COMPENDIUM REPORT
GOOD PRACTICES IN THE COUNCIL OF EUROPE TO PROMOTE VOLUNTARY MEASURES IN MENTAL HEALTH SERVICES

Report commissioned by the
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COUNCIL OF EUROPE
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TO PROMOTE VOLUNTARY MEASURES
IN MENTAL HEALTH

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EXECUTIVE SUMMARY

This report provides a compendium of good practices to promote voluntary measures in mental health care and support. It draws from practices submitted to the DH-BIO Secretariat by delegations representing the 47 Member States of the Council of Europe (COE) as well as civil society stakeholders. The compendium fulfils the aim set out in the *DH-BIO Strategic Action Plan on Human Rights and Technologies in Biomedicine 2020-2025* to:

> assist member States [by developing] a compendium of good practices to promote voluntary measures in mental healthcare, both at a preventive level and in situations of crisis, by focusing on examples in member States.

The practices may *directly* aim to reduce, prevent, or even eliminate coercive practices in mental health settings, and others will *indirectly* result in similar outcomes by advancing the general aim to promote voluntary mental health care and support.

The compendium is not meant as an exhaustive list of leading practices in COE Member States. Instead, it is meant as an initial step toward compiling practices aimed at promoting voluntary mental healthcare and support, and reducing and preventing coercion in mental health settings. More generally, the materials promote compliance with the Convention on the Rights of Persons with Disabilities (CRPD), notwithstanding debates about coercion in mental healthcare which will be noted in Part 1(B) of the report.

Part I of the report sets out the terminology, scope, background, and research limitations.

Part II presents the good practices, which are organised under the following categories:

- hospital-based initiatives;
- community-based initiatives;
- ‘hybrid models’ that combine hospital- and community-based responses; and
- other initiatives toward alternatives to coercion, including advance planning, professional training and education programs.

There may be other ways to categorise these practices. For this compendium, these broad categories provided a useful conceptual framework to generalise diverse initiatives across the COE.

Part III provides a brief concluding discussion. It discusses demographic issues (for example, experiences of women compared to men, and older people compared to other adults), and provides a brief list of factors that appeared to enable and promote leading practices.

Finally, appendices provide supplementary material.

- **Appendix A** contains the questionnaire distributed by the DH-BIO Secretariat to COE Member States, which requested information about examples of good practices. This questionnaire indicates how the DH-BIO Secretariat framed its interpretation of a ‘good practice’.

- **Appendix B** provides a table of empirical research literature from the COE that is relevant to the aims of the compendium, which summarises the country, aim, methods and findings of each study. This supplementary material can help readers contextualise the leading practices shared by COE Member States and civil society stakeholders, helping to highlight when a good practice may be part of a broader international trend in policy and practice, or when an evidence-base for a particular practice does (or does not) exist.

The compendium is written so that readers can skip ahead to relevant sections. A table summarising the practices appears in the next section, which includes the relevant page number for each individual practice.

The compendium is also written so that its content can be amended and updated as definitions of ‘good’ and ‘leading’ practices change over time. An easily searchable database that can be regularly updated could be created to assist COE policymakers and stakeholders.

The growing body of research on the relative success of measures to reduce and prevent coercion suggests there is a strong evidence base for responding to people in distress without coercion. The compendium practices suggest that assumptions about the appropriateness and necessity of coercion that many governments, professionals, and communities appear to hold, need to be re-visited.

From a policy perspective, the good practices in the Compendium suggest that coercion-free services or services that greatly reduce coercive measures can be advanced at three interconnected levels: national oversight, organisational culture change, and independent, systemic advocacy. Other factors for the success of practices in this compendium include:

- governments and services being explicit about the harms of coercion and committing to active steps to reduce, prevent and even eliminate coercion;
- top-down and local-level leadership that seeks to create and maintain culture change toward coercion-free crisis support, whether in an individual service or initiative, or in service systems as a whole;
- the involvement of people with lived experience of mental health services and interventions, persons with psychosocial disabilities, and so on in decision-making at all levels, from local-service provision and administration, to the development of research agendas, and national law and policy developments.

At the coalface, in hospitals and other mental healthcare settings, the findings align with recommendations from the World Health Organization (WHO, 2021, p.8), which suggest that the creation of services free of coercion requires actions on several fronts including:

- education of service staff about power differentials, hierarchies and how these can lead to intimidation, fear and loss of trust;
- helping staff to understand what is considered a coercive practice and the harmful consequences of its use;
- systematic training for all staff on non-coercive responses to crisis situations including de-escalation strategies and good communication practices;
- individualised planning with people using the service including crisis plans and advance directives;
- modifying the physical and social environment to create a welcoming atmosphere including the use of ‘comfort rooms’ and ‘response teams’ to avoid or address and overcome conflictual or otherwise challenging situations;
- effective means of hearing and responding to complaints and learning from them;
- systematic debriefing after any use of coercion, as well as systems of redress, in an effort to avoid incidents happening in the future; and
- reflection and change concerning the role of all stakeholders including the justice system, the police, general health care workers.

This compendium suggests that with investment in alternative practices and an explicit commitment to reduction and prevention initiatives, that many contemporary coercive measures are not necessary—and at least some can be eliminated entirely. There is a compelling legal and moral case for mandating the introduction of such practices and providing accountability measures to ensure a fuller transition to rights-based and recovery-oriented responses to distress and mental health crises.

TABLE OF PRACTICES

‘Hospital-Based Initiatives

Practice	*Description*	*Page*
Basal Exposure Therapy combined with Complementary External Control *Norway*	*Basal Exposure Therapy is a ward-based practice with a strong psychotherapeutic focus that allows people to stay on wards for up to three months. Medication is auxiliary and subservient to the therapeutic process. A ‘Complementary External Regulation’ practice occurs simultaneously and is explicitly designed to eliminate coercive measures from the care process.*	p.26
Guidelines on Prevention of Coercion and Therapy for Aggressive Behaviour *Germany*	*These Guidelines were developed for German adult psychiatric services to prevent and reduce coercive measures against mental health service users whose actions are considered aggressive. 12 evidence- and consensus-based recommendations were drawn from the guidelines and are being implemented in 52 psychiatric admission wards.*	p.29

‘High and Intensive Care’ Units *The Netherlands*	*As part of a national policy to reduce the use of seclusion in the Netherlands, ‘High and Intensive Care Units’ were developed. The Units are acute admission wards focusing on restoring and maintaining the relationships of the person with their social network and preventing crisis.*	p.33
‘No Force First’ Policies *United Kingdom*	*The ‘No Force First’ initiative aims to move ward cultures from a focus on ‘containment to one of recovery’. The aim is to create coercion-free environments. This approach, which began in the United States, is being adopted by some UK based mental health trusts.*	p.34
Open Door Policy *Internationally*	*‘Open door policy’ refers to a policy of maintaining open rather than locked doors in mental health settings so as to protect rather than deprive the liberty of patients/service users.*	p.36
Open Dialogue in a High Security Psychiatric Ward *Norway*	*The Department of Specialised Psychiatry at Akershus University Hospital, a high security psychiatric ward in Oslo, Norway, has undertaken a program based on the ‘Open Dialogues’ practice. Early reports suggest success in helping to end the use of any coercive measures for individuals who had previously been subjected to high amounts of coercion in other closed psychiatric institutions.*	p.38
Reducing mechanical restraint in acute mental health inpatient wards (multiple) *International*	*Multiple programmes, practices and policy-measures have sought to reduce and eliminate the use of restraint in mental health settings. Approaches include: improvements to ward physical environments, increasing opportunities for support and connection, and greater access to peer workers, family, and other informal support. Initiatives from Norway and Spain, including the Six Core Strategies approach, are outlined.*	p.40

Safewards *United Kingdom and internationally*	*The ‘Safewards’ model aims to reduce the restraint and seclusion of people on psychiatric wards, as well as reducing conflict between service users/patients and staff. The model provides staff with practices and concepts to help improve the culture of hospital settings and the physical characteristics of wards, with attention to staff interactions with service users and family/friends.*	p.45
Weddinger Modell *Germany*	*The Weddinger Model is a recovery-oriented concept for acute psychiatric settings. It promotes the rights and responsibilities of patients and focuses on developing the skill of multi-professional teams. Traditional hospital practices such as therapy planning are made more transparent to prioritise the active involvement of the person and her/his supporters.*	p.48
Workbook for Hospitals and Wards to Reduce Coercion and Increase Occupational and Patient Safety *Finland*	*This workbook aims to help hospitals and wards providing involuntary psychiatric care to reduce the use of coercion against patients and to increase occupational and patient safety.*	p.49

Community'-Based or Non-Hospital Initiatives

Practice	Description	Page
Community mental health initiative *Novara, Italy*	*This mobile support program assists people in crisis and those discharged from psychiatric wards in their own home. The initiative helped lower rates of involuntary admissions compared to other Italian services despite the service having fewer resources overall.*	p.51
Family Group Conferencing *The Netherlands*	*Family Group Conferencing is a strategy for responding to individuals in mental health crises that involves a dialogue or 'conference' with a person's family and social network to drive decisions about support.*	p.52
Hugarafl *Iceland*	*Hugarafl (which roughly translates as 'Mindpower') is a peer-run, non-government organisation operating in Reykjavík. Hugarafl host various activities, including peer-led self-help groups, peer support, counselling, activism, policy advising, and mental health promotion in education.*	p.53
Mental Health Mobile Units *Greece*	*Mobile Units are used to provide support to people in rural and remote areas. They seek to ensure the person is not cut off from the community through hospitalisation. The units work with local community, other health services, as well as key individuals (local authorities, the police department, prosecutors) to secure the person's right to remain an active member of the community.*	p.55

Open Dialogues Model *Finland and internationally*	The 'Open Dialogue Approach to Acute Psychosis' is a Finnish practice that is now operating in countries as diverse as Norway, Denmark, the UK, Italy, Portugal, Germany, Poland, the Netherlands, USA, and Australia. Care decisions are made in the presence of the individual and her/his wider networks. Psychotherapeutic approaches are taken to promote dialogue between the person and her/his support network.	*p.56*
Personal Ombud Programme (‘Personligt Ombud Skåne’ or ‘PO’) *Sweden*	*The PO scheme involves personal assistance and individual advocacy for persons experiencing crisis and/or psychosocial disability. The 'assistants' or 'advocates' are statutorily appointed to assist a person to make legal decisions in a facilitative rather than coercive fashion.*	p.59
Respite Houses *Internationally*	*Various models for respite houses exist, three of which are described here: Bochum Crisis Rooms (Germany); Soteria House (Sweden and internationally); and Weglaufhaus (Germany). All three have an anti-coercion focus and aim to provide support, safety and shelter for people in need of psychosocial support.*	p.60
TANDEMplus ***Mobile Crisis Support*** *Belgium*	*‘TANDEMplus’ is a mobile crisis service involving interdisciplinary teams that support people during and shortly after a mental health crisis. The crisis teams help a person to (re)activate her/his local support network, including connecting to both formal and informal sources of support. Emphasis is placed on the person defining the kind of support she/he would like to receive.*	p.63

‘Hybrid’ Programs

Practice	Description	Page
‘Activity quality of care project Deinstitutionalisation of care for the mentally ill’ *Czech Republic*	*The Czech Republic is reducing coercion in mental health settings within a broader programme of ‘deinstitutionalisation’. The program draws on European Investment and Structural Funds and applies the World Health Organization QualityRights Toolkit. It involves multiple measures to transition away from largescale psychiatric facilities while ensuring high quality services in mental health, including prevention of involuntary psychiatric interventions and other coercive measures.*	p.66
‘Citizen Psychiatry’ ***East Lille Public Psychiatry*** *France*	*Over the past three decades, the city of Lille has progressively developed a program of ‘citizen psychiatry’ in which mental health services’ aim to avoid resorting to traditional hospitalisation, and instead ‘integrate the entire health system’ into the city, via a network involving all interested partners: service users, carers, families and elected representatives. Within this broad approach to mental health services, there are several specific practices detailed in the report.*	p.69
‘Improved cooperation between psychiatry and home care’ *Sweden*	*This small-scale initiative in the Eksjö municipality, successfully reduced rates of involuntary psychiatric interventions through a program that focused on improving the interactions between individuals in mental health crises, nurses providing home based care, and inpatient and outpatient psychiatrists*	p.78

‘Patient-led action plan’ to appeal compulsory treatment orders *The Netherlands*	*This practice functions as a form of appeal process available to individuals who are subject to an involuntary psychiatric intervention, but one in which the medical director who imposes it retains discretion to proceed or withdraw the intervention order. The individual is asked to propose a support arrangement or ‘action plan’. The medical director who imposed the original intervention order may or may not accept the action plan.*	*p.80*
Reducing compulsory admission at a psychiatry emergency outpatient clinic *Norway*	*An Oslo emergency outpatient clinic sought to reduce compulsory admission by providing ‘focused interventions’ for people experiencing acute mental health crises, and ‘improving the decision-making of staff who impose compulsory admission’. Over a 12-year period, service data indicated a 70 percent decrease in the number of admissions to acute hospital care, and a reduction of compulsory admissions compared to voluntary admissions from 79 to 40 percent.*	p.82
Trieste Model *Italy*	*This model is described as an ‘open door—no restraint’ initiative which aims to ‘de-hospitalise’ responses to mental health across the city of Trieste. The core of the program involves a network of ‘Community Mental Health Centres’ with relatively few beds, one general hospital psychiatric unit, a network of supported housing facilities, and several social enterprises/co-operative businesses.*	p.84

Other Initiatives

Practice	Description	Page
Advance Planning Initiatives, *International*	*Advance planning includes practices variously termed 'advance statements', 'advance directives', 'joint crisis planning', and so on. These measures can help individuals to convey their preferences for how others might respond to them during a crisis, and may help to avoid a person being subject to coercive measures. Examples from Spain and France are described.*	p.87
Peer Support and the Peer Workforce, *International*	*Several peer-support initiatives are listed.* ***Hearing Voices Network** groups are based on the idea that members – those who experience hearing, seeing or sensing things that others do not – can share successful strategies with each other in a safe and mutually supportive space.* ***Intentional Peer Support** is a form of informal support. People are taught to take a supportive role for people in crises using concepts and practices to improve understanding and responses to crisis.* ***Médiateur de santé pairs ('peer to peer mediator')** is a French peer-to-peer health mediator program that provides formalised education for former and ongoing users of mental health care services, who are trained via tertiary institutions to join mental health care teams.*	p.90
BE RIGHT – Multinational Training Initiative for Health and Social Care Professionals in Mental Health Settings, *Multinational*	*'BE RIGHT' is a training package on human rights in mental health settings. The contents and methods of the training are meant to highlight the susceptibility of persons with mental health conditions and psychosocial disabilities to rights violations, including in the very social and health services designed to help them.*	p.94

I. BACKGROUND

Introduction

In 2019, the Council of Europe (COE) Committee on Bioethics (DH-BIO) committed to develop a ‘compendium of good practices to promote voluntary measures in the field of mental healthcare’. The *DH-BIO Strategic Action Plan on Human Rights and Technologies in Biomedicine 2020-2025* (p.15) states that:

> In mental healthcare for persons with psychosocial disabilities the focus is shifting towards avoiding recourse to involuntary measures. To assist member States in this shift, the Committee on Bioethics intends to develop a compendium of good practices to promote voluntary measures in mental healthcare, both at a preventive level and in situations of crisis, by focusing on examples in member States.

This report provides this compendium. It compiles good examples provided by DH-BIO delegations representing the 47 Member States of the COE, as well as civil society stakeholders. The primary contribution from a civil society stakeholder was a submission by Mental Health Europe, which included several practices.

This report is written for a diverse audience, including policymakers, people with firsthand experience of mental health services and their representative organisations, mental health professionals, family supporters and carers, disabled people’s organisations and other civil society organisations, and the broader public. It is not meant as an exhaustive list of leading practices in COE Member States. Instead, it is meant as an initial step toward compiling practices aimed at promoting voluntary mental healthcare and support, and reducing and preventing coercion in mental health settings.

The next section, **Part I** will set out the terminology, scope, background, and research limitations of the compendium, before the practices are listed in **Part II.**

Terminology

Terms defined in this section:

- ‘Persons with mental health conditions and psychosocial disability’
- ‘Good practices’
- ‘Involuntary measures’, ‘coercion’ and ‘coercive practices’

This report uses the term ‘**persons with mental health conditions and psychosocial disability**’ to broadly describe the individuals who have experienced mental health crises or ongoing impairments, including those who use mental health services or have been subject to involuntary interventions in mental health settings. This terminology draws from the *COE Strategic Action Plan 2020-2025* (Council of Europe, 2019, p.15), which uses the terms ‘persons with mental health difficulties’ and ‘persons with psychosocial disabilities’.[1] ‘Persons with mental health conditions and psychosocial disabilities’ is also used by the United Nations Human Rights Council (2017, p.4) in its *Resolution on Mental Health and Human Rights*, and the terms also appear in the World Psychiatric Association (WPA) 2020 *Position Statement on Implementing Alternatives to Coercion: A Key Component of Improving Mental Health Care* (Rodrigues et al., 2020).

The term ‘**psychosocial disability**’ is simply used here to refer to disability related to mental health conditions. It is a term that has become prominent since the Convention on the Rights of Persons with Disabilities (CRPD) came into force in 2008. *Psychosocial* disability is distinct from *intellectual* disability (sometimes referred to as developmental or learning disability) and *cognitive* disabilities (such as persons with dementia and brain-injury). This report does *not* engage with services that are specifically designed for persons with *intellectual* disability and/or *cognitive* disability. However, it is acknowledged that these groups may also experience mental health conditions and engage with mental health services, including experiencing coercive interventions. Further, in some countries, there may be no clear separation of services for people with intellectual, cognitive and psychosocial disabilities.[2]

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[1] A slight change is adopted for this report, replacing ‘mental health *difficulties*’, as used in the COE Strategic Action Plan, with the ‘mental health *conditions*’ as used by the UN Human Rights Council and World Psychiatric Association.

[2] There is also evidence that persons with intellectual and cognitive disabilities experience mental health conditions at higher rates compared to others (see eg, Hughes-McCormack et al., 2017), and may also experience coercion at higher rates (European Agency for Fundamental Rights, 2012). However, it is outside the scope of this report to include services designed *specifically* with attention to persons with intellectual and cognitive disabilities.

This report uses the term '**good practices in mental healthcare**' to describe practices submitted by COE delegations that met the broad aim of 'promot[ing] voluntary measures in mental healthcare, both at a preventive level and in situations of crisis' (as per the *DH-BIO Strategic Action Plan on Human Rights and Technologies in Biomedicine 2020-2025* (p.15)). This term is not used to imply that the practices are perfect models or 100 percent compliant with the CRPD. Instead, the practices are presented as examples of steps towards change—broadly, they are 'good practices to promote voluntary measures in the field of mental healthcare' and hence, aim to decrease the use of involuntary measures in fulfilment of COE Disability Strategy aims. Some are at an early stage of development. Others are more established. Some may have components that are viewed by human rights bodies or civil society advocates as being positive, while also retaining aspects viewed as negative. Finally, even if good practices are working well in one place, replication in other places always requires taking into account new settings, and generally requires participation of all stakeholders, particularly mental health service users and other persons with psychosocial disabilities (Flynn and Gómez-Carrillo, 2019).

