

BACKGROUND NOTE



What is coercion?

Coercion or **coercive measures** refer to involuntary, forced or non-consensual practices used in mental health services against people with mental health problems.

Involuntary, forced or non-consensual placement/commitment or treatment can be defined as any treatment or placement in/commitment to hospital or other institution administered against someone's expressed wishes – expressed verbally or by any other means (body language, advance directive, etc.)

Why coercion must end?

The **United Nations Convention on the Rights of Persons with Disabilities** (UN CRPD) – signed and ratified by all EU Member States and the EU itself – requires the transition of all mental health services and legislation towards totally consensual practices, which are free from coercion and substitute decision-making. The UN CRPD supports the notion that compulsory treatment should be abolished in the protection of human rights including “the enjoyment of the highest attainable standard of health, access to justice, the right to liberty, and even the right to life.”

Despite legal obligations, there are **no mental health systems across Europe** that have yet switched to fully consensual practices. Europe remains dependent on outdated practices in mental health care:

- Informed consent to medical treatment is at the centre of **good quality healthcare**; non-consensual practices challenge this presumption.
- Involuntary “treatments” such as forced medication or forced electroshock can be **particularly traumatic** when administered against patients' will.
- Coercion is the reason why people with mental-ill health avoid or delay contact with the healthcare system. Fear of losing their dignity and autonomy results in further **negative health outcomes** due to life-threatening distress and crises, which in turn leads to even more coercion.
- There is **no empirical evidence** that coercion helps patients who are potentially dangerous to themselves or others.
- Coercion paves the way for **massive and systemic violations of human rights**, including violations of the right to healthcare based on free and informed consent and the right to active and informed participation in decisions.

Personal testimonies collected in Mental Health Europe's [Mapping and Understanding Exclusion](#) report document overwhelmingly negative experiences of involuntary placement and treatment:

- trauma, fear and pain from the use of physical restraint;
- involuntary hospitalisation;
- pressure to sign consent forms for admission or treatment;
- absence of information and social isolation.

“What coercion in mental health ultimately does is to silence and isolate those who are already suffering from mental illness. Crucially, it reduces our ability to listen and respond to their needs.” - Dunja Mijatović, the Council of Europe Commissioner for Human Rights

“Violence in psychiatry is ubiquitous. They hold us with mental belts to reality. They talk about us without us. They do everything so that we cannot be integrated into society, depriving us of personality and individuality. They enter our lives without knocking. They often take away our dignity by forcing us to take medicine, while medicines are a powerful chemical weapon of psychiatry. The patient who does not want to take medications is controlled and his consciousness is simplified and adapted to life in a crowd. It is shameful that people who feed others with psychotropic medication, do it with stubbornness and without thinking about the violence that comes from them.” - User of psychiatric services, Poland

“Coercion in mental healthcare feels like being punished for having problems. What people really need is not coercion, it is support.” - Ex-user of mental health services, Netherlands

“The CRPD has formulated the basic principle: No forced psychiatric interventions. I think after ten years we can take for granted that this principle stands within the CRPD. Now we need to address its implementation and alleviate the fears that society and professional communities still have with respect to non-forced interventions.” - Markus Schefer, member of the United Nations Committee on the Rights of Persons with Disabilities

Facts and figures

Recent evidence in MHE’s [Mapping and Understanding Exclusion report](#) shows:

- an increase in the use of coercion, including in England, Scotland, Ireland, Belgium, France and the Netherlands;
- in Austria and Sweden, the rate of involuntary placement has been relatively stable since the early 2010s;
- two countries – Finland and Germany – reported a decrease following legislative changes and targeted programmes to reduce the use of coercion in psychiatry;
- a 60% reduction in restraint and seclusion in Israel was achieved through a national initiative;
- Spain shows positive signs through the adoption of legislation to reduce coercion in the Navara region and the adoption of strategy to reduce restraint in Andalusia;
- the regulation of involuntary placement and treatment varies greatly across Europe.

How to improve quality and human rights standards in mental health?

MHE’s [‘Promising practices in prevention, reduction and elimination of coercion across Europe’](#) report offers an overview of successful and promising practices to prevent, reduce and eliminate coercion in mental health care, including restraint and seclusion. It aims to highlight positive examples across Europe and beyond. Although there is no one-size-fits-all approach to end coercion, many examples share some common aspects, including:

- greater focus on the will and preferences of service users;
- better training of staff members and public officials;
- improving communication with users and their physical environments;
- better collaboration between different services (for example, social services, health authorities, employment services, local leisure opportunities);
- better monitoring and data collection on the use of coercion and joint reviews of the incidents to see what can be learned.

Our evidence shows that to implement a new culture in mental health care, a combination of both grass-root work and overarching strategies is the best way forward. Only the elimination of coercion will ensure systemic change leading to a human-rights based mental health system, compliant with the UN Convention on the Rights of Persons with Disabilities.