**Alternatives to Coercion Review – Literature Selected for Full Review**

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| AUTHOR | YEAR | REGION/  COUNTRY | POPULATION  SAMPLE | AIM | TYPE OF STUDY | MAIN FINDINGS |
| Aagaard, J; Tuszewski, B; Kølbæk, P | 2017 | Denmark | 240 men and women starting as recipients of Assertive Community Treatment during a five-year period. | To see whether Assertive Community Treatment (ACT) may have the quality to reduce the use of several types of coercion including compulsory admissions. | Quantitative - analysis of service data from the Danish National Case Register at three psychiatric hospitals. | An assertive approach appears to reduce hospitalisation including some involuntary admissions. ACT is preferable from both team and patient perspectives. The researchers recommend revision of the criterion of 'severe mental illness' to facilitate ACT to be offered to a larger group of patients. In addition, the researchers recommend that the introduction of Crisis Intervention Teams should be considered and allocated to psychiatric emergency rooms. |
| Allen, M | 2003 | United  States | N/A | To summarise the reasons why housing for people with psychiatric diagnosis should be provided free of the use of coercion. | Qualitative - analysis of legal, policy documents and research reports. | Mental health services appear to be using coercive practices or 'leveraging' with housing. That is, threatening discontinuation of housing services or eviction if psychiatric intervention is not accepted. This practice appears to breach the Americans with Disabilities Act, and according to the author has multiple, negative flow-on effects. |
| Andersen, K; Nielsen, В | 2016 | Denmark | 235 men and women admitted to a closed ward during 2011-2013 were randomly selected. | To identify possible external (extramural) factors that may increase the risk of coercion during admission to a closed psychiatric ward. | Quantitative - retrospective analysis of case report data. | 66 people (28% of the sample) were subject to coercion. The time of forced procedures was predominately during the first hours after admission. The risk of forced measures being applied was sig-nificantly higher if patients were involuntarily admitted (OR = 6.4 (3.4- 11.9)), or were acutely intoxicated by substances at the time of admission (OR = 3.7 (1.7-8.2)). The researchers recommend that extramural factors should be considered when seeking to reduce coercion, and suggest better integrated efforts between mental health and substance abuse services as a way to reduce coercion. |

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| Ashcraft,  L; Anthony, W | 2008 | United  States | Service data on 14,500 adults per year for a four- year period (incl. 4,600 brought to service involuntarily) | To evaluate a policy to eliminate physical and mechanical restraint and evaluate the success of the programme at two crisis centres in the United States. | Quantitative - analysis of case report data. | Existing records indicated that over a 58-month follow- up period (January 2000 to October 2004), the larger crisis centre took ten months until a month registered zero seclusions and 31 months until a month recorded zero restraints. The smaller crisis centre achieved these same goals in two months and 15 months, respectively. |
| Ashcraft, L; Bloss, M; Anthony, WA | 2012 | United  States | 12,346 adults who used a mental health crisis centre over a two year period. | To evaluate the success of the 'No Force First' approach developed by Recovery Innovations and evaluate the success of the programme in reducing chemical restraint at a crisis centre in the United States. | Quantitative - analysis of case report data (before and after introduction of 'No Force First'). | At the crisis centre, chemical restraint was used for 56 of 12,346 people served over the two-year period (0.45%). The percentage of service recipients who received chemical restraint in any month ranged from 0% to 1.27 %. For rough comparative purposes, data were obtained from state records on the use of restraints by comparable programs: chemical restraints were used for 3.9% of individuals served statewide. |
| Asher, L; et al | 2017 | Ethiopia | 35 adults with schizophrenia, 'their caregivers, community leaders and primary and community health workers' in rural Ethiopia. | To understand the experiences of, and reasons for, restraint of people with schizophrenia in community settings in rural Ethiopia in order to develop constructive and scalable interventions. | Qualitative - in-depth interviews and 5 focus group discussions with thematic analysis. | Most of the participants with schizophrenia and their caregivers had personal experience of the practice of restraint. The main explanations given for restraint were to protect the individual or the community, and to facilitate transportation to health facilities. These reasons were underpinned by a lack of care options, and the consequent heavy family responsibility and a sense of powerlessness amongst caregivers. All types of participants cited increasing access to treatment as the most effective way to reduce the incidence of restraint. The authors conclude that a scale up of accessible and affordable mental health care may go some way to address the issue of restraint. |

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| Azeem, M; et al | 2011 | United  States | 458 youth (females 276/ males 182) | To determine the effectiveness of six core strategies based on trauma-informed care in reducing the use of seclusion and restraint with hospitalised youth between July 2004 and March 2007. | Quantitative - analysis of case report data and demographics, including age, gender, ethnicity, number of admissions, type of admissions, length of stay, psychiatric diagnosis, number of seclusions, and restraints | Seventy-nine patients or 17.2% (females 44/males 35) 'required' 278 seclusions/restraints (159 seclusions/119 restraints), with average number of episodes 3.5/patient (range 1-28). Thirty-seven children and adolescents placed in seclusion and/or restraints had three or more episodes. In the first six months of study, the number of seclusions/restraints episodes were 93 (73 seclusions/20 restraints), involving 22 children and adolescents (females 11/males 11). Comparatively, in the final six months of the study following the training program, there were 31 episodes (6 seclusions/25 restraints) involving 11 children and adolescents (7 females/4 males). The major diagnoses of the youth placed in seclusion and/or restraint were disruptive behaviour disorders (61%) and mood disorders (52%). This study shows a downward trend in seclusions/restraints among hospitalised youth after implementation of National Association of State Mental Health Program Directors' Six Core Strategies based on trauma-informed care. |
| Bak, J; Zoffmann, V; Sestoft, DM; Almvik, R; Brandt- Christensen, M | 2014 | Denmark,  Norway | Survey data from all psychiatric hospital units in Denmark (87) and Norway (96) that treated adult inpatients. | To examine how potential mechanical restraint preventive factors in hospitals are associated with the frequency of mechanical restraint episodes. | Quantitative - cross-sectional survey of psychiatric units. | Three mechanical restraint preventive factors were significantly associated with low rates of mechanical restraint use: 'mandatory review' (exp[B]=.36, p <  .01), 'patient involvement' (exp[B]=.42, p < .01), and 'no crowding' (exp[B] = .54, p < .01 ). None of the three restraint preventive factors presented any adverse effects. Authors recommend implementing the measures. |
| Bak, J; Zoffmann, V; Sestoft,  DM; Almvik,  R; Siersma,  VD; Brandt- Christensen, M | 2015 | Denmark,  Norway | Survey data from all psychiatric hospital units in Denmark (87) and Norway (96) that treated adult inpatients. | To test the hypothesis that 'factors of nonmedical origin' may explain the differing number of mechanical restraint (MR) episodes between Denmark and Norway. An earlier study found MR was used twice as frequently in Denmark than Norway. | Quantitative - cross-sectional survey of psychiatric units. | Six MR preventive factors confounded [Aexp(B)>  10%] the difference in MR use between Denmark and Norway, including staff education (- 51%), substitute staff (- 17%), acceptable work environment (- 15%), separation of acutely disturbed patients (13%), patient- staff ratio (- 11%), and the identification of the patient's crisis triggers (- 10%). Researchers suggest these preventive factors might partially explain the difference in the frequency of MR episodes observed in the two countries. None of the six MR preventive factors presents any adverse effects. |

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| Ba riff i, FJ; Smith, MS | 2013 | Argentina | N/A | To analyse legal and policy materials concerning Argentina's National Mental Health Law (NMHL), and determine whether its 'supported decision- making' measures may improve compliance with the Convention on the Rights of Persons with Disabilities (CRPD) and reduce involuntary interventions. | Qualitative - analysis of case law, policy documents and research reports. | The NMHL establishes thresholds for depriving persons with disabilities of their liberty and for restricting their exercise of legal capacity that are inconsistent with the CRPD. However, despite the NMHL's significant shortcomings, it has the potential to contribute both to increased autonomy for users of the mental health system and also to less restrictive legal capacity restrictions. The authors conclude that while the NMHL is inconsistent with the CRPD, it may still help promote a shift away from involuntary commitments and legal capacity restrictions if its implementation results in the dissemination of 'better' practices that have emerged thus far. |
| Barrett, В; Waheed, W; Farrelly, S; Birchwood, M; Dunn, G; Flach, С; Henderson, С; Leese, M; Helen L; Marshall, M; Rose, D; Kim S; Szmukler, G; Thornicroft, G; Byford, S | 2013 | England | 569 participants were chosen from four English mental health trusts. | To test the  effectiveness of 'Joint Crisis Plans' (JCP), a form of (non-statutory) advance planning, in reducing rates of compulsory treatment. They compared JCP plus treatment as usual (TAU) to TAU alone for patients aged over 16, with at least one psychiatric hospital admission in the previous two years. | Quantitative - economic evaluation within a multi-centre randomised control trial. | The addition of JCPs to TAU had no significant effect on compulsory admissions or total societal cost per participant over 18-months follow-up. From the service cost perspective, however, evidence suggests a higher probability (80%) of JCPs being the more cost-effective option. Exploration by ethnic group highlights distinct patterns of costs and effects. Whilst the evidence does not support the cost-effectiveness of JCPs for White or Asian ethnic groups, there is at least a 90% probability of the JCP intervention being the more cost-effective option in the Black ethnic group. The researchers argue that the results by ethnic group are sufficiently striking to warrant further investigation into the potential for patient gain from JCPs among Black patient groups. |

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| Borckardt, J; et al | 2011 | United  States | Participants were patients and staff in an inpatient psychiatrie hospital, for a total of 89,783 patient-days over a 3.5-year period from January 2005 through June 2008. | To use an experimental design to examine the effect of systematic implementation of behavioural interventions on the rate of seclusion and restraint in an inpatient psychiatric hospital. | Quantitative - a variant of the multiple baseline design. Each of five inpatient units was randomly assigned to implement the intervention components in a different order, and each unit served as its own control. | A significant reduction of 82.3% (p=.008) in the rate of seclusion and restraint was observed between the baseline phase (January 2005 through February 2006) and the follow-up, postintervention phase (April 2008 through June 2008). After control for illness severity and nonspecific effects associated with an observation- only phase, changes to the physical environment were uniquely associated with a significant reduction in rate of seclusion and restraint during the intervention rollout period. These data suggest that substantial reductions in use of seclusion and restraint are possible in inpatient psychiatric settings and that changes to the physical characteristics of the therapeutic environment may have a significant effect on the use of seclusion and restraint. |
| Boumans,  CE; Walvoort,  SJ; Egger, Jl;  Hutschemaekers,  GJ | 2015 | Netherlands | 4 detailed case examples, involving 4 adults in the South East of the Netherlands. | To examine how the 'methodical work approach' worked to reduce seclusion, by providing a detailed case study. The study complemented a quantitative study on the approach (see below), which reportedly led to a reduction in the use of seclusion in a ward with a high seclusion rate. | Case Study - the team of this ward implemented the methodical work approach. | The 'methodical work approach', which has been adopted largely in Dutch and Flemish settings, appears to have provided guidance for the multidisciplinary team, the patient and the family to work together in a systematic and goal-directed way to reduce seclusion. Positive changes were reported in the team process: increased interdisciplinary collaboration, team cohesion, and 'professionalization'. It is argued that the implicit or non-specific effects of an intervention to prevent seclusion may constitute a major contribution to the results and therefore merit further research. This study follows from a study to test whether reductions in rates of seclusion occur (see below). |

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| Boumans,  CE; Walvoort,  SJ; Egger, JI; Sourren, P; Hutschemaekers, GJ | 2014 | Netherlands | 134 adults admitted to an experimental ward and 544 adults in control wards for the intensive treatment of adults with psychosis and substance use disorders in the South-East of the Netherlands. | To test effectiveness of an intervention, the 'methodical work approach', designed to reduce seclusion. This is a 'systematic, transparent and goal- directed way' of working, characterised by 'an emphasis on cyclic evaluation and readjustment of the working process'. | Quantitative - analysis of case report data (before and after introduction of the methodical work approach). | The methodical work approach has five phases: (i) translation of problems into goals; (ii) search for means to realise the goals; (iii) formulation of an individualised plan; (iv) implementation of the plan; and (v) evaluation and readjustment. Compared to control wards within the same hospital, at the ward where the methodical work approach was implemented, a more pronounced reduction was achieved in the number of incidents and in the total hours of seclusion. The authors conclude that the methodical work approach can contribute to a reduction in the use of seclusion. |
| Bowers, L; Haglund, К; Muir-Cochrane, E; Nijman, H; Simpson, A; Van Der Merwe, M | 2010 | England | A total of 1227 responses were obtained, with the highest number coming from staff, and the smallest from visitors. | To survey the beliefs and attitudes of patients, staff and visitors to the practice of door locking in acute psychiatry. Locking doors in psychiatric wards has increased in the UK in recent years, but has received little attention by researchers. | Quantitative - cross-sectional questionnaire of staff, patients and visitors at psychiatric units. | Analysis identified five factors (adverse effects, staff benefits, patient safety benefits, patient comforts and cold milieu). Patients were more negative about door locking than the staff, and more likely to express such negative judgments if they were residing in a locked ward. For staff, being on a locked ward was associated with more positive judgments about the practice. There were significant age, gender and ethnicity effects for staff only. Patients registered more anger, irritation and depression as a consequence of locked doors than staff or visitors thought they experienced. |