'**Involuntary measures**' are defined by DH-BIO as 'any placement and/or treatment of a person without that person's free and informed consent or against the will of the person'. The term 'involuntary measures' will be used interchangeably with '**coercion**' and '**coercive practices**'. These terms will be used to refer to a range of involuntary interventions.

All COE Member States have legal provisions for the assessment, admission and treatment of people on an involuntary basis. Intervention typically occurs through detention and involuntary treatment in hospital, or compulsory treatment in the community. Coercive practices also include the use of seclusion (when a person is confined alone in a room or area where free exit is prevented) and different forms of restraint (when a person's freedom of movement is restricted by physical, mechanical or chemical means) in specialised mental health services.

Involuntary measures may also occur 'unofficially' (Molodynski et al., 2016); for example, where a person is threatened with formal involuntary intervention by clinicians if they do not accept 'voluntary' support. Where relevant, this report will depart from the broad terms of 'involuntary measures', 'coercion' and 'coercive practices', to describe specific interventions that are being addressed, such as involuntary electro-convulsive therapy, seclusion, and mechanical or physical restraint.

Background: Growing Research and Advocacy on Coercion

This compendium report adds to recent policy, research and practice seeking to promote voluntary and coercion-free forms of support, care and treatment (see eg. Barbui et al., 2020; Flynn & Gómez-Carrillo, 2019; Gooding et al., 2020; Hirsch & Steinert, 2019; C.

Huber & Schneeberger, 2021; Sashidharan et al., 2019). More recently, the COST (European Cooperation in Science and Technology) funding agency has funded the establishment of a research network, 'FOSTREN: Fostering and Strengthening Approaches to Reducing Coercion in European Mental Health Services' (see <www.fostren.eu> [accessed 30/09/2021]).

Some of the prominent existing resources are listed briefly below, which have informed and should be considered complementary to this compendium.

Non-Government Organisations and National Human Rights Institutions

In 2019, Mental Health Europe (MHE) (2019) released a report, *Promising practices in prevention, reduction and elimination of coercion across Europe*. The following year, the European Network of National Human Rights Institutions (ENNHRI) partnered with MHE to publish a report, *Implementing Supported Decision-Making: Developments Across Europe and the Role of National Human Rights Institutions*. Both reports include several promising practices that align with this compendium and appear in Part II.

The MHE and ENNHRI reports build upon advocacy by persons with lived experience of mental health conditions and psychosocial disabilities and their representative organisations, who have consistently pointed out the human rights implications of involuntary psychiatric intervention and have advocated for alternatives. (For a collection of such practices, see Gooding et al. 2018, p.201; see also MIA, n.d.; CHRUSP, n.d; Russo & Wallcraft, 2011).

World Health Organisation – QualityRights Toolkit and Good Practice Guidance

The World Health Organisation (WHO) (2020) *QualityRights Initiative* provides a comprehensive set of resources for improving quality of care and reducing coercive practices. It includes policy and program checklists and training resources, which have been piloted and launched in low-, middle- and high-income countries. The resources are designed for use by a range of actors (service providers, individual healthcare practitioners, national bodies, and so on). Implementation studies have occurred in Gujarat, India, in partnership with the World Psychiatric Association (2020) as a 'Case Study of Alternatives to Coercion in Mental Health Care', and an implementation is underway in the Czech Republic (see below p.66).

In addition, in 2021 the WHO has published an important resource titled, *Guidance on community mental health services: Promoting person-centred and rights-based approaches*. This resource is part of the WHO *Guidance and technical packages on community mental health services* set of publications (World Health Organization, 2021). The materials include a list of exemplary services from around the world with a focus on non-coercive practices. Specific recommendations and action steps are presented for developing community mental health services that respect human rights and focus on recovery. This comprehensive document is accompanied by a set of seven technical packages focused on specific categories of mental health services and guidance for setting up new services. For more information see:

- **WHO assessment toolkit guidance**
  https://www.who.int/publications/i/item/who-qualityrights-tool-kit

- **WHO QualityRights Service transformation guidance**
  https://www.who.int/publications/i/item/9789241516815

- **QualityRights training and guidance modules**
  https://www.who.int/publications/i/item/who-qualityrights-guidance-and-training-tools

- **WHO Guidance on community mental health services**
  https://www.who.int/publications/i/item/guidance-and-technical-packages-on-community-mental-health-services

World Psychiatric Association – Implementing Alternatives to Coercion

In 2020, the World Psychiatric Association (WPA) published a position statement titled, ‘Implementing Alternatives to Coercion: A Key Component of Improving Mental Health Care’ (Rodrigues et al., 2020). The statement includes the following:

> *…implementing alternatives to coercion is an essential element of the broader transition across the mental health sector toward recovery-oriented systems of care.* Recovery-oriented treatment and care require not only respect for human rights and service user involvement, but realisation of rights through sound pathways to non-coercive care. This includes attention to all the important steps along the way – prevention, early intervention, and continuity beyond clinical settings – to provide integrated and personalised care, maximise therapeutic outcomes and promote the rights and recovery of people with mental health conditions and psychosocial disabilities. (Rodrigues et al., 2020) (Emphasis in original)

The position statement was developed internationally, in consultation with national psychiatry associations, and includes a brief list of implementation resources (see World Psychiatric Association, 2020). The statement aimed to recommend ‘action and an optional protocol designed to support [the associations] to engage… in ways that suit their local circumstances’ (Herrman, 2020, p.256).

Council of Europe – Disability Strategy (2017-23)

As noted, the momentum for reducing, preventing and eliminating coercion in mental health settings aligns with the COE Disability Strategy (2017-2023) (Section 3.4), which refers to the importance of *supported* rather than *substituted* decision-making. The section 'Equal recognition before the law' contains the following:

> States are required under the UNCRPD, as far as possible to replace substituted decision-making with systems of supported decision-making. […]
>
> Council of Europe bodies, member States and other relevant stakeholders should seek to:
>
> a) Support member States in their efforts to improve their legislation, policies and practices with regard to ensuring legal capacity of persons with disabilities.
>
> b) Identify, collect and disseminate existing good practices on supported decision-making systems and practices that persons with disabilities have available for being able to exercise their legal capacity and have access to choices and rights.

In general, these policy documents and advocacy materials convey high-level agreement on key components of good mental health policy around the globe, from promotion, to prevention, treatment and rehabilitation.

The Question of Elimination

There remain disagreements about the possibility and desirability of eliminating involuntary mental health interventions altogether (see W. Martin & Gurbai, 2019; Pūras & Gooding, 2019; Russo & Wooley, 2020). This compendium report will not engage with these debates, which have been well-covered elsewhere (see e.g. Gill, 2019; Gooding, 2017; Martin & Gurbai, 2019; Russo & Wooley, 2020; Sugiura et al., 2020; Szmukler, 2019). Instead, this compendium seeks to build upon the view that expanding *voluntary* options for support, and ramping up efforts to reduce and prevent coercion, can help to navigate a way through disagreements about the possibility of eliminating involuntary psychiatric interventions (McSherry, 2014; Ruck Keene, 2019). Focusing on practical examples that have reduced or eliminated the use of coercion can encourage practical action toward achieving the highest quality support for people experiencing mental health crises and psychosocial disability.

Scope

This compendium generally focuses on practices in formal mental health services in the COE Member States (for example, psychiatric wards or mobile mental health teams). However, there may be positive voluntary practices that occur *outside* of formal mental health services (for example, a peer-run respite centre, which may or may not receive funding from government health agencies). Further, there may be examples that combine both initiatives in formal healthcare services with broader social, economic and political change. For example, 'citizen psychiatry' practices in the French city of Lille seek to integrate community associations and local businesses into efforts to address social exclusion and isolation of people with mental health conditions and psychosocial disability (see below p.**Erreur ! Signet non défini.**). The compendium will aim to provide a range of examples from formal, informal, healthcare and non-healthcare contexts.

Designing the Research Compendium

In July 2020, the DH-BIO Secretariat distributed a questionnaire to member countries and stakeholder representatives requesting examples of 'good practices in mental health care'. The questionnaire asked about various features of the initiatives, and included the following questions:

- In which areas is the practice implemented (healthcare, employment, housing, training/education, social policies…)?
- If the practice is linked to healthcare, at what stage of the healthcare path is it implemented (general health care, admission, follow up…)?
- What is the aim of the practice?
- Does the practice address a specific situation (crisis situation, follow-up to hospitalisation, homelessness…)?

Other questions related to the scope of practice (national, regional or local), the individuals concerned, and the degree of service user involvement.

To read the questionnaire in full, see **Appendix A on p.**Erreur ! Signet non défini..

The answers to the questionnaires were provided to a consultant (Dr Piers Gooding). The materials were supplemented with reference to existing scholarly and 'grey' literature,[3] and compiled into the list found in Part II of this report. The consultant undertook some follow up inquiries with key individuals who were delegated as contact points for particular submissions. Submissions were stored and numbered (1-29) and are occasionally referenced throughout the report (e.g. 'Submission 17'). Some delegates submitted

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[3] 'Grey literature' refers to information produced at various levels of government, non-government, academia, business, industry and other areas of civil society, in electronic and print formats, in which commercial publishing is not the primary activity of the producing body.

multiple practices within the same country, which were additionally labelled from A to D (e.g., ‘Submission 17A’).

Limitations

Again, this collection does not claim to be exhaustive. It is meant as an initial step to highlight good practices within COE Member States, including those promoted by civil society organisations. Ideally, the collection will be iterative and can be refined and expanded over time.

The broad definition of ‘good practices’ used in this report brings benefits and downsides. One risk is that defining good practices broadly will mean practices may be included that do not, on balance, promote and protect people’s human rights. Another possibility is that programs that reduce coercion in a small way (for example, minor reductions in seclusion rates on a ward) provide a false sense that enough action is being taken overall. For a detailed analysis of community mental health services that employs a rights-based criteria and assesses compliance, see the WHO Guidance on Community Mental Health Services report (World Health Organization, 2021).

However, the broad scope used in this report also has benefits; it allows delegates and civil society stakeholders to submit a wide range of practices that they see as promoting rights and creating coercion-free care and support. This can provide policymakers and others with more options that are appropriate to their context—and such practices can be analysed in more depth against rights-based and other criteria. This broad approach also allows for the inclusion of innovative practices that have not been subject to formal, scholarly research—this is particularly important for small-scale practices developed and led by mental health service user groups and disabled people’s organisations, which might be excluded in a systematic review with a strict inclusion criteria.

II. GOOD PRACTICES FOR REDUCING AND PREVENTING COERCION IN MENTAL HEALTH SETTINGS IN THE COUNCIL OF EUROPE

Categorising Good Practices

Practices were provided for the following countries: Belgium, the Czech Republic, Finland, France, Germany, Greece, Italy, Iceland, Portugal, the United Kingdom, Norway, the Netherlands, Spain, Sweden, Switzerland, and elsewhere. One submission was provided by Mental Health Europe that contained multiple practices (Submission 27).

The practices have been arranged according to their **setting** and **aim.** The relevant areas that appeared in the good practices are:

- **Hospital-based practices** (11 practices);
- **'Community'-based or non-hospital practices** (8 practices); and
- **Hybrid practices** in which efforts were made to better integrate hospital- and non-hospital initiatives, acute and non-acute services (6 practices)
- **Other initiatives** toward reduction of coercion and promotion of voluntary practices, including advance planning mechanisms, peer support and the peer workforce, and training for mental health practitioners and others (6 practices)

Within each category, the practices are arranged in alphabetical order.

A. Hospital-Based Initiatives

The following hospital-based initiatives were submitted:

Basal Exposure Therapy (BET) combined with Complementary External Control (CER), Norway

Basal Exposure Therapy (BET) and Complementary External Regulation (CER) are Norwegian practices with a strong psychotherapeutic focus that are designed for people who do not find success with conventional treatments. BET involves a hospital ward where people are given 'an opportunity to expose themselves to their innermost fears in a safe, secure environment, rather than perpetuating and exacerbating phobic conditions through the continued excessive use of avoidant coping strategies' (Submission 17C). The practice is premised on the idea that symptoms of severe, complex mental health challenges may originate from an impending or pervasive fear response, which the person is unable to address. The condition reportedly 'manifests as a fear of disintegrating, of being engulfed by a total void or of being trapped forever in eternal pain' in what is described as an 'existential catastrophe anxiety' (Submission 17C) (see Heggdal, 2012).

Service users/patients are never treated without consent. However, some individuals are detained in the hospital ward under civil commitment legislation. In such cases, 'the aim of BET is to establish a working alliance with the service user, and on that basis terminate' involuntary status and proceed with the therapy with the person's informed consent (Submission 17C). The CER practice that occurs alongside BET, and which is discussed below, is designed explicitly to 'eliminate coercive measures from the care process' (Submission 17C).

A person can be admitted for BET inpatient treatment, if they have extensive prior treatment without notable and lasting effect, as well as 'severe psychosocial dysfunction.' There are six beds, and all service users have single bedroom. Inpatient care at the BET ward has a mean total duration of 3 months with a range of 1-4 months. However, length of inpatient stay is flexible and adapted to the needs of individual service users and based on practical circumstances. Normally, the treatment is offered within two stays. First, a short stay for approximately four weeks with emphasis on working-alliance and psychoeducation, and then a longer stay f–or 2-3 months working within the BET modality towards exposure.

Reportedly, there is 'in practice, no use of restraint measures' (Submission 17C). 'Shielding', defined as the confinement of patients to a single room or a separate unit/area inside the ward, accompanied by a member of staff, has been used on two occasions 'to protect life and health' between March 2018 and December 2020.

The primary intervention in BET is psychosocial and 'medication is auxiliary, or subservient to the therapeutic process' (Submission 17C). Service users are given the opportunity to taper from their medications. The rationale for tapering is that medications can 'prevent the person from accessing their inner experiences, and thereby also obstruct his or her opportunity to make use of exposure therapy' (Submission 17C) (see Hammer, Heggdal, Lillelien, Lilleby, & Fosse, 2018). During the weeks or months prior to admission, the BET team often initiates a dialogue about tapering medications with the informed consent of the service user (Hammer et al., 2018). Tapering or discontinuation is generally done very slowly, one drug at a time. The timeline and chronology are usually decided during a dialogue aimed at promoting autonomy and user participation. Some service users do not wish to taper their use of drugs.

CER is an approach initiated as soon as the person enters the 24/7 BET service. CER aims to facilitate and consolidate positive functional choices and actions, and to eliminate coercive measures from the care process (Heggdal, 2012). CER's primary strategy is 'under-regulation'; therapists interact with service users in a non-hierarchical manner, treating them as equals who are fully responsible for their own choices and actions (Heggdal, 2012). For example, the people admitted to the BET unit are free to leave the ward whenever they want (unless, on rare occasions, a person is detained involuntarily, as noted above). At the same time, they are held accountable for being on time for appointments (Heggdal et al., 2016). The BET team never reminds or tells people to take their medications or eat their meals. At all times, there is acknowledgment and recognition that the people using the services are capable of making their own decisions. They are, however, encouraged to notify staff members when they leave the unit and to be transparent about any plans they may have to leave.

If a service user harms him or herself while on the ward, the BET team will not impose any restrictive measures. Instead, follow-up will focus exclusively on providing the medical attention the person requires after the self-harm event (for example, getting stitches for any wounds). After addressing the person's medical needs, the under-regulated approach is continued.

Over the past two years, there has been only one occasion when the safety and well-being of other service users or therapists were threatened at the BET unit. Good communication and verbal de-escalation are used to address conflict, and the person may be asked to leave the unit or to consider referral to another unit. At the BET unit, service users are invited to 'take ownership of their problems as the starting point for a dialogue with BET therapists to address the challenges they face' (Submission 17C).

In situations in which a service user's actions present an acute threat to life and/or health, and no efforts are made to initiate or maintain dialogue, the service team, together with the service user, may agree on a strategy to introduce an 'over-regulation' phase. Over-regulation is a coordinated approach whereby the service user is under-stimulated, i.e., everything is slowed down (Heggdal, 2012). Therapists speak slowly and pause for longer than usual before responding, and the service user is met in ways that 'do not support and maintain dysfunctional behavior and marginalizing interactions' (Submission 17C). By creating a low-stimulation environment, the aim of 'over-regulation' is to 'allow the service user to experience a situation without any of the dependency associated with being ‘regulated’ by health care workers’ and attention is given to ensuring therapists are available when a person wishes to initiate dialogue to hear what the user thinks and suggests (Hammer, Fosse, Lyngstad, Møller, & Heggdal, 2016; Heggdal, 2012; Heggdal et al., 2016).

In principle, staff may alternate between under-regulation and over-regulation to support the service users and facilitate progress and improvement. However, over-regulation is ‘very rarely used by the service’ (Submission 17C). Since the start of the development of the CER strategy in 2006 it has been necessary to deploy this ‘control element’ on ‘no more than four or five occasions’. In each case, the service user’s life and health were at risk in acute situations, and the BET team had to take over some control to ‘prevent the person from taking his/her own life or inflicting severe, irreversible physical injury’. However, ‘well-coordinated under-regulation is the primary means used by the service to address suicidal and self-harming actions’ (Submission 17C).

The successful application of the CER strategy reportedly ‘secures and strengthens the person’s autonomy, ensuring that the inpatient stay can be used to address mental health challenges rather than dealing with acute crises’ (Submission 17C) (See also Heggdal et al., 2016).

Guidelines on Prevention of Coercion and Therapy for Aggressive Behaviour, Germany

In 2018, an expert group of the German Association for Psychiatry, Psychotherapy and Psychosomatics (DGPPN) published guidelines on how to deal with ‘coercion and violence’ in adult psychiatric services in Germany. The DGPPN is the largest scientific medical association focussing on mental health in Germany. The Guidelines are titled, *Prevention of Coercion: Prevention and Therapy of Aggressive Behavior in Adults [S3 Leitlinie: Verhinderung von Zwang: Prävention und Therapie aggressiven Verhaltens bei Erwachsene]*.[4] (hereafter ‘the Guidelines’)

The Guidelines, in part, aim to prevent and reduce coercive measures that occur *in response to aggressive behaviour in adults*. (They do not address the issue of coercive measures against people who are self-harming and/or who do not act violently). The Guidelines are premised on the view that some forms of coercion in mental health settings are unavoidable in some cases, which requires that ‘human rights and dignity must be respected and legal rules strictly followed’ in accordance with standard principles of least restrictive and best interests interventions (Submission 3C).

The guidelines concern healthcare settings; particularly psychiatric wards and ‘community-based mental health services’. The Guidelines include training and education of staff, and information for service users and those subject to involuntary interventions, their relatives as well as for policy makers.

The expert group behind the Guidelines was interdisciplinary and consisted of service users, family members, health professionals including physicians, psychologists, nurses and caregivers, as well as scientists and legal experts. Tilman Steinert and colleagues (2020) summarise the content of the Guidelines as follows:

> Measures which were effective in clinical trials were staff educational programs and regular training of the employees, enrichment of the ward environment, structured risk assessment and early interventions [e.g., Brøset Violence Checklist], individualized treatment planning, especially advanced care planning for patients who already experienced violence and coercion, as well as debriefing techniques. Interventions were especially helpful if they were combined with each other, incorporated organizational changes and were endorsed by the management of the clinic. Therefore, several complex interventions consisting of different measures were developed in the past few years, e.g., internationally Six Core Strategies and

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[4] The German-language Guidelines are available here: <https://www.awmf.org/uploads/tx_szleitlinien/038-022l_S3_Verhinderung-von-Zwang-Praevention-Therapie-aggressiven-Verhaltens_2018-11.pdf> [accessed 20 January 2021].

