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Ending coercion in mental health: the need for a human rights-based approach

Parliamentary Assembly

1. Across Europe, a growing number of persons with mental health conditions or psychosocial disabilities are subject to coercive measures such as involuntary placement and treatment. Even in countries where so-called restrictive laws have been introduced to reduce the recourse to such measures, the trend is similar, indicating that in practice such laws do not seem to produce the intended results.

2. The overall increase in the use of involuntary measures in mental health settings mainly results from a culture of confinement which focuses and relies on coercion to "control" and "treat" patients who are considered potentially "dangerous" to themselves or others. Indeed, the notion of risk of harm to oneself or others remains a strong focus in justifications for involuntary measures across Council of Europe member States, despite the lack of empirical evidence regarding both the association between mental health conditions and violence, and the effectiveness of coercive measures in preventing self-harm or harm to others. Reliance on such coercive measures not only leads to arbitrary deprivations of liberty but, being unjustified differential treatment, it also violates the prohibition on discrimination.

3. Evidence from sociological fieldwork research on persons with mental health conditions, on the other hand, points to overwhelmingly negative experiences of coercive measures, including pain, trauma and fear. Involuntary "treatments" administered against the will of patients, such as forced medication and forced electroshocks, are perceived as particularly traumatic. They also raise major ethical issues, as they can cause potentially irreversible damage to health.

4. Coercion also has a deterring effect on persons with mental health conditions who avoid or delay contact with the health-care system for fear of losing their dignity and autonomy, which ultimately leads to negative health outcomes, including intense life-threatening distress and crisis situations, which in turn lead to more coercion. There is a need to break this vicious circle.

5. Mental health systems across Europe should be reformed to adopt a human rights-based approach which is compatible with the United Nations Convention on the Rights of Persons with Disabilities, and respectful of medical ethics and of the human rights of the persons concerned, including of their right to health care on the basis of free and informed consent.

6. A number of positive examples from within and outside Europe, including hospital-based strategies, community-based responses, such as peer-led crisis or respite services, and other initiatives, such as advance planning, have proven to be highly successful in preventing and reducing recourse to coercive practices. These promising practices are also highly effective in assisting persons with mental health conditions during crisis situations, and should thus be placed at the centre of mental health systems. Services which rely on coercion should be considered unacceptable alternatives that must be abandoned.

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1. *Assembly debate* on 26 June 2019 (23rd Sitting) (see Doc. 14895, report of the Committee on Social Affairs, Health and Sustainable Development, rapporteur: Ms Reina de Bruijn-Wezeman; and Doc. 14910, opinion of the Committee on Equality and Non-Discrimination, rapporteur: Ms Sahiba Gafarova). *Text adopted by the Assembly* on 26 June 2019 (23rd Sitting).
See also Recommendation 2158 (2019).

7. In view of the elements above, and convinced that greater awareness, cross-stakeholder co-ordination and political commitment are crucial in initiating and sustaining the much-needed change in mental health policies, the Parliamentary Assembly urges the member States to immediately start to transition to the abolition of coercive practices in mental health settings. To this end, it calls on the member States to:

7.1. develop, as a first step, a roadmap to radically reduce recourse to coercive measures, with the participation of all stakeholders, including in particular persons with mental health conditions and service providers;

7.2. develop effective and accessible support services for persons experiencing crises and emotional distress, including safe and supportive spaces to discuss suicide and self-harm;

7.3. develop, fund and provide resources for research on non-coercive measures, including community-based responses such as peer-led crisis or respite services, and other initiatives, such as advance planning;

7.4. dedicate adequate resources to prevention and early identification of mental health conditions and early, non-coercive intervention, especially in children and young people, without stigmatisation;

7.5. fight the stereotypes against persons with mental health conditions and, in particular, the erroneous public narrative about violence and persons with mental health conditions, through effective awareness-raising activities involving all relevant stakeholders, including service providers, media, police and law-enforcement officers and the general public, as well as people with lived experience of mental health conditions;

7.6. review the curricula of higher education institutions, in particular those of schools of medicine, law and social work, to ensure that they reflect the provisions of the United Nations Convention on the Rights of Persons with Disabilities;

7.7. fight against the exclusion of persons with mental health conditions by ensuring that they have access to appropriate social protection, including housing and employment;

7.8. provide adequate social and financial support to families of persons with mental health conditions to enable them to cope with the stress and pressure of supporting their loved ones.