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| Bowers, L; Stewart, D; Papadopoulos, С; lennaco, JD | 2013 | England | Secondary analysis of cross-sectional data collected from 136 acute psychiatric wards across England in 2004-2005. | This study investigated wards with the counterintuitive combination of 'low containment and high conflict' or 'high containment and low conflict'. | Quantitative - secondary analysis of cross-sectional service data collected from 136 psychiatric wards. | Safe, calm inpatient psychiatric wards that are conducive to positive therapeutic care have thought to have lower rates of coerced medication, seclusion, manual restraint and other types of containment, and, usually, rates of conflict - for example, aggression, substance use, and absconding - are also low. Sometimes, however, wards maintain low rates of containment even when conflict rates are high. This study wanted to understand these anomalies. The researchers created a typology of different ward characteristics (e.g. high/low conflict, high/low containment, socio-economic disadvantage in the area). Among the variables significantly associated with the various typologies, some, such as environmental quality, were changeable, and others - such as social deprivation of the area served - were fixed. High-conflict, low-containment wards had higher rates of male staff and lower-quality environments than other wards. Low-conflict, high-containment wards had higher numbers of beds. High-conflict, high-containment wards utilised more temporary staff as well as more unqualified staff. No overall differences were associated with low-conflict, low-containment wards. Wards can make positive changes to achieve a low-containment, nonpunitive culture, even when rates of patient conflict are high. |
| Bowers, L; et al | 2015 | England | Staff and patients in 31 randomly chosen wards at 15 randomly chosen hospitals. | To test the efficacy of the Safewards model in reducing the frequency of 'conflict' and 'containment'. | A pragmatic cluster randomised controlled trial with psychiatric hospitals and wards as the units of randomisation. The main outcomes were rates of conflict and containment. | The Safewards model enabled the identification of ten interventions to reduce the frequency of both. For shifts with conflict or containment incidents, the experimental condition reduced the rate of conflict events by 15% (95% Cl 5.6-23.7%) relative to the control intervention. The rate of containment events for the experimental intervention was reduced by 26.4% (95% Cl 9.9-34.3%).  Simple interventions aiming to improve staff relationships with patients can reduce the frequency of conflict and containment. |

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| Bruckner, TA; Yoon, J; Brown, TT; Adams, N | 2010 | United  States | Quarterly counts of involuntary 72-hour holds (N=593,751) and 14-day psychiatric hospital-isations (N=202,554) for 28 Californian counties, with over 22 million inhabitants, from 2000-07. | To test the hypothesis that the incidence of two types of involuntary treatment, 72-hour holds and 14-day psychiatric civil commitments, declines as the service access and quality is improved by the $3.2 billion tax revenue investment associated with the Mental Health Services Act ( M H SA) i n California. | Quantitative - analysis of case report data (before and after introduction of the Act). A fixed-effects regression approach adjusted for temporal patterns in treatment. | The petitions for involuntary 14-day hospitalisations, but not involuntary 72-hour holds, fell below expected values after disbursement of MHSA funds. In these counties, 3,073 fewer involuntary 14-day treatments- -approximately 10% below expected levels-could be attributed to disbursement of MHSA funds. Results remained robust to alternative regression specifications. The researchers conclude that fewer than expected involuntary 14-day holds for continued hospitalisation may indicate an important shift in service delivery. MHSA funds may have facilitated the discharge of clients from the hospital by providing enhanced resources and access to a range of less-restrictive community-based treatment alternatives. |
| Chalmers, A; Harrison, S; Mollison, K; Molloy, N; Gray, К | 2012 | Australia | Case study: implementation of practice in a 29-bed acute adult psychiatric inpatient unit in Victoria, Australia. | To reflect upon the implementation of sensory-based approaches within the environment of a psychiatric inpatient unit. A variety of sensory- based principles were planned, developed and implemented over a 3-year period. | Case Study - Analysis of case report data and descriptive statistics. | Preliminary data regarding sensory room use and acute arousal ratings within the high-dependency area were analysed. It showed a significant reduction in patient distress levels, as per consumer and clinician ratings. The majority of sensory room sessions were conducted by nursing staff. A significant reduction was also found for 'acute arousal ratings', 'pre to post', for the 'HDU engagement program'. Several issues were uncovered throughout implementation of the sensory- based strategies. Findings indicate the importance of cultural change, compared with simply an environmental change, giving all staff and consumers the confidence to utilise a variety of sensory-based methods during times of need. Further Australian research is required to explore the positive contribution sensory modulation can potentially make across the spectrum of psychiatric settings. |

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| Chambers, M; Gallagher, A; Borschmann, R; Gillard, S; Turner, K; Kanta ris, X | 2014 | England | 19 adult service users detained under mental health legislation. | This paper reports on the experiences of 19 adults detained under mental health legislation. These service users had experienced coercive interventions and they gave their account of how they considered their dignity to be protected (or not), and their sense of self being respected (or not). | Qualitative - in- depth interviews with thematic analysis. | The service users considered their dignity and respect compromised by 1) not being 'heard' by staff members, 2) a lack of involvement in decision-making regarding their care, 3) a lack of information about their treatment plans particularly medication, 4) lack of access to more talking therapies and therapeutic engagement, and 5) the physical setting/environment and lack of daily activities to alleviate their boredom. Dignity and respect are important values in recovery and practitioners need time to engage with service user narratives and to reflect on the ethics of their practice. Respecting the dignity of others is a key element of the code of conduct for health professionals. Often from the service user perspective this is ignored. |
| Corlett, S | 2013 | England | N/A | This paper aims to review recent trends in detention under the Mental Health Act 1983 in England and the relationship to trends in access to mental health services. | Qualitative - policy research review based on Care Quality Commission, which monitors the Mental Health Act and regulates health and social care. | The paper suggests that a steady increase in coercion is related to tightening access to mental health care and that these form a toxic relationship that undermines people's mental health, recovery and rights. These trends might be reversed by a combination of rights-based measures, shared decision-making and commissioning a better level and mix of mental health services. The paper updates and discusses knowledge on trends and cites recent evidence from the Care Quality Commission and from Mind. |

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| Croft, B; Isvan, N | 2015 | United  States | 278 adult service users. This analysis used propensity score matching to create matched pairs of 139 users of peer respite and 139 non-users of respite with similar histories of behavioural health service use and clinical and demographic characteristics. | This study examined the relationship between peer respite and use of inpatient and emergency services among adults receiving publicly funded behavioural health services. By providing a safe and supportive space for individuals experiencing or at risk of experiencing a mental health crisis, a peer respite may reduce the need for traditional crisis interventions. | Quantitative - analysis of case report data.  A two-stage regression model first predicted the likelihood of inpatient or emergency service use after the peer respite start date and then predicted hours of inpatient and emergency service use among 89 individuals who used any inpatient or emergency services. | After the authors controlled for relevant covariates, the odds of using any inpatient or emergency services after the programme start date were approximately 70% lower among respite users than nonrespite users, although the odds increased with each additional respite day. Among individuals who used any inpatient or emergency services, a longer stay in respite was associated with fewer hours of inpatient and emergency service use. However, the association was one of diminishing returns, with negligible decreases predicted beyond 14 respite days. By reducing the need for inpatient and emergency services for some individuals, peer respites may increase meaningful choices for recovery and decrease the behavioural health system's reliance on costly, coercive, and less person-centreed modes of service delivery. |
| Cullberg, J; Levander, S; Holmqvist, R; Mattsson, M; Wieselgren, l-M | 2002 | Sweden | 253 adults with first episode psychosis (FEP) from a catchment with a population of 1.5 million. | To evaluate one-year outcomes in first episode psychosis patients in the Swedish Parachute project. Research participants were asked to participate in this 5-year project. | Quantitative - analysis of case report data, using historical (control (n=71 )) and prospective (experimental (n=64)) populations. | A total of 175 patients (69%) were followed up through the first year of treatment. Global Assessment of Functioning (GAF) values were significantly higher than in the historical comparison group but similar to the prospective group. Psychiatric in-patient care was lower as was prescription of neuroleptic medication. Satisfaction with care was generally high in the Parachute group. Access to a small overnight crisis home was associated with higher GAF. The researchers argued that it is possible to successfully treat FEP patients with fewer in-patient days and less neuroleptic medication than is usually recommended, when combined with intensive psychosocial treatment and support. |

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| Cullberg, J; Mattsson, M; Levander, S; Holmqvist, R; Tomsmark, L; Elingfors, C; Wieselgren, l-M | 2006 | Sweden | 61 consecutive first episode schizophrenia patients were followed over 3 years, and compared to 66 service users from 'treatment as usual' and high quality service groups. | To undertake a three-year follow- up of the Swedish 'Parachute Project', which uses 'need- specific treatments', considering treatment costs and clinical outcomes for first episode schizophrenia patients. | Quantitative - analysis of case report data comparing Parachute Project group with 'treatment as usual' (n=41 ) and prospective group from a high quality psychiatric centre (n = 25). | Symptomatic and functional outcome was significantly better compared with the Historical group and equal with the Prospective group. During the first year, the direct costs for in- and out-patient care per patient in the Parachute project were less than half of those in the Prospective group. The researchers conclude that the evidence supports the feasibility, clinically and economically, of a largescale application of 'need- specific treatments' for first episode psychotic patients. |
| De Jong, G; Schout, GG | 2013 | Netherlands | N/A | The aim of the study is to answer the question of whether Family Group Conferencing (FGC) is an effective tool to generate social support, to prevent coercion and to promote social integration in public mental health care (PMHC). | Qualitative - policy analysis, and study design. | The paper merely sets out the proposed study, which is reported upon in the 2017 paper by the same authors, led by Schout (see below). The paper sketches the context for using FGC in the Netherlands, in which there has been a steady growth in conferences being organised each year. An amendment in the Dutch Civil Code designates FGC as good practice. Clients in PMHC often have a limited network. The authors proposed that they will research the applicability of FGCs in PMHC over the following two years by evaluating forty case studies. |
| Evans, M; Boothroyd, R; Armstrong, M | 1997 | United  States | Demographic data are reported on the 238 children and families who received the full course of in- home services during the 26-month study period. | This article describes a 3-year research demonstration project. This project, which was conducted in the Bronx, New York, examined the efficacy of 3 models of intensive in-home services as alternatives to hospitalisation for children experiencing serious psychiatric crises. | Mixed Methods - Analysis of case report data and descriptive statistics. | The three models were characterised as 'alternatives to hospitalization'. The first, Home-Based Crisis Intervention (HBCI), was modelled on the Homebuilders model of family preservation; the second, Enhanced HBCI (HBCI+), added respite care, flexible service money, parent advocate and support services, and additional staff training in cultural competence and violence management. Crisis Case Management, the third model, used case managers to assess child and family needs and link them to services, as well as respite care and flexible money. The apparent benefits and limitations of each model is presented along with supporting evidence. |

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| Eytan, A; Chatton, A; Safran, E; Khazaal, Y | 2013 | Switzer  land | This search retrieved data on a total of 2,227 hospitalisations for 1,584 patients in a single hospital in Geneva, Switzerland. | From October 2006, only certified psychiatrists were authorised to require a compulsory admission to this facility, while before all physicians were, including residents. This study sought to assess the impact of this change of procedure on the proportion of compulsory admissions. | Quantitative - analysis of case report data (before/ after new requirement). All medical records of patients admitted respectively 4 months before and 4 month after the implementation of the  procedure were  retrospectively  analysed. | The overall proportions of compulsory and voluntary admissions were 63.9 % and 36.1 % respectively.  The average length of stay was 32 days (SD ± 64.4). During the study period, 25% of patients experienced two hospitalisations or more. Compared with the period before October 2006, patients hospitalised from October 2006 up were less likely to be hospitalised on a compulsory basis (OR = 0.745, 95 % Cl: 0.596-0.930). Factors associated with involuntary admission were young age (20 years or less), female gender, a diagnosis of psychotic disorder and being hospitalised for the first time. The authors argue that their results 'strongly suggest that limiting the right to require compulsory admissions to fully certified psychiatrists can reduce the rate of compulsory versus voluntary admissions'. |
| Fenton, WS; Mosher, LR; Herrell, JM; Blyler, CR | 1998 | United  States | 185 adults who experienced an 'illness exacerbation' and were willing to accept voluntary treatment were randomly assigned to the acute psychiatric ward of a general hospital or a community residential alternative. | The authors report a prospective randomised trial to test the clinical effectiveness of a model of acute residential alternative treatment for patients with persistent mental illness requiring hospital-level care. | Quantitative - economic evaluation within a dual-centre randomised control trial. | The authors report that of 185 patients, 119 (64%) were successfully placed at their assigned treatment site. Case mix data indicated that patients treated in the hospital (N=50) and the alternative (N=69) were comparably ill. Treatment episode symptom reduction and patient satisfaction were comparable for the two settings. Nine (13%) of 69 patients randomly assigned to the alternative required transfer to a hospital unit; two (4%) of 50 patients randomly assigned to the hospital could not be stabilised and required transfer to another facility. Psychosocial functioning, satisfaction, and acute care use in the 6 months following admission were comparable for patients treated in the two settings and did not differ significantly from functioning before the acute episode. Hospitalisation is a frequent and high- cost consequence of severe mental illness. The authors conclude that for patients who do not require intensive general medical intervention and are willing to accept voluntary treatment, the alternative programme model studied provides outcomes comparable to those of hospital care. |

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| Fisher, WA | 2003 | United  States | N=260 adults overall. 148 adult service users, 54% of whom had been restrained or secluded; 112 staff (about 15% of the inpatient clinical staff at the time), 47% of whom were paraprofessionals. | This article describes elements associated in the literature with successful reduction of seclusion and restraint, and looks at their application in a successful restraint reduction programme at Creedmoor Psychiatric Center, a large, urban, state- operated psychiatric hospital. | Mixed Methods - data included rates of restraint and seclusion but also surveys gathering staff knowledge, evaluation of training programmes, and information about staff and recipient attitudes and actions. | The essential elements of such programmes are high level administrative endorsement, participation by recipients of mental health services, culture change, training, data analysis, and individualised treatment. These elements were applied successfully to a restraint reduction programme at Creedmoor Psychiatric Center, a large, urban, state-operated psychiatric hospital that reduced its combined restraint and seclusion rate by 67% over a period of 2 years. |
| Flammer, E; Steinert, T | 2016 | Germany | 2,071 adults diagnosed with psychotic disorders and at least one admission during at least one of the three time periods were included, for a total of 3,482 admissions. | In one German state, 'involuntary medication of psychiatric inpatients was illegal during eight months from July 2012 until February 2013'. The authors examined whether the number and duration of mechanical coercive measures (seclusion and restraint) and the number and severity of violent incidents changed in this period. | Quantitative - A cross-sectional analysis was conducted of admission- related routine data collected in seven psychiatric hospitals. | Data was collected in three time periods (period 1, July 2011 -February 2012; period 2, July 2012-February 2013; and period 3, July 2013-February 2014). The mean number of mechanical coercive measures and violent incidents per admission increased significantly during period 2, when involuntary medication was not possible, and decreased significantly during period 3. They also differed significantly between periods 1 and 3. The percentage of admissions involving seclusion increased during period 2 significantly and was significantly different during period 1 compared with period 3. The severity of illness and the length of hospitalizsation did not change over the three periods. The authors note that '[Restriction of involuntary medication was associated with a significant increase in use of mechanical coercive measures and violent incidents'. |