Safewards and in Germany Weddinger Modell. While the Six Core Strategies include top-down-elements focusing on the organization of a psychiatric ward or clinic, Safewards emphasizes the communication among patients and staff on a specific ward. The Weddinger Modell, developed in 2010 in Berlin, Germany, is an innovative model of psychiatric care focusing on recovery, participation, supported decision-making and the prevention of coercive measures on psychiatric wards [discussed in this compendium at p.48].

After the publication of the Guidelines, an expert group convened and derived 12 recommendations from the Guidelines. The recommendations were established via a consensus and rating method involving 23 external expert groups comprising of service users, family members and professionals. The recommendations were adopted in November 2018 by the DGPPN and are listed below.

12 recommendations to implement the DGPPN Guidelines:

1. Implement a standardised recording of coercive measures and aggressive incidents with the possibility of regular evaluation at ward level.

2. Implement internal standards adapted to the guidelines regarding the indication, initiation, review, documentation, and debriefing of coercive measures, or review existing standards, as appropriate.

3. Hold a monthly team meeting, chaired by the department or ward manager, to analyze data on coercive measures and aggressive incidents and discuss the background.

4. Implement a training plan for all employees with patient contact in de-escalation/aggression management and ensure that all employees receive training at least once every two years.

5. Ensure that any coercive measures restricting or depriving freedom (restraint, seclusion) are accompanied by continuous observation and personal care.

6. Ensure that debriefings after coercive measures with the affected patients take place and are documented.

7. Employ or involve peers on the ward.

8. Create an action plan for the aggression-reducing design of the spatial environment on the ward and review it annually.

9. Introduce a risk assessment with the Brøset Violence Checklist (BVC) or another instrument for all patients at risk according to clinical assessment and make sure that clinical consequences result. For scores above BVC 2, e.g., the patient is contacted for de-escalation within half an hour, usually by at least two persons.

10. During debriefing after a coercive measure, recommend all patients to draw up a joint crisis plan for the prevention of future coercion.

11. Introduce measures to ensure guideline-based pharmacotherapy [based on the guideline with regard to aggressive behavior, but also the disorder-specific other guidelines (“guideline-based treatment of the underlying disease”)], and, e.g., monthly random check or hold regular meetings during rounds.

12. Introduce complex interventions for reducing coercion that can be operationalised into individual modules (e.g., Safewards, Weddinger Model, Six Core Strategies).

The recommendations are not, strictly speaking, evidence-based; research is required to establish their feasibility and efficacy in reducing coercion.

As a first step, Steinert and colleagues tested whether these recommendations are feasible in a pilot study. Once feasibility was established, a randomised control trial was undertaken described as the Implementation of Guidelines on Prevention of Coercion and Violence in Psychiatry (the PreVCo study) which included 52 psychiatric admission wards, and is ongoing at the time of writing (Steinert et al., 2020). Management at each psychiatric ward will be invited to choose three of the recommended interventions that appeared most relevant and desirable to their service. A randomised controlled trial will be conducted ‘stratified by the amount of coercive measures and implemented aspects of the guidelines’ (Steinert et al., 2020, p.3).

Steinert and colleagues (2020, p.3) note that ‘[t]here is good evidence for all 12 individual elements and a high consensus among 23 expert groups, including professionals, patients, and their relatives who were involved in the development of the guidelines.’ The recommendations were only established by the expert groups if the recommendation was *measurable* in terms of the degree of implementation. Reportedly, all psychiatric hospitals in Germany are likely to have implemented at least some interventions or strategies to reduce coercion but Steinert and colleagues report that ‘no clinic has fully implemented all recommendations suggested in the guidelines’ (Steinert et al., 2020 p.2).

The Guidelines and recommendations have been disseminated in several ways, including via:

- free online access to the guidelines;
- the creation of a short, practice-oriented version of the guideline and distribution of free copies to all psychiatrists in Germany;
- publications regarding the Guidelines in scientific journals;
- training of implementation consultants;
- funding of scientific implementation by DGPPN and government/public funding bodies.

The recommendations incorporated the '**Weddinger Modell**', which refers to a 'recovery-oriented care concept' for improving acute psychiatric care, that appears to have had a tangible impact in smallscale trials on reducing a person's chances of being subject to mechanical restraints and seclusion (Czernin et al., 2020 p.242). (The Weddinger Modell is discussed in this report at p.48).

Finally, the Guidelines are 'S3 guidelines', indicating that they hold the 'highest methodological quality of guidelines developed in Germany', and that 'they are evidence and consensus based taking into account all available scientific literature and the opinion of acknowledged specialists in the field' (Steinert et al., 2020 p.2). This process encompassed 4 systematic reviews and a formalised consensus process, assisted by a working group of scientific medical societies (the 'AWMF'). In this case, 22 societies in the field consented to the Guidelines, and one patient organisation did not. A comprehensive methods-report is available (in German) on the creation of the Guidelines (see Bechdolf et al, 2019).

High and Intensive Care Units, The Netherlands

As part of a national policy to reduce the use of seclusion in the Netherlands, High and Intensive Care (HIC) Units were developed. HIC Units are acute admission wards focusing on ‘restoring and maintaining contact and crisis prevention’ (Submission 27). The Units require a multidisciplinary team (psychiatrists, nurses, psychologists, service users) of a sufficient size, who must be specifically trained in crisis management, handling aggression and suicidal behaviour. One aim of the HIC Units is to reduce the use of seclusion and reduce the number of beds devoted to mental health care (Submission 27). The Units were developed in 2013 by a multidisciplinary group of Dutch experts, including service users and family representatives (Submission 27).

A specific architectural environment is cultivated that includes one-person bedrooms, large and light living rooms and the availability of outdoor spaces. The Units are designed to offer a welcoming and healing environment (Submission 27).

The techniques used include methods such as a careful assessment of the risk of escalation and setting up an individual crisis plan in consultation with the person concerned and their relatives. This plan describes how escalation can be prevented. In the event that stress and anxiety arise, a person is never left alone. Collaboration between staff members, the outpatient team, users and relatives is central. In addition, frequent risk assessment enables staff members to act proactively and prevent escalation (Submission 27). Reportedly, the initiative has led to an overall reduction of seclusion, but seclusion is still being used as a practice.

According to Mental Health Europe (Mental Health Europe, 2019, pp.3-4):

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

(For more information, see Mental Health Europe, 2019 pp.3-4; van Melle et al., 2019)

No Force First,
United Kingdom

The 'No Force First' initiative aims to change ward cultures from a focus on containment to one of recovery. The ultimate aim is to create coercion-free environments. This approach, which began in th United States, is being adopted by some UK based mental health trusts (Submission 27). The underlying idea is that 'there is no such thing as a forced recovery'.

The 'No Force First' policy aims to create coercion-free environments through the following initiatives:

- promoting collaboration between users and staff members to make wards more recovery focused;
- developing training programmes in collaboration with users and promoting training in de-escalation techniques;
- developing a cooperative culture, rather than a restrictive culture, to reduce incidents of aggression, self-harm and physical intervention;
- developing a deeper understanding of users in order to see their experiences in a trauma-informed, empathetic manner, and working together to build resilience;
- including the experiences of service users and engaging in co-production work;
- awareness-raising among users and relatives;
- recording of data on the use of coercion and immediate analysis after an incident (Submission 27).

The UK Mersey Care NHS Foundation Trust used the 'No Force First' policy along with other initiatives and recorded a reduction of approximately 60% in the use of physical interventions during the first two years of implementation (Submission 27). The approach was then implemented across all wards of the trust and, between April 2016 and August 2017, there was a 37% reduction in the use of restraint, as well as a reduction in staff sick leave (which led to financial savings as a result of less sickness-related absence). The Trust now has a strong culture of collaborative empowerment where staff and service users work together to reduce conflict and promote safety and recovery. Looking to the future, members of staff are encouraged to openly share learning from events that do not go as planned, and develop creative solutions. The focus is not around blaming individuals, but instead looking at the system and how it contributed to the event and could be improved (Submission 27).

According to the Mersey Care Trust website, there are three levels on which change must take place to promote No Force First care:

Organisational – the Board must have the serious ambition to make change and turn ideas into reality despite opposition or conflicting views from peers

Professional – clinicians and GPs must confront their own practices and practices of others, a difficult challenge to change day to day methods and gently change the system without confrontation

Experts by experience – they have given so much to help co-produce practice, having the courage to tell their stories and, in some cases, having the courage to stand up and address and influence large groups of people. (See https://www.merseycare.nhs.uk/about-us/striving-for-perfect-care/no-force-first/ [accessed 12/04/2021]).

The website reports that '[b]oth staff and patients have shown great courage in accepting No Force First and making Mersey Care a better caring environment'. (See https://www.merseycare.nhs.uk/about-us/striving-for-perfect-care/no-force-first/ [accessed 12/04/2021]).

‘Open Door Policy’, Internationally

‘Open door policy’ refers to a policy of maintaining open doors in mental health settings and particularly hospital-based settings that otherwise would be ‘closed’ or ‘locked’. Germany appears to have the most advanced use and evaluation of open door policies in acute psychiatric settings in high-income countries (Gooding et al., 2020, p.33). A trial has also occurred in Switzerland, at the Universitäre Psychiatrische Kliniken (UPK), and in the UK, efforts have been undertaken to canvas the views of stakeholders on open door policies (Bowers et al., 2010).

Other services discussed in this report are likely to practice some form of ‘open door policy’, even as they may not describe it this way (see, for example, the Norwegian BET initiative above). In **Italy**, for example, Roberto Mezzina (2014, p.440) reports on the outcomes of an *‘open door...* no restraint system of care for recovery and citizenship' in the city of Trieste, Italy. The Trieste model is discussed below in the Hybrid Approaches Section. Other mental health crisis services not included in this report may also practice some form of an open-door approach.

A compilation of research on the use of an ‘open door policy’ or ‘open acute psychiatry’ in mental healthcare settings in Germany was submitted to the DH-BIO. This included material from two implementation sites (UPK in Basel and Charité, Universitätsmedizin Berlin) as well as supplementary materials concerning its use in 21 German hospitals (Huber et al., 2016a; see also Cibis et al., 2017; Huber et al., 2016b; Lang et al., 2016; Lang & Heinz, 2010; Schneeberger et al., 2017).

Christian Huber and colleagues (2016a, 2016b), and Andres Schneeberger and colleagues (2017) undertook two largescale studies of service data concerning 349,574 admissions to 21 German psychiatric inpatient hospitals from 1998 to 2012. Huber and colleagues (2016a) sought to compare hospitals *with* and *without* ‘locked wards’. They reported that treatment on ‘open wards’ was associated with a *decreased* probability of:

- suicide attempts,
- absconding with return, and
- and absconding without return.

Treatment on an open ward was not associated with a decreased probability of death by suicide (Huber et al, 2016a). In a second study using the same dataset, Schneeberger and colleagues measured the effects of open versus locked door policies against rates of ‘aggressive incidents’ and restraint/seclusion and found that both aggressive behavior and ‘[r]estraint or seclusion during treatment [were] less likely in hospitals with an open door policy’ (Schneeberger et al., 2017).

Some concerns have been raised that the term ‘open door policy’ was classified arbitrarily in the data set (Pollmächer and Steinert, 2016). Huber and colleagues (2016b. p.1103) refute this claim, and conclude as follows:

> With respect to patient safety and coercive measures, results of previous studies have observed that opening formerly locked wards reduces violence and coercion. This reduction does not happen at the expense of placing aggressive patients on other still locked wards, and is not compensated by an increase of coercive measures elsewhere. In our experience, a change in professional attitudes towards patients that promote personal contact and de-escalation is a key component of open door policies. (Huber et al., 2016b. p.1104) (original citations removed)

It is outside the scope of this compendium to engage with debates about German open door policies, though they should be considered by actors seeking to replicate the practice.

Another German study published in 2017, by Mara-Lena Cibis and colleagues (2017), compared the impacts on an acute psychiatric hospital ward of phases in which the ward was ‘closed’ and ‘90% of daytime opened’. The authors observed that during the phase of opened doors there were ‘significantly reduced aggressive assaults ($p < 0,001$) and coercive medication ($p = 0,006$) compared to the closed setting, while the absconding rate did not change ($p = 0,20$)’ (Cibis et al., 2017, p.141). The authors noted a limitation that the ‘retrospective non-experimental design’ means that ‘no causal interpretations can be drawn’ but concluded that the results support the claim that open door policies are ‘associated with reduction of aggressive assaults and coercive medication without increasing absconding rates’ (Cibis et al., 2017, p.141).

The research on open door policies suggests that factors which facilitated its implementation include strong psychotherapeutic skills among staff, highly motivated and well-staffed nursing personnel, and the commitment of ward and hospital leadership, who must take responsibility for the initiative.

Service users report greater satisfaction with the practice. The initiative, according to the submission, results in decreased appeals against treatment, decreased discharges against medical advice, decreased coercive measures, enhanced ward atmosphere, and decreased transfer of patients.

Open Dialogue in a High Security Psychiatric Ward: 'Reflecting Processes in the Care of Persons with Severe Mental Disorders', Norway

The Department of Specialised Psychiatry at Akershus University Hospital, which is a high security psychiatric ward in Norway, has undertaken a program based on the 'Open Dialogues' practice. (Open Dialogues is discussed more fully under the 'Community-Based Initiatives' section of this compendium at p. 52).

Open Dialogues is traditionally undertaken in people's homes as a form of psychotherapeutic community outreach. It is based on the principle that all involved parties in the person's care and treatment, and most importantly, the person herself/himself, are given an opportunity to give their opinion on what they believe is the best treatment and care under the circumstances. This dialogue occurs before support and treatment decisions are made.

Unusually, the Akershus University Hospital use Open Dialogue techniques in a specialised secure ward in a psychiatric hospital—making it among the first efforts to apply Open Dialogue in a secure psychiatric facility.

The initiative occurs as follows. 'Reflecting Processes' or 'Talks' take place in the form of planned discussions between the person and staff, where one staff member talks with the person on a topic relevant to her/his care and treatment. Either the patient or staff can raise topics. Other staff members (or other persons important to the care of the main person) who are present, are only listening. At certain points the talk between the staff member and the patient are paused, and the other persons present are encouraged to present their reflections and thoughts relevant to the actual problem or topic discussed while listening. This step invites a broader perspective and discussion about the apparent needs of the person and the actions needed to adjust support according to the person's preferences.

The meetings last as long as the person wants, and decisions on her/his treatment and care are made while all persons taking part in the meeting are present. Thus, treatment staff neither make treatment decision nor discuss them without the person being present. The frequency and schedule of meetings is also decided with everyone present.

Open dialogue and reflective talks provide a way of promoting service users' and their networks involvement and inclusion in support and treatment planning. Even if the ward is a locked high security psychiatric ward, and patients are subjected to regime related restrictions, the open dialogue and reflective talks approach reportedly goes some way to mitigating the coercive nature of a high security ward (Submission 17D).

Reportedly, the program has had success in helping to end the use of any coercive measures for individuals who had previously been subjected to high amounts of coercion in other closed psychiatric institutions before their transfer to the specialised unit at Akershus University Hospital (Submission 17D).

Case studies that highlight the impact of the practice, include the following:

> A childhood trauma survivor who had a history of extreme self-harm as well as psychiatric hospitalisation, which had involved mechanical restraint and continuous monitoring for two years prior to transfer to Akershus. He was then engaged in Open Dialogue and Reflecting Talks treatment, was never subject to mechanical restraint during his inpatient stay, and was discharged into the community after approximately one year. The person lives in his own flat and receives support from community health- and social care services according to his preferences.

A person with a long history of violence and aggression had, for ten years, been subject to seclusion, use of restraint measures and other restrictive regimes. Following her transfer to the high security ward at Akershus University Hospital the open dialogue and reflective talks approach was initiated. Reportedly '[d]uring the one and a half year inpatient stay, mechanical restraint measures was used 4-5 times for very short periods, which was a dramatic reduction compared to the application of such use at the previous hospital'. The person was subsequently discharged to her own flat in the community, and took part in follow up reflecting talks meetings as an outpatient.

The two cases suggest 'it is possible to rehabilitate persons that are considered to be chronic cases with a long history of violence and extreme self-harm… They had both been long-term patients in closed psychiatric wards, and had been subjected to coercive measure over long periods' (Submission 17D).

Systematic data collection to assess readmissions rates and circumstances related to readmission is currently underway (see also Jacobsen, 2018; von Peter et al., 2019).

Reducing mechanical restraint and seclusion in acute mental health inpatient wards

Across Europe, it is lawful for individuals to be secluded and/or restrained in mental health services and other settings to control or manage their behaviour. Attempts have been made by governments, mental health services and others to reduce and even eliminate the use of restraint and seclusion (see eg Gooding et al., 2020; Hirsch & Steinert, 2019). Two practices were submitted for inclusion in this compendium.

Lovisenberg diaconal hospital, Clinic for Mental Health – Norway

A concerted effort was undertaken at a major hospital in Oslo, Norway, to reduce the use of mechanical restraint in a psychiatric ward; the initiative led to an 85% reduction in the use of mechanical restraints during the five-year study period (2012-17) (Submission 17A). The hospital, Lovisenberg diaconal hospital, Clinic for Mental Health, is in an area facing significant socio-economic disadvantage.

The project focused on workforce professional development, involving targeted interventions aimed at the health care professionals on the ward. The aim was to improve the staff competence to handle episodes involving aggression through training and guidelines. The intervention had a clear and ambitious goal of reducing the use of mechanical restraint. Elements of the initiative included:

- Removing bed with visible belts used for mechanical restraints from the ward;
- Visualising days of non-mechanical restraint use on a calendar for staff on a daily basis;
- Implementing systematic use of violence assessment of all patients (there exist several tools for this purpose) placing an emphasis on finding the reason for the aggression;
- Implementing standard routine for information to new patients about the ward's attitudes about aggression and conflict;
- Changing physical environment and staff attitude to emphasise that the person has the opportunity to get out of tense situations and not feel trapped, for example by being offered a blanket on the couch as opposed to being ordered/pushed to go to room if sleepy;
- Facilitate and stimulate principles that promote a 'learning organisation' process. The newly established practice is consistent with contemporary psychological theories of aggression;
- Ward-rules were revised and reduced as much as possible. Some of the existing ward-rules were considered provocative by some patients, and so on.

The project addressed acute admissions sessions and the initial 40 hours on the acute admissions ward. Previous experience shows that most episodes involving the use of mechanical restraints occur during the first six hours after admission to the ward. This supports the importance of planning an intervention that address these first hours after an admission, to be able to prevent the use of mechanical restraints.

Again, in the five years after the initiative began, rates of mechanical restraint dropped 85% (Submission 17A). During this period, there was no registered a rise in injures to staff or sick leave. Mean duration of physical holding was eight minutes for female patients and 13 minutes for male patients. The targeted intervention is now implemented in regular treatment, and the results have reportedly shown stability over time. Health authorities in part of Norway (HelseSørØst) in which the trial took place have decided to implement the principles from the project as regular practice in all the psychiatric hospitals in the region. The practice is now made mandatory by the health authorities and auditing will be undertaken.

