three regions.	This study examined the impact of family group conferences on coercive treatment in adult psychiatry.	Mixed methods - survey and observational data, used to evaluate outcomes of family group conferences.	Family group conferences seems a promising intervention to reduce coercion in psychiatry. It helps to regain ownership and restores belongingness. If mental health professionals take a more active role in the pursuit of family group conferences and reinforce the plans with their expertise, they can strengthen the impact even further.
Mann-Poll, PS, et al (2018)	Netherlands	Five inpatient wards participated: three admission wards for adults, one admission ward for elderly and one ward providing long- stay resident care to adult patients.	The purpose of this study was to examine the impact of a seclusion reduction programme over a long time frame, from 2004 until 2013.	Quantitative analysis of government data.	This study shows a significant reduction in number and duration of seclusion incidents over a long time frame. Organisational leadership and a tailored package of interventions to reduce seclusion were used as key elements. However, reducing the use of seclusion remains challenging and requires time, grounding in the organisation and continuous organisational and professional awareness.

Mezzina, R; Vidoni, D (1995)	Italy	39 new patients with 'acute and severe crises' in a 4-year follow- up study at the community mental health center in Trieste (CMHC).	To assess the impact of the Trieste model of mental health service delivery; particularly 'multi-disciplinary interventions employing a wide range of responses to the existential and social needs arising during a crisis'.	Mixed methods - service data analysis.	According to the authors, the evaluation indicates: ′1) a generally good outcome of the initial crisis; 2) a low relapse rate; 3) a tendency towards favourable long-term outcomes'. Further: 'In terms of practice, voluntary and compulsory hospitalization were avoided in favor of short-term day and night support in the CMHC. There were no suicides, no crimes, no drop-outs. Social adjustment remained unchanged. The study demonstrates that the mental health services in Trieste are able to cope with acute crises without psychiatric hospitalization.'
Morrison, AP, et al (2014)	United Kingdom (country not specified)	74 individuals were randomly assigned to receive either cognitive therapy plus treatment as usual (n=37), or treatment as usual alone (n=37).	To examine the feasibility and effectiveness of using cognitive behavioural therapy (CBT) in people with schizophrenia who are not taking medication.	Quantitative - a single-blind randomised controlled trial at two UK centres between Feb 15, 2010, and May 30, 2013.	Mean PANSS total scores were consistently lower in the cognitive therapy group than in the treatment as usual group, with an estimated between-group effect size of -6.52 (95% CI -10.79 to -2.25; p=0.003). Cognitive therapy significantly reduced psychiatric symptoms and seems to be a safe and acceptable alternative for people with schizophrenia spectrum disorders who have chosen not to take antipsychotic drugs. Evidence-based treatments should be available to these individuals. A larger, definitive trial is needed.

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

Olsson, H; Schön, U-K (2016)	Sweden	13 'key care workers' at a maximum-security forensic psychiatric hospital.	To determine what resources forensic staff use to avoid or prevent violent situations, and to explore how these practices resemble the domains of recovery-oriented care.	Qualitative analysis of in-depth interview texts with thematic analysis.	Staff prevent violent situations using tacit knowledge and experience, and through a shared collegial responsibility. Staff safeguard patients, encourage patient participation, and provide staff consistency. The results have implications for forensic care as well as psychiatry regarding the process of making recovery a reality for patients in the forensic care setting.
Osborn, D; et al (2010)	England	Experience of 314 patients in four residential alternatives and four standard services were compared.	To compare patient satisfaction, ward atmosphere and perceived coercion in the two types of service, using validated measures.	Quantitative analysis of data collected using: the Client Satisfaction Questionnaire, the Service Satisfaction Scale - Residential form, etc.	'Alternatives to traditional in-patient services' appear to be associated with a better experience of admission. Community alternatives were associated with greater service user satisfaction and less negative experiences. Some but not all of these differences were explained by differences in the two populations, particularly in involuntary admission.
Papageorgiou, A; et al (2010)	England	156 in-patients about to be discharged from compulsory treatment under the *Mental Health Act* participated.	To evaluate whether use of advance directives by patients with mental illness leads to lower rates of compulsory readmission to hospital.	Quantitative analysis of inpatients' usual psychiatric care with usual care plus the completion of an advance directive.	Fifteen patients (19%) in the intervention group and 16 (21%) in the control group were readmitted compulsorily within 1 year of discharge. There was no difference in the numbers of compulsory réadmissions, numbers of patients readmitted voluntarily, days spent in hospital or satisfaction with psychiatric services. There was no difference in the numbers of compulsory réadmissions, numbers of patients readmitted voluntarily, days spent in hospital or satisfaction with psychiatric services. Users' advance instruction directives had little observable impact on the outcome of care at 12 months.
Paterson, B; Bennet, L; Bradley, P (2014)	Netherlands	Random sample of 252 from the 2,682 patients consecutively coming into contact with two psychiatric emergency teams in Amsterdam.	Aim is to study the links between opinions about prior psychiatric treatment, insight, service engagement and the risk of (new) civil detentions.	Quantitative analysis of patient sociodemographic and clinical characteristics, and information about prior involuntary admissions.	More satisfaction with prior treatment seems to reduce the risk of civil detention remarkably. Low levels of satisfaction seem to be mainly dependent on a history of previous involuntary admission. These findings seem to open up a new perspective for diminishing the risk of (new) civil detention by trying to enhance satisfaction with treatment, especially for patients under detention.
Poulsen, HD (2002)	Denmark	472 admissions to all psychiatric wards at one hospital were selected randomly by selecting every fifth admission.	To investigate the prevalence of 'extralegal deprivation of liberty' - restrictions in leaving a psychiatric ward other than a formal involuntary commitment of detention - in a hospital population.	Quantitative - survey of large sample of psychiatric admission data (staff must record imposition of restricted leave).	Extra-legal deprivation of liberty seems to be a common phenomenon at the psychiatric ward also among patients admitted voluntarily. Reasons for using this type of coercion are probably complex, but it seems to be most common among severely ill patients.