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| Fletcher, J; Spittal, M; Brophy, L; et al | 2017 | Australia | 13 wards opted into a 12-week trial to implement Safewards and 1 -year follow up. The comparison group was all other wards (/? = 31) with seclusion facilities in the jurisdiction. | To assess the impact of implementing Safewards on seclusion in Victorian inpatient mental health services in Australia. | Quantitative - before-and-after design, with a comparison group matched for service type, using mandatorily reported service data. | Seclusion rates were reduced by 36% in Safewards trial wards by the 12-month follow-up period (incidence rate ratios (IRR) = 0.64,) but in the comparison wards seclusion rates did not differ from baseline to posttrial (IRR = 1.17) or to follow-up period (IRR = 1.35). Fidelity analysis revealed a trajectory of increased use of Safewards interventions after the trial phase to follow up. The findings suggest that Safewards is appropriate for practice change in Victorian inpatient mental health services more broadly than adult acute wards, and is effective in reducing the use of seclusion. |
| G i 1 burt. H; Slade, M; Rose, D; Lloyd-Evans,  В; Johnson, S; Osborn, David P J | 2010 | England | 40 adults living in residential alternative services who had previously experienced hospital inpatient stays. | To explore patients' subjective experiences of traditional hospital services and residential alternatives to hospital. To address gap in research on the 'preferences and experiences of people with mental illness in relation to residential alternatives to hospital'. | Qualitative - purposive sampling, thematic analysis of interview data. | Patients reported an overall preference for residential alternatives. These were identified as treating patients with lower levels of disturbance, being safer, having more freedom and decreased coercion, and having less paternalistic staff compared with traditional in-patient services. However, patients identified no substantial difference between their relationships with staff overall and the care provided between the two types of services. The authors conclude that 'for patients who have acute mental illness but lower levels of disturbance, residential alternatives offer a preferable environment to traditional hospital services: they minimise coercion and maximise freedom, safety and opportunities for peer support'. |
| Goulet, MH; Larue, C; Ashley, JL | 2018 | Canada | Acute adult psychiatric care unit specialised in first-episode psychoses with 27 beds. | To develop and evaluate a 'postseclusion and/or restraint review' (PSRR) intervention implemented in an acute psychiatric care unit. | Case study design, qualitative in nature, with an added quantitative component. | Nurses reported that they were able to explore the patient's feelings during the PSRR intervention with patients, which led to restoration of the therapeutic relationship. PSRR with the treatment team was perceived as a learning opportunity, which allowed the therapeutic intervention to improve. Both the use of seclusion and the time spent in seclusion were significantly reduced 6 months after the implementation of PSRR intervention. Results suggest the efficacy of PSRR in overcoming the discomfort perceived by both staff and patient and, in the meantime, in reducing the need for coercive procedures. Systematic PSRR could permit to improve the quality of care and the safety of aggressiveness management. |

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| Gjerberg, E; Hem, MH; Forde, R; Pedersen, R | 2013 | Norway | 11 interdisciplinary focus group interviews consisting of nurses, auxiliary nurses and some members of staff without formal qualifications, (N = 60). | This article examines what kinds of strategies or alternative interventions nursing staff in Norway used when patients resist care and treatment and what conditions the staff considered as necessary to succeed in avoiding the use of coercion. | Qualitative - inter-disciplinary focus group interviews with nursing home staff. | In many Western countries, studies have demonstrated extensive use of coercion in nursing homes, especially towards patients suffering from dementia. The study indicated that the nursing home staff usually spent a lot of time trying a wide range of approaches to avoid the use of coercion. The most common strategies were deflecting and persuasive strategies, limiting choices by conscious use of language, different kinds of flexibility and one-to-one care. According to the staff, their opportunities to use alternative strategies effectively are greatly affected by the nursing home's resources, by the organisation of care and by the staff's competence. |
| Greenfield, TK; Stoneking, ВС; Humphreys, К; Sundby, E; Bond, J | 2008 | United  States | 393 adults, 'civilly  committted'. | This experiment compared the effectiveness of an unlocked, mental health consumer- managed, crisis residential programme (CRP) to a locked, inpatient psychiatric facility (LIPF) for adults civilly committed for severe psychiatric problems. | Mixed methods - randomised control trial with economic evaluation and interviews with thematic analysis. | Following screening and informed consent, participants were randomised to the CRP or the FIPF and interviewed at baseline and at 30-day, 6-month, and 1-year post admission. Outcomes were costs, level of functioning, psychiatric symptoms, self-esteem, enrichment, and service satisfaction. Treatment outcomes were compared using hierarchical linear models. Participants in the CRP experienced significantly greater improvement on interviewer-rated and self- reported psychopathology than did participants in the FIPF condition; service satisfaction was dramatically higher in the CRP condition. CRP-style facilities are a viable alternative to psychiatric hospitalisation for many individuals facing civil commitment. |
| Groot, P; van Os J | 2018 | Netherlands | 1194 adult users of tapering strips | To observe the use of 'tapering strips', which allow gradual dosage reduction and minimise the potential for withdrawal effects. A tapering strip consists of antidepressant medication, packaged in a roll of small daily pouches, each with the same or slightly lower dose than the one before it. | Quantitative - observational and survey study of 1194 users. | Of 1194 users of tapering strips, 895 (75%) wished to discontinue their antidepressant medication. In these 895, median length of antidepressant use was 2-5 years (IQR: 1-2 years- > 10 years). Nearly two-thirds (62%) had unsuccessfully attempted withdrawal before (median = 2 times before, IQR 1-3). Almost all of these (97%) had experienced some degree of withdrawal, with 49% experiencing severe withdrawal (7 on a scale of 1-7, IQR 6-7). Tapering strips represent a simple and effective method of achieving a gradual dosage reduction. |

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| Guan, L; et al | 2015 | China | 266 patients found in  restraints in their family homes from 2005 across China were recruited in Stage One of the study in 2009. In 2012, 230 of the 266 cases were re-interviewed (the Stage Two study). | To implement a nationwide two- stage follow-up study to measure the effectiveness and sustainability of the 'unlocking and treatment' intervention and its impact on the well-being of patients' families. Outcome measures included the patient medication adherence and social functioning, family burden ratings, and relocking rate. | Mixed methods - two-stage follow-up study, interviews pre-post intervention, outcome tests | 96% of patients were diagnosed with schizophrenia. Prior to unlocking, their total time locked ranged from two weeks to 28 years, with 32% having been locked multiple times. The number of persons regularly taking medicines increased from one person at the time of unlocking to 74% in 2009 and 76% in 2012. Pre-post tests showed sustained improvement in patient social functioning and significant reductions in family burden. Over 92% of patients remained free of restraints in 2012. The authors report that 'Practice-based evidence from our study suggests an important model for protecting the human rights of people with mental disorders and keeping them free of restraints can be achieved by providing accessible, community based mental health services with continuity of care. China's "686" Programme can inform similar efforts in low-resource settings where community locking of patients is practiced.' |
| Hackett, R; Nicholson,  J; Mullins, S; Farrington,  T; Ward, S; Pritchard, G; Miller, E; Mahmood, N | 2009 | England | Access data was analysed for 200- 300 adults. | The project aimed to empower the Pakistani community to seek mental health support earlier within their own community, build up trust in mainstream services and enhance the clinical pathways within services to provide more culturally appropriate care. | Mixed methods - qualitative report from 'link worker' (see Main Findings) and quantitative service data on access rates. | Black and Minority Ethnic (BME) communities receive different pathways into mental health care with BME service users often presenting in crisis. The Sheffield Crisis Resolution Home Treatment joined with the local Pakistani Muslim Centre (PMC) to work in partnership. The PMC had existing links with the Pakistani community and provided a range of social, respite and occupational opportunities. The partnership created an innovative new role: the Pakistani link worker. The EPIC partnership strengthened the PMC's influence and raised awareness of mental health issues in the community. Through integration of the link worker within the everyday practice of clinicians, pathways of care showed evidence of positive change including more referrals to the PMC from psychiatric services. The EPIC project piloted a model of partnership working that is effective and transferable. |

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| Haycock, J; Finkelman, D; Presskreischer, H | 1993 | United  States | N/A - sociolegal analysis of law and alternative legal pathways | To review the statutes, regulations and case law governing civil commitment in Massachusetts, review the practice of civil commitment in this US state and consider whether the process of mediation could provide an alternative to civil commitment. | Qualitative - analysis of existing laws, and exploration of alternative legal pathways to civil  commitment. | The authors argue that the process of mediation might better fit the therapeutic objectives that underlie clinical participation in the civil commitment process. They argue that 'No amount of tinkering from a rights- based agenda with commitment criteria is likely to correct the failures of our current system'. They note: 'how mediated agreements between clinicians and patients would work cannot be exhaustively described in advance of experimenting with such an alternative. Some of that experimentation need not wait on the full implementation of a mediation model. Even without instituting a full-blown mediation process, some of our suggestions could be incorporated into current civil commitment procedures.' |
| Henderson, С; Farrelly, S; Flach, C; Borschmann, R; Birchwood,  M; Thornicroft,  G; Waheed, W; Szmukler, G | 2017 | England and Wales | 221 Joint Crisis Plans, which are plans formulated by service users and their clinical team with involvement from an external facilitator, compared to 424 'baseline routine care plans'. | The authors aimed to estimate the demand for an informed advance treatment refusal under the Mental Capacity Act 2005 (England and Wales) within a sample of service users who had had a recent hospital admission, and to examine the relationship between refusals and service user characteristics. | Mixed methods - content analysis of Joint Crisis Plans, and routine care plans in subsamples from a multi-centre randomised controlled trial of Joint Crisis Plans (plus routine mental health care) versus routine care alone (CRIMSON) in England. | 99 of 221 (45%) of the Joint Crisis Plans contained a treatment refusal compared to 10 of 424 (2.4%) baseline routine care plans. No Joint Crisis Plans recorded disagreement with refusals on the part of clinicians. Among those with completed Joint Crisis Plans, adjusted analyses indicated a significant association between treatment refusals and perceived coercion at baseline (odds ratio = 1.21, 95% Cl 1.02-1.43), but not with baseline working alliance or a past history of involuntary admission. They demonstrated significant demand for written treatment refusals in line with the Mental Capacity Act 2005, which had not previously been elicited by the process of treatment planning. Future treatment/crisis plans should incorporate the opportunity for service users to record a treatment refusal during the drafting of such plans |

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| Henderson, С; et al | 2004 | England | 160 people with an operational diagnosis of psychotic illness or non- psychotic bipolar disorder who had experienced a hospital admission within the previous two years. | To investigate whether a form of advance agreement for people with severe mental illness can reduce the use of inpatient services and compulsory admission or treatment. | Quantitative: Single blind randomised controlled trial, with randomisation of individual patients. The investigator was blind to allocation. | Use of the Mental Health Act was significantly reduced for the intervention group, 13% (10/80) of whom experienced compulsory admission or treatment compared with 27% (21/80) of the control group (risk ratio 0.48, 95% confidence interval 0.24 to 0.95, P = 0.028). The authors concluded that the use of Joint Crisis Plans reduced compulsory admissions and treatment in patients with severe mental illness. The reduction in overall admission was less. According to the authors '[t]his is the first structured clinical intervention that seems to reduce compulsory admission and treatment in mental health services/ |
| Henderson, С; Flood, С; Leese, M; Thornicroft, G; Sutherby, К; Szmukler, G | 2009 | England | 62 adults who received a Joint Crisis Plan. | To report participants' and case managers' use of and views on the value of Joint Crisis Plans (JCPs), shown to reduce compulsory hospitalisation and violence. | Mixed methods - qualitative research in the form of questionnaires. | Intervention group participants were interviewed on receipt of the JCP, on hospitalisation, and at 15-month follow-ups; case managers were interviewed at 15 months. 46-96% of JCP holders (N = 44) responded positively to questions concerning the value of the JCP at immediate follow up. At 15 months the proportions of positive responses to the different questions was 14- 82% (N = 50). Thirty-nine to eighty-five per cent of case managers (N = 28) responded positively at 15 months. Comparing the total scores of participants who had completed both the initial and follow up questionnaires showed a shift in responses, from positive to no change, from the immediate follow up to 15 months (means 6.1 vs. 8.3, difference 2.2, 95% Cl 0.8, 3.7, P = 0.003) where a higher score indicates less positive views. The two items that received highest endorsement also showed least shift over time, i.e. whether the participant would recommend the JCP to others (90% initial vs. 82% at 15 months) and whether they felt more in control of their mental health problem as a result (71% at initial vs. 56% at 15 months). Case managers at 15 months were more positive than service users, with total score means of 5 vs. 7.8 (difference -2.8, 95% Cl -4.5, -1.2, P = 0.002). |