The initiative was reportedly cost-neutral, as it did not require more staff resources or extra cost. Service users were reportedly involved in developing the tool for assessing aggressiveness, and service user organisations have expressed support for the project (Submission 17A).

Factors which facilitated the implementation of the practice include: management ownership over the project; involvement of all staff in the project; local development; the simplicity of initiatives; staff being held responsible for the interaction with patients prior to the emergence of conflict; and so on. Barriers to implementation included: the large scale and complexity of hospitals (making it challenging to introduce new practices); the challenge of maintaining new routines; initial reluctance of some staff who criticised the project and claimed that it was not justifiable and professional and may lead to dangerous situations; maintaining good practice during periods with shortage of time and resources, and so on. (For more information see Halvorsen, 2016; Vel et al., 2016).

Six Core Strategies for Reducing Seclusion and Restraint use – Spain and Internationally

In 2017 in Andalusia, Spain, an initiative was introduced to adult psychiatric services based on the ‘Six Core Strategies for Reducing Seclusion and Restraint use’. The result was a reported 15% reduction in the total time mechanical restraint was imposed on service users throughout Andalusia (Submission 9). Andalusia is a large region of Spain (pop. 8.4m) with 20 acute mental health inpatient wards. In 2011, a working group on Human Rights and Mental Health was created under the Regional Mental Health Office of the Andalusian Health Service. The group developed the ‘Comprehensive Mental Health Plan of Andalusia’ which partly sought to apply the CRPD to the daily practices of mental health services. (Other practices that form part of this plan are discussed at p.**Erreur ! Signet non défini.**).

The ‘Six Core Strategies’ program, which Andalusian health authorities drew upon, has been used in coercion reduction/prevention initiatives in several countries. The Strategies were originally set out in 2005 by the US National Technical Assistance Center (2005), and are set out below.

Six Core Strategies to Reduce the Use of Seclusion and Restraint
(US National Technical Assistance Center, 2005)

1. 'Leadership towards organizational change'— articulating a philosophy of care that embraces seclusion and restraint reduction;
2. 'Using data to inform practice' — using data in an empirical, 'non-punitive' way to examine and monitor patterns of seclusion and restraint use;
3. 'Workforce' — developing procedures, practices and training that are based on knowledge and principles of mental health recovery;
4. 'Use of seclusion and restraint reduction tools' — using assessments and resources to individualise aggression prevention;
5. 'Consumer roles in inpatient settings' — including consumers, carers and advocates in seclusion and restraint reduction initiatives; and
6. 'Debriefing techniques' — conducting an analysis of why seclusion and restraint occurred and evaluating the impacts of these practices on individuals with lived experience.

These strategies have been used in services in the United States, Canada, Spain, Australia and New Zealand and are subject to a growing body of research (for more information see Melbourne Social Equity Institute, 2014).

In Andalusia, the reduction initiative was carried out in the following phases:

1. **Leadership and formation of a core group:** A core group was formed in May 2015 and there were periodic face-to-face meetings with the nursing managers and clinical coordinators of the 20 acute mental health inpatient wards.
2. **Analysis of the situation, co-ordination and feedback:** A virtual platform was created for communication between the core group and the leaders of the wards. The group shared information on the strategies as well as experiences from the wards themselves, so as to integrate local developments on reduction of mechanical restraint, and so on.

3. **Awareness training of the heads of the wards:** Nursing managers and clinical coordinators of the 20 acute mental health inpatient wards received a one-day awareness training in 2016.

4. **Unified record of mechanical restraint in Andalusia**: The core group designed a consistent record for all the episodes of mechanical restraint in all Andalusian hospitalisation wards, for monitoring purposes. This unified record was based on the mechanical restraint records of the 20 wards. They defined key indicators for ongoing evaluation. The database was initiated in July 2016, and since then there has been an ongoing evaluation of the data by the Regional Mental Health Office of the Andalusian Health Service, with active participation of the local clinical leaders.

5. **Design of two training courses developed locally in each ward.** The materials were made available to the heads of the wards through the virtual platform.
   - A course with a duration of 7 hours was designed in 2017 with the aim of reducing the use of mechanical restraint. The course was initiated in April 2018.
   - In 2018, a training course of 7 hour was designed, aimed at reviewing mechanical restraint episodes, and identifying how they could have been avoided. The course was focused on reflecting on the episodes conducted in the ward in a concrete period of time, and learning to analyse in detail some mechanical restraint episodes among professionals, and to analyse them with service users. The course was initiated in 2019.

The Working Group monitored the percentage of episodes of mechanical restraint, percentage of different persons in mechanical restraint, total number of hours, average duration, bed occupation of the ward at the moment of the mechanical restraint episode, clinical diagnosis, motive and state of the person, sex, and origin of the person (e.g. Spain, Europe, others). They also collected data of the impact of the training courses on staff knowledge.

Between the years of 2017-19, across the whole of Andalusia, the data suggested: a 15% reduction in total hours of mechanical restraint in the period 2017-2019 but with important differences between wards.

The indicators of reduction comprised of the number of episodes, number of different persons and average duration of restraint, all analysed at hospital level.

28 training courses were conducted in all wards in 2018, and 15 courses in 2019. In total, 615 professionals of all categories participated, above all nursing and psychiatry. Global satisfaction with the course was very high (in a scale from 1 to 10 the average rating was 8.7 in 2018 and 9 in 2019).

The involvement of the Andalusian School of Public Health was reportedly key to the initiative, given its expertise on human rights, the CRPD, implementation methodologies, and given its history of work with mental health services of the Andalusian Health Service. Although the Andalusian School of Public Health is part of the Andalusian public health system, it is somewhat independent and does not have a strong clinical focus, which was reportedly 'important for questioning mechanical restraint from a Human Rights approach' (Submission 9). Other helpful factors included: involvement of local clinical leaders; the inclusion of restraint reduction as an objective in the broader policy or Mental Health Plan of Andalusia; the capacity for good quality data collection to highlight the large differences between similar wards, which highlighted 'the enormous impact of ward culture on rates of mechanical restraint'; and the 'critical public opinion regarding mechanical restraint, and the need [for] elimination of this practice, especially by the service user's movement' (Submission 9).

Reported barriers included negative culture on wards, and the competencies (knowledge, skills and attitudes) of the professionals. There were considerable differences between the 20 wards, including different 'starting points' in terms of the existing rates of restraint-use. However, the sharing of positive practices across wards has reportedly been a valuable gain. Reportedly, there is also a lack of clear legislation on mechanical restraint in Spain, and the CPRD needs be better integrated into legislation.

Concerns were raised in the submission that several other prominent initiatives for reducing coercive practices were not occurring across Andalusia: such as advance planning, 'assertive community treatment, home hospitalisation and other alternatives that could prevent hospitalisations, and therefore the risk of receiving coercive measures like mechanical restraint'. Reportedly, the working group is seeking to ensure more state resources for these other initiatives.

Safewards

The ‘Safewards’ model is a program that aims to reduce the restraint and seclusion of people on psychiatric wards, as well as reducing conflict between service users and staff (Submission 25). The model provides staff with practices and concepts to help improve the culture of hospital settings, with attention to staff interactions with service users and family/friends, as well and the physical characteristics of wards.

According to one health department that is implementing Safewards, the objectives of the program are:

- Better relationships between staff and patients;
- Increased safety, reduced coercion;
- Less time wasted on containment, more invested in engagement;
- Fewer assaults, fewer injuries;
- An environment that is peaceful and conducive to supporting people in their journey of recovery. (See https://metrosouth.health.qld.gov.au/safewards [accessed 8/4/2021]).

It further states that:

> The Safewards program model proposes that conflict within a ward can arise when a consumer is faced with situations that increase their emotional distress or 'flash points'. The Safewards approach focusses on what staff can do before the consumer reaches a flashpoint by being aware of potential triggers and determining the best method to reduce the impact or best containment method for the situation. (See https://metrosouth.health.qld.gov.au/safewards [accessed 8/4/2021]).
>
> The model helps us to work together with consumers to reduce conflict and containment as much as possible and make the inpatient units a more therapeutic and peaceful place.

There are 10 ‘Safewards Interventions’ under the model. These are:

1. **Discharge Messages** – prior to discharge, patients are encouraged to write a positive and helpful message that is then placed on a message board/discharge tree. These messages can be viewed by visitors for reassurance and to increase feelings of hope.

2. **Mutual Help Meetings** – starting the day in partnership, facilitated by staff, patients are encouraged to identify ways of helping and supporting each other during the day.

3. **Clear Mutual Expectations** – our expectations of each other whilst on the inpatient unit (patients and staff).

4. **Calm Down Methods** – creating an environment and the opportunity for low stimulus and serene time out. A box of equipment is offered before considering PRN medication.

5. **Talk Down (De-escalation)** – a drawing together of the range of de-escalation techniques on a poster that is displayed in staff areas. Staff are given in-service follow-up on these techniques on a regular basis.

6. **Reassurance** – following an anxiety provoking incident on the inpatient unit, patients are followed up either in small groups or alone to give reassurance and understanding of what happened. Staff maintain a higher visibility post-incident so patients feel more safe and secure.

7. **Positive Words** – during each handover, staff make an effort to say something positive about each patient and/or identify contributing factors to difficult behaviours.

8. **Bad News mitigation** – raising staff awareness during handovers and ward rounds, of potential 'bad news' events that patients may experience. Staff then follow-up by conveying the 'bad news' sympathetically to the patient and offering support.

9. **Soft Words** – statements that are 1-2 sentences long are provided to staff on how to speak to patients in any of the three primary flashpoints: saying no; asking to stop behaviour; and asking patients to do something they don’t want to do.

10. **Know each other** – each staff member provides non-controversial information about themselves that they are happy to be communicated to the patients. Patients are also encouraged to share similar information about themselves. (See https://metrosouth.health.qld.gov.au/safewards [accessed 8/4/2021]).

Factors which have facilitated the implementation of the practice, include support from senior and local managers, as well as people with lived experience of mental health conditions or psychosocial disabilities as champions to promote implementation (Submission 25). Barriers include lack of support from managers and local-level figures, scarce resources, need for translation of Safewards material to local languages, support from managers across the mental health sector (from directors to ward managers), the challenge of adjusting the Safewards interventions to the specific setting, and the challenge of applying the practices in aged care settings (Submission 25).

Len Bowers and colleagues undertook a cluster randomised control of the practice in 31 randomly chosen wards at 15 randomly chosen hospitals in the UK, and found that simple interventions aiming to improve staff relationships with patients can reduce the frequency of conflict and coercion (Bowers et al., 2015). Research also suggests the initiative creates financial benefits by diverting resources away from conflict and coercion (Bowers, n.d.).

For more information, the Safewards homepage provides advice on implementation, outlines supporting evidence, and offers materials translated from English to Spanish, German, Danish, Polish, Finish, Turkish, and Czech (see www.safewards.net [accessed 8/4/2021]).

Weddinger Modell

The Weddinger Modell, developed in 2010 in Berlin, is a model of psychiatric care for acute settings that focuses on recovery, participation, supported decision-making and the prevention of coercive measures on psychiatric wards (Submission 29). There is some evidence that the model decreases an individual's likelihood of being subject to coercive measures and reduces their average length of hospitalisation; it also reportedly enhances ward atmosphere. The Weddinger Model is a cost-neutral initiative that re-orients care away from traditional professional hierarchies in which treatment is 'done to' the relevant person. Instead, treatment decisions are made in active discussion with the person along with informal supporters whom the person wishes to involve. One key aim is to increase the transparency and accountability to the individual about the services they receive. The model aims to support the individual with assistance that is tailored to her or his circumstances.

A study by Czernin and colleagues (2020) compared two groups of service users, one treated according to the Weddinger Modell (intervention group; *n*=122) and the other one conventionally (control group; *n*=235). The results showed a significant reduction of the maximum frequency of restraint events as well as the duration of seclusion incidents in the group of patients treated according to the Weddinger Modell. The authors concluded that the implementation of the Weddinger Modell and similar treatment concepts in inpatient psychiatric setting can help reduce coercion (Czernin et al., 2020).

Further information on the Weddinger Modell is also available in a report by Mahler et al (2014).

Workbook for Hospitals and Wards to Reduce Coercion and Increase Occupational and Patient Safety: Combining Six Core Strategies and Safewards, Finland

In 2016, the Finnish National Institute for Health and Welfare published a working paper to help ‘hospitals and wards providing involuntary psychiatric care to reduce the use of coercion against patients and to increase occupational and patient safety’ (Makkonen et al., 2016, p.6). The Finnish language workbook outlines ways to ensure the ‘patient's sovereignty is respected as much as possible’ within the law and includes ‘operating models for the prevention of coercive measures, based on research evidence and solid practical experience’ (Makkonen et al., 2016, p.6). The practices are: the Six Core Strategies (discussed above), the ‘application of psychiatric patient intent, and assessment methods of violence risk,’ methods of preventing seclusion and restraint, and the Safewards model.

According to the authors, ‘[a]ll levels of psychiatric care and treatment systems play an important role in reducing coercive measures’ (Makkonen et al., 2016, p.6). Further:

> The workbook describes the importance of versatile outpatient care in reducing coercive measures. The expertise and attitudes of hospital staff in addition to the care culture and space solutions are in a major role in reducing coercive measures and increasing safety. The workbook presents concrete solutions to improve staff expertise and to promote the application of a care culture that reduces the need for coercion. The photos show how the minimalistic environment of the isolation room has been made more humane at relatively low cost. Based on the stories of people who have been involved with coercion, readers have a chance of getting some idea of how patients subjected to it feel. Coercion should not be reduced at the expense of occupational and patient safety. Both of these viewpoints are described in the last chapter. Reducing coercion is a continuous process, and hopefully this workbook will have a sequel in the form of a cookbook-style guide in reducing coercion.

No materials concerning the success of the initiative, or the relative rates of coercion before and after the publication of the workbook were identified.

B. Community-Based Initiatives

‘Community’ here effectively refers to non-hospital initiatives, or initiatives that are not taking place in larger, institutional facilities. The following ‘community’-based initiatives were submitted:

Community mental health initiative
Novara, Italy

In the Northern Italian city of Novara, a mobile support program was developed by the South Unit Area to assist people in mental health crisis in their own home, including those who have been just discharged from a psychiatric ward. The program has reportedly produced relatively low rates of involuntary admissions compared to other Italian services despite the program having less resources for mental health services than other parts of Italy (Submission 12).

The Unit covers an area with approximately 168000+ inhabitants. It comprises of the following (Submission 12):

- One psychiatrist and two nurses available for urgent interventions during opening hours (8am-8pm weekdays)
- ‘Daily oral assumption of therapy at South Community Mental Health Centers, to improve compliance and therapy adherence’.
- 100% of outpatient visits occur within 30 days after hospital discharge (within 72 hours).

In 2017, data was compared with that collected for departments of mental health at the Regional, National, and city level using the Italian National Mental Health Information System (year 2017). The South Unit Area has the same avarage of treated prevalence of any mental health disorder despite having less resources (contributing to staff, residential facilities and rehabilitation centres) than Italy, but the number of involuntary admissions is fewer.

Family Group Conferencing
The Netherlands

Family Group Conferencing is a '"family-driven" decision-making model and social network strategy' (Schout, Meijer, et al., 2017). In the Netherlands, where it was developed for the mental health context, a Family Group Conference is called an *Eigen Kracht*-conference. This translation emphasises the essence of this practice: using the strength and resources of people to make a plan and make decisions for the future and thus directing their own lives. According to Mental Health Europe:

> The underlying idea is very simple. If you have problems in your life that cannot be easily solved, you ask your social network to think things over with you. Everyone has a social network – large or small, close or less close – regardless of what happened in the past. Most people solve their problems or concerns this way. But when people have become isolated and think that no one cares about them anymore, or when they are too ashamed to turn to their own people, an Eigen Kracht-conference may be the answer. An independent coordinator will help them to organize an Eigen Kracht-conference. (Submission 28)

Family Group Conferencing is a voluntary consultation process, adapted from a Māori-led process for resolving family court disputes, in which an independent co-ordinator facilitates a series of discussions between an individual and her or his key social network. The individual selects friends and/or family, or professionals, to discuss issues of concern and seek solutions, including composing a plan which sets out the steps to be taken.

The role of the co-ordinator is to think 'with' the group, help remove barriers to participation, and seek consensus. Clinicians may have a background support role, or could have a role in facilitating any outcomes of decisions that involve clinical care. Meijer and colleagues (2017) conducted a study involving 41 family group conferences in three Dutch regions. Using survey and observation to identify the impact of the practice on coercive treatment in adult psychiatry, the authors concluded that family group conferencing 'seems a promising intervention to reduce coercion in psychiatry' by helping to 'regain ownership and restore[] belongingness' (Meijer et al, 2017, p.1862). (For more information, see: https://www.eigen-kracht.nl/ [accessed 9/4/2021]; see also De Jong & Schout, 2010; Schout, Meijer, et al., 2017; Schout, van Dijk, et al., 2017)).

Hugarafl
Iceland

Hugarafl (which roughly translates as ‘Mindpower’) is a non-profit, peer-run, non-government organisation in operation in Reykjavík since 2003 (Submission 22). According to its website:

> Hugarafl [translation: Mindpower] is an Icelandic peer run NGO founded in the year 2003 by individuals with a vast personal and professional knowledge of the mental healthcare system. These individuals had the common goal of wanting to change the mental healthcare system in Iceland and make it better. Everything that Hugarafl does is decided upon and done by people with lived experiences of emotional distress and/or professional background working as equals. Participating in the work of Hugarafl is for everyone working on their mental health on their own terms (https://hugarafl.is/about-hugarafl/ [accessed 8/4/2021]).

Hugarafl might be described as an ‘advocacy and capacity-building organisation’. It is engaged in various activities, including peer-led self-help groups, peer support, counselling, activism and mental health promotion in education. Hugarafl takes an active role in forming and giving feedback on policy reforms relating to mental health, housing, health care, social services, education and employment. Hence, they are focused on building the capabilities of service users, professionals, and beyond that, government services and systems. Under pandemic conditions, the health ministry have asked Hugarafl to meet them regularly to discuss how they could help the public and prevent psychological distress (Submission 22).

Hugarafl still provides individual support, including ‘robust vocational rehabilitation for people working on their personal recovery following a mental health crisis’, which is also overseen by a psychologist and occupational therapist (Submission 22). According to Hugarafl representatives:

> Due to the flexibility of Hugarafl’s practice (no set time boundary, no need for referrals, no cost to members, no need for diagnosis), we tend to catch those that fall between the cracks in conventional practice settings. This has led to our vital role as a follow-up and connection to people once they have exhausted or been discharged from traditional service providers. (Submission 22).

The group have several aims:

- To eradicate prejudice related to emotional and psychological challenges in Icelandic society.
- To safeguard the human rights of individuals with lived experiences of emotional distress.

