

Mysore Declaration on Coercion in Psychiatry

**Raveesh BN and Peter Lepping
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Introduction

1.1 Coercion is recognized as a problem in health services around the world. There is a growing desire to explore the reasons for the use of coercion and develop an evidence base of research to inform debates and discussion as well as change in practice. At a recent international symposium in Mysore, India a group of experts from Europe and India articulated a set of best practice principles to support the minimization of the use of coercion. We urge health practitioners and policy makers in government and medical education to consider these principles and translate them into clinical practice.

The Indian context

2.1 There is rapid change in socioeconomic, cultural, and psychosocial profiles of the traditional rural-oriented and family-centered societies of India and Asia in general. Despite these changes, family and friends are intimately involved in patients' care in India. For example, covert administration of antipsychotic medication by family members under medical advice to noncompliant patients with schizophrenia is observed to be common practice. Various standards on coercion and restraint have been defined in Europe with varying degrees of success in implementing them. There is a lack of data in India regarding the use of coercive measures and other forms of leverage in medical practice. This makes international comparisons difficult. It is therefore all the more important to be aware of the patients' individual rights and preferences regarding the necessity, mode, and venue of psychiatric treatment, along with the recognition of the legitimate interests and wishes of family members.

2.2 The draft proposed amendments to the Mental Health Act of India 1987 (MHA 1987) classifies "admissions" as patients being 'independent' and able to decide for him/herself, without support or requiring minimal support. "Supported admissions" are those where the patient needs substantial or high levels of support, although the draft proposals remain vague about provisions for assessing and implementing admissions. High levels of support (bordering on 100% support) are to be viewed as a temporary phenomenon and as soon as the person is judged to be able to make independent decisions, he or she should be allowed to make his or her own decisions.

The declaration

3.1 There is an urgent need for the recognition and implementation of the rights of persons with mental illness, following principles with regard to equality, security, liberty, health, integrity and dignity of all people, with a mental illness or not. All parties responsible for the care and treatment of mental illness should work towards the elimination of all forms of discrimination, stigmatization, and violence, cruel, inhuman or degrading treatment. We affirm that disproportionate, unsafe or prolonged coercion or violence against persons with mental illness constitutes a violation of the human rights and fundamental freedoms, and impairs or nullifies their enjoyment of those rights and freedoms. We will strive to uphold the human rights of persons with mental illness. We will work towards the