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| Heumann, К; Bock, T; Lincoln, TM | 2017 | Germany | 83 service users | In recent years the legal basis in Germany for the use of coercive measures in psychiatry has changed, yet there is no regulation of the type or amount of 'milder measures', which must now be used. The authors investigated which and how many 'milder measures' were experienced by service users before coercion was used and which measures they value as potentially helpful to avoid it. | Quantitative - online survey of 83 service users. Their experience with 21 milder measures and their evaluation of whether the measures were helpful were assessed by self-reporting. | On average, participants reported 5.4 experienced milder measures. The most frequent reason provided for why measures failed were structural factors, followed by staff behaviour, and reasons caused by the participants themselves. The only milder measure rated by less than 50% as potentially helpful in avoiding coercive measures was being persuaded to take medication. Although many milder measures are perceived as potentially helpful, only few seem to be made use of in routine clinical practice. The authors conclude that in order to prevent coercion staff members should apply a wider range of milder measures. |
| Hojlund M; Hogh L; Bojesen, А; Munk-Jorgensen P; Stenager E | 2018 | Denmark | Data from 101 admissions after implementation of interventions were compared with data from 85 admissions in a historical reference cohort. | To quantify and compare the use of antipsychotic and anxiolytic medications in connection with the implementation of a programme to reduce coercion and restraint. | Mixed methods - quantitative analysis of service data combined with observational study in a general psychiatric ward. | Mean defined daily doses of antipsychotics, benzodiazepines or the total amount of both showed no difference before and after implementation of the programme. The data showed that neither total dose of antipsychotics (adjusted 0: .05, 95% confidence interval (Cl): -0.20 to 0.31), total dose of benzodiazepines (adjusted 0: -.13, 95%CI: -.42 to 0.16) nor total amount of both drugs (adjusted 0: .00, 95%CI: -.26 to 0.21) increased after implementation. A decrease in coercive measures from 2013 to 2016 has not lead to significant increases in the use of antipsychotic medication or benzodiazepines. The interventions are useful in establishing restraint-free wards, and careful monitoring of the psychopharmacological treatment is important for patient safety. |

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| Høyer, G; K j e 11 i n, L; Engberg, M; Kaltiala-Heino,  R; Nilstun, T; Sigurjónsdóttir, M; Syse, A | 2002 | Denmark,  Finland,  Iceland,  Norway,  and Sweden  (Northern  Europe) | Not stated | Study called 'Paternalism and Autonomy—A Nordic Study on the Use of Coercion in the Mental Health Care System,' is a joint study involving all the five Nordic countries (Denmark, Finland, Iceland, Norway, and Sweden). | Mixed methods - textual analysis and interviews with ethicists, lawyers, and physicians,  'core interview' with service users, data from medical records and related documents | Preliminary data from all Nordic countries suggest that perceived coercion tends to be a 'dichotomized phenomenon', measured both by the 'MPCS' and the 'Coercion Ladder', and this dichotomized pattern remains even when formally voluntarily and involuntarily admitted patients are studied separately. The authors report being 'unable to produce a good explanation for the bimodal distribution of perceived coercion' and raise 'questions about flaws in the instruments used to measure perceived coercion' and 'if perceived coercion really is a dichotomized phenomenon and, in this way, more resembles the concept of "integrity."' |
| Huber, CG; Schneeberger, AR; Kowalinski, E; Fröhlich,  D; Felten, S von; Walter,  M; Zinkler, M; Beine, K; Heinz, A; Borgwardt, S; Lang, UE | 2016 | Germany | 349 574 admissions to 21 German psychiatric inpatient hospitals from Jan 1, 1998, to Dec 31, 2012. | To compare hospitals without locked wards and hospitals with locked wards and to establish whether hospital type has an effect on these outcomes. | Quantitative - naturalistic observational study with linear mixed- effects models to analyse the data. | Patients at risk are often admitted to locked wards in psychiatric hospitals to prevent absconding, suicide attempts, and death by suicide. However, there is insufficient evidence that treatment on locked wards can effectively prevent these outcomes. In the 145 738 propensity score-matched cases, suicide (OR T326, 95% Cl   1. 803-2-113; p=0-24), suicide attempts (1-057, 0-787- 2. 412; p=0-71), and absconding with return (1-288, 0-874-1 -929; p=0-21 ) and without return (1 -090, 0-722- 1 -659; p=0-69) were not increased in hospitals with an open door policy. Compared with treatment on locked wards, treatment on open wards was associated with   a decreased probability of suicide attempts (OR 0-658, 95% Cl 0-504-0-864; p=0-003), absconding with return (0-629, 0-524-0-764; p<0-0001), and absconding without return (0-707, 0-546-0-925; p=0■ 01), but not completed suicide (0-823, 0-376-1-766; p=0-63). Lock-ed doors might not be able to prevent suicide and absconding. |

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| Hustoft, К; Larsen, TK; Bronnick, K; Joa, 1; Johannessen, JO; Ruud, T | 2018 | Norway | 3338 patients referred for admission in 20 Norwegian acute psychiatric units across 3 months in 2005-06 (about 75% of national acute units). | The aim of this study was to investigate the extent to which Involuntarily Hospitalised (IH) patients were converted to a Voluntary Hospitalisation (VH), and to identify predictive factors leading to this conversion. | Quantitative - analysis of service data using generalized linear mixed modelling. | The incident of conversion from involuntarily hospitalisation (IH) to voluntary hospitalisation (VH) was analysed. Out of 3338 patients referred for admission, 1468 were IH (44%) and 1870 were VH. After re- evaluation, 1148 (78.2%) remained on involuntary hos-pitalisation, while 320 patients (21.8%) were converted to voluntary hospitalisation. The predictors of conversion from involuntary to voluntary hospitalisation after re-evaluation of a specialist included patients wanting admission, better scores on Global Assessment of Symptom scale, fewer hallucinations and delusions and higher alcohol intake. The 24h re- evaluation period for patients referred for involuntary hospitalisation, as stipulated by the Norwegian Mental Health Care Act, appeared to give adequate opportunity to reduce unnecessary involuntary hospitalisation, while safeguarding the patient's right to VH. |
| Husum, TL; Bjorngaard, JH; Finset, A; Ruud, T | 2010 | Norway | The study includes data from 32 acute psychiatric wards and 1214 involuntarily admitted persons. | This study investigates to what extent use of seclusion, restraint and involuntary medication for involuntary admitted patients in Norwegian acute psychiatric wards is associated with patient, staff and ward characteristics. | Quantitative - multilevel logistic regression using Stata was applied with service data from patients that were linked to data about wards. | The total number of involuntary admitted patients was 1214 (35% of total sample). The percentage of patients who were exposed to coercive measures ranged from 0-88% across wards. Of the involuntary admitted patients, 424 (35%) had been secluded, 117 (10%) had been restrained and 113 (9%) had received involuntary depot medication at discharge. Data from 1016 patients could be linked in the multilevel analysis. The authors conclude that the substantial between- ward variance, even when adjusting for patients' individual psychopathology, indicates that ward factors influence the use of seclusion, restraint and involuntary medication and that some wards have the potential for quality improvement. They conclude that interventions to reduce the use of seclusion, restraint and involuntary medication should take into account organisational and environmental factors. |

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| Jaeger, M;  Kette 1er, D; Rabenschlag, F; Theodoridou, A | 2014 | Switzerland | 39 mental health professionals. | This pilot study aimed at investigating how mental health professionals on acute psychiatric wards recognise different levels of formal and informal coercions and treatment pressures as well as their attitude towards these interventions. | Mixed methods - cross- sectional survey using a questionnaire that consisted of 15 vignettes describing typical clinical situations on five different stages of the continuum of coercion. | Low levels of coercion are recognised adequately while higher levels are grossly underestimated. The degree of coercion inherent to interventions comprising persuasion and leverage was underestimated by professionals with a positive attitude and overestimated by those with a negative attitude towards the respective interventions.  No associations of the ability to recognise different levels of coercion with ward or staff related variables were found. Higher knowledge on ambiguous variations of coercive interventions seems to foster more balanced reflections about their ethical implications. The authors conclude that '(a)dvanced understanding of influencing factors of professionals!?! attitudes towards coercion could lead to improved training of professionals in utilizing interventions to enhance treatment adherence in an informed and ethical way'. |
| Jaeger, M; Konrad, A; Rueegg, S; Rabenschlag, F | 2015 | Switzerland | 63 service users of an acute psychiatric unit in Switzerland. | This naturalistic observational study seeks to evaluate the subjective perspective and functional outcome of inpatients before and after structural alterations. The changes made were the introduction of treatment conferences and conjoint treatment planning, reduction of the total time spent on reports about patients (in their absence), and recovery-oriented staff training on an acute psychiatric unit. | Mixed methods - interview and surveying. During 1 year (2011/2012) eligible patients on the study unit were interviewed on a voluntary basis using established instruments to assess several recoveryrelevant aspects. | Two different samples (before and after the project; n = 34 and n = 29) were compared with regard to subjective parameters (e.g. patients' attitudes toward recovery, quality of life, perceived coercion, treatment satisfaction, and hope), clinical and socio-demographic basic data, as well as the functional outcome according to the Health of the Nation Outcome Scales (HoNOS). Some patient attitudes towards recovery and their self-assessment of the recovery process improved during the study.  Other subjective parameters remained stable between samples. Functional outcome was better in subjects who were treated after the implementation of the new concept. The length of stay remained unchanged. The implementation of recovery-oriented structures and providing the necessary theoretical underpinning on an acute psychiatric unit is feasible and can have an impact on attitudes and knowledge of personal recovery. |

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| Janssen, WA; Noorthoorn,  EO; Nijman, HLI; Bowers, L; Hoogendoorn, AW; Smit, A; Widdershoven, GAM | 2013 | Netherlands | 718 persons who had been secluded over 5,097 admissions on 29 different admission wards over seven Dutch psychiatric hospitals. | To test the hypothesis that difference in seclusion figures between wards may predominantly be explained by differences in patient characteristics, as these are expected to have a large impact on these seclusion rates. Nurses and ward managers tend to hold this view, assuming more admissions of severely ill patients are related to higher seclusion rates. | Mixed methods - descriptive analysis of service data, exploring relationship between patient and ward characteristics and the wards' number of seclusion hours per 1,000 admission hours. | The extreme group analysis showed that seclusion rates depended on both patient and ward characteristics.  A multivariate and multilevel analyses revealed that differences in seclusion hours between wards could partially be explained by ward size next to patient characteristics. However, the largest deal of the difference between wards in seclusion rates could not be explained by characteristics measured in this study. The authors concluded ward policy and adequate staffing may, particularly on smaller wards, be key issues in reduction of seclusion. |
| Janssen, WA; van de Sande,  R; Noorthoorn, EO; Nijman,  HLI; Bowers, L; Mulder, CL; Smit, A; Widdershoven, GAM; Steinert, T | 2011 | Netherlands | Seclusion and restraint data from 31,594 admissions for 20,934 patients.  12 Dutch mental health institutes, comprising 37 hospitals and 227 wards containing 6812 beds. | The aim of this article is to identify problems in defining and recording coercive measures.  The study contributes to the development of consistent comparable measurements definitions and provides recommendations for meaningful dataanalyses illustrating the relevance of the proposed framework. | Mixed methods - literature was reviewed to identify various definitions and calculation modalities used to measure coercive measures in psychiatric inpatient care. | Considerable variation in ward and patient characteristics was identified in this study. The chance to be exposed to seclusion per capita inhabitants of the institute's catchment areas varied between 0.31 and 1.6 per 100.000. The number of seclusion incidents per 1000 admissions varied between 79 up to 745.  The authors conclude that coercive measures can be reliably assessed in a standardised and comparable way under the condition of using clear joint definitions. Methodological consensus between researchers and mental health professionals on these definitions is necessary to allow comparisons of seclusion and restraint rates. The study contributes to the development of international standards on gathering coercion related data and the consistent calculation of relevant outcome parameters. |

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| Johnson, S; Nolan, F; Pilling, S; Sandor,  A; Hoult, J; McKenzie,  N; White, IR; Thompson, M; Bebbington, P | 2005 | England | 260 residents of the inner London Borough of Islington who were experiencing crises severe enough for hospital  admission to be considered. | To evaluate the effectiveness of a crisis resolution team. | Quantitative - randomised control trial, examining service users' satisfaction. | Patients in the experimental group were less likely to be admitted to hospital in the eight weeks after the crisis (odds ratio 0.19, 95% confidence interval 0.11 to 0.32), though compulsory admission was not significantly reduced. A difference of 1.6 points in the mean score on the client satisfaction questionnaire (CSQ-8) was not quite significant (P = 0.07), although it became so after adjustment for baseline characteristics (P = 0.002). Crisis resolution teams can reduce hospital admissions in mental health crises. They may also increase satisfaction in patients, but this was an equivocal finding. |
| Kalisova, L; et al | 2014 | Bulgaria,  Czech  Republic,  Germany,  Greece,  Italy,  Lithuania,  Poland,  Spain,  Sweden and England. | Involuntarily admitted patients (N = 2,027) divided into two groups, the first (N = 770) subject to at least one coercive measure, the other (N = 1,257) had not received a coercive measure during hospitalisation. | This study aims to identify whether selected patient and ward-related factors are associated with the use of coercive measures. | Mixed methods - descriptive data, including patients' sociodemographic and clinical characteristics and centre- related  characteristics.  Tested in a  multivariate  logistic  regression  model,  controlled  for countries'  effect. | The frequency of coercive measures varied significantly across countries, being higher in Poland, Italy and Greece. Those who received coercive measures were more often male and diagnosed with psychotic disorder (F20-F29). According to the regression model, patients with higher levels of psychotic and hostility symptoms, and of perceived coercion had a higher risk to be coerced at admission. Controlling for countries' effect, the risk of being coerced was higher in Poland. Patients' sociodemographic characteristics and ward-related factors were not identifying as possible predictors because they did not enter the model.  The use of coercive measures varied significantly in the participating countries. Clinical factors, such as high levels of psychotic symptoms and high levels of perceived coercion at admission were associated with the use of coercive measures, when controlling for countries' effect. These factors should be taken into consideration by programmes aimed at reducing the use of coercive measures in psychiatric wards. |