- To strengthen the role and full, active participation of people with lived experience of emotional distress in Icelandic society.
- To have a positive impact on the Icelandic mental healthcare system.
- To promote and work according to Empowerment (by Judi Chamberlin) and the Empowerment Paradigm of Recovery Healing, and Development (by Daniel Fisher and Laurie Ahern). (Submission 22)

Staff members comprise of occupational therapists, a psychologist, a person with psychology training and education, ‘Neuro-Linguistic Programming coach’, Gestalt therapist, trauma-focused counsellor, yoga teacher and people with lived experience of emotional distress. This team works in unison with volunteers who collectively make the day-to-day working of Hugarafl. Participation in Hugarafl is free and open to all people over 18. A person neither requires an Icelandic residence nor a referral or diagnosis to participate. (For more information see https://hugarafl.is/about-hugarafl/; Hermannsdóttir, 2017; Hrannarsdóttir, 2017).

Mental Health Mobile Units
Greece

In Greece, Mental Health Mobile Units aim to reduce involuntary hospital admissions by working to keep individuals, particularly those in remote and rural areas, connected to their family and communities (Submission 27). According to Mental Health Europe (Mental Health Europe, 2019, p.7):

> From the foundation of the first Unit in 1981 to the inclusion of Mobile Units in Greek law, more than 25 units have been founded and are still operational all over Greece. Mobile Units are now used as a basis for the provision of mental health services and the protection of the rights of mental health users, particularly in small and remote prefectures.

Reportedly, the local community, other health services as well as key individuals (local authorities, police department, and prosecutors) do not merely assist, but actively participate in the work of the Mobile Units, securing the person’s right to remain an active member of the community. By allowing persons to stay in their communities and offering services as close to the user’s home as possible, the Mobile Units ensure stability and continuity of care. Factors for success are prevention, information of local inhabitants, timely interventions, therapeutic treatment and maintaining contact with both the family of the user as well as the community. The Mobile Units treat individuals as a bio-psycho-social whole, meaning that they deal with social or work-related issues whilst taking the necessary steps for users to access appropriate treatment if they choose. Comparisons of data with prefectures where no Mobile Units are in place show that the percentage of involuntary hospitalisations is much lower (Submission 27).

According to one 10-year review of the practice:

> The MMHU I-T and other similar units in Greece are a successful paradigm of a low-cost service which promotes mental health in rural, remote, and deprived areas. This model of care may be informative for clinical practice and health policy given the ongoing recession and health budget cuts. It suggests that rural mental healthcare may be effectively delivered by integrating generic community mental health mobile teams into the primary care system (Peritogiannis et al., 2017, p.556).

Another study indicated that hospitalisations were reduced significantly among those who used the service: ‘within the first 2 years of operation of the [mobile unit] hospitalizations of treatment engaged patients were reduced significantly by 30.4%’ (Peritogiannis et al., 2011).

Open Dialogues Model
Finland and Internationally

The 'Open Dialogue Approach to Acute Psychosis' is a practice developed in Finland in which care decisions are made in the presence of the individual and his or her wider networks. The practice is presented as an alternative to hospital, particularly where it is practiced as home or community-based practice (for a hospital-based version see above, p.38), and strongly emphases support on the basis of the person’s wishes and preferences, and the way that she/he prefers to frame her/his experience of distress. Open Dialogue is therefore strongly associated in the literature with being an alternative to or leading to the reduced likelihood of involuntary measures.

Psychotherapeutic approaches are taken with the aim of developing dialogue between the person and their support system as a therapeutic intervention. Service providers aim to facilitate regular 'network meetings' between the person and his/her immediate network of friends, carers and family, and several consistently attending members of the clinical team. A strong emphasis is placed on equal hearing of all voices and perspectives as both a means and an objective of treatment in itself.

The Open Dialogue practice was described by the European Network of National Human Rights Institutions and Mental Health Europe (2020, p.17) as follows:

> Service providers aim to facilitate regular ‘network meetings’ between the person and his/her choice of an immediate network of friends, carers or family, and members of the healthcare team. A strong emphasis is placed on transparency in treatment planning, and decision-making processes aim to respect a person’s will and preferences, safeguarded from undue influence. Such support enables the person to retain their legal capacity and to make the final decision on, for example, his/her treatment, after exchanges and reflection within the group.

There is a growing evidence-base that highlights the success of the Open Dialogue model. A recent Finnish study surveys 19-years worth of evidence on clinical and functional improvements, including reduction of hospital treatment, disability allowances and the use of neuroleptics (Bergström et al., 2018).

12 Key Elements of ‘Dialogic Practice’ in Open Dialogue

According to Mary Olsen and colleagues (2014), the 12 key elements of the ‘dialogic practice that has emerged from Open Dialogues are as follows:

1. Two (or More) Therapists in the Team Meeting
2. Participation of Family and Network
3. Using Open-Ended Questions
4. Responding to Clients’ Utterances
5. Emphasizing the Present Moment
6. Eliciting Multiple Viewpoints
7. Use of a Relational Focus in the Dialogue
8. Responding to Problem Discourse or Behavior in a Matter-of-Fact Style and attentive to Meanings
9. Emphasizing the Clients’ Own Words and Stories, Not Symptoms
10. Conversation Amongst Professionals (Reflections) in the Treatment Meetings
11. Being Transparent
12. Tolerating Uncertainty

The positive results of Open Dialogues in practice have led to the dissemination of this practice in other countries including a first wave in other Scandinavian countries (Norway, Denmark) and a second in other countries (United Kingdom, Italy, Portugal [see below], Germany, Poland, Netherlands, USA, Australia) (Submission 10). An international network has thus developed, with annual seminars and conferences where clinicians and service users host periodic meetings to exchange experiences and discuss progress (Submission 10).

Introducing Open Dialogue into the care systems of all these countries occurred in two major areas: first, a culture of dialogic communication was established among staff, service users, family members, and other members of a person’s social network (Submission 23). Second, community-based multidisciplinary treatment teams were organised to provide primarily outpatient services. These changes are in full accordance with the recommendations made by the WHO in its Comprehensive Action Plan on Mental Health

2013-2020, promoting an increase in the availability and frequency of use of services, as well as the effective coordination of existing services and the mobilisation of community resources, assuming that such moves will result in a significant decrease in hospitalisations and a reduction in care costs, and a substantial improvement in recovery rates (Submission 23).

Portugal

In Portugal, efforts are underway to implement the Open Dialogue approach nationwide (Submission 10). A group of organisations (ACES Lisboa Norte, CHLN, SPMS, Camara de Lisboa, Hospitalização Domiciliária, Santa Casa da Misericórdia, Centro Nacional de TeleSaúde) met in 2019, with the aim of undertaking training of core team-members in 2020, before initiating a pilot study in 2021. The initiative will be refined in 2022, and research will be conducted to compare the outcomes for people in pilot sites compared to those who receive treatment as usual.

It is noteworthy that Open Dialogues emerged from Finland, which has one of the highest rates of involuntary psychiatric intervention per capita in all of Europe (and indeed, the world); in contrast, Portugal has among the lowest in the world (Sheridan Rains et al., 2019, see Table 1). Hence, it is not self-evident that Open Dialogues necessarily leads to reductions in involuntary psychiatric measures even as it may be a promising and rights-promoting practice for other reasons. The indicators used to measure the performance of the Open Dialogue approach include hospitalisation rates, prevalence and incidence of chronic conditions, use of neuroleptic medication, degree of functional recovery and residual symptoms, and economic cost of each case (including costs related to disability) (Bergström et al., 2018; Submission 23). Aside from the use of Open Dialogues approach in the secure psychiatric ward of Akershus University Hospital, there does not appear to be any studies that explicitly link Open Dialogues to coercion reduction—again, which does not suggest it is not important for other reasons.

Personal Ombud Programme Sweden

In 1995, the Swedish Personal Ombudsman Programme ('Personligt Ombud Skåne' or 'PO') was founded by persons with psychosocial disabilities as a 'User-controlled Service with Personal Agents' (Submission 27). This form of personal assistance involves facilitating decision-making, including by making demands of public authorities and social services about the support to which the individual is entitled. The 'assistants' or 'advocates' are statutorily appointed to assist a person to make legal decisions in a facilitative rather than coercive fashion. The PO is a professional, highly skilled person, usually a lawyer or social worker who works only for his/her client and does not work in alliance with psychiatric or social services or any other authority, nor with the client's relatives or any other person (Submission 27). The Ombudsman takes great care and time to build trust and to ensure that users receive the help and services which they prefer and to which they are entitled. The practice is not designed for one specific situation (such as hospitalisation, homelessness or acute crises) but instead is meant as a service to accompany a person throughout her/his psychosocial difficulties.

In 2000, the PO system was expanded to include the whole country (Submission 27). Although there are no empirical studies yet available concerning its impact on coercion, a five-year Government evaluation of the programme has shown that the scheme is profitable in socioeconomic terms; individuals with PO support require less care and their psychosocial situation improves. Since then, the National Board of Health and Welfare promoted the PO as a 'new social profession' and in 2013 a new regulation established permanent funding for the PO system (Submission 27). A PO holds an independent position in a municipality's social services. Municipalities may run the PO service or sub-contract them to non-governmental organisations. The system emerged after advocates felt that existing legal capacity systems – such as guardianship, or civil commitment – did not meet the needs of many people with psychosocial disabilities.

The Commissioner for Human Rights of the Council of Europe, Nils Muižnieks, reported that in 2013 a new regulation established permanent funding for the PO system in the regular welfare system (Swedish National Board of Health and Welfare, 2008). As of 2014, according to Muižnieks, 310 POs provided support to more than 6,000 individuals and 245 municipalities (84 % of all municipalities in Sweden) included POs in their social service system. The OHCHR recommend the 'PO Skåne' programme - an iteration of the PO programme run by persons with psychosocial disabilities - as an appropriate supported decision-making statutory mechanism. Muižnieks writes that 'recourse to the Personal Ombudsmen system could be a way of limiting coercive practice in psychiatric institutions' (Swedish National Board of Health and Welfare, 2008). As such, the system has received attention internationally and given rise to similar services in other countries.

Respite Houses

Crisis or respite houses tend to offer a smaller scale residential alternative for people in crisis, sometimes designed for specific groups, including women, minority ethnic groups and homeless people (see Gooding et al., 2018, pp.67-77). Such alternatives to hospitalisation may be staffed predominately or even entirely by those who have used services or faced involuntary psychiatric interventions, or may be staffed by typical mental health professionals (such as psychiatrists, psychologists, social workers, and so on)—or a mixture of the two. Only one example of a respite house was submitted for the purposes of this compendium.

Bochum Crisis Rooms – Bochum, Germany

The Bochum Crisis Rooms provides assistance for people experiencing 'psychosocial crises and acute mental and psychiatric emergencies' (Submission 27). In 2001, the Landes-verbandes Psychiatrie-Erfahrener (the LPE NRW), the regional umbrella organisations of people with experience using mental health services, set up a contact point for people experiencing crisis. In 2013, 'crisis rooms' were added, which have subsequently allowed for overnight accommodation. There had always been the possibility of spontaneous overnight stays in the rooms of the drop-in centre—an option that appears to be rare in self-advocacy and in the formal mental health system (Submission 27). The drop-in centre and crisis rooms in Bochum are located in three separate flats on different floors of a high rise building: the largest flat on the second floor contained a crisis room for one person in addition to the drop-in centre; a second flat offers additional crisis accommodation; and a third flat exists for administrative work and groups.

People in acute crises can move to the accommodation options for up to three months and be supported by mental health practitioners, including psychiatrists (Submission 27). Every crisis support is individual and tailored to each person; there is no fixed plan. In principle, all people who are in or visit the drop-in centre are involved in the crisis work in Bochum. The roles change almost automatically, and there are different forms of remuneration and voluntary work. The crisis rooms were funded by various health insurance companies from 2013 to 2017, and as of mid-2017, the North Rhine-Westphalia Welfare Foundation has taken over the funding.

Soteria House – International

The Soteria model is a type of respite house, sometimes described as a ‘Therapeutic Community Residence’, of which one aim is to prevent hospitalisation (Submission 27). Soteria facilities are typically small, residential settings for responding to people experiencing psychosis, and reportedly appear in Switzerland, Germany, Sweden, Budapest and Denmark (Calton et al., 2008). The approach consists of a small, community-based, residential treatment environment with strong use of peer and allied professional staffing rather than clinical staff. Soteria House reportedly focus on empowerment, peer support, social networks, and mutual responsibility (Submission 27). It tends to involve minimal use of psychotropic medication based on the personal choice of each resident. In the US, the Department of Mental Health Vermont, has stated that 'further analysis may be warranted to assess how Vermont's future support and implementation of the Soteria model can reduce the need for involuntary medication for individuals experiencing a psychiatric crisis' (Vermont Department of Mental Health Services, 2017, p.5).

Weglaufhaus, "Villa Stöckle" – Berlin, Germany

The Weglaufhaus is a non-profit respite house for homeless people experiencing crises that has operated in Berlin, Germany, since 1989 (Submission 21). Half of its staff members are people who have themselves experienced using psychiatric services or being subject to involuntary psychiatric interventions. The Weglaufhaus’ main function is to provide support, safety and shelter for people in need of psychosocial support, helping them build a solid foundation for their self-chosen future (Submission 21). Residents need to be at least 18 years-old, homeless, in need of 24/7 support, and legally in a position to receive social welfare from the German government.

Weglaufhaus is part of the World Network of Users and Survivors of Psychiatry. Residents are usually seeking to avoid an involuntary hospitalisation, or broadly looking for an alternative to psychiatry that does not use coercion. According to Submission 21, the respite house has several characteristics:

- Diagnoses are not used. There is no coercion. Psychiatrists are not allowed in the house
- Psychotropic drugs can be discontinued, but don’t have to be.
- The work done by the team is as transparent as possible to the residents. Residents can view their files. They can also attend staff meetings.
- The work is based on the ‘antipsychiatric approach’ and biased towards the residents.
- The focus of the work is on supporting the self-determination of the residents.
- There is a floor for trans*, non-binary and intersex people.

- “Traditional” social work, like helping people to get back into social welfare, health insurance, legal status and consultation.

There is an open day at the house once per week for former residents, and a monthly association meeting. Some German-language research exists on the Weglaufhaus (https://www.weglaufhaus.de/literatur/forschungsarbeiten-zum-berliner-weglaufhaus/ [accessed 8/04/2021]).

TANDEMplus:
Mobile Crisis Support and Social Network Development
Belgium

'TANDEMplus' is a small mobile crisis service that supports people during, and shortly after, they experience a crisis. A key aim of TANDEMplus is to help a person to '(re)activate her/his local support network' (Submission 7). This includes identifying the kind of support that the person would like to receive based on her/his expressed needs, and connecting the person with the appropriate people or community services. TANDEMplus only intervenes on a short-term basis, in a completely non-coercive manner, with the average length of intervention being 29.5 days. ("L'équipe mobile Tandemplus," https://www.cbcs.be/L-equipe-mobile-Tandemplus [accessed 22/01/2021]). According to Human Rights Watch (Hancock, 2019), which has promoted the service:

> The only "treatment" TANDEMplus offers is support, in the form of regular home visits to talk through people's emotions and concerns. They help the person find coping strategies and tackle practical problems that have brought them to the point of crisis, be it a debt issue, help with household bills, or mending ties with family members. They also refer them to social workers or other services. The support is only given with the person's full consent, reflecting TANDEMplus' core philosophy: that the person has control over their own life.

TANDEMplus is a bilingual service (French and Dutch). It operates mainly in areas of Brussels with lower socio-economic status and works with adults over 18 years of age who are experiencing a crisis or have difficulty finding psychiatric support that meets their needs.

Outreach workers are sent in pairs to meet the caller either in their homes or in another place of their choosing. If possible, the person who contacted the service is asked to be present for this first visit. The agreement of the relevant person is always needed before any meeting takes place.

At the time of writing, the service has 8 outreach workers. The staff members do not require professional mental health training to be part of the service, though most have a professional background in mental health. A strong emphasis is placed on staff member's ability to communicate, collaborate, be personable, creative, and so on. At present, the team includes clinical psychologists, social workers, nurses and educators. The team has one psychiatrist.

People seeking support can call a hotline that operates from 9:00am-3:00pm during the week. At least one staff member on the hotline team is someone with lived experience of using mental health services. Just under half of calls tend to result in a home visit, while the other calls typically relate to information sharing and guidance and advice (Submission 7).

Following the first visit, the service provides regular home visits (on average 2-3 per week), as well as regular phone calls (available from 9:00am-5:00pm). TANDEMplus does not prescribe or manage psychotropic medication or diagnose people, but rather attempts to find ways to address the issues that have led the person to experience a crisis. A staff member describes the service thus, “Our work is to lay a foundation around the person that’s sufficiently solid for them to continue making progress psychologically” (Submission 7).

An important aspect of TANDEMplus is that it connects with other health and social services, community groups, and so on, to create long-term support system for the person. TANDEMplus is part of the larger network of dozens of social and health services (“Partenaires Archief,” Hermesplus, https://hermesplus.be/fr/notre-operation/partenaires/ [accessed 30/3/2021]). TANDEMplus seeks to liaise actively with these other systems of support to avoid a situation of fragmented service provision that a person must navigate alone.

If there is a risk of violence, the initial meeting with the person will take place in a safe public setting. If the risk is too great, the support will be interrupted. If there is serious risk (either to the person or others), then the person’s family or care providers are given information about how they can initiate an involuntary intervention. If appropriate, the team will stay involved during the crisis period and may accompany the person to hospital if she/he wishes. The TANDEMplus team will not initiate an involuntary hospitalisation. Some circumstances have required police intervention, which temporarily ends the involvement of TANDEMplus. The policy of TANDEMplus is that ‘care is not compatible with police intervention’ (Submission 7).

According to a 2019 evaluation, the TANDEMplus intervention connected 49% of the service users to the ambulatory care system in Brussels, including mobile structured care and outpatient facilities, mental health centres, health care providers, home care, assistance to the homeless, consultation and coordination services, and other community organisations (Submission 7). 22% of the referrals made by TANDEMplus were to inpatient care, either in a psychiatric hospital or mental health unit in a general hospital. The remaining individuals were not connected to other services, either because they did not want it, or because they did not maintain contact with TANDEMplus (Submission 7).

According to Human Rights Watch access to the program is entirely free of charge for people using the service (Hancock, 2019). Furthermore, their names are not registered, they do not need to have medical insurance or ID, and they can remain entirely anonymous if they wish.

Human Rights Watch have also conducted a cost-benefit analysis and indicated that compared to a stay in a psychiatric or general hospital ward, the type of home-based support provided by TANDEMplus is more economical than hospital-based care (Hancock, 2019).

C. ‘Hybrid’ Approaches in Policy and Programming

The following practices did not fit easily into the ‘hospital’ or ‘community’ binary. Instead, the practices listed below combined efforts in both contexts. This included efforts to bring hospital-based expertise to individuals and families experiencing crises in their homes and communities. It also included efforts to ensure ‘community’-based resources (in community associations, housing arrangements, advocacy, businesses offering employment, and so on) are feeding back into – and even transforming – services in health facilities.

The following hybrid approaches were submitted:

‘Activity quality of care project: Deinstitutionalization’
Czech Republic

Several COE Member States are continuing to ‘deinstitutionalise’, in the sense of various policies and practices designed to close down large-scale institutions in which persons with mental health conditions and psychosocial disabilities, and other disabilities, are placed and detained. Efforts to reduce coercion in mental health services in these countries cannot be neatly distinguished from the broader aims of deinstitutionalisation.