Putkonen, A; et al (2013)	Finland	13 wards of a secured national psychiatric hospital in Finland.	To study whether seclusion and restraint could be prevented in the psychiatric care of persons with schizophrenia without an increase of violence.	Quantitative - randomised controlled trial, comparing monthly incidence rate ratios (IRRs) of coercion and violence.	The proportion of patient-days with seclusion, restraint, or room observation declined from 30% to 15% for intervention wards (IRR=.88, 95% confidence interval [CI]=.86-.90, p<.001) versus from 25% to 19% for control wards (IRR=.97, CI=.93-1.01, p=.056). Seclusion-restraint time decreased from 110 to 56 hours per 100 patient-days for intervention wards (IRR =.85, CI = .78-.92, p<.001) but increased from 133 to 150 hours for control wards (IR R = 1.09, CI=. 94-1.25, p=.24). Seclusion and restraint were prevented without an increase of violence in wards for men with schizophrenia and violent behaviour. A similar reduction may also be feasible under less extreme circumstances.
Robertson, JP; Collinson, C (2011)	England	Two groups of staff working in local community outreach teams in adult mental health and learning disability services in a midlands city.	To undertake an exploration into outreach workers' experiences of assisting clients with positive risk-taking (PRT), including dimensions of risk staff face, and factors influencing their risk approaches.	Qualitative analysis of interview transcripts.	The study highlighted different understandings of positive risk-taking PRT at different levels within organisations and a need for better informed, coherent organisational approaches to its practice. Interpersonal trust relies upon such organisational coherence; without it some staff may see themselves as gambling when undertaking PRT, whereas others may retreat into conservative interventions. Such conservative practices were perceived as potentially dangerous, promoting coercion and disrupting therapeutic relationships, and so increasing risks over a longer time period. Research is needed into the use of systems failure analysis and risk assessment tools to highlight how PRT can generate successful outcomes.
Russo, J; Rose, D (2013)	Europe	Study involved one focus group in each of 15 European countries and extended to a total of 116 participants.	The purpose of this paper is to discuss human rights assessment and monitoring in psychiatric institutions from the perspectives of those whose rights are at stake.	Qualitative analysis of focus group data.	Paper highlights human rights issues which are not readily visible and therefore less likely to be captured in institutional monitoring visits. Key issues include the lack of interaction and general humanity of staff, receipt of unhelpful treatment, widespread reliance on psychotropic drugs as the sole treatment and the overall impact of psychiatric experience on a person's biography.
Schneeberger, AR; et al (2017)	Germany	Seclusion or restraint data in 21 German hospitals.	To examine the effects of open vs. locked door policies on aggressive incidents which remain unclear.	Quantitative analysis of hospital data. Naturalistic observational design and analysis of the occurrence of aggressive behaviour.	Restraint or seclusion during treatment was less likely in hospitals with an open door policy. On open wards, any aggressive behavior and restraint or seclusion were less likely, whereas bodily harm was more likely than on closed wards. Hospitals with open door policies did not differ from hospitals with locked wards regarding different forms of aggression. Other restrictive interventions used to control aggression were significantly reduced in open settings. Open wards seem to have a positive effect on reducing aggression.