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| Keski-Valkama, A; Sailas, E; Eronen, M; Koivisto, A-M; Lönnqvist, J; Kaltiala-Heino, R | 2007 | Finland | National survey of psychiatric hospitals | To evaluate the nationwide trends in the use of seclusion and restraint were investigated in Finland over a 15- year span which was characterised by legislative changes aiming to clarify and restrict the use of these measures. | Quantitative - structured postal survey of Finnish psychiatric hospitals, using data from the National Hospital Discharge Register. | The total number of the secluded and restrained patients declined as did the number of all inpatients during the study weeks, but the risk of being secluded or restrained remained the same over time when compared to the first study year. The duration of the restraint incidents did not change, but the duration of seclusion increased. The authors conclude that legislative changes solely cannot reduce the use of seclusion and restraint or change the prevailing treatment cultures connected with these measures, and argue that the use of seclusion and restraint should be vigilantly monitored and ethical questions should be under continuous scrutiny. |
| Kleintjes, S; Lund, C; Swartz, L | 2013 | Ghana,  Kenya,  Rwanda,  South  Africa,  Tanzania,  Uganda and  Zambia | 11 members of leadership in mental health self-help organisations (including carers). | This paper reports on overarching strategies which supported the establishment and sustainability of nine mental health self-help organisations in seven African countries. | Qualitative - interviews with thematic analysis. | The interviews suggest that self-help organisations can provide crucial support to users' recovery in resource- poor settings in Africa. Support of ministries, NGOs, DPOs, development agencies and professionals can assist to build organisations' capacity for sustainable support to members' recovery. Organisations' work include advocacy to destigmatise mental disorders and promote the protection of user's rights, activities to improve access to health care and to income generation and social support, participation in legislative and policy reform, and capacity building of members. |
| Kogstad, RE | 2009 | Norway | 335 adult service users | To investigate violations of dignity considered from the clients' points of view, and to suggest actions that may ensure that practice is brought in line with human rights values. | Qualitative - interviews with thematic content analysis. | The authors conclude that '[mjental health clients experience infringements that cannot be explained without reference to their status as clients in a system which, based on judgments from medical experts, has a legitimate right to ignore clients' voices as well as their fundamental human rights'. They argue that 'recommendations and practices should be harmonized with the new UN Convention on the Rights of Persons with Disabilities (2006)'. |

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| Kontio, R; Välimäki, M; Putkonen, H; Kuosmanen, L; Scott, A; Joffe, G | 2010 | Finland | 22 nurses and 5 physicians | To explore nurses' and physicians' perceptions of what actually happens when an aggressive behaviour episode occurs on the ward and what alternatives to seclusion and restraint are actually in use as normal standard practice in acute psychiatric care. | Qualitative - focus group interview with thematic content analysis. | The participants believed that the decision-making process for managing patients' aggressive behaviour contains some in-built ethical dilemmas. They thought that patients' subjective perspective received little attention. Nevertheless, the staff proposed and appeared to use a number of alternatives to minimise or replace the use of seclusion and restraint. The authors conclude that '[mjedical and nursing staff need to be encouraged and taught to: (1) tune in more deeply to reasons for patients' aggressive behaviour; and (2) use alternatives to seclusion and restraint in order to humanize patient care to a greater extent.' |
| Kokanovió, R; et ai | 2018 | Australia | 90 mental health service users who reported diagnoses of schizophrenia, psychosis, bipolar disorder and severe depression; family members supporting them and mental health practitioners. | The study aims to explore from several perspectives the barriers and facilitators to supported decisionmaking in an Australian context. Supported decision-making was considered in terms of interpersonal experiences and legal supported decisionmaking mechanisms. | Qualitative - interview data was analysed thematically across all participants. | Negative interpersonal experiences in the mental health care system undermined involvement in decisionmaking for people with psychiatric diagnoses and family carers. Mental health practitioners noted their own disempowerment in service systems as barriers to good supported decision-making practices. All groups noted the influence of prevailing attitudes towards mental health service users and the associated stigma and discrimination that exist in services and the broader community. They reported that legal supported decisionmaking mechanisms facilitate the participation of mental health service users and their family supporters in supported decision-making. The authors conclude that enabling supported decision-making in clinical practice and policy can be facilitated by (1) support for good communication skills and related attitudes and practices among mental health practitioners and removing barriers to their good practice in health and social services and (2) introducing legal supported decision-making mechanisms. |

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| Larrobia, С; Botega, NJ | 2001 | South  America:  Argentina,  Bolivia,  Brazil, Chile,  Colombia,  Ecuador,  Guyana,  Paraguay,  Peru,  Suriname,  Uruguay,  and  Venezuela | A postal survey was conducted of all South American countries (health ministries, national psychiatric associations and key informants). | This study aims to gather information available on the changes in mental health services in South American countries following the 'social and political upheavals of recent decades'. | Quantitative - postal survey to assess the development of mental health programmes and the organisation of alternative psychiatric care centres such as the psychiatric units in general hospitals (PUGH). | The survey results indicate that most of the mental health programmes were implemented during the 1980s and 1990s, and aimed at incorporating psychiatric care into primary health care, as well as relocating provision from large hospitals to decentralised services (which is likely to be strongly associated with less coercive responses). Most of the countries surveyed have less than 0.5 psychiatric beds per 1000 inhabitants. This change reflects a tendency to reduce the total number of psychiatric beds and increase the number of PUGH. Over the last 10 years this increase was significant in some countries (50-75 %), but was not reflected in the availability of adequate human and material resources. A transition from a system based on large mental hospitals to alternative service provision is on the way in South American countries. Intensive efforts have to be made to collect and disseminate information, as well as to monitor the development and outcome of the mental health programmes in these countries. |
| Lawlor, C; Johnson, S; Cole, L; Howard, LM | 2012 | England | 287 women admitted to an acute psychiatric inpatient ward or a women's crisis house in four London boroughs during a 12-week period were included. | To explore ethnic variations in compulsory detentions of women, and to explore the potential role of immediate pathways to admission and clinician-rated reasons for admission as mediators of these differences. | Quantitative - descriptive data drawn from health services. | 287 women from White British, White Other, Back Caribbean, Black African and black other groups were included. Adjusting for social and clinical characteristics, all groups of Black patients and White other patients were significantly more likely to have been compulsorily admitted than White British patients; White British patients were more likely than other groups to be admitted to a crisis house and more likely than all the Black groups to be admitted because of perceived suicide risk. Immediate pathways to care differed: White Other, Black African and Black Other groups were less likely to have referred themselves in a crisis and more likely to have been in contact with the police. When adjustment was made for differences in pathways to care, the ethnic differences in compulsory admission were considerably reduced. There are marked ethnic inequities not only between White British and Black women, but also between White British and White Other women in experiences of acute admission. Differences between groups in help-seeking behaviours in a crisis may contribute to explaining differences in rates of compulsory admission. |

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| Lay, В; Nordt, С; Rössler, W | 2011 | Switzerland | 9689 inpatients from the year 2007 aged 18-70. | This study addresses three coercive measures and the role of predictive factors at both patient and institutional levels. | Quantitative - used 'generalized estimating equation' models to analyse variation in rates between psychiatric hospitals. | The authors report quotas of 24.8% involuntary admissions, 6.4% seclusion/restraint and 4.2% coerced medication. Results suggest that the kind and severity of mental illness are the most important risk factors for being subjected to any form of coercion. Variation across the six psychiatric hospitals was high, even after accounting for risk factors on the patient level suggesting that centre effects are an important source of variability. However, effects of the hospital characteristics 'size of the hospital', 'length of inpatient stay', and 'work load of the nursing staff' were only weak ('bed occupancy rate' was not statistically significant). |
| Lay, В; Blank, С; Lengier, S; Drack, T; Bleiker, M; Rössler, W | 2015 | Switzerland | 238 inpatients who had at least one compulsory admission during the past 24 months. | The aim of this study was to evaluate an intervention programme for people with severe mental illness that targets the reduction in compulsory psychiatric admissions. In the current study, the researchers examine the feasibility of retaining patients in this programme and compare outcomes over the first 12 months to those after treatment as usual (TAU). | Quantitative - randomised controlled intervention study conducted currently at four psychiatric hospitals in the Canton of Zurich. | Participants were assigned at random to the intervention or to the TAU group. The intervention programme consists of individualised psycho-education focusing on behaviours prior to illness-related crisis, crisis cards and, after discharge from the psychiatric hospital, a 24-month preventive monitoring. In total, 238 (of 756 approached) inpatients were included in the trial. After 12 months,  80 (67.2 %) in the intervention group and 102 (85.7 %) in the TAU group were still participating in the trial. Of these, 22.5 % in the intervention group (35.3 % TAU) had been compulsorily readmitted to psychiatry; results suggest a significantly lower number of compulsory réadmissions per patient (0.3 intervention; 0.7 TAU).  This interim analysis suggests beneficial effects of this intervention for targeted psychiatric patients. |

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| Lay, В; Kawohl, W; Rössler, W | 2018 | Switzerland | 238 inpatients who had at least one compulsory admission during the past 24 months. | The aim of this study was to evaluate an intervention programme for people with severe mental illness that targets the reduction in compulsory psychiatric admissions. In the current study, the researchers examine the feasibility of retaining patients in this programme and compare outcomes over the 24 months to those after treatment as usual (TAU). | Quantitative - randomised controlled intervention study conducted currently at four psychiatric hospitals in the Canton of Zurich. | Fewer participants who completed the 24-month programme were compulsorily readmitted to psychiatry (28%), compared with those receiving TAU (43%). Likewise, the number of compulsory réadmissions per patient was significantly lower (0.6 v. 1.0) and involuntary episodes were shorter (15 v. 31 days), compared with TAU. A negative binomial regression model showed a significant intervention effect (RR 0.6; 95% confidence interval 0.3-0.9); further factors linked to the risk of compulsory readmission were the number of compulsory admissions in the patient's history (RR 2.8), the diagnosis of a personality disorder (RR 2.8), or a psychotic disorder (RR 1.9). Dropouts (37% intervention group; 22% TAU) were characterised by a high number of compulsory admissions prior to the trial, younger age and foreign nationality. This study suggests that this intervention is a feasible and valuable option to prevent compulsory re-hospitalisation in a 'high-risk group of people with severe mental health problems, social disabilities, and a history of hospitalisations'. |
| Lewis, M; Taylor, К; Parks, J | 2009 | United  States | A 900-bed tertiary care academic medical centre located in an urban, socioeconomically distressed area. | A group of direct care psychiatric nurses in a large urban teaching hospital created an evidenced- based performance improvement programme that resulted in a decrease in the use of seclusion and restraint. | Quantitative - service data (before/after intervention). | No additional funds were required to develop this program. The public health prevention model was the framework utilised. Early results show a 75% reduction in the use of seclusion and restraint with no increase in patient or staff injuries since its implementation. |
| Lindgren, 1; Falk Hogstedt, M; Cullberg, J | 2006 | Sweden | 24 first-episode  psychosis  patients  diagnosed  between 1990-92  and 32 between  1993-96. | The aim of the present study was to follow the patients in the two groups for 5 years, comparing the outcome. | Quantitative analysis using Soteria Nacka recovery scale. | The results showed that easily accessible need-adapted treatment with integrated overnight care might be advantageous for first-episode psychotic patients. The duration of untreated psychosis was shorter and the outcome better |

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| Long, CG; West, R; Afford, M; Collins, L; Dolley, О | 2015 | England | 38 women admitted to the medium secure unit of an independent charitable trust. | Aims of the study are to assess the effectiveness of interventions designed to minimise the use of seclusion in response to risk behaviours by comparing matched patients before and after change. | Quantitative analysis of study interventions to reduce the use of seclusion. | A significant decline in both the number of seclusions and risk behaviour post-change was complemented by improved staff ratings of institutional behaviour, increased treatment engagement and a reduction in time spent in medium security. Staff and patients differed in terms of their ratings of the most effective strategies introduced. Patients favoured the Relational Security item of increased individual engagement and timetabled Behaviour Chain Analysis sessions. Staff viewed on ward training and use of de-escalation techniques as most effective. Findings confirm results from mixed gender forensic mental health samples that seclusion can be successfully reduced without an increase in patient violence or alternative coercive strategies. |
| Looi, G-M E; Engström, А; Sävenstedt, S | 2015 | Sweden | Total of 19 self- reports | The aim of this study was to describe how people who self-harm perceive alternatives to coercive measures in relation to actual experiences of psychiatric care. | Qualitative -content analysis of self- reports. | The researchers came up with three themes from the literature: 'a wish for understanding instead of neglect; a wish for mutual relation instead of distrust; a wish for professionalism instead of a counterproductive care'. They argue that if the caregivers can understand and collaborate with the patient, there is seldom any need for coercive measures. [Only abstract available] |
| Lyons, C; Hopley, Р; Burton, CR; Horrocks, J | 2009 | England | Postal  questionnaires and 24 group meetings with service users and carers | To gain an understanding of how users and carers define a crisis and what range of crisis services, resources and interventions service users and carers thought would help avoid unnecessary hospital admission. | Quantitative analysis of questionnaires and group meetings. | There is emerging evidence that crisis resolution services can provide alternatives to hospital admission, reducing demand on inpatient beds. The authors conclude that expressed preferences of service users and carers for pre-emptive services that are delivered flexibly will present a challenge for service commissioners and providers, particularly where stringent access criteria are used. Home-based pre-emptive services that reduce the need for unnecessary hospital treatment may avoid progression to social exclusion of service users. |