The Czech Republic has initiated such a project in the form of a 2013 mental health policy that was boosted in 2017 with European Investment and Structural Funds (Submission 18). The subsequent National Action Plan for Mental Health Care includes selected measures to address, ‘inter alia, the rights of people with mental illness, support for the quality of psychiatric care and services in mental health and prevention of involuntary hospitalisations’ (Submission 18).

The Strategy for the Reform of Psychiatric Care aims to avoid simply shifting people from institutions to hospitals or ejecting people from psychiatric institutions and hospitals without the provision of follow-up support and resources. Instead, the aim is to create a range of services so that ‘inpatient care does not replace other care in the social environmental system in order to meet health and social needs’ (Submission 18). 17 psychiatric hospitals are participating in the reform process.

The Ministry of Health required the directors of individual hospitals to change the structure of care provided so that services are provided in service user’s own social environment (e.g. the establishment of community mental health centres). Effort is also underway to assist individuals who have been detained in hospitals for periods longer than six months to transition back to living outside of the institutional environment. From 1 January 2019 to 31 May 2019, 736 long-term hospitalised patients were released (Submission 18). 43% of long-term hospitalised patients have nowhere to live.

Another feature of reform has been a largescale survey of mental health service users and their family members, comprising of more than 700 respondents from across the Czech Republic (research which is underway at the time of writing) (Submission 18).

The overall Strategy is closely linked to the WHO QualityRights project (see above p.19). In 2018, in cooperation with the WHO, a mapping of the quality of care was carried out in a total of 17 psychiatric hospitals. The output of this quality of care mapping, which was based on WHO QualityRights standards (following the CRPD), was evaluation reports for psychiatric hospitals and a summary evaluation report. The evaluation team consisted of a doctor, a person with experience of a mental health condition and psychosocial disability, a social worker, and a lawyer.

Each hospital was provided with a consultation process and educational program for workers (doctors, nurses, medical orderlies, social workers and other paramedical professions) on selected issues concerning the implementation of the CRPD. These programmes are implemented by quality managers and are always thematically focused on the real need or demand of the psychiatric hospital. The implementation of full-time education and thematic workshops in psychiatric hospitals has been suspended due to the Covid-19 pandemic, and have temporarily occurred via webinars.

For the first half of 2021, online educational programs are being prepared focusing on the following topics for example:

- Human rights;
- Arbitration and the right to decide for oneself;
- Recovery and the right to health;
- Freedom from coercion, violence and abuse;
- Mental health, disability and human rights, and so on.

In addition to these educational programs implemented in individual hospitals, seminars for hospital management were held in cooperation with the Office of the Public Defender of Rights of the Czech Republic. These seminars focused on the legal liability of health professionals, the basics of human rights, the issue of regime measures and the issue of prevention of the use of restraints measures. These seminars also took into account the need to anchor the issue in a managerial and procedural approach of particular psychiatric hospitals (Submission 18).

In cooperation with the WHO, an e-training educational program focused on quality and human rights WHO QualityRights was published in November 2019, which includes a module focused on the prevention of the use of restraints measures. This e-training educational program, which is available on the website https://humanrights-etrain-qualityrights.coorpacademy.com/login is open to all interested stakeholders, is available in the Czech language version and psychiatric hospitals are systematically supported in its implementation into internal education within the organization. As of 1 December 2020, a total of 2,395 people had completed this educational program (Submission 18).

By June 2021, the Ministry of Health is set to publish its Recommended Practices for Psychiatric Hospitals. The forthcoming best practices include:

- Prevention and use of restraints measures in psychiatry;
- Best practice for complaints (including Easy to read version);
- Recommended procedure for the issue of liability of healthcare professionals;

- Recommended procedure - evaluation of quality and human rights within the internal processes of a psychiatric hospital;
- Guardianship and other support measures; and
- Hospitalisation and treatment without patient consent, informed consent.

The Government Council for Mental Health has discussed the possibility of establishing a new separate department within the organisational structure of the Ministry of Health in 2022, to promote and protect the rights of persons in healthcare, including reducing rates of involuntary psychiatric initiatives.

‘Citizen Psychiatry’
East Lille mental health service network – France

The Eastern Lille mental health service network (59G21[5]) has been transformed over the past three decades with a primary aim of avoiding resorting to traditional hospitalisation (Submission 19A). The change was co-ordinated at EPSM Lille métropole, a mental health centre in the towns of Faches Thumesnil, Ronchin, Lesquin, Hellemmes, Mons en Baroeul, and Lezennes.

The WHO (2021, p.161) Guidance on community mental health services describe the network as follows:

> The mental health network of East Lille promotes the concept of “citizen psychiatry”. Serving a population of 88 000 in the south-east region of the Lille metropolitan area, the network has been built over 40 years of mental health system reorganization and reform. The East Lille network demonstrates that a shift from inpatient care to diversified, community-based interventions for people with mental health conditions and psychosocial disabilities can be achieved with an investment comparable to that of more conventional mental health services. The approach supports respect of human rights of individuals who use mental health services, and their empowerment – even while operating in a more restrictive national legal context.

The Public Mental Health Institution Lille Métropole (*Etablissement Public de Santé Mentale Lille Métropole* (EPSM)) plays a central role in administering the network, including regional oversight and planning mechanisms (World Health Organization, 2021, p.161).

The Submission (19A) suggests several themes that underly the network, including: human rights, and a belief that mental health conditions do not impeded someone exercising those rights; a commitment to not conflate mental health care with suppression of violence and risk; the need for society, and thus mental health services, to adapt to people’s needs, and not the other way around; commitment to closing medical and social institutions that effectively exclude residents from their communities; a commitment to fighting stigma and discrimination based on mental health conditions, including challenging stereotypes about dangerousness and lack of capacity.

The formal services in the network engage as a partner with other stakeholders, including people who use the service and their families, NGOs, elected officers in the municipalities, and others who are involved in the mental health field.

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[5] France operates with a sectorised mental health system. For adult services the country is divided into approximately 850 sectors, each with a population of about 70,000. The East Lille sector has the number 59G21 and only serves adults. Six suburban towns are included in this sector: Faches-Thumesnil, Hellemmes-Lille, Lesquin, Lezennes, Mons-en-Barœul and Ronchin.

Within this broad initiative, two key components of the program are the *Coordination Territoriale du Parcours de Rétablissement* (‘Territorial Coordination of the Recovery Path’) and ‘Availability, Reactivity, Outreach’.

Territorial Coordination of the Recovery Path

This component involves ‘integrating the entire health system into the city, via a network involving all interested partners: users, carers, families and elected representatives’ (Roelandt et al., 2010).

With nearly 70 outpatient care systems, the service provides the population with prevention, diagnostic, care and monitoring services and equipment for adults, adolescents and children. Medico-Psychological Centres (CMP) or Mental Health Centres (CSM) constitute the entry point of the system. These centres organize prevention, diagnostic, outpatient care and intervention actions at home. The initiative reportedly involves a system of community care that keeps affected people as close as possible to their homes, residences, families and communities (Submission 19A). The policy and program arrangements link together health, political and social organisations and agencies: including general practitioners and health actors, elected representatives, associations and user representatives, social and medico-social actors, and social landlords. All of these elements are based on ‘local mental health councils’ which bring together all the partners (Submission 19A).

This multi-service arrangement reportedly helps to provide consistent support that assists a person wherever they are in her or his trajectory through a mental health crises, rather than creating strict divisions between the kind of support a service offers. As an example, a person may, at different times, spend time at an inpatient unit, draw on intensive home crisis unit, undertake assertive community treatment and outpatient consultations, or use a ‘leisure support service’. All these services are staffed by the same professional group – comprised of peer helpers, psychologists and psychiatrists – and they exchange information regularly.

The various options are designed to respect self-determination and avoid coercive care, particularly through emergency room visits or coercive measures that appear in services outside the East Lille Public Psychiatry service network. Broadening the range of care options allows for closer access to people's wishes, and reportedly improves engagement with the support being offered (Submission 19A).

Since 2014, the EPSM explicitly adopted a ‘recovery-oriented’ approach, with each worker trained to adhere to a charter of commitment to recovery-oriented care. This reportedly makes service culture consistent across the various services provided. Service users are encouraged to create advance directives (see p.**Erreur ! Signet non défini.** for examples) and recovery plans to assist services to adhere to their wishes during crises. At the meta level, it is the coordination via the local mental health council that enables the mobilisation of partner services to advocate for people's rights and guarantee them the best possible health and social support. The council also offers prevention and information on mental health, crisis and post-crisis care, and support for people in difficulty in their daily lives. Reportedly, outreach and coordination with frontline actors helps to build trust and improve access to care by reducing coercive practices (Submission 19A).

The inpatient units are actively working on reducing the need for restraint and on alternatives to hospitalisation.

The intensive crisis unit takes care of 15 users, for an average of 14.6 days, and is available 24/7, with a presence from 8am to 10am and a nightly telephone service.

Outpatient consultations and crisis support use recovery and crisis prevention plans (based on the model of advanced directives), which make it possible to coordinate the user's care pathway according to her/his values and wishes in all the structures she/he encounters. These plans are formulated with the person, their relatives, but also in conjunction with their GP or other partners if the person so wishes.

Access to peer support is guaranteed by hiring peer health mediators (see below 'Section E(b)(iii) *Médiateur de santé pairs*' p.92). At the organisational level, elected user representatives participating in the development of the service also 'provides a measure of health democracy' (Submission 19A).

Twice-daily telephone coordination between the departments (9am and 8.45pm) is essential to the service, with a dedicated permanent medical on-call service. Every morning, a call is made to emergency services to find out if anyone in crisis has turned up in the area, so that the service might anticipate the necessary interventions. Availability and reactivity are also of paramount importance, especially to avoid the aggravation of situations and the coercive interventions that may result. To this end, the service offers:

- assessment of new applications within 48 hours
- emergency management in outpatient settings and at home
- intensive follow-up at home
- the development of outreach by being a force for proposing care for people in difficulty
- long-term follow-up for people with psychosocial disability; and
- the management of psychiatric hospitalisations. (Submission 19A)

Increased coordination with the GP is carried out, through meetings, telephone calls if necessary, and a consultation letter sent at each meeting with the user.

Finally, through the service's partnerships, its staff provide advocacy for individuals, promoting their rights, including by demanding resources, housing, access to health, and so on.

‘Availability, reactivity, outreach’

The second key component of the EPSM approach is a mobile emergency unit, the ‘**Intensive Service Integrated in the City’ (*Soins Intensifs Intégrés dans la Cité*) (SIIC)**, which has operated for 15 years and is the largest mobile team in France in terms of the number of people it supports. SIIC has two distinct missions:

- Permanent access to care (24 hours a day, 7 days a week): medical on-call duty and telephone duty and coordination with local organisations; and
- Capability for intensive support for 15 situations at any one time that may be of a crisis nature or in need of intensive contact.

The medical on-call activity is carried out in coordination between the on-call doctor and the SIIC team. It aims to ensure a fast and adapted response to urgent situations to allow a person’s entry into the care system. The service includes emergency interventions in the home in case of crisis situations, which remain the responsibility of the SIIC service rather than generic emergency services (like police or ambulances).

The decision about a person entering services is a medical one, and the ‘procedures are defined in dialogue between the user, her/his relatives, the team and the doctor’ (Submission 19B). The SIIC is a service designed to respond to exceptional crisis situations. It should also enable users to develop autonomous crisis management tools

In addition, a **Service Médico-Psychologique de Proximité** (SMPP) operates, which offers two dedicated ambulatory EPSM services (World Health Organization, 2021, p.161). The SMPP services are composed of a multi-professional team (doctors, nurses, social workers, psychologists, psychiatrists, peer health mediators, secretaries) who work in close collaboration to guarantee quality care by adapting to the needs of the population. According to the WHO review of the SMPP:

> A person is referred to an SMPP by their general practitioner. Referral is followed by an assessment of both mental and physical health needs within 48 hours. Each assessment is then discussed by a multidisciplinary team, which identifies care and support needs. Consultations take place at a range of venues, such as a social and support centre for youths where they can directly access the SMPP without a doctor’s referral. There is no waiting list, and the service can also undertake home consultations.

The concept of a ‘care pathway’ is the basis for the SMPP partnering with other local services. The pathway must meet the needs of people living with mental health conditions and psychosocial disabilities, and their carers and families, and to do so with attention to their local area. To achieve this, a partnership between SMPP and the local towns is essential. Consultations can take place in diverse local venues (the local mission, a swimming pool, a social service centre, an addiction support centre, a community health centre, and so on). Two multidisciplinary meetings are held each week to orientate new requests according to the needs of the users and to refine the adequacy of the diagnosis and the care offer. The aim of SMPP is to engage a person in a cooperative relationship to promote recovery.

Three other key elements of the East Lille mental health services network are:

- An approach of 'recovery-oriented empowerment'
- The development of crisis prevention and management plans, and
- 'Alternatives to Seclusion and Restraint'

Each will be discussed briefly below.

'Recovery Oriented Empowerment'

Recovery-oriented care (ROC), which was a model or approach to care integrated into the 59G21 service in 2014, is aimed at helping the user to live better with his or her condition or disability and to retain opportunities for a rich family, professional and social life (Submission 19H). This approach is based on a partnership model: 'It respects the individual's right to be in the driver's seat but also recognises the value of having professional co-driver(s) and natural support(s)' (Submission 19H). ROC is meant to enable users to lead their recovery, and focus on overcoming the alienation and marginalisation confronting people with mental health conditions and psychosocial disabilities. Three 'levels of alienation' are described:

- Level 1 in relation to the illness and symptoms;
- Level 2 in relation to the representation of oneself as a sick person, i.e. 'internalised stigma';
- Level 3 regarding alienation generated by the organisation of society and its ability (or inability) to include people with mental health conditions and psychosocial disability (Submission 19H).

In more practical terms, ROC as it is practiced in the East Lille network is comprised of the following actions:

- *integration of experiential knowledge* (that is, involvement of 'experts by experience') in the training of professionals, which:

  - improves the knowledge of health and social associations
  - maintains hope about the evolution of a person's troubles
  - fosters more horizontal care-giver/carer relationships (i.e. seeks to mitigate power assymetries between care givers and receivers
  - Integrates peer health mediators into professional teams (there were 5 in 2020)
- ► *development of health democracy*
  - the creation of participatory spaces and tools
  - quarterly user forum facilitated by a peer health mediator and spokespersons
  - regular 'talking to users' meetings facilitated by peer health mediators
  - suggestion/complaint sheet on the consultation sites
  - a mechanism for service users to report undesirable events to management
  - QualityRights evaluation carried out by the WHO, and integration of recommendations into the cluster project (see World Health Organization, 2021, p.161-63).
- ► *election of the centres' user spokespersons*
  - election of 3 spokespersons for the centres service users;
  - participation of spokespersons with a strong involvement in the cluster's steering committee, organisational meetings and working groups;
  - participation of a user spokesperson in the QualityRights training course.

Additional tools for recovery orientation used at 59G21 include: formal recovery-oriented training for management; the creation of a 'Recovery Charter' that staff members sign as a commitment to the process; service-level commitment to employ peer-to-peer mediators and the development of appropriate workplace adjustments for those workers where needed; and the creation of the crisis prevention plan as a tool (detailed in the next sub-section).

'Crisis prevention and management plan'

The Crisis Prevention and Management Plan, or simply the 'Crisis Plan', is effectively an advance planning tool (Submission 19G). (For a fuller discussion of advance planning methods, see p.**Erreur ! Signet non défini.**). A Crisis Plan is meant to serve as a relapse prevention method, to be written during or after a person experiences hospitalisation or intensive outreach. The user, family and friends or health professionals can then use the crisis plan each time warning signs of a crisis appear. The Crisis Plan is a dynamic 'recovery oriented' tool to help people become aware of their strengths and resources, to help them identify the triggers of and warning signs of ill-health and crisis, and finally to enable them to give advance directives on the actions and attitudes that will enable them to avoid or manage the crisis.

These directives also make it possible to reduce the challenge of caring. By being aware of the user's crisis plan, the professionals, family and support persons know what to do to best respect the user's rights, needs and desires if he or she experiences a period of crisis. The first person concerned is the user herself/himself who makes her/his crisis plan, but it also concerns all the people she/he considers involved in his recovery process who may provide assistance with the plan if the person chooses. This is reportedly a very common practice in the 59G21 service and in other services of EPSM Lille-Métropole. Other services within France that take a recovery-oriented approach have developed similar tools. See for example, the 'GPS' program used in Ile-de-France, which is described at p.88 of this report.

➡ 'Alternatives to Seclusion and Restraint'

As described above, the entire healthcare pathway at EPSM is designed to promote access to care in ways that preserve autonomy, and therefore avoid restrictions on freedom. It is 'exceptional' for a user to be placed in restraint at the central clinic that forms part of the 59G21 service network (the Jérôme Bosch [JB] clinic).

The JB Clinic has 10 hospital beds and 2 rooms have a companion bed for those wishing to have the company of a trusted person or accompaniment during their time at the clinic. A person's support network is engaged by the service to help with negotiation, safety and avoiding conflict.

The average length of hospitalisation in 2019 was 6.5 days. Upon admission, according to the WHO (2021, p.162) review of the service, 'both written and verbal information about an individual's rights and obligations is provided'.

Restraint is viewed as a dysfunction which is the subject of an adverse event report, and is generally perceived as an act of abuse (Document 19I). Reportedly, in 2019, there was only one instance of restraint (which lasted 3h); in 2020, there were reportedly zero instances. The JB clinic does not have any seclusion rooms.

The theme of freedom is particularly important to the 59G21 service. The goal of the program is 'zero seclusion/isolation, zero restraint' (Submission 19I). The practices aim to defuse situations of violence before, during and after a crisis. Reportedly, 'situations of violence are less frequent, as long as rights are respected and restrictions are minimal, discussed and justified' (Submission 19I). The choice to leave the doors open helps to combat the impression of being shut in.

The features of the EPSM and 59G21 service above, are considered to be pre-requisites to avoid and limit hospitalisation. Other features of the alternatives to seclusion and restraint approach include the following:

- professionals receive specific "OMEGA" training that enables them to identify the risk of a crisis 'upstream' and to defuse it if necessary (98% of staff had received the training in 2020);
- violence prevention and management plan is worked on with the user from the moment of admission and throughout his or her stay;
- a carer is permanently and individually present, if necessary;
- all staff members benefit from the input of the peer staff members who provide a more experiential view of the complex situations. Access to peer support is seen as essential in the approach to recovery-oriented care, to instil hope in users and carers, and change the cultures of professionals (Submission 19I);
- staffing levels are adjusted in line with the potential level of risk, including the possibility of constant presence and supervision with a person if necessary;
- 'prevention agents' are occasionally called in to provide relief in certain situations. The presence of these agents is beneficial and reassuring for both other users and professionals. The prevention agents are security professionals who intervene on an ad hoc basis to accompany the person on a constant basis, 24 hours a day for as long as the situation requires. In 2019, the number of users requiring a prevention worker was 20, which occurred over 138 days.

If a person is placed under restraint (which occurs very rarely as noted above), a restraint protocol is adhered to and a post-event analysis is carried out with the user and the team. An Undesirable Event Sheet is drawn up to better understand what went wrong. An interdisciplinary feedback meeting, based on the situation, leads to recommendations.

