Union Européenne des Médecins Spécialistes (U.E.M.S.)
European Union of Medical Specialists
SECTION OF PSYCHIATRY

UEMS Section of Psychiatry, Human Rights Working Group Position Paper

Maintaining Human Rights and Recovery Principles when coercive practices are considered

The aim of this position paper is to ensure that psychiatric practice and training are based on the principles of human rights and recovery.

Coercive practice refers to any non-consensual treatment or intervention. This may include admission to hospital, administration of medication, seclusion, restraint, and close observation. Coercive practice should represent a last resort measure; it must always be subject to rigorous scrutiny and challenge and alternatives should be always sought. It is important to note that coercive practices of themselves are not therapeutic and may in fact be counter therapeutic even when initiated in the person's best interest. Coercive practice in psychiatry remains unavoidable in situations of extreme risk or the right to treatment in cases of incapacity due to severe mental illness. A minority of people with life-threatening illness, those whose illness may pose serious risk to others, or who lack capacity and would benefit from treatment, may require treatment without their consent. A person should only be deprived of the fundamental right to liberty and self-determination strictly in accordance with relevant and protective legislation – this would be expected to be appropriately informed Mental Health Legislation. Any increase in rates of coercive practices must be reviewed and of concern given the evidence- based interventions that have been shown to eliminate or reduce coercive practice.
Interventions in psychiatry should be delivered based on informed consent in a way that is not coercive, respects individual will and autonomy, and supports people through their recovery process.

The use of coercive practices may be reduced or eliminated by educating psychiatrists in a number of key areas. These areas include:

- human rights,
- the principles of medical ethics,
- competency in obtaining valid informed consent
- the use of a holistic bio-psycho-social approach to mental disorder and disability ,
- the assessment and prevention of risk,
- the assessment of mental capacity,

- the use of interventions to maximise patients' participation in decision-making,
- the application of recovery principles and
- the alternatives to coercive practices

Psychiatrists need to have a knowledge of the UN Convention on the Rights of Persons with Disabilities (CRPD) and relevant other international laws and national mental health legislation. Further information about the promotion of the rights of people with psychosocial, intellectual and cognitive disabilities is available at: WHO QualityRights e-training on mental health.

The decision to use a coercive intervention is based on the consideration of several issues. Some of the issues relate to the psychiatrist's assessment of situational variables which contribute to risk of harm, need for treatment, the person's capacity for decision making, the person's best interests and the person's preferences. Other issues relate to the skills of the psychiatrist, including conflict resolution, de-escalation, problem-solving and emotional regulation (both their own and other peoples'). Training in these topics should focus on their application to challenging situations.

Special attention should be devoted to the elimination of potential environmental triggers of aggression in the hospital setting such as: lack of information about diagnosis, treatment plan and rights; restriction of freedom of movement; lack of privacy; inflexible house rules; poor levels of communication including insufficient exploration of concerns; unexplained rejection of demands; unwanted contact with other patients including those who are agitated/behaviourally challenging; lack of or inappropriate activity resulting in under or overstimulation or frustration. A welcoming environment, appropriately resourced in terms of facilities and staff skills, staff numbers and attitudes is essential to reduce the likelihood of coercion.

Psychiatrists need competences to use evidence-based interventions that can prevent or significantly reduce the use of coercive measures such as de-escalation; "saying yes and can do" culture; use of a comfort room with sensory modulation; a trained response team; joint crisis intervention; the use of advance directives; individualized plans to identify and manage triggers and signs of distress to prevent the future tense and conflictual situation as well as use of multiple modalities to produce systemic change at the level of the institution. A comprehensive approach that is focused on systemic change will offer the best chance to eliminate or

reduce coercive interventions in practice. Such approaches will characterize services that are recovery-focused and trauma-informed with a culture of respect for human rights. The most successful services will have a plan to prevent and reduce the use of coercive measures, which will be regularly monitored to evaluate its effectiveness. People with lived experience and their families should take part in the training of psychiatrists. There are further examples of best practice in the bibliography, also available at https://rm.coe.int/compendium-final-en/1680a45740

When anticipating or managing conflict the safety and dignity of service users and the safety of staff are priorities.
Psychiatrists must be aware that coercive practice can have negative consequences for the health of all concerned. To mitigate this risk, a post-incident intervention such as de-briefing of patients and staff should always be held following every occasion on which a coercive measure was used.

A competent psychiatrist is able to assess when a patient needs to be admitted to hospital urgently, including in situations where there is risk to life or of other serious harm. Psychiatrists are also able to assess the person's capacity to agree to hospital admission. It follows that they will have a thorough understanding of the criteria for determining capacity and will also have expertise in methods of supporting a person who needs assistance to understand the relevant information or to communicate their wishes. In situations when a person, even with support, does not have the necessary degree of capacity, the competent psychiatrist is able to properly use the applicable legislation.

The European Union of Medical Specialists (UEMS) Section of Psychiatry holds strongly to the view that therapeutic cultures that are unequivocally based on recovery and that demonstrate respect for human rights contribute to the prevention of coercive practices. We support a holistic recovery approach which includes three dimensions of recovery: clinical, functional and personal. This should be the basis for the organisation of mental health services and interventions. It is important to espouse optimism: people can and do recover from serious mental health challenges. The principles of recovery should be included on a service as well as individual treatment level. For a description of each principle see Appendix.

Change is most likely to happen when all stakeholders are involved in changing policy and implementing evidence-based practice: people with lived experience, their families, health systems, communities and legislators. Existing Mental Health Legislation should be reviewed in light of this position statement and need for revision and amendments assessed. It should also underpin and guide new Mental Health legislation where it has yet to be drawn up.

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Appendix: Recovery Principles

The recovery focussed approach of supporting people in overcoming the challenges caused by mental illness has now become an internationally accepted standard for the provision and organisation of mental healthcare services. This approach entails a shift of perspective, from a clinical focus on symptoms, to a focus on strength, wellness, and social inclusion (WHO 2019). Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential (SAMHSA's working definition of recovery). Recovery is not synonymous with medical remission; it can be achieved with and without remission.

In this appendix we will describe the principles of recovery focussing on the role of psychiatrists in facilitating the recovery process of people who have a mental disorder.

Hope and optimism about the future is the basic ingredient of recovery; no one can recover without hope- The psychiatrist-patient relationship should be based on a shared belief in the reality of recovery**.** Hope and optimism for recovery should be maintained during the entire process of care and should be part of the culture of every service. The psychiatrist should hold in mind that people can and do recover from mental disorders; information about psychiatric diagnosis and treatment should include the message of recovery.

Recovery is person driven with many pathways- Treatment should be based on the patient's informed consent. There will be collaborative agreement to the goals of treatment which will be driven by the patient's preferences. Each person is unique with distinct needs, strengths, preferences, value, goals, culture and different life experiences. As a result, the path that each person will take toward recovery will be unique. The psychiatrist should be receptive to and support pathways to recovery in addition to the clinical. It should be remembered that recovery is not a linear process; setbacks are to be expected, therefore it is important that the psychiatrist fosters resilience.

Identity, self-esteem, self-respect and empowerment- Recovery is supported by positive self-perception, self-esteem, self-respect, self-efficacy, positive identity, as well as by perceived respect from others. These are the factors that empower people to take control of their lives and build resilience. Being diagnosed with mental illness and the consequent self-stigma can spoil a person's sense of identity and self-confidence. The psychiatrist should address this as the first step in supporting the recovery process. The psychiatrist supports

the person to move from a position in which their identity is dominated by illness to one that is personal and positive.

Holistic- The psychiatrist should have a holistic approach to treatment that is based on a bio-psycho-social understanding of mental disorder and its treatment. They should take a whole person approach, which include assessing and supporting interventions in all areas relevant to recovery such as: symptoms management, building resilience, promoting positive identity perception, housing- having a stable and safe place to live, social inclusion including employment, leisure, and participation in resource community life, relationship and support from others, skills for everyday life, benefits and so on.

Culture, meaning and purpose - Culture has many dimensions and it includes ethnicity, race, religion, age, gender, family values, the region of the country and others. We must also consider the culture of service providers, which should be recovery oriented. Culture shapes the meaning of illness, influences how individuals manifest and communicate their symptoms, cope with psychological challenges, and their willingness to seek treatment. Culture, including values, traditions, and beliefs are keys to determining a person's journey and their pathway to recovery. Psychiatrists support people in becoming aware of their values and purpose and connecting them to their treatment goals. Meaning and purpose are expressed in many ways such as meaningful activities including work, family caregiving, creativity and more, being productive, participating in society, and in spiritual life and religious observance. Psychiatrists should be responsive and respectful to the health beliefs, cultural, gender and linguistic needs of diverse people and groups.

Strengths and responsibilities- Recovery promotes a person's strengths by increasing self-efficacy and improving their functioning in different life areas as well as taking responsibility for their own care. Psychiatrists should assess peoples' strengths as well as weakness and use interventions that empower people to manage their life. They should respect and support self-determination as a human right as well as advocate for communities to provide opportunities and resources to foster social inclusion and recovery and so counter stigma and discrimination against mentally ill people.

Relationships, self-help, peer support and social inclusion- Recovery is supported by different type of relationships including therapeutic relationships with the psychiatrist and other mental health professionals, relationships with families, friends, self-help groups, peers and their wider social network. The establishment of trusting, empathetic and

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consistent relationships with the patient can lead to better outcomes and is key to the patient receiving effective and appropriate care. The psychiatrist moves from being the sole expert to being a coach and partner on the patient's journey of recovery. Psychiatrists should assume that the goal of a patient's treatment is to live a satisfying life in the community, so interventions that facilitate social skills building, self-help, social inclusion, and resilience should be essential parts of the care plan. This will require collaboration with other professions and services. The psychiatrist will advocate for peer support whenever it is useful for the patient and will welcome peer workers as equal members of the treatment team.

Addressing trauma- Trauma (current and past) related to -violence, emotional abuse and any other adversity must be addressed if recovery is to be enduring and successful. Services and support should be trauma-informed to foster safety (physical and emotional) and trust, and should promote choice, empowerment, and collaboration to avoid re-traumatisation. The psychiatric assessment must include information about trauma and its contribution to the person's current mental health difficulties. Interventions should focus on working with the consequences of trauma. Mental health services must be organised in such a way to avoid traumatisation.

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