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| Maguire, T; Young, R; Martin, T | 2011 | Australia | Forensic hospital with 116 beds, providing acute, rehabilitation and continuing care programmes for men and women. | To present a project that was undertaken at an Australian forensic mental health hospital to reduce seclusion. These initiatives are based on the Six Core Strategies that have been successfully used in North America to reduce seclusion. | Quantitative - service data following intervention. | The frequency and duration of seclusion events were reduced but there was less reduction in the number of patients that were secluded. At this time, seclusion may be necessary for the general safety of the unit. It is possible that the strategies were successfully supported by the identified opportunities to reduce the frequency and duration of seclusion but the challenges were significantly powerful in the early period of admission to prompt the need for seclusion. Reducing seclusion in a forensic hospital is a complex undertaking as nurses must provide a safe environment while dealing with volatile patients and may have little alternative at present but to use seclusion after exhausting other interventions. |
| Mann-Poll,  PS; Smit, A; Noorthoorn, ЕО; Janssen, WA; Koekkoek, В; Hutschemaekers, GJM | 2018 | Netherlands | Five inpatient wards  participated: three admission wards for adults, one admission ward for elderly and one ward providing long- stay resident care to adult patients. | The purpose of this study was to examine the impact of a seclusion reduction programme over a long time frame, from 2004 until 2013. | Quantitative analysis of government data. | This study shows a significant reduction in number and duration of seclusion incidents over a long time frame. Organisational leadership and a tailored package of interventions to reduce seclusion were used as key elements. However, reducing the use of seclusion remains challenging and requires time, grounding in the organisation and continuous organisational and professional awareness. |

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| Martin, A; et al | 2008 | United  States | The inpatient service had a bed capacity of 15; during the five-year interval of the study, the unit had an average of 198 admissions per year, a bed occupancy of 92%, and a length of stay of 29 days. | To describe changes in use of restraint and seclusion in a child psychiatric inpatient setting after the implementation of the collaborative problem solving (CPS) model of care. | Quantitative - service data seclusion and restraint incidents, service user demographics. | During this five-year period, and after the complete implementation of the CPS model by early 2006, there was a marked reduction in the use of restraints (from 263 to seven events per year, representing a 37.6- fold reduction, slope В =-.696) and seclusion (from 432 to 133 events per year, representing a 3.2-fold reduction, В =-.423). The mean duration of restraints decreased from 41 ±8 to 18±20 minutes per episode, yielding cumulative unitwide restraint use that dropped from 16± 10 to ,3±.5 hours per month (a 45.5-fold reduction, В =-.674). The mean duration of seclusion decreased from 27±5 to 21 ±5 minutes per episode, yielding cumulative unitwide seclusion use that dropped from 15±6 to 7±6 hours per month, a 2.2-fold reduction (p for trend <.01 or better for all slopes). Strong racial differences emerged. Black children were more than four times as likely to be restrained or secluded as their white peers; Hispanic children were 50% more likely than whites to be restrained or secluded, although the difference was statistically significant only for seclusion. |
| Maylea, С | 2017 | Australia | N/А (Case study) | This paper considers a case study of the powers given to social workers by the Victorian Mental Health Act 2014 | Case study - qualitative in nature, doctrinal legal analysis. | This paper outlines the coercive powers available to social workers under the Mental Health Act 20!4 (Vic), arguing that using these powers may be less restrictive than not using them. The use of coercion is problematic in social work practice, but the exercise of these powers by social workers, rather than by police or paramedics, has the potential to be a less coercive approach. The author argues that if social workers are uncomfortable with exercising these powers themselves, this might raise the question of whether they should be exercised at all. |
| Meijer, E; Schout, G; de Jong, G; Abma, T | 2017 | Netherlands | 41 family group conferences were studied in three regions. | This study examined the impact of family group conferences on coercive treatment in adult psychiatry. | Mixed methods - survey and observational data, used to evaluate outcomes of family group conferences. | Family group conferences seems a promising intervention to reduce coercion in psychiatry. It helps to regain ownership and restores belongingness. If mental health professionals take a more active role in the pursuit of family group conferences and reinforce the plans with their expertise, they can strengthen the impact even further. |

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| Mezzina, R; Vidoni, D | 1995 | Italy | 39 new patients with 'acute and severe crises' in a 4-year follow- up study at the community mental health center in Trieste (CMHC). | To assess the impact of the Trieste model of mental health service delivery; particularly 'multi-disciplinary interventions employing a wide range of responses to the existential and social needs arising during a crisis'. | Mixed methods - service data analysis. | According to the authors, the evaluation indicates: Ί) a generally good outcome of the initial crisis; 2) a low relapse rate; 3) a tendency towards favourable long-term outcomes'. Further:  'In terms of practice, voluntary and compulsory hospitalization were avoided in favor of short-term day and night support in the CMHC. There were no suicides, no crimes, no drop-outs. Social adjustment remained unchanged. The study demonstrates that the mental health services in Trieste are able to cope with acute crises without psychiatric hospitalization.' |
| Minas, H; Diatri, H | 2008 | Indonesia | Cross-sectional observational research in a natural setting, carried out during a six- month period of working as the only psychiatrist in a remote district | To investigate the nature of 'Pasung'  - restraint and confinement by families - the clinical characteristics of people restrained, and the reasons given by families and communities for applying such restraint. | Qualitative analysis of observational data | Physical restraint and confinement {'pasung') by families of people with mental illness is known to occur in many parts of the world but has attracted limited investigation. This preliminary observational study was carried out on Samosir Island in Sumatra, Indonesia. The provision of basic community mental health services, where there were none before, enabled the majority of the people who had been restrained to receive psychiatric treatment and to be released from 'pasung'. |
| Morrison, AP; et ai | 2014 | United Kingdom (country not specified) | 74 individuals were randomly assigned to receive either cognitive therapy plus treatment as usual (n=37), or treatment as usual alone (n=37). | To examine the feasibility and effectiveness of using cognitive behavioural therapy (CBT) in people with schizophrenia who are not taking medication. | Quantitative - a single-blind randomised controlled trial at two UK centres between Feb 15, 2010, and May 30, 2013. | Mean PANSS total scores were consistently lower in the cognitive therapy group than in the treatment as usual group, with an estimated between-group effect size of -6.52 (95% Cl -10.79 to -2.25; p=0.003). Cognitive therapy significantly reduced psychiatric symptoms and seems to be a safe and acceptable alternative for people with schizophrenia spectrum disorders who have chosen not to take antipsychotic drugs. Evidence-based treatments should be available to these individuals. A larger, definitive trial is needed. |

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| Noorthoorn,  ЕО; Voskes, Y; Janssen, WA; Mulder, CL; van de Sande, R; Nijman, HLI; Smit, A; Hoogendoorn, AW; Bousardt, A; Widdershoven, GAM | 2016 | Netherlands | Data (2008 to 2013) were from a national register | In 2006, a goal of reducing seclusion in Dutch hospitals by at least 10% each year was set. More than 100 reduction projects in 55 hospitals have been conducted, with €35 million in funding. This study evaluated the results. | Quantitative analysis of government data | Hospital participation in the register ranged from eight in 2008 to 66 in 2013, and admissions ranged from 11,300 to 113,290. The average yearly nationwide reduction of secluded patients was about 9%. Reduction was achieved in half of the hospitals. Some hospitals saw increased rates. In some hospitals where seclusion decreased, use of forced medication increased. Higher seclusion rates were associated with psychotic and bipolar disorders, male gender, and several ward types. Seclusion decreased significantly, and forced medication increased. Rates varied widely between hospitals. For many hospitals, more efforts to reduce seclusion are needed. |
| Norredam, M; Garcia-Lopez, A; Keiding, N; Krasnik, A | 2010 | Denmark | Sample of 6476 individuals with psychiatric inpatient contact from a total cohort of 312, 300 persons | To investigate differences in risk of compulsory admission and other coercive measures in psychiatric emergencies among refugees and immigrants compared with that among native Danes. | Quantitative analysis of government data | Coercive measures in psychiatry are more likely to be experienced by migrants than by native Danes. |
| Norvoll, R; Hem, MH; Pedersen, R | 2017 | Norway | Seven semi structured telephone interviews with key informants in charge of 'central development projects and quality-assurance work in mental health services in Norway'. | This article aims to increase understanding of how ethics can contribute to reducing coercive practices and improving their quality through a qualitative study of key informants from development projects and facilities in Norway that use little coercion. | Qualitative analysis of semi-structured telephone interviews | This study indicates that ethics can contribute significantly to development projects and quality assurance about coercion by offering more systematic ways of dealing with moral concerns.  The interrelatedness of organisational environments, professional aspects and moral issues underlines the need for integrated and process oriented ethics. Further studies are needed to investigate how systematic use of various kinds of clinical ethics support could contribute to development work on coercion. |

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| Olsson, H; Schön, U-К | 2016 | Sweden | 13 'key care workers' at a maximum- security forensic psychiatric hospital. | To determine what resources forensic staff use to avoid or prevent violent situations, and to explore how these practices resemble the domains of recovery- oriented care. | Qualitative analysis of in-depth interview texts with thematic analysis. | Staff prevent violent situations using tacit knowledge and experience, and through a shared collegial responsibility. Staff safeguard patients, encourage patient participation, and provide staff consistency. The results have implications for forensic care as well as psychiatry regarding the process of making recovery a reality for patients in the forensic care setting. |
| Osborn, D; Lloyd-Evans,  B; Johnson, S; Gilburt, H; Byford, S; Leese, M; Slade, M | 2010 | England | Experience of 314 patients in four residential alternatives and four standard services were compared. | To compare patient satisfaction, ward atmosphere and perceived coercion in the two types of service, using validated measures. | Quantitative analysis of data collected using: the Client Satisfaction Questionnaire, the Service Satisfaction Scale - Residential form, etc. | 'Alternatives to traditional in-patient services' appear to be associated with a better experience of admission. Community alternatives were associated with greater service user satisfaction and less negative experiences. Some but not all of these differences were explained by differences in the two populations, particularly in involuntary admission. |
| Ostrów, L | 2010 | United  States | N/A | To present a case study of Groundhogs' (a group of consumers in Massachusetts) organising strategies, intended to inform consumer groups in other states and counties that are interested in peer-run crisis respites (PRCRs). | Case study - qualitative in nature. | This brief reports the organising strategies of the Massachusetts group, Groundhogs, that has organised for peer-run crisis respites (PRCR). The analysis and options imparted here can be useful for consumers in other states and counties embarking on a similar mission. The authors write: 'If we are to be successful as a movement in bringing about recovery-oriented, consumer-driven systems, we need to be effective organizers of policy change and service innovation.  The experience of Groundhogs in Massachusetts is informative for models of community and consumer organizing.' [Not peer reviewed] |

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| Papageorgiou, A; King, M; Janmohamed, A; Davidson, 0; Dawson, J | 2002 | England | 156 in-patients about to be discharged from compulsory treatment under the Mental Health Act participated. | To evaluate whether use of advance directives by patients with mental illness leads to lower rates of compulsory readmission to hospital. | Quantitative analysis of inpatients' usual psychiatric care with usual care plus the completion of an advance directive. | Fifteen patients (19%) in the intervention group and 16 (21%) in the control group were readmitted compulsorily within 1 year of discharge. There was no difference in the numbers of compulsory réadmissions, numbers of patients readmitted voluntarily, days spent in hospital or satisfaction with psychiatric services. There was no difference in the numbers of compulsory réadmissions, numbers of patients readmitted voluntarily, days spent in hospital or satisfaction with psychiatric services. Users' advance instruction directives had little observable impact on the outcome of care at 12 months. |
| Paterson, B; Bennet, L; Bradley, P | 2014 | Netherlands | Random sample of 252 from the 2,682 patients consecutively coming into contact with two psychiatric emergency teams in Amsterdam. | Aim is to study the links between opinions about prior psychiatric treatment, insight, service engagement and the risk of (new) civil detentions. | Quantitative analysis of patient sociodemographic and clinical characteristics, and information about prior involuntary admissions. | More satisfaction with prior treatment seems to reduce the risk of civil detention remarkably. Low levels of satisfaction seem to be mainly dependent on a history of previous involuntary admission. These findings seem to open up a new perspective for diminishing the risk of (new) civil detention by trying to enhance satisfaction with treatment, especially for patients under detention. |
| Poulsen, HD | 2002 | Denmark | 472 admissions to all psychiatric wards at one hospital were selected randomly by selecting every fifth admission. | To investigate the prevalence of 'extralegal deprivation of liberty' - restrictions in leaving a psychiatric ward other than a formal involuntary commitment of detention - in a hospital population. | Quantitative - survey of large sample of psychiatric admission data (staff must record imposition of restricted leave). | Extra-legal deprivation of liberty seems to be a common phenomenon at the psychiatric ward also among patients admitted voluntarily. Reasons for using this type of coercion are probably complex, but it seems to be most common among severely ill patients. |

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| Putkonen, A; Kuivalainen, S; Louheranta, 0; Repo-Tiihonen, E; Ryynänen, 0-P; Kautiainen, H; Tiihonen, J | 2013 | Finland | 13 wards of a secured national psychiatric hospital in Finland. | To study whether seclusion and restraint could be prevented in the psychiatric care of persons with schizophrenia without an increase of violence. | Quantitative - randomised controlled trial, comparing monthly incidence rate ratios (IRRs) of coercion and violence. | The proportion of patient-days with seclusion, restraint, or room observation declined from 30% to 15% for intervention wards (IRR=.88, 95% confidence interval [CI]=.86-.90, p<.001) versus from 25% to 19% for control wards (IRR=.97, Cl=.93-1.01, p=.056). Seclusion-restraint time decreased from 110 to 56 hours per 100 patient-days for intervention wards (IRR =.85,  CI = .78-.92, p<.001) but increased from 133 to 150 hours for control wards ( IR R = 1.09, СI=. 94-1.25, p=.24). Seclusion and restraint were prevented without an increase of violence in wards for men with schizophrenia and violent behaviour. A similar reduction may also be feasible under less extreme circumstances. |
| Puteh, 1; Marthoenis, M; Minas, H | 2011 | Indonesia | 59 'former ex- pasung patients were examined'. The majority (88.1%) were men, aged 18 to 68 years. | To report the findings of a preliminary investigation of the demographic and clinical characteristics of patients who have been admitted to the Banda Aceh Mental Hospital as part of the Aceh Free Pasung program. | Qualitative - cross-sectional descriptive study  conducted at the Banda Aceh Mental Hospital. | Physical restraint and confinement of the mentally ill (called 'pasung' in Indonesia) is common in Aceh. The authors report that 'development of a community mental health system and the introduction of a health insurance system in Aceh (together with the national health insurance scheme for the poor) has enabled access to free hospital treatment for people with severe mental disorders, including those who have been in pasung.' Further, 'The demographic and clinical characteristics of this group of ex-pasung patients are broadly similar to those reported in previous studies. The Aceh Free Pasung programme is an important mental health and human rights initiative that can serve to inform similar efforts in other parts of Indonesia and other low and middle-income countries where restraint and confinement of the mentally ill is receiving insufficient attention'. |
| Raveesh, BN; Pathare, S; Noorthoorn,  EO; Gowda,  GS; Lepping, P; Bunders-Aelen, JGF | 2016 | India | A total of 210 psychiatrists and 210 caregivers participated in the study. | The objective of this study was to assess attitudes of Indian psychiatrists and caregivers toward coercion. | Quantitative analysis of a 15-item questionnaire | Caregivers and psychiatrists felt that the lack of resources is one of the reasons for coercion. Furthermore, they felt that the need on early identification of aggressive behaviour, interventions to reduce aggressiveness, empowering patients, improving hospital resources, staff training in verbal de-escalation techniques is essential. There is an urgent need in the standardised operating procedure in the use of coercive measures in Indian mental health settings. |