The bedrooms are individual and respect privacy and confidentiality. Rooms are equipped with TV sets. The space and equipment promote well-being ('psychomotricity room, hydrotherapy, activity area, calming room, computer room'). The architecture of the clinic favours circulation, it includes open spaces with free access to the outside garden. The control of these spaces is essential to meet the safety needs of all. The clinic offer areas for wandering and personal accompaniment, a source of calm without deprivation of liberty. The clinic has an aromatherapy system throughout the entire structure, diffusing soothing essences day and night.

The continuous availability of psychiatrists to adjust care is essential, as this ensures that the teams are not left in a closed system. Regarding peer support, there are measures for support persons to advocate for users' rights, including any constraints associated with hospitalisation.

Summarising the impact and achievements of the East Lille mental health network

According to the World Health Organisation (2021, p.163) the important achievement of this network can be summarised by noting ‘the steadily decreasing rate of hospital admissions, from 497 admissions in 2002 to 341 admissions in 2018, despite the considerable increase in the number of people receiving care in the network over the same period, from 1677 people in 2002 to 3518 people per year in 2018’. Further:

> The average length of stay at the in-patient unit also decreased from 26 days to seven days over the same period. An independent assessment team conducted a who QualityRights evaluation in September 2018 across all of East Lille’s mental health services. Three of the potential five themes were fully achieved:
>
> i) the enjoyment of the highest attainable standard of physical and mental health,
> ii) freedom from coercion, violence and abuse, and
> iii) the right to live independently in the community.
>
> The remaining two themes: (iv) the right to an adequate standard of living and v) the right to legal capacity and personal liberty and security, were partially achieved. The existing French legal framework was found to be an important barrier for the full achievement of these latter two themes.

Other signs of success, according to WHO (2021, p.164) include the low rates of expenditure on hospitalisation relative to the rest of mental health services (28.5%) compared to 61% nationwide in France, as well as lower costs for mental health services in East Lille compared to surrounding metropolitan areas—costs which have been decreasing steadily from 2013–2017, from €3131 to €2915 per year (as at June 2021).

‘Improved cooperation between psychiatry and home care’
Sweden

This small-scale initiative in the Eksjö municipality of Sweden, successfully reduced rates of involuntary psychiatric interventions through a program that focused on improving the interactions between individuals in mental health crises, nurses providing home based care, and inpatient and outpatient psychiatrists (Submission 30). Over a six-month period, the trial saw a 66% reduction in compulsory admissions. The cohort of patients was small, with 170 patients enrolled in home care during this period.

According to the submission:

> In order to reduce the number of admissions by [an involuntary psychiatric intervention order, which is made under Swedish law after a ‘care certificate’ is issued], the nurses driving the improvement work needed to build a deeper relationship with the patients who accounted for the majority of forced admissions. The relationship can be an end in itself, but also a means to achieve other goals. [The nurses] therefore visited these patients regularly and had ongoing and longer conversations with them. In person-centred care, the patient narrative is essential to enable the partnership. Nurses also made contact with relatives, where the patient in question agreed to this.

Improving the communication between psychiatrists and the nurses/municipal homecare providers was also important. Research at the beginning of the project indicated that interactions between homecare nurses and inpatient and outpatient psychiatrists were fraught, and perceived by staff to be generally negative (Submission 30).

According to the submission, the practice had three key elements:

- First, the service drew on a pre-existing service-development process for ‘continuous improvement’ based on the four steps of ‘plan’, ‘do’, ‘study’ and ‘learn’ (for which the Swedish acronym is PDSA).
- Second, the mental health practitioners aimed to provide ‘person-centred care’, on which a large international body of literature exists. The model was described in the submission as avoiding reducing the person to his or her mental health condition, and ‘involv[ing] a shift from a model in which the patient is [viewed as] passive to one in which he or she is active in planning and implementing his or her own health plan’ (Submission 30).
- Third, teamwork was a primary focus among healthcare practitioners, as previous research had identified tension and dissatisfaction in encounters between municipal homecare providers and inpatient and outpatient psychiatrists. This had led to friction in the experience of individuals in mental health crises as they transitioned between emergency, inpatient and outpatient care.

Practical steps taken as a result of this process included adjustments to improve home-based care (for example, extending the period of outpatient psychiatric care for individuals with higher support needs) and additional training (including training on old age-related psychosocial and cognitive disabilities).

In the six-months prior to the trial, six involuntary admissions were issued by the home health service. In the six-month period of the trial, only two such admissions were made—again, representing a 66% reduction.

‘Patient-led action plan’ to appeal compulsory treatment orders
The Netherlands

This practice functions as a form of appeal process available to a person who is subject to an involuntary psychiatric intervention (Submission 30). However, it is a process that places the onus on the individual herself or himself to propose an alternative care arrangement and gives discretion to approve or reject the alternative plan with the ‘medical director’ that issued the original involuntary intervention. In the Netherlands, medical directors can authorise involuntary psychiatric interventions.

Under this appeal process, individuals who are deemed by a medical director to require involuntary psychiatric intervention are given a letter indicating that an involuntary order is being prepared. The letter states that the person may draw up an action plan, including setting out how she or he wishes to avoid compulsory medical care. The person must submit this plan in writing within three days of receiving the letter from the medical director. The medical director will decide within two days whether the patient will be given time to do so. If so, the patient will have two weeks' time to draw up the action plan. In this case, the medical director postpones the preparation of the care authorisation temporarily. A template is available for those wishing to make such an action plan, which lists the steps she/he can take for making the plan. The document can be downloaded from the service website, or she/he can ask the medical director for such a document.

The patient can draw up the action plan together with health professionals, friends or family (Submission 30). The patient can also ask a patient advocate or a lawyer for advice. In the action plan, the person can describe what she or he wants to do and what care she or he would like to receive to avoid compulsory medical care. This description can cover various kinds of care, including clinical care, family-based care or social care. The person can also request other support or services, such as domestic help, municipal services, pastoral care, and day care.

The medical director assesses the person’s action plan and asks for a medical statement from an independent psychiatrist. The public prosecutors can stop the preparation of a care authorisation if the medical statement reveals that compulsory medical care can be prevented using the action plan. If the action plan is not sufficient to avoid compulsory medical care, the medical director will continue preparing the care authorisation.

The medical director can also decide at an earlier stage – that is, before the two weeks for drawing up the plan have elapsed – that she or he will continue preparing the care authorisation. The medical director can do so if drawing up the action plan is not proceeding quickly enough or if postponing the preparation of the care authorisation is no longer possible because of the serious harm or perceived danger of the situation. Before doing so, the medical director will discuss it with the patient and their representative. The patient will also be notified about the decision in writing. No empirical information was available at the time of writing concerning the impact of this appeal process on rates of involuntary intervention.

Reducing compulsory admission at a psychiatry emergency outpatient clinic Norway

A psychiatric emergency outpatient clinic in Storgata, Oslo, sought to reduce compulsory admission by providing ‘focused interventions’ for people experiencing acute mental health crises (Submission 17B), and improving the decision-making of staff who impose compulsory admission. Hence, the aim was to reduce (but not eliminate) compulsory admissions. The initiative was trialled between 2001-2013, after which it was implemented into regular practice at the clinic.

Service data indicated a 70 percent decrease in the number of admissions to acute hospital care from 2005-2013. The amount of compulsory admissions compared to voluntary admissions was reduced from 79 percent (hence, 21 percent voluntary) to 40 percent (hence, 60 percent voluntary) in the period 2000-2008. This result persisted to 2013. From 2013 to the time of writing, the percentage of compulsory admissions has varied from 43-53 percent.

The principles for admissions developed as part of the initiative are still used as guidelines for admissions. The interventions include a ‘a checklist, personal feedback, an audit of the journals, and abolishment of printed forms’ (Ness et al., 2016)

The project developed in four steps.

Step 1 (initiated in 2001) involved reducing the proportion of involuntary admissions from 80 percent to 50 percent. Various methods were used, including: admitting doctors being encouraged not to compulsorily admit patients who accepted the admission voluntarily; a ‘Handbook’ being produced which set out ideal referral practice; doctors being discouraged from compulsorily admitting patients with a diagnosis of personality disorders and patients where suicide was the primary indication for admission, and so on. (For more details, see).

Step 2 (initiated in 2006) involved removing templates for compulsory admissions so as to encourage individual consideration of each case and to raise awareness and accountability for decisions of the decision -makers, as well as the requirement for an inter-disciplinary team to make a determination to impose treatment.

Step 3 (introduced in 2007) required individual feedback for staff about their own practice, including their rates of compulsory admissions. They were further encouraged to discuss indication for compulsory admissions with a colleague every time before admission.

> **Step 4** (introduced in 2009) involved a review of admission records – with a focus on the *staff*'s role in the admission process – by three senior psychiatrists from three acute psychiatric wards. Each employee's record was reviewed anonymously to assess the decisions they had made about admission. The same procedure was performed after one year by a senior psychiatrist who gave individual feedback to the employees. (The idea was that if one staff member was admitting people involuntarily at higher rates than others that they would be informed and the trend would be discussed and addressed where needed).

Most of the individual psychiatrists who authorised a higher percentage of compulsory admissions compared to other staff were not aware that they were doing so. When such facts were established, some psychiatrists were not pleased and criticized the project. Some were concerned that the suicide rate of patients would increase. No evidence was provided of any suicide rate increase (Submission 17B).

The initiative was reportedly cost neutral.

Service users were not involved in developing, implementing or monitoring the initiative, but reportedly, the leaders of the initiative were inspired by 'user organizations who campaigned for a decrease in compulsory admissions' (Submission 17B). During the project period, Norway had a clear policy aim to reduce involuntary psychiatric treatment. (For further information about the project, see Ness et al., 2016).

Trieste Model – 'Open Door
No Restraint System of Care for Recovery and Citizenship'
Italy

The Trieste Model is described as an *'open door...* no restraint system of care for recovery and citizenship' in the city of Trieste, Italy (Mezzina, 2014, p.440). Trieste is a city of approximately 236,000 people in the north-eastern region, Friuli Venezia Giulia. In the mid-late 20th century, policymakers in Trieste sought to transition mental health services from a clinical model based on treating illness (for example, with a focus on clinical symptom reduction), to a wider approach that focuses on aspects of their social context that can be altered to foster belonging, safety, and social inclusion.

According to Roberto Mezzina, '[t]he core of the organization is a network of Community Mental Health Centers active 24 hours a day, 7 days a week... with relatively few beds in each of them. The system coordinated by the [Department of Mental Health] also comprises one general hospital psychiatric unit, a network of supported housing facilities and several social enterprises. (Mezzina, 2014, p.440) The Trieste Model has been the subject of considerable research (Portacolone et al., 2015). The WHO cite the approach to public psychiatry as one of the most progressive in the world, and Trieste has been the site of a collaborating centre of the WHO for over four decades (see <https://apps.who.int/whocc/Default.aspx>) with the goal of disseminating its practices across the world (Portacolone et al., 2015).

One challenge for evaluating the evidence for specific practices within the overall Trieste Model, according to Mezzina, is that 'it has not been possible to evaluate the effectiveness of single interventions (i.e. psychoeducational, rehabilitative, psychotherapeutic) because these are interwoven in its "whole system" approach' (Mezzina, 2014, p.440). Nevertheless, there have been several 'cohort studies on patients with psychosis, family burden studies, research on crisis intervention, user and family member satisfaction, and attitude toward community care', according to Mezzina (2014, p.440). Most appear to be Italian-language studies.

Mezzina reports that '[f]ewer than 10 people per 100,000 of the population receive a [compulsory psychiatric treatment order], usually for approximately 7 to 10 days', which is 'approximately 1% of all episodes of residential care' (Mezzina, 2014, p.442). In addition, 'most of them are handled by the [Community Mental Health Centres], which have come to take over most [general hospital psychiatric unit] admissions'. In 2014, Mezzina summarised the largely Italian-language evidence base as follows:

> Crisis management at [Community Mental Health Centers] also proved effective in preventing relapses and chronic courses. A national survey carried out in 13 centers showed that crisis care provided by 24/7 [Community Mental Health Centers] is more

> effective in crisis resolution and at 2-year follow-up, particularly when related to trusting therapeutic relationships, continuity and flexibility of care, and service comprehensiveness. A 50% reduction occurred in emergency presentation of general hospital casualty for approximately 20 years... Qualitative research particularly highlighted some major social factors connected to services and the connection between recovery, social inclusion, and participatory citizenship. Recent data suggest 75% compliance with antipsychotic medication (n = 587), a situation related to the quality of therapeutic relationship and social network enhancement. User satisfaction with services has been high right from the early years and, more recently, recorded 83% in two [Community Mental Health Centers].

Reportedly, some forensic psychiatric services 'are managed de facto with an open door policy' (Mezzina, 2018, p.340), though English-language evidence on the outcomes and precise nature of such interventions appears to be limited.

Several caveats are noteworthy. Portacolone and colleagues reviewed the implementation of the Trieste Model in the US city of San Francisco, and concluded that the success of the Trieste model appears to require a low youth population, low rates of drug use, and adequate housing with high social inclusion (Portacolone et al., 2015). Without such conditions, according to Portacolone and colleagues, it can be difficult for community-focused, de-hospitalised systems to work. Some psychiatrists have argued that it is therefore misleading to cite Trieste as an exemplar, when different cultural, social, economic and political circumstances might require alternative arrangements (Allison et al., 2020). Even within Italy, according to Carta and colleagues (2020), the principles and ideas behind the Trieste Model have been applied to varying degrees in different regions, and with extremely varying levels of success. Nevertheless, Trieste remains an important site in global efforts to reduce and prevent coercive mental health practices.

D. Other Initiatives Toward Reduction of Coercion

Several other initiatives emerged that defied easy categorisation. The following practices are grouped under the sub-categories of:

Advance Planning

There is a large body of research on the use by persons with mental health conditions and psychosocial disabilities of various forms of advance planning (Weller, 2013). Advance planning includes practices variously described in English as 'advance statements', 'advance directives', 'joint crisis planning', and so on. These measures can help to avoid the type of crisis situations in which individuals are subject to coercive measures. Some research has considered the impact of various advance planning methods on reducing the use of coercive practices (see Barbui et al., 2020, p.5), with generally positive results, particularly in the most recent meta-analyses (see de Jong et al., 2016). Trends in mental health policy suggest a general agreement that advance planning is an important element in a suite of desirable practices, including as a means to reduce recourse to coercion and promote human rights (Weller, 2013). According to Chris Maylea and colleagues (2018):

> psychiatric advance directives or similar documents have been legislated, implemented, or piloted in a number of jurisdictions. These include some states in the United States, Belgium, Ireland, Scotland, India, and England, Wales, and Canada. There is a wide variation in the legislative form. The documents may have no legal force, decision makers may have to 'have regard' to them, they may be overturned by a tribunal or other higher authority, or they may be entirely binding in certain circumstances. They may be used to offer advance consent to treatment, in effect 'binding' the person making them, which is sometimes described as a Ulysses clause, or they may be used to select, restrict, or refuse specific treatments, in effect 'binding' the treating team or other decision maker. Despite this variety, all of the models are intended to empower a person and assist in supporting their will and preferences.

Several COE Member States have some form of advance planning in mental health services. Examples from Spain and France are listed below.

ACP-Mental Health – Spain

In 2016 in Andalusia, Spain, for example, the Andalusian School of Public Health produced a guide for advance care planning in mental health (Submission 9, 28). The program is described as ACP-MH for short. The European Network of National Human Rights Institutions and Mental Health Europe (2020, p.18) describe the program as follows:

> The aim is to promote the autonomy of persons with psychosocial disabilities and support people in their decision-making. Users can complete a document explaining symptoms they usually notice when entering in a crisis situation, what makes them feel good and bad when experiencing distress, who their contact person is, who they

> would allow to visit, the type of care they prefer in case of crises, persons who can take decisions for them, information about their general health, diet etc. This is then included in their medical record and made available to health professionals when they are unable to fully express their wishes and decisions.
>
> This advance planning option for persons with mental health conditions and psychosocial disabilities in Andalusia formed part of a group of practices aimed at promoting human rights in services designed to assist people in mental distress and ill-health. Alongside the advance statement program, for example, was a reduction of mechanical restraint initiative that formed part of the broader Comprehensive Mental Health Plan of Andalusia (2016-2020). (See above, p.41).

At present, uptake of ACP-MH is low, which is consistent with trends in the use of advance planning worldwide (see Weller, 2013). A research study carried out by the team found that ACP-MH processes in Andalusia varies among mental health services and professionals. Most participants, both users and professionals, consider ACP-MH as a useful tool to respect user's preferences. Reported benefits include a better relationship and communication between professionals and users, greater participation of users in their process of illness, users' feeling of respect, better self-knowledge and autonomy to manage their mental health problems. Reported weaknesses include the lack of guarantee that user's preferences will be followed, or even consulted by professionals who will take care of patients in the moment decisions need to be taken. Availability and viability of the options selected by users can also become a limitation. Most professionals reported a lack of teamwork, and stated that some colleagues do not believe in ACP-MH, since they are 'stuck in an old model where only professionals know what is best for patients' (Submission 28). Some also think that the entire system needs to change in order to accept and introduce ACP-MH as one more right that needs to be respected. The research concluded that mental health services in Andalusia need more information, teamwork and training on ACP-MH. The tool requires services to evolve into a model of a 'professional-user relationship based on communication and acceptance that users have rights, among them discussing and choosing their mental health preferences for the future' (Submission 28). More information, training and coordination in mental health services is required in order to respect user's rights related to autonomy and decision making in mental health issues.

'My GPS' – France

'My GPS - A Guide to Prevention and Care' ('My GPS' for short) is a booklet created for and with people with mental health conditions and psychosocial disabilities. The booklet provides a way for each person to express their wishes in advance of a crisis. Information can be organised under headings such as: 'What helps me when I am not well?', or 'What wishes I would like to have respected if I am hospitalised'. The My GPS kit has been designed primarily for mental health crisis situations. However, much of the information in the booklet is intended to prevent crisis and hospitalisation. The questions in the booklet prompt the person to reflect on the nature of previous crises in her/his life, her/his preferences, and ideas about what she/he thinks helps her/him and what does not help during periods of crisis. A person can refer to My GPS when they start to feel unwell, and others around them can draw on the booklet to support the person more effectively.

More generally, My GPS aims to:

- Promote autonomy, and voluntary support that that takes account of the person's choices
- Promote consultation between users, professionals and/or relatives concerning individual care and support
- Promote the active involvement of the person in his/her recovery
- Promote shared decision making

If a person does enter hospital, or is involuntarily detained, mental health professionals may refer to the My GPS guide to identify and respect, as far as possible, the person's wishes and needs (Submission 26B). However, the information contained in the booklet is intended to avoid crisis and hospitalisation.

The My GPS educational kit was developed by Marie Condemine and Ofelia Lopez Hernandez (psychologists, PRISM Association), in partnership with ‘Psycom’. It was reportedly developed through ‘a participatory approach, with people living with a mental disorder, relatives, health and social professionals’ (Submission 26B). The My GPS educational kit was awarded the Jury's prize in the *Health Users' Rights 2020* competition by the French Ministry of Solidarity and Health, and was granted the *Health Users' Rights 2020* label by the Ile-de-France Regional Health Agency (Submission 26B).

Peer Support and the Peer Workforce International

Formal ‘peer support’, in which former or current service users take on a professional role in services, are associated with numerous improvements on numerous issues that can impact the lives of persons with mental health conditions and psychosocial disabilities (Repper & Carter, 2011). There does not appear to be research that explicitly seeks to identify a causal relationship between the increase in number of people with lived experience in professional roles at a particular service, and a reduction in coercion. However, there does seem to be an implicit belief in much of the literature that the improvements associated with a larger peer workforce will improve service provision such that, indirectly, coercion will be reduced.

The active involvement of people with lived experience of using mental health services or being subject to involuntary psychiatric intervention in the practice and policies that affect them is also a directive of the CRPD (Article 4(3)). The active involvement of people with this lived experience is by no means limited to the coalface of service provision. Examples from around the world, highlight the variety of roles people with psychosocial disabilities can play concerning mental health, including in research, policymaking, legal advocacy, and so on. However, this sub-section is concerned with direct peer support in mental health *services* (including in hospitals and community services).

A meta-analyses of studies on peer support workers in mental health services, by Julie Repper and Tim Carter (2011, p.392), indicated that such workers 'can lead to a reduction in admissions among those with whom they work', and hence, are likely to indirectly drive down the use of coercive practices. With sufficient training, supervision and management, according to Repper and Carter, this cohort has the 'potential to drive through recovery-focused changes in services' (Repper and Carter, 2011, p.392).

Hearing Voices Network – International

Hearing Voices Network groups are based on the idea that members – that is, those who experience hearing, seeing or sensing things that others do not – can share successful strategies with each other in a safe and mutually supportive space. Hearing Voices Network groups appear worldwide, in countries as diverse as Greece, Denmark, the UK, Uganda, Japan, Australia and the US (Submission 27). In the UK alone, there are reportedly over 180 groups, including groups for young people, people in prison, women and people from ‘Black and Minority Ethnic’ communities (Submission 27).

In one systematic assessment of the impact and effectiveness of Hearing Voices Network self-help groups involving 62 groups affiliated with the English Hearing Voices Network, researchers concluded that attendance ‘was credited with a range of positive emotional, social and clinical outcomes’ (Longden et al., 2018, p.184). Aspects that were particularly valued included: opportunities to meet other voice hearers, provision of support that was unavailable elsewhere, and the group being a safe and confidential place to discuss difficult issues (Longden et al., 2018, p.184). Participants perceived Hearing Voices Network groups to facilitate ‘recovery processes and to be an important resource for helping them cope with their experiences’ (Longden et al., 2018, p.184). Successful groups supply a safe context for participants to share experiences, and enable dissemination of strategies for coping with voices as well as considering alternative beliefs about voices.They aim to offer a safe haven where people with shared experiences feel accepted, valued and understood.

There are several differences among Hearing Voices Network groups, even as they share basic values. The differences include, but are not limited to:

Membership

The membership of most groups is purely made up of people with lived experience of voices, visions and other unusual sensory perceptions. Some groups have open sessions that welcome family members and/or supporters too. Some groups focus on a particular group (people from specific cultural groups, genders or ages, for example). Others are open to all.

Setting

The Hearing Voices network includes groups in a range of settings, including: independent community groups; voluntary sector organisations; mental health teams; inpatient units; secure mental health units; prisons. They are also aiming to provide support groups that are also available online.

Facilitation

Some groups are 100% user-led, with all facilitators having personal experience of voice-hearing. Some others are facilitated by people with a combination of personal and professional experience. In some settings, groups may be facilitated completely by people with professional, but not personal, experience. While these groups are no less valuable than any other, the broader network encourage these groups to find ways of more actively involving people with personal experience in their running and facilitation.

For more information, see: https://www.intervoiceonline.org/; https://www.hearing-voices.org [accessed 12/04/2021]

Intentional Peer Support – the United Kingdom and Internationally

'Intentional Peer Support' (IPS) is a practice that is designed to improve informal relationships of support for people in distress (Submission 27). Darby Penney and colleagues (2021) refer to IPS as ‘a peer-developed, theoretically based, manualized approach that is used in multiple countries’. It is designed to help informal support persons, though it can also be a technique employed by paid staff (Stone et al., 2010), to support a person in a way that helps them to focus on the relationship, and to mutually determine helpful ways to respond to crisis.

Intentional peer support often involves talking very overtly about power—who has it, who does not and how it can be shared through negotiation. The aim is to challenge some of the traditional dynamics that come up in informal care and support for people in crises, and instead create relationships that are more mutual, and in which power is shared rather than taken by those providing care. There is currently no peer-reviewed empirical research into Intentional Peer Support. However, Penney and colleagues (2021) have developed and tested a measure that can be administered to service users to provide quantitative data for assessing ‘IPS core competencies’ in outcomes research, which provides a foundation for future process-oriented research on IPS to systematically document and appraise participant experiences. At present, IPS may be useful in operationalising elements of rights-based support for people in psychological distress and mental health crises which help prevent coercive interventions (see Gooding, 2018, p.202). For more information, see: https://www.intentionalpeersupport.org/what-is-ips/ [accessed 12/04/2021].

Médiateur de santé pairs (‘peer to peer mediator’) – France

An example of peer support workforce creation and development is the *médiateur de santé pairs* (‘peer to peer mediator’), which was developed in France by the *Centre Collaborateur de l'Organisation Mondiale de la Santé pour la recherche et la formation en santé mentale* (French World Health Organization Collaborating Centre for Research and Training in Mental Health).

The program draws on international trends, particularly in high income countries, to integrate former or current service users into mental health care teams but does so by providing graduates of the trainee program with a tertiary qualification. The program began in 2012, in 3 pilot regions, with 30 peer health mediators who divided their time between university-based training and professional activity in a psychiatry department. In December 2017, a more formalised arrangement was made in which health-peer mediator training formed part of an existing Bachelor of Health and Social Sciences degree from the Bobigny Paris University 13 and CCOMS. 35 peer health mediator positions were filled in 6 regions ‘in areas of psychiatry, hospitals and medico-social structures’ (Submission 15). The training comprised of both theory and practice. The theoretical component was organised in partnership with the University of Paris 8 and the training sessions took place in the 3 regions. The practical training involved 15 adult psychiatry institutions (5 sites per region).

As training registration was conditional on recruitment at one of the 15 sites, participants in this program were hired under a professional contract. This contract covered the year of training and internship as well as the year of service placement. The programme has been the subject of qualitative evaluation, which reported positive results, as well as quantitative study, which is underway at the time of writing. (For more information, see http://www.ccomssantementalelillefrance.org/ [accessed 3/4/2021]).

Training

Various forms of human rights based training exist (see, for example, Part I, Section B ‘World Health Organisation – QualityRights Toolkit and Good Practice Guidance’ p.19). The Médiateur de santé pairs, for example, could be described as a training program in addition to being a workforce development strategy. One explicit training initiative – BE RIGHT – was submitted for inclusion in the compendium.

BE RIGHT – Multinational Training Initiative for Health and Social Care Professionals in Mental Health Settings

‘BE RIGHT’ is a training package concerning on human rights in mental health care settings. The contents and methods of the training are meant to highlight the susceptibility of persons with mental health conditions and psychosocial disabilities to rights violations in the very social and health services designed to help them. The training involves reflective practices to assist professionals’ to interrogate widely-held attitudes toward mental health.

The training is reportedly ‘highly practical, interactive, compelling and driving to action’ (http://www.beright-mh.eu/ [accessed 1/4/2021]). It was delivered as part of a pilot test conducted with 5 partner organisations (including the Andalusian School of Public Health in Spain, noted earlier in the report) to a total of 75 individual professionals and is now publicly available through the ‘Be Right e-learning platform’. The platform is available in six EU languages (see https://training.beright-mh.eu/?lang=en [accessed 1/04/2021]).

The program emphasises the voice of individuals with personal experience of mental health conditions and psychosocial disabilities, who were reportedly directly involved in the development of the training materials and the delivery of the training. According to the ‘Be Right’ website:

> BE RIGHT project seeks to give voice to individuals with personal experience of mental illness to speak about how they want to be treated. This will be achieved by directly involving individuals with mental condition in the development of the training materials and the delivery of the training (co-production). In order to provide a comprehensive tool for persons with mental illness to learn about their rights and empower them to stand for their rights an educational board game in human rights for service users will be created.

Thanks to the involvement of different actors- specialists in human rights, social service and health service professionals working directly with persons with mental illness, and the users themselves-, the resulting products will have a special value, built on variety of experiences, insights and expertise (http://www.beright-mh.eu/index.php/be-right-the-project/ [accessed 1/04/2021]).

It is not immediately clear whether the material in the BE RIGHT training explicitly addresses the reduction or prevention of involuntary psychiatric interventions.

III. DISCUSSION

This final part of the report will briefly consider demographic considerations in the practices listed in Part II, before proposing factors that appear common across the good practices.

A. Demographic Variation

Within any country, different economic and social groups may experience mental health services (and all services) differently. People from lower income groups, women, men, children and young people, older persons, LGTBI+, migrants, refugees and asylum seekers, ethnic minorities, and so on, are all likely to experience coercive measures differently.

Demographic matters were only generally noted in submissions for this report in relation to the broader population to which a particular service operated. For example, the Belgian TANDEMplus program serves a part of Brussels with high numbers of migrants, people living in small houses and/or public housing, and populations with higher rates of unemployment and drug use. Other studies noted similar socio-economic disadvantage in the areas in which services operated (such as the Norwegian restraint-reduction program at Lovisenberg diaconal hospital, Clinic for Mental Health).

However, none of the practices appear to have been explicitly designed for specific sub-populations.

Gender

None of the practices/initiatives/programs appear to include an explicit focus on the role of gender, and the different experiences and needs of women and men.

Some programs noted differential outcomes along gender lines. For example, the Six Core Strategies program in Andalusia, Spain, has produced findings that of those who were subject to mechanical restraint, 65% were male and 35% female. This pattern remained over the 3-year implementation of the program, even as the program led to a 15% drop in restraint overall. However, these gendered dynamics do not appear to have been further analysed in the resources currently available, and cannot be said to reveal much about the importance of gender regarding alternatives to coercion as a whole.

There appear to be only a handful of empirical studies in the broader literature concerning reduction and prevention of coercion that explicitly considers differences according to gender (see eg Long et al., 2015). According to studies by Clive Long and colleagues (2015), gender has a significant impact on how coercion is experienced. These impacts are likely to occur in combination with other socio-economic characteristics. For example, in the UK, Black-British men are overrepresented in involuntary psychiatric interventions (Gajwani et al., 2016). Another study from the UK, found that there are 'marked ethnic inequities' between white British women and black British women, but also between white British and 'white other' women in experiences of acute admission, including in how coercion is applied (Lawlor et al, 2012). Further research may be required to consider more broadly the important gender dimensions of efforts to reduce and prevent coercion.

Racial and Ethnic Minorities

None of the initiatives in the compendium included an explicit consideration of the experience of racial and ethnic minorities—although, as with the gender dynamic, this consideration may be occurring on the ground at the level of the service or community organisation itself. One submission noted the higher numbers of migrant groups in an area in which a practice took place (TANDEMplus) but this observation did not form a core part of the practice itself.

As noted, the broader literature indicates that ethnic minorities or migrant groups tend to experience mental health services, and indeed coercive practices, differently compared to others (see eg, Lawlor et al., 2012; Norredam et al., 2010). The 2019 review of the UK *Mental Health Act 1983* (England and Wales), for example, reported that between 2017-18 'there were 289 detentions per 100,000 population for the black or black British group, compared to 72 for the white group' and that '[community treatment order] rates for the black or black British group were over eight times greater than for those in the white group' (Legraien, 2018).

Economic characteristics may explain some of the ethnic differences discussed in the literature. However, at least in the UK, according to Phoebe Barnett and colleagues (Barnett et al., 2019, p.314), identifying socioeconomic and clinical moderators by ethnic group and involuntary status is difficult because such information is 'infrequently reported, preventing meaningful investigation'; it is possible that similar issues of poor data quality occur across Europe. Some ethnic or cultural groups have established or lobbied for their own services, such as Sharing Voices Bradford in the UK, a support programme particularly for Black British and migrant people in mental health crisis, particularly those facing social exclusion, isolation and discrimination (Gooding et al., 2018, p.206).

Older Persons

There is evidence to suggest that older persons are experiencing involuntary interventions in mental health contexts at higher rates compared to others (Gooding, 2018 p.112). None of the practices in this compendium appeared to explicitly address this group, at least in the submission materials, although the East Lille Citizen Psychiatry model appeared to include specific outreach programs for older people. Further, some supplementary research identified the explicit focus on older persons by one service – the Greek Mobile Mental Health Units – which tended to serve older people in remote and rural areas in Greece (Peritogiannis et al., 2017).

Other Demographic Issues

Several studies in the broader literature have focused on specific groups, such as prisoners or persons held in forensic mental health facilities (see e.g., Maguire et al., 2012; Olsson & Schön, 2016), children and adolescents (see e.g., Martin et al., 2008), and older adults (see e.g., Gjerberg et al., 2013; Mann-Poll et al., 2018), though there was nothing of this nature in the submission materials. There are also likely to be significant differences comparing low-income/high-income, young/older, people with intellectual and cognitive disabilities, rural/urban, and so on.

Regarding the challenges facing rural and remote area populations, the Greek mobile mental health units and the Finnish Open Dialogues approach appear to be well suited.

There have been calls for further cross-national study on demographic characteristics of people who experience involuntary psychiatric interventions (Curley et al., 2016, p.53).

B. Factors for Success

Factors for success behind practices in this compendium can be listed into several themes.

General Themes

► Unambiguously seeking to reduce and prevent coercion

As a general comment, being explicit that coercion is extremely undesirable (even if some view it as being necessary in limited circumstances) and committing to active steps to reduce, prevent and even eliminate coercion, is a necessary pre-condition for success in this area. Such statements of intent are clearly not enough on their own, and mechanisms of accountability are required (see below, Policy and Practice). Yet, making this premise explicit helps to refine the focus of any law, policy or practice toward prevention, reduction and, if indeed it is possible, elimination.

► Top-down and local-level leadership is required

One key theme across the practices was that both top-down and local-level leadership appear important. Without both, it seems difficult to create and maintain culture change toward reducing, ending and preventing coercion, whether in an individual service or initiative, or in the service system as a whole.

► Service user, survivor, peer leadership and involvement

Leadership should include peer involvement at both top- and local-levels, both as a human rights imperative (see CRPD Article 4(3)) but also given there is compelling evidence that the involvement of service users and persons with psychosocial disabilities improves the efficacy of reduction and prevention strategies (Gooding et al., 2018). To this end, governments could promote resourcing for people with lived experience of mental health crises and interventions, including resources for training formalised peer workers, as well as promoting and supporting peer leadership in policy-level work. In addition, the existence of independent, peer-run organisations that operate alongside government mental health services, functioning in a systemic advocacy role, also appears to play a positive role in several of the reduction and prevention initiatives in this compendium.

Policy and Practice

From a **policy perspective**, the good practices in the Compendium suggest that coercion-free services or services that greatly reduce coercive measures can be advanced at three interconnected levels:

Figure 1. Policy-level changes

1. **national oversight** could include national policies aimed at reducing, preventing and eliminating seclusion and restraint, legislative restrictions, mandates upon governments to collect data, including reporting on 'progress on alternative treatment options';
2. **organisational culture change** would aim to move services toward rights-based, recovery, and trauma-informed care, individual- and family-led supports; and
3. **independent, systemic advocacy** would be directed at public opinion, politicians, policymakers and service providers to promote the importance of voluntary and coercion-free support (Gooding et al, 2018, p.117).

Some of the most comprehensive systems of reform – such as in East Lille and Trieste – have occurred on the municipal or provincial level. Attention is needed to expanding the lessons of these initiatives to the national and regional levels.

Important work to draw out these lessons is captured in the *WHO Good Practice Guidance on Community Based Mental Health Services Promoting Human Rights and Recovery* (2021, p.8). The Guidance elaborates on the broad policy proposals noted above, and states that 'the creation of services free of coercion requires actions on several fronts including':

1. **education of service staff** about power differentials, hierarchies and how these can lead to intimidation, fear and loss of trust;

2. **helping staff** to understand what is considered a coercive practice and the harmful consequences of its use;
3. **systematic training for all staff** on non-coercive responses to crisis situations including de-escalation strategies and good communication practices;
4. **individualized planning** with people using the service including crisis plans and advance directives;
5. **modifying the physical and social environment** to create a welcoming atmosphere including the use of ‘comfort rooms’ and ‘response teams’ to avoid or address and overcome conflictual or otherwise challenging situations;
6. **effective means of hearing and responding to complaints** and learning from them;
7. **systematic debriefing** after any use of coercion in an effort to avoid incidents happening in the future; and
8. **reflection and change** concerning the role of all stakeholders including the justice system, the police, general health care workers and the community at large. (see also World Health Organization, 2019)].

Hospital-level Success

Similarly, the success of **hospital-level** initiatives listed in this compendium were often grounded in:

- Engagement of and anchoring of the leaders on the ward;
- Active involvement of core, frontline staff so they had a sense of commitment to the practice;
- Engagement and demand from the health authorities;
- Follow up from health authorities and revision of practice;
- Clear leadership of the service;
- Available data (statistics) of own practice and number of admissions/compulsory admissions for personal feedback;
- A culture that is open to learning and trying out new approaches; and
- Stable group of staff.

As a final note, it may be tempting for governments, professional groups, and advocates to direct attention to hospital-based initiatives, given this is where most formal coercive measures take place. However, the good practices in the **‘Community-Based initiatives’, ‘Hybrid’ and ‘Other Initiatives’ Sections** highlight the many steps outside the hospital which are needed and can promote the broad aim of creating coercion-free support.

Indeed, the traditional dichotomy of hospital-based care on the one hand, and ‘community’-based care on the other, may be less helpful than a distinction between ‘crisis support’ (which may or may not take place in a hospital) and ‘general support’ (Gooding et al, 2018, p.116). Expanding government and public perceptions of 'crisis support' beyond merely the hospital, to instead include a range of options in various settings – the home, respite centres, peer-run drop-in services, mobile support units, family group conferencing arrangements, personal advocacy – can help to reframe the focus away from the institutional environments in which coercive practices traditionally occur.

C. Conclusion

There is growing evidence for the success of measures to reduce and prevent coercion in mental health settings and crisis support services. This evidence suggests that many assumptions about the appropriateness and 'necessity' of coercion held by many governments, professionals and communities need to be re-visited.

Few if any governments have sought to systematically reduce and prevent coercive practices, and none in the COE have explicitly committed to aspiring to coercion-free support. What would happen if a single city, country or region implemented the broad range of measures outlined in this report, and others like it? At present, the answer to this question is not clear because implementation of alternatives has been largely *ad hoc*, contained to provincial or municipal levels, or focused only on specific types of coercion and not system-wide patterns. The practices set out in the compendium hint at what is possible.

The compendium suggests that many contemporary coercive measures are not 'necessary' if there is investment in alternative practices and an explicit commitment to reduction, prevention and elimination initiatives. There is a compelling legal and moral case for mandating the introduction of such practices and providing accountability measures to ensure a broader transition to rights-based and recovery-oriented systems.

It is hoped that this compendium might inform a policy framework for COE Member States and civil society to help chart the path ahead.