					Future research should focus on mental health care policies targeted at empowering treatment approaches, respecting the patient's autonomy and promoting reductions of institutional coercion.
Schout, G; et al (2017a)	Netherlands	Two case examples of families/social networks.	To address the question what Family Group Conferencing (FCG) adds to the existing methods to reduce coercion in mental health care and promote inclusion.	Qualitative analysis of evaluation study data	Research indicates that there are grounds for a wider application of FGC in mental health, even outside the framework of coercive care. Study observed that clients and/or their social network were not always able to participate in a conference, let alone to bring in enough self-direction; so that during the private time a plan could be established.
Schout, G; et al (2017)	Netherlands	17 families/ social networks engaged in family group conferencing.	To identify barriers to applying Family Group Conferences. 'An answer to this question provides insights regarding situations in which Family Group Conferences may (not) be useful'.	Qualitative - 17 case studies	The following barriers emerged: '(1) the acute danger in coercion situations, the limited time available, the fear of liability and the culture of control and risk aversion in mental health care; (2) the severity of the mental state of clients leading to difficulties in decision-making and communication; (3) considering a Family Group Conference and involving familial networks as an added value in crisis situation is not part of the thinking and acting of professionals in mental health care; (4) clients and their network (who) are not open to an Family Group Conference.' Awareness of the barriers for Family Group Conferences can 'help to keep an open mind for its capacity to strengthen the partnership between clients, familial networks and professionals' and 'can help to effectuate professional and ethical values of social workers in their quest for the least coercive care'.
Seikkula, J (2003)	Finland	Data from 69 service users, of whom 45 who were given Open Dialogue support were compared with 14 service users in typical acute services.	To evaluate the Open Dialogue (OD) approach that aims to treat psychotic patients in their home.	Quantitative analysis of government patient data	As part of the Need-Adapted Finnish model, the Open Dialogue (OD) approach aims to treat psychotic patients in their home. Treatment involves the patient's social network, starts within 24 hours of initial contact, and responsibility for the entire treatment rests with the same team in inpatient and outpatient settings. Patients in the Open Dialogue in Acute Psychosis (ODAP) group had fewer relapses and less residual psychotic symptoms and their employment status was better than patients in the comparison group. The OD approach, like other family therapy programmes, seems to produce better outcomes than conventional treatment. OD emphasises using fewer neuroleptic medication.
Siponen, U; Välimäki, M; Kaivosoja, M; Marttunen, M;	Finland	Data for all adolescents aged 13-17 from two Finnish	The aim of the study was to explore features associated with	Quantitative analysis of government	Factors other than the characteristics of the adolescents themselves - such as 'divorces, single parent families, social exclusion' - are associated with use of compulsory care,

Kaltiala-Heino, R (2011)		districts between years 1996-2003.	compulsory intervention of adolescents at the regional level by comparing two hospital districts clearly differing in this regard.	hospital discharge data.	although an ecological study design cannot establish causality.
Slade, M; et al (2010)	England	Admission cost data were collected for six alternative services and six standard services.	To explore short-term outcomes and costs of admission to alternative and standard services, and address the gap in research on outcomes following admission to residential alternatives to standard in-patient mental health services which are underresearched.	Quantitative - Health of the Nation Outcome Scales (HoNOS), Threshold Assessment Grid (TAG), Global Assessment of Functioning (GAF).	All outcomes improved during admission for both types of service (n = 433). Adjusted improvement was greater for standard services in scores on HoNOS (difference 1.99, 95% CI 1.12-2.86), TAG (difference 1.40, 95% CI 0.39-2.51) and GAF functioning (difference 4.15, 95% CI 1.08-7.22) but not GAF symptoms. Admissions to alternatives were 20.6 days shorter, and hence cheaper (UKE3832 v. £9850). Standard services cost an additional £2939 per unit HoNOS improvement. The absence of clear-cut advantage for either type of service highlights the importance of the subjective experience and longer- term costs.
Thomsen, CT; et al (2018)	Denmark	Clinical data obtained from recipients of patient-controlled admission in all the five regions in Denmark where patient- controlled admission is available.	To assess whether implementing patient-controlled admission (PCA) can reduce coercion and improve other clinical outcomes for psychiatric inpatients.	Quantitative analysis of patient- controlled admission data.	Implementing patient-controlled admission (PCA) did not reduce coercion, service use or self-harm behaviour when compared with treatment as usual (TAU). In a paired design, the outcomes of PCA patients during the year after signing a contract were compared with the year before. The PCA group had more in-patient bed days (mean difference = 28.4; 95% CI: 21.3; 35.5) and more medication use ($P < 0.0001$) than the TAU group. Before and after analyses showed reduction in coercion ($P = 0.0001$) and in-patient bed days ($P = 0.0003$). Beneficial effects of PCA were observed only in the before and after PCA comparisons. Lurther research should investigate whether PCA affects other outcomes to better establish its clinical value.
Thomsen, C; et al (2017)	Denmark	Study population included all individuals aged 18-63 years with a psychiatric inpatient admission during January 1, 1999-December 31, 2014	To identify risk factors associated with coercive measures, to better identifying possible causes of (and hence remedies to) coercion.	Quantitative analysis of psychiatric inpatient admission data.	Clinical characteristics were the foremost predictors of coercion and patients with organic mental disorder had the highest increased risk of being subjected to a coercive measure (OR=5.56; 95% CI=5.04, 6.14). The risk of coercion was the highest in the first admission and decreased with the number of admissions (all $p<0.001$). The following socioeconomic variables were associated with an increased risk of coercion: male sex, unemployment, lower social class and immigrants from low and middle income countries (all $p<0.001$). Early retirement and social relations, such as being

					married and having children, reduced the risk of being subjected to coercive measure (all p<0.05). These findings can assist researchers in identifying patients at risk of coercion and thereby help targeting new coercion reduction programmes.
Thornicroft, G; et al (2013)	England	569 participants were randomly assigned (285 to the intervention group and 284 to the control group)	To assess whether the additional use of Joint Crisis Plans improved patient outcomes compared with treatment as usual for people with severe mental illness.	Quantitative analysis of CRIMSON (Crisis Impact: Subjective and Objective coercion and eNgagement) randomised controlled trial data.	The findings are inconsistent with two earlier Joint Crisis Plans (JCP) studies, and show that the JCP is not significantly more effective than treatment as usual. There is evidence to suggest the JCPs were not fully implemented in all study sites, and were combined with routine clinical review meetings which did not actively incorporate patients' preferences. The study therefore raises important questions about implementing new interventions in routine clinical practice.
van der Post, Louk FM; et al (2014)	Netherlands	Random sample of 252 from the 2,682 patients consecutively coming into contact with two psychiatric emergency teams in Amsterdam.	Aim is to study the links between opinions about prior psychiatric treatment, insight, service engagement and the risk of (new) civil detentions.	Quantitative analysis of sociodemographic and clinical characteristics and information about prior involuntary admissions.	More satisfaction with prior treatment seems to reduce the risk of civil detention remarkably. Low levels of satisfaction seem to be mainly dependent on a history of previous involuntary admission. These findings seem to open up a new perspective for diminishing the risk of (new) civil detention by trying to enhance satisfaction with treatment, especially for patients under detention.
van der Schaaf, PS; et al (2013)	Netherlands	Service data on 77 Dutch psychiatric hospitals and also a benchmark study on the use of coercive measures in 16 Dutch psychiatric hospitals.	To explore the effect of design features on the risk of being secluded, the number of seclusion incidents and the time in seclusion, for patients admitted to locked wards for intensive psychiatric care.	Quantitative analysis by combining data of building quality and safety with data on frequency and type of coercive measures.	A number of design features had an effect on the use of seclusion and restraint. The study highlighted the need for a greater focus on the impact of the physical environment on patients, as, along with other interventions, this can reduce the need for seclusion and restraint.
Vruwink, FJ, et al (2012)	Netherlands	Dutch hospitals that received a government grant program, which in 2006 (start of program) numbered 34 and by 2009 (end of program) numbered 42.	To establish whether the numbers of both seclusion and involuntary medication changed significantly after the start of this national programme designed to reduce seclusion in Dutch hospitals.	Quantitative analysis (using Poisson regression to estimate difference in logit slopes) of Dutch Health Care Inspectorate data for seclusion and	After the start of the nationwide programme the number of seclusions fell, and although significantly changing, the reduction was modest and failed to meet the objective of a 10% annual decrease. The number of involuntary medications did not change; instead, after correction for the number of involuntary hospitalisations, it increased.

				involuntary medication.	
Zinkler, M (2016)	Germany	Service data on a network of Bavarian hospitals	To review data on the use of coercion, against data on the use of coercive treatment in a group of Bavarian hospitals since 2014. Additionally, detailed data from one institution with an uncommon approach to violence and coercion is presented.	Quantitative data analysis of use of coercion in network of psychiatric hospitals	In a 15-month period starting in 2014, Germany's Constitutional Court and Federal Supreme Court restricted involuntary treatment 'in all but life-threatening emergencies' in response to the CRPD. National and local data suggests that giving up coercive medication is not straightforward and problems arise when one form of coercive treatment (coercive medication) is stopped but other forms of coercion (restraint) and violence in psychiatric institutions increase. The author writes that '[djata from a ... local mental health service suggest that the use of coercive medication could be made obsolete.'