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| Riahi, S; et al | 2016 | Canada | 326-bed, tertiary level, specialised mental health care facility in Ontario, Canada. | To evaluate the Six Core Strategies for Restraint Minimisation at a recovery-oriented, tertiary level mental health care facility and its effect on mechanical restraint and seclusion incidents. | Quantitative - service data, retrospective review examines restraint practices. | Strategies were implemented in a staged manner across 3 years. The total number of mechanical restraint and seclusion incidents decreased by 19.7% from 2011/12 to 2013/14. Concurrently, the average length of a mechanical restraint or seclusion incident decreased 38.9% over the 36-month evaluation period. Implementation of the Six Core Strategies for Restraint Minimisation effectively decreased the number and length of mechanical restraint and seclusion incidents in a specialised mental health care facility. |
| Robertson, JP; Collinson, С | 2011 | England | Two groups of staff working in local community outreach teams in adult mental health and learning disability services in a midlands city. | To undertake an exploration into outreach workers' experiences of assisting clients with positive risk-taking (PRT), including dimensions of risk staff face, and factors influencing their risk approaches. | Qualitative analysis of interview transcripts. | The study highlighted different understandings of positive risk-taking PRT at different levels within organisations and a need for better informed, coherent organisational approaches to its practice. Interpersonal trust relies upon such organisational coherence; without it some staff may see themselves as gambling when undertaking PRT, whereas others may retreat into conservative interventions. Such conservative practices were perceived as potentially dangerous, promoting coercion and disrupting therapeutic relationships, and so increasing risks over a longer time period. Research is needed into the use of systems failure analysis and risk assessment tools to highlight how PRT can generate successful outcomes. |
| Rosen, J; O'connell, M | 2013 | United  States | 14 adults admitted to a mental health respite program. | To examine clients who were admitted to a mental health respite programme in the first 3 months of 2011 in order to identify the ability of the programme to reduce symptom distress and to explore related psychosocial factors. | Quantitative analysis of entry and exit questionnaires. | Measures of symptom distress, mental health confidence, and self-esteem all improved significantly over time spent in the respite program. However, the immediate impact of the respite programme on external indicators of functioning were not observed. A common definition for purpose and implementation of respite is lacking, and a better understanding of these details could improve current programmes as well as define a structure for newly created ones. |

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| Russo, J; Rose, D | 2013 | Europe | Study involved one focus group in each of 15 European countries and extended to a total of 116 participants. | The purpose of this paper is to discuss human rights assessment and monitoring in psychiatric institutions from the perspectives of those whose rights are at stake. | Qualitative analysis of focus group data. | Paper highlights human rights issues which are not readily visible and therefore less likely to be captured in institutional monitoring visits. Key issues include the lack of interaction and general humanity of staff, receipt of unhelpful treatment, widespread reliance on psychotropic drugs as the sole treatment and the overall impact of psychiatric experience on a person's biography. |
| Salomon, С Hamilton, В; Elsom, S | 2014 | Australia | 98 Australian consumers involved with participating organisations completed an anonymous survey  detailing past antipsychotic discontinuation attempts. | To gain an understanding of consumer experiences of antipsychotic discontinuation. This study was designed to increase understanding of antipsychotic discontinuation from consumer perspectives. | Quantitative - survey. | Of the 88 participants who reported at least one discontinuation attempt, over half (n = 47, 54.7%) reported stopping without clinician knowledge or support. This group was 35% (confidence interval 15.4-54.6%) more likely to stop abruptly than those (n = 41, 45.3%) stopping with clinician support (P = 0.002). Only 10 participants (23.3%) recalled being given information about discontinuation symptoms other than relapse; however, 68 participants (78.2%) reported experiencing a range of discontinuation symptoms including physical, cognitive, emotional, psychotic or sleep-related disturbances. Findings cannot be readily generalised because of sampling constraints. However, the significant number of participants who reported discontinuation symptoms, in addition to psychosis, is consistent with previous research. This study provides new insight into consumer motivations for discontinuation and possible problems in clinical communication that may contribute to frequent non-collaborative discontinuation attempts. Mental health nurses, who play a pivotal role in medication communication events, may benefit from increased awareness of consumer perspectives on this topic. |

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| Schneeberger, AR; Kowalinski,  E; Fröhlich, D; Schröder, K; von Felten, S; Zinkler, M; Beine, KH; Heinz, Andreas; Borgwardt, S; Fang, UE; Bux, DA; Huber, CG | 2017 | Germany | Seclusion or restraint data in 21 German hospitals. | To examine the effects of open vs. locked door policies on aggressive incidents which remain unclear. | Quantitative analysis of hospital data. Naturalistic observational design and analysis of the occurrence of aggressive behaviour. | Restraint or seclusion during treatment was less likely in hospitals with an open door policy. On open wards, any aggressive behavior and restraint or seclusion were less likely, whereas bodily harm was more likely than on closed wards. Hospitals with open door policies did not differ from hospitals with locked wards regarding different forms of aggression. Other restrictive interventions used to control aggression were significantly reduced in open settings. Open wards seem to have a positive effect on reducing aggression. Future research should focus on mental health care policies targeted at empowering treatment approaches, respecting the patient's autonomy and promoting reductions of institutional coercion. |
| Schout, G; van Dijk, M; Meijer, E; Fandeweer, E; de Jong,G | 2017 | Netherlands | Two case examples of families/social networks. | To address the question what Family Group Conferencing (FCG) adds to the existing methods to reduce coercion in mental health care and promote inclusion. | Qualitative analysis of evaluation study data | Research indicates that there are grounds for a wider application of FGC in mental health, even outside the framework of coercive care. Study observed that clients and/or their social network were not always able to participate in a conference, let alone to bring in enough self-direction; so that during the private time a plan could be established. |

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| Schout, G; et al | 2017 | Netherlands | 17 families/ social networks engaged in family group conferencing. | To identify barriers to applying Family Group Conferences. 'An answer to this question provides insights regarding situations in which Family Group Conferences may (not) be useful'. | Qualitative - 17 case studies | The following barriers emerged: '(1) the acute danger in coercion situations, the limited time available, the fear of liability and the culture of control and risk aversion in mental health care; (2) the severity of the mental state of clients leading to difficulties in decision-making and communication; (3) considering a Family Group Conference and involving familial networks as an added value in crisis situation is not part of the thinking and acting of professionals in mental health care; (4) clients and their network (who) are not open to an Family Group Conference.' Awareness of the barriers for Family Group Conferences can 'help to keep an open mind for its capacity to strengthen the partnership between clients, familial networks and professionals' and 'can help to effectuate professional and ethical values of social workers in their quest for the least coercive care'. |
| Seikkula, J | 2003 | Finland | Data from 69 service users, of whom 45 who were given Open Dialogue support were compared with 14 service users in typical acute services. | To evaluate the Open Dialogue (OD) approach that aims to treat psychotic patients in their home. | Quantitative analysis of government patient data | As part of the Need-Adapted Finnish model, the Open Dialogue (OD) approach aims to treat psychotic patients in their home. Treatment involves the patient's social network, starts within 24 hours of initial contact, and responsibility for the entire treatment rests with the same team in inpatient and outpatient settings. Patients in the Open Dialogue in Acute Psychosis (ODAP) group had fewer relapses and less residual psychotic symptoms and their employment status was better than patients in the comparison group. The OD approach, like other family therapy programmes, seems to produce better outcomes than conventional treatment. OD emphasises using fewer neuroleptic medication. |

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| Shields, LS; et al | 2013 | India | N = 51. Clients (n = 39) and carers (n = 12) seeking mental health treatment at outpatient clinics in urban and rural settings. | To explore the feasibility and utility of psychiatric advance directives (PADs) in India, with a focus on the need for individual control over decision making and barriers to implementation, by exploring views of its central stakeholders, service users and carers. | Qualitative - interviews with thematic analysis. | Clients engaged in a number of forms of decision making (passive, active, and collaborative) depending on the situation and decision at hand and had high levels of self-efficacy. Most clients and carers were unfamiliar with PADs, and while some clients felt it is important to have a say in treatment wishes, carers expressed concerns about service user capacity to make decisions. After completing PADs, clients reported an increase in self-efficacy and an increased desire to make decisions. The authors conclude that 'PADs could potentially mitigate the risks of coercive treatments to persons with severe mental illness.' |
| Siponen, U; Välimäki, M; Kaivosoja, M; Marttunen, M; Kaltiala-Heino, R | 2011 | Finland | Data for all adolescents aged 13-17 from two Finnish districts between years 1996-2003. | The aim of the study was to explore features associated with compulsory intervention of adolescents at the regional level by comparing two hospital districts clearly differing in this regard. | Quantitative analysis of government hospital discharge data. | Factors other than the characteristics of the adolescents themselves - such as 'divorces, single parent families, social exclusion' - are associated with use of compulsory care, although an ecological study design cannot establish causality. |
| Slade, M; et al | 2010 | England | Admission cost data were collected for six alternative services and six standard services. | To explore short-term outcomes and costs of admission to alternative and standard services, and address the gap in research on outcomes following admission to residential alternatives to standard in-patient mental health services which are underresearched. | Quantitative - Health of the Nation Outcome Scales (HoNOS), Threshold Assessment Grid (TAG), Global Assessment of Functioning (GAF). | All outcomes improved during admission for both types of service (n = 433). Adjusted improvement was greater for standard services in scores on HoNOS (difference 1.99, 95% Cl 1.12-2.86), TAG (difference 1.40, 95% Cl 0.39-2.51) and GAF functioning (difference 4.15, 95%  Cl 1.08-7.22) but not GAF symptoms. Admissions to alternatives were 20.6 days shorter, and hence cheaper (UKE3832 v. £9850). Standard services cost an additional £2939 per unit HoNOS improvement. The absence of clear-cut advantage for either type of service highlights the importance of the subjective experience and longer- term costs. |

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| Sledge, WH; Tebes, J; Rakfeldt, J; Davidson, L; et al | 1996 | United  States | 197 patients were enrolled in the 2-year research programme and followed for 10 months. | To investigate the clinical feasibility and the outcome for patients of a programme designed as an alternative to acute hospitalisation. | Quantitative analysis of random-design study data. | The clinical, functional, social adjustment, quality of life, and satisfaction outcome measures were not statistically different for the patients in the two treatment conditions; however, there was a slightly more positive effect of the experimental programme on measures of symptoms, overall functioning, and social functioning. The experimental condition, a combined day hospital/ crisis respite community residence, seems to have had the same treatment effectiveness as acute hospital care for urban, poor, acutely ill voluntary patients with severe mental illness. |
| Sledge, WH; Tebes, J; Wolff, N; Helminiak, TW | 1996 | United  States | 197 patients were enrolled in the 2-year research programme and followed for 10 months. | To compare service use and costs for acutely ill psychiatric patients treated in a day hospital/crisis respite programme or in a hospital inpatient program. | Quantitative analysis of data collected for developing service use profiles and estimates of per-unit costs. | On average, the day hospital/crisis respite programme cost less than inpatient hospitalisation. The average saving per patient was +7,100, or roughly 20% of the total direct costs. There were no significant differences between programmes in service utilisation or costs during the follow-up phase. The programmes were equally effective, but day hospital/crisis respite treatment was less expensive for some patients. Potential cost savings are higher for nonpsychotic patients. Cost differences between the programmes are driven by the hospital's relatively higher overhead costs. The roughly equal expenditures for direct service staff costs in the two programmes may be an important clue for understanding why these programmes provided equally effective acute care. |
| Smith, G; et al | 2005 | United  States | Records of patients older than 18 years who were civilly committed to one of the nine state hospitals in Pennsylvania were included in the analyses. | To examine the use of seclusion and mechanical restraint from 1990 to 2000 and the rate of staff injuries from patient assaults from 1998 to 2000 in a state hospital system, during a period of intervention to reduce rates. | Quantitative analysis of data collected pre/post intervention. | The rate and duration of seclusion and mechanical restraint decreased dramatically during this period; from 4.2 to 0.3 episodes per 1,000 patient-days. The average duration of seclusion decreased from 10.8 to 1.3 hours. The rate of restraint decreased from 3.5 to 1.2 episodes per 1,000 patient-days. The average duration of restraint decreased from 11.9 to 1.9 hours. Patients from racial or ethnic minority groups had a higher rate and longer duration of seclusion than whites. Many factors contributed to the success of this effort, including advocacy efforts, state policy change, improved patient- staff ratios, response teams, and second-generation anti psychotics. |

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| Suryani, L; et al | 2011 | Indonesia | 404,591 people clinically interviewed, of which 895 persons with mental health conditions were identified. 23 experienced physical restraint/ confinement. | This study identified, mapped and treated the clinical features of mentally ill people, who had been isolated and restrained by family and community members as a result of a functional failure of the traditional medical, hospital-based mental health model currently practiced in Indonesia. | Quantitative - 10-month epidemiological population survey  carried out in Karangasem regency of Bali, Indonesia. | Duration of restraint ranged from 3 months to 30 years (mean = 8.1 years, SD = 8.3 years). According to the authors, 'Through the application of a holistic intervention model, all patients exhibited a remarkable recovery within 19 months of treatment.' They conclude that 'the development of a community-based, culturally sensitive and respectful mental health model can serve as an optimum promoter of positive mental health outcomes'. |
| Swanson, J; Swartz, M; Elbogen, E; Richard Van Dorn; Wagner, R; Moser LA; Wilder C; Gilbert AR | 2008 | United  States | A total of 239 patients were assigned to be offered 'facilitated' advance planning; about 60% completed planning. | This study examined whether completion of a Facilitated Psychiatric Advance Directive (F-PAD) was associated with reduced frequency of coercive crisis interventions. | Quantitative analysis of randomised controlled trial data. | F-PAD completion was associated with lower odds of coercive interventions (adjusted OR = 0.50; 95% Cl = 0.26-0.96; p < 0.05). PADs may be an effective tool for reducing coercive interventions around incapacitating mental health crises. Less coercion should lead to greater autonomy and self-determination for people with severe mental illness. |

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| Swartz, MS; Swanson, JW; Hannon, MJ | 2003 | United  States | Surveyed 85 mental health professionals, and 104 individuals with schizophrenia spectrum conditions. | To examine what extent do experiences with different forms of coercion and pressures to adhere to treatment create barriers that may inhibit future help seeking for mental health problems. | Quantitative analysis of survey data. | Of the clinicians, 78% reported that overall they thought legal pressures made their patients with schizophrenia more likely to stay in treatment. Regarding involuntary outpatient commitment, 81% of clinicians disagreed with the premise that mandated community treatment deters persons with schizophrenia from seeking voluntary treatment in the future. Of the consumer sample, 63% reported a lifetime history of involuntary hospitalisation, while 36% reported fear of coerced treatment as a barrier to seeking help for a mental health problem-termed here 'mandated treatment- related barriers to care.' In multivariable analyses, only involuntary hospitalisation and recent warnings about treatment nonadherence were found to be significantly associated with barriers that may inhibit future help seeking. These results suggest that mandated treatment may serve as a barrier to treatment, but that ongoing informal pressures to adhere to treatment may also be important barriers to treatment. |
| Tanenbaum, SJ | 2012 | United  States | Survey of directors of 15 consumer- operated service organisations (service user led organisation) and follow up interview with 6 directors. | This study examines the operation of consumer-operated service organisations in one US state, and argues these organisations, which are new following 'deinstitutionalisation', are overlooked by proponents of bringing back largescale psychiatric hospitals. | Mixed methods - quantitative analysis of mail survey, with follow up quantitative telephone interviews. | Consumer-operated service organisations (COSOs) emerge as more self-governing and community-based than required by certification requirements and as developing internally and externally in tandem. COSOs are not only adjunct or alternative service providers, but also civic associations and loci for the expression of citizenship by mentally ill people. The authors argue that 'COSO membership consists of seriously mentally ill people (in various stages of recovery), and COSO services and linkages with other community groups provide the elements of hospital care that community-based clinical providers cannot: food, shelter, recreation, and socializa-tion.' Furthermore because COSOs are not content to replace the hospital but also participate in the recovery movement, they provide peer support and advocacy training and, perhaps most importantly, insist on self-governance and other forms of citizenship. |

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| Thomsen, CT; Benros, ME; Maltesen, T; Hastrup, LH; Andersen, PK; Giacco, D; Nordentoft, M | 2018 | Denmark | Clinical data obtained from recipients of patient-controlled admission in all the five regions in Denmark where patient- controlled admission is available. | To assess whether implementing patient- controlled admission (PCA) can reduce coercion and improve other clinical outcomes for psychiatric inpatients. | Quantitative analysis of patient- controlled admission data. | Implementing patient-controlled admission (PCA) did not reduce coercion, service use or self-harm behaviour when compared with treatment as usual (TAU). In a paired design, the outcomes of PCA patients during the year after signing a contract were compared with the year before. The PCA group had more in-patient bed days (mean difference = 28.4; 95% Cl: 21.3; 35.5) and more medication use (P < 0.0001) than the TAU group. Before and after analyses showed reduction in coercion (P = 0.0001) and in-patient bed days (P = 0.0003). Beneficial effects of PCA were observed only in the before and after PCA comparisons. Lurther research should investigate whether PCA affects other outcomes to better establish its clinical value. |
| Thomsen, С; Starkopf, L; Hastrup, LH; Andersen, PK; Nordentoft, M; Benros, ME | 2017 | Denmark | Study population included all individuals aged 18-63 years with a psychiatric inpatient admission during January 1, 1999- December 31, 2014 | To identify risk factors associated with coercive measures, to better identifying possible causes of (and hence remedies to) coercion. | Quantitative analysis of psychiatric inpatient admission data. | Clinical characteristics were the foremost predictors of coercion and patients with organic mental disorder had the highest increased risk of being subjected to a coercive measure (OR=5.56; 95% Cl=5.04, 6.14). The risk of coercion was the highest in the first admission and decreased with the number of admissions (all p<0.001). The following socioeconomic variables were associated with an increased risk of coercion: male sex, unemployment, lower social class and immigrants from low and middle income countries (all p<0.001). Early retirement and social relations, such as being married and having children, reduced the risk of being subjected to coercive measure (all p<0.05). These findings can assist researchers in identifying patients at risk of coercion and thereby help targeting new coercion reduction programmes. |

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| Thornicroft, G; et al | 2013 | England | 569 participants were randomly assigned (285 to the intervention group and 284 to the control group) | To assess whether the additional use of Joint Crisis Plans improved patient outcomes compared with treatment as usual for people with severe mental illness. | Quantitative analysis of CRIMSON (Crisis Impact: Subjective and Objective coercion and eNgagement) randomised controlled trial data. | The findings are inconsistent with two earlier Joint Crisis Plans (JCP) studies, and show that the JCP is not significantly more effective than treatment as usual. There is evidence to suggest the JCPs were not fully implemented in all study sites, and were combined with routine clinical review meetings which did not actively incorporate patients' preferences. The study therefore raises important questions about implementing new interventions in routine clinical practice. |
| Valenti, E; et al | 2015 | Inter  national:  Canada,  Chile,  Croatia,  Germany,  Italy,  Mexico,  Norway,  Spain,  Sweden,  United  Kingdom. | Focus groups with mental health  professionals were conducted in ten countries. | This paper aims to identify the attitudes and experiences of mental health professionals towards the use of informal coercion across countries with differing sociocultural contexts. | Qualitative analysis of focus group interviews in ten countries with different sociocultural contexts. | A disapproval of informal coercion in theory is often overridden in practice. This dissonance occurs across different sociocultural contexts, tends to make professionals feel uneasy, and requires more debate and guidance. |
| van der Post,  Louk FM; Peen, J; Visch, 1; Mulder, CL; Beekman, ATF; Dekker, JJM | 2014 | Netherlands | Random sample of 252 from the 2,682 patients consecutively coming into contact with two psychiatric emergency teams in Amsterdam. | Aim is to study the links between opinions about prior psychiatric treatment, insight, service engagement and the risk of (new) civil detentions. | Quantitative analysis of sociodemographic and clinical characteristics and information about prior involuntary admissions. | More satisfaction with prior treatment seems to reduce the risk of civil detention remarkably. Low levels of satisfaction seem to be mainly dependent on a history of previous involuntary admission. These findings seem to open up a new perspective for diminishing the risk of (new) civil detention by trying to enhance satisfaction with treatment, especially for patients under detention. |

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| van der Schaaf, PS; Dusseldorp, E; Keuning, FM; Janssen, WA; Noorthoorn, EO | 2013 | Netherlands | Service data on 77 Dutch psychiatric hospitals and also a benchmark study on the use of coercive measures in 16 Dutch psychiatric hospitals. | To explore the effect of design features on the risk of being secluded, the number of seclusion incidents and the time in seclusion, for patients admitted to locked wards for intensive psychiatric care. | Quantitative analysis by combining data of building quality and safety with data on frequency and type of coercive measures. | A number of design features had an effect on the use of seclusion and restraint. The study highlighted the need for a greater focus on the impact of the physical environment on patients, as, along with other interventions, this can reduce the need for seclusion and restraint. |
| Vruwink, FJ; Mulder, CL; Noorthoorn, EO; Uitenbroek, D; Nijman, HLI | 2012 | Netherlands | Dutch hospitals that received a government grant program, which in 2006 (start of program) numbered 34 and by 2009 (end of program) numbered 42. | To establish whether the numbers of both seclusion and involuntary medication changed significantly after the start of this national programme designed to reduce seclusion in Dutch hospitals. | Quantitative analysis (using Poisson regression to estimate difference in logit slopes) of Dutch Health Care Inspectorate data for seclusion and involuntary medication. | After the start of the nationwide programme the number of seclusions fell, and although significantly changing, the reduction was modest and failed to meet the objective of a 10% annual decrease. The number of involuntary medications did not change; instead, after correction for the number of involuntary hospitalisations, it increased. |

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| Wanchek, TN; Bonnie, RJ | 2012 | United  States | 500 Medicaid recipients who had a mental health diagnosis and at least one temporary detention order (TDO). | This study examined whether lengthening the holding period for an individual experiencing a mental health crisis under a temporary detention order (TDO) can reduce the number and length of post-TDO involuntary hospital commitments. | Quantitative analysis of data from Virginia Court System and Virginia Medicare claims database. | Longer TDO periods were correlated with an increased probability of a dismissal of the commitment petition rather than hospitalisation after a TDO. Among individuals who were hospitalised, longer TDO periods were correlated with an increased likelihood of voluntary hospitalisation, rather than involuntary commitment, and shorter hospitalisations, although the net care time (TDO period plus post-TDO hospitalisation) increased for individuals whose TDO length was greater than 24 hours. |
| Watson, S; Thorburn, К; Everett, M; Fisher, KR | 2014 | Australia | N/A | To apply three different frameworks currently used in mental health services (human rights, personal recovery, and trauma-informed) to the text of the National Standards for Mental Health Services 20! 0 as well as the public text of speakers' notes regarding lived experience from the Care Without Coercion Conference 2010 | Qualitative analysis of both a key national policy document as well as public text from speakers of a national conference. | The analysis sought to analyse the degree to which national policy documents reflect a shift signalled in the three frameworks. The authors identified the use of force in many aspects of policy. The authors suggest pathways to apply the frameworks in national policy, which they argue would bring about freedom from violence; support for decision making; access and choice about community and inpatient options; safety and risk management; and greater understanding of current policy frameworks through engagement with people with lived experience about the options and impact of support processes that exclude the use of force. |

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| Wieman, D; et al | 2014 | United  States | Service data for 43 inpatient psychiatrie facilities | To examine implementation and outcomes of the Six Core Strategies for Reduction of Seclusion and Restraint (6CS) in 43 inpatient psychiatric facilities. Facilities were classified into five implementation types: stabilised (N=28), continued (N=7), decreased (N=5), discontinued (N = 1), or never implemented (N=2). | Quantitative - a prototype Inventory of Seclusion and Restraint Reduction Interventions (ISRRI) 'tracked fidelity' over time. | Overall, the stabilised group reduced the percentage secluded by 17% (p=.002), seclusion hours by 19% (p=.001), and proportion restrained by 30% (p=.03). The reduction in restraint hours was 55% but nonsignificant (p=.08). Individual facility effect sizes varied; some rates increased for some facilities. The dose-effect hypothesis was supported for two outcomes, seclusion hours and percentage restrained. The order of implementation group effects in relation to each outcome varied unpredictably. The 6CS was feasible to implement and effective in diverse facility types. Fidelity over time was nonlinear and varied among facilities. Further research on relationships between facility characteristics, fidelity patterns, and outcomes is needed. |
| Winick, BJ | 1996 | United  States | N/A | Article analyses how living wills and other advance directive instruments may be used in mental health contexts. | Qualitative analysis of law relevant to living wills and advance directives, particularly case law. | Advance directive instruments can be a useful means of planning for mental illness and of avoiding disputes concerning hospitalisation and treatment. The avoidance of hearings, either judicial or administrative, to resolve these controversies would produce considerable fiscal and administrative savings. It also could prevent diversion of scarce clinical resources from treatment to dispute resolution. In addition, it would avoid the patient dissatisfaction that results when patients lose such hearings and that sometimes produces a psychological reactance that undermines the chances for successful treatment. |

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| Wisdom, JP; Wenger, D; Robertson, D; Van Bramer, J; Sederer, LI | 2015 | United  States | Three  participating mental health treatment centres that adopted the Six Core Strategies program. | To evaluate the Positive Alternatives to Restraint and Seclusion project of the New York State Office of Mental Health (OMH). | Quantitative - service data from state- operated and licensed inpatient and residential treatment programmes for 'children with severe emotional disturbances'. | The three participating mental health treatment facilities demonstrated significant decreases in restraint and seclusion episodes per 1,000 client-days. Each identified specific activities that contributed to success, including ways to facilitate open, respectful two-way communication between management and staff and between staff and youths and greater involvement of youths in programme decision making. |
| Zinkler, M | 2016 | Germany | Service data on a network of Bavarian hospitals | To review data on the use of coercion, against data on the use of coercive treatment in a group of Bavarian hospitals since 2014. Additionally, detailed data from one institution with an uncommon approach to violence and coercion is presented. | Quantitative data analysis of use of coercion in network of psychiatric hospitals | In a 15-month period starting in 2014, Germany's Constitutional Court and Federal Supreme Court restricted involuntary treatment 'in all but life-threatening emergencies' in response to the CRPD. National and local data suggests that giving up coercive medication is not straightforward and problems arise when one form of coercive treatment (coercive medication) is stopped but other forms of coercion (restraint) and violence in psychiatric institutions increase. The author writes that '[djata from a ... local mental health service suggest that the use of coercive medication could be made obsolete.' |