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Review

Coercion and compulsion in mental healthcare—An international perspective

Andrew Molodynski [a,b,*], Lucinda Turnpenny [c], Jorun Rugkåsa [c], Tom Burns [c], Driss Moussaoui [d,e] the World Association of Social Psychiatry International Working Group on Coercion [1]

[a] Oxford Health NHS Foundation Trust, UK
[b] Oxford University, Department of Psychiatry, UK
[c] Social Psychiatry Group, Oxford University, Department of Psychiatry, UK
[d] Department of Psychiatry, Ibn Rushd University Psychiatric Centre, Casablanca, Morocco
[e] World Association of Social Psychiatry (WASP), Morocco

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ABSTRACT

Background: Coercion has always existed in psychiatry and is increasingly debated. The 'move into the community' in many countries over recent decades and the evolution of community services have substantially altered the locus of coercion. In many countries psychiatric services remain poorly funded and patchy. Substantial differences between regions and countries in the provision of services, the role of the family, and the wider economic and political climate are likely to lead to different sources and experiences of coercion.

Discussion: This paper explores a number of factors that may affect the prevalence and type of coercion in psychiatric services and in society and their impact upon those with severe mental illnesses. Differences in service provision are explored and wider societal issues that may impact are considered along with relevant evidence.

Conclusions: Coercion is commonly experienced by those with severe mental illnesses but is poorly understood. The vast majority of research relates to High Income Group countries with developed community services and formal mental health legislation that adopt the so-called 'medical model'. Further research and collaboration is urgently required to increase our understanding of these issues, which are difficult to define and measure. An evidence base that is relevant worldwide, not just to a small group of countries, is needed to inform training and the care of all patients. A particular focus must be expanding our knowledge and understanding of coercion in cultures outside those where such research has traditionally taken place to date.

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* Corresponding author at: Oxford Health NHS Foundation Trust, UK. Tel.: +44 1235 799800.
E-mail address: andrew.molodynski@oxfordhealth.nhs.uk (A. Molodynski).
[1] See Appendix A.

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1. Introduction

The use of coercion is a frequent cause of debate and concern. 'Coercion' is defined in the Oxford English Dictionary as 'to constrain or restrain by the application of superior force, or by authority resting upon force' (Simpson, 2009). For coercion to exist, one person or group must have power over another. This idea was asserted by Hobbes (1651) and later developed by (1797). Hobbes proposed that coercion is a necessary part of state functioning, and Kant suggested that it is justified if it acts in the good of society by contributing to the freedom of others. Herein lies the basis for much of the debate about coercion: how to strike the balance between the rights of individuals and of communities.

Within psychiatric practice, 'coercion' is frequently described as a subjective experience arising from compulsory actions taking place in an individual's environment (Rhodes, 2000). The literature often refers to 'perceived coercion' in order to distinguish the experience from (objective) interventions that may increase or reduce such feelings (Newton-Howes, 2010). The power to compel (i.e. to insist on containment and/or treatment) has existed in mental health services in most countries for many years through legislation. In relation to mental health treatment, 'compulsion' generally refers to forced treatment under legitimate legal authority, ideally subject to scrutiny and with rights of appeal. Terminology in the area is extremely complex. There are both 'subjective' and 'objective' aspects to coercion. The latter may involve 'threats' or the actual use of compulsion while the former involves the perception of threats of the use of force if one does not act according to the wishes of another. Perceived coercion may occur in the absence of 'objective' coercion but the two usually occur together. In this discussion we shall be considering both aspects.

1.1. Coercion in a wider context

Since the emergence of recognisable modern mental health care 200 years ago, there has been ongoing vigorous debate as to whether the state and its agents have a right (or indeed a responsibility) to intervene in the lives of those with mental illness to alleviate their symptoms and improve their situation. Such intervention has taken different forms over time and across societies. Many people with mental illnesses receive support and treatment from both professionals and informal carers (such as family or partners). Perceived coercion can arise from either or both of these sources as well as from wider social or cultural expectations (Canvin et al., 2013). The sources of coercion acting upon or experienced by the individual may vary widely depending on (among other factors) the types of services and the role of the family. These factors are affected by jurisdiction, locality, cultural norms and individual circumstances. When studying mental health care it is also important to consider the very different contextual issues that stem from political and economic circumstances, for example the role played by psychiatric services in the former Soviet Union some decades ago (Bonnie, 2002). It is likely that investigations of coercion are more sensitive to such differences than trials of specific medications or well defined therapeutic interventions, because the issues arising are so clearly affected by the wider social context.

2. The literature on coercion

The overwhelming majority of the academic literature on coercion and compulsion in mental health care is based in a small number of economically developed nations. It may therefore be of limited relevance to those planning, delivering, and using services in other parts of the world. The literature is complex and patchy in a variety of respects. With a relatively limited amount of high quality research originating from a small number of centres, it may be inevitable that some topics will be concentrated upon to the detriment of others. One area that has been focussed upon is coercive intervention in the community. This is irrelevant in many areas of the world as community services do not exist in an organised and formal way, let alone legal powers to compel acceptance of them.

The literature has often also been divided along professional lines with clinical, legal or philosophical/ethical approaches. The former has typically examined the effects upon outcome in terms of symptoms, functioning, and hospital use (Swartz et al., 2001) whereas the last two have tended to focus on civil liberties, the role of the state and arguments for and against coercive intervention (Eastman, 1997). Recently there have been attempts to take interdisciplinary approaches to the subject (Kallert et al., 2005; Swartz et al., 2010).

While there is relatively little empirical research published, there is no shortage of opinion and comment. Many argue that an individual should have the right to decline interventions, assuming they possess the ability to understand the issues and have capacity (Dawson and Szmukler, 2006). An increasing number of clinicians and academics contend that those with mental health problems have positive rights also (i.e. the right to be given effective treatment and support for their health problems) (Fennel, 1999). Some treatment programmes delivered to professionals, which combine high quality services with substantial explicit coercion in the form of conditions to remain in employment (DuPont et al., 2009), appear to be very effective. Severely mentally ill individuals frequently live in desperate circumstances in the community even in the most affluent societies, and advocates of assertive efforts to intervene argue that not to help can be seen as active neglect. In less affluent societies, treatment for some may not be available in any meaningful sense. This effectively removes the right of an individual to make a positive choice to have (or not to have) treatment for their condition and is therefore restrictive. This restriction of choice due to lack of resources may be perceived as coercive by the individual concerned.

3. Institutional coercion

Since the provision of institutions, severely ill patients have received treatment during long-term stays within them. Such institutions have also been (and still are) used to provide containment and boundaries are frequently blurred. Some patients do not have a clear understanding of whether they are detained or not (Sjöström, 2005). A recent report by the care quality commission (a government department charged with scrutiny) in England and Wales reported that in 20% of hospital visits voluntary patients might be detained 'in all but name' as unaware they were able to leave (CQC, 2013). Researchers in Germany interviewed consecutive admissions to hospital and concluded that whether someone was admitted voluntarily or compulsorily had no significant effect on short term outcome (Steinert and Schmid, 2004). There are few if any other similar studies and none that we are aware of in countries with developing services. In less economically developed nations the majority or entirety of care may be centred in large institutions as this is all that is provided or can be afforded. In the most disadvantaged nations (or regions within them) there may be no meaningful state provision at all with families often providing all aspects of care and containment.

Traditionally, research on coercion within institutions has focused upon the use of legislation and chemical and physical restraint alongside the reported experiences of service users. Attempts have been made to establish associations between such factors and medium to long term outcomes such as readmission,