Towards human rights compliant alternatives to coercion
A European perspective

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Who we are, what we do

- We are a European umbrella organisation
- Advocating for the rights of people living with mental ill health
- Advocating for mental health promotion and prevention and quality services
- Representing +73 members across 30 European countries
- Active in the field of mental health and in European institutions since 1985
- Our members are mental health professionals, national organisations, services-providers, users & ex-users of services, family organisations...
Strategic priorities

Human-rights based & recovery
Ensure a human rights–based and recovery-centered approach to mental health

Parity of esteem
Valuing mental health equally with physical health

Community based care
Advocate for deinstitutionalisation and for better community based care

Mental health at work
Promote for better mental health at work
International legal framework
United Nations Convention on the Rights of Persons with Disabilities (UN CRPD)

• Adopted in 2006, entered into force in May 2008

• Includes people with long-term mental ill-health (psychosocial disabilities)

• CRPD and modern mental health practice: competing principles

  - Social model of disability vs biomedical model
  - Dignity and individual autonomy vs protection
  - Care vs charity
  - Equality in the community vs institutionalization
  - Participation and inclusion, nothing about us without us
CRPD and coercion

- Right to legal capacity (article 12)
  - Right to make decisions and have those respected by others
  - Abolish substitute decision-making regimes
  - Abolish mental health laws that permit forced treatment

- Right to liberty and consent (articles 14, 15, 17)
  - Absolute prohibition of detention on basis of impairment, including Perceived risk or dangerousness tied to impairment
  - Need of care or treatment tied to impairment
  - Seclusion and restraint are not compatible with the prohibition on torture
  - Support for free and informed consent regarding treatment
CRPD and coercion

- Right to independent living (article 19)

- Right to health (article 25): provide health services and care
  - Including early identification and intervention
  - Close to people’s own communities, including in rural areas
  - On the basis of free and informed consent
Today in Europe, tens of thousands of people with mental health problems live in psychiatric and other institutions.
Mapping and Understanding Exclusion in Europe

- Launched January 2018
- Authored by Mental Health Europe and Kent University Tizard Centre
- Gives an (updated) overview of European countries’ mental health laws and the state of play of institutional and community-based services in the mental health field in Europe
Mapping and Understanding Exclusion in Europe

- Covers 36 countries
  - based on literature review
  - official data
  - input from MHE’s network of members and independent experts

- Wider scope than the first edition from 2012
  - mapping of coercive practices
  - guardianship regimes (full/partial)
  - emerging issues in the mental health field

- Also includes testimonies from persons with lived experience of “exclusion” (involuntary placement and/or treatment or long-term institutionalisation)
Main findings

- Tens of thousands of people with mental health problems are living in psychiatric and other institutions in Europe today.

- Regulation of involuntary placement and treatment varies greatly across Europe.

- Severe lack of official and reliable data.
  - Data should be approached with extreme caution.
  - Data should be interpreted in local context.

- Where relatively reliable data exists.
  - Increase in England, Scotland, Ireland, Belgium, and France.
  - Relatively stable since the early 2010s in Austria and Sweden.
  - Decrease following legislative changes and targeted programmes in Finland and Germany.
Main findings

- Institutional care, the use of coercion, forced medication, loss of rights and reliance on involuntary hospitalisation of people living with mental ill health are not only a Central and Eastern European problem.

- Over-reliance on coercion
  - forced treatment outside of institutions (CTOs etc) rapidly expanding (*France and Scotland: CTOs represented 40% of all compulsory treatment in 2015*)
    - increase of forced treatment and placement in hospitals in some countries

- Potentially promising reforms in 10+ countries on
  - legal capacity
  - guardianship laws
  - transition from institutions to community based-services

- Hope: successful programmes to reduce coercion, restraint and seclusion
What should community-based services look like?

- Good community-based services provide HOPE
- Ensure that people remain included and receive support in the community
- Range of support services that are person-centered, recovery-oriented, empowering
- Do not require you to comply with certain rules or restrictions
- Peer support, empowerment and personal budgets can be means for preventing an institutional culture
Policy recommendations I

1. States shall adopt policies aiming at reduction of coercion and ultimately eliminate such practices in line with human rights standards.

2. States shall document institutional placements and make data publicly available.

3. Better monitoring of deinstitutionalisation programmes and ensure those are in line with Article 19 of the CRPD.
Policy recommendations II

4. EU support to transition towards CBS through their Multiannual Financial Framework Post-2020

5. Exchange of information and practices between EU MS on mental health reforms

6. EU should provide funding for research on alternatives to coercion and scaling up of promising practices
Where to find more information?

- Full report and video are available in English on MHE’s website: https://mhe-sme.org/what-we-do/projects-campaigns/

- Most country fiches, and the Executive Summary, are translated into the language of the respective country. Available on MHE’s website

MHE is keen to ensure the report is as accurate as possible!

Do not hesitate to let us know if there are any inaccuracies in the report or if there is more recent data available

We aim for this report to be a living instrument!
What is next for MHE?

Cross-national scoping and gathering of best practices / solutions to coercion, restraint and seclusion

Aim: to give an overview of policies, practices, plans (i.e. zero vision strategies) to reduce forced or involuntary placement or hospitalization, treatment, and the use of seclusion and restraint

Work in progress: contact marie.fallon@mhe-sme.org to share best practices
General Trends

- Advanced directives and anticipated treatment plans
- Intentional Peer Support
- Supported decision-making, e.g. Personal Ombudsman in Sweden
Hospital-based programmes

Sweden (region of Västra Götaland): ‘To Come to One’s Own Rights’

- Psychiatric ward for people experiencing psychosis
- Training to hospital management, staff, service providers involving users

Results:

- decrease in use of coercive measures
- huge decrease in use of restraint: approximately 90%
- fewer forced injections
- users of services show more satisfaction with service
- staff enjoy their work more
Hospital-based programmes

Italy - No Restraint Psychiatric Units of General Hospitals (SPDCs)

- 320 SPDCs
- No more than 15 beds part of the territorial community mental health service
- Average of involuntary admissions is between 10 and 15% of the admissions to SPDC
- Some SPDCs are completely open and that have abandoned the use of restraints for many years
- Openness, trust and collaboration with people both inside and outside the hospital
- New skills for mental health professionals but also new general attitudes towards persons with mental health problems
- Involve organizations and services both at hospital and community level like user and family associations, local authorities, police and justice system
Community-based programmes

Greece - Mental Health Mobile Units

- more than 25 units since the 1980s
- especially in small and remote prefectures
- individuals considered as a bio-psycho-social whole
- reduction in the number of involuntary hospital admissions
  - through prevention, informing the local inhabitants, timely intervention, maintaining contact with both the family of the user but also the community, awareness-raising among prosecutor and police

Respite houses (Soteria): non-medical staff, social network, empowerment of residents, ‘being with them’ in crisis, consent

Open Dialogue: transparency with person, empathy, positive regard, involvement of social network, 80% no relapse and full employment
Challenges to reducing and eliminating coercion

- Holistic mental health system is crucial
- Need for integration and availability of mental health into primary care services (mobile units, mental health centres) and for continuity in care
- Prevention of crisis situations
- Effective work at territorial level with good quality out-patient and community services
- Focus on the emotional/therapeutic bond with the person
- Empowerment of users
Thank you for your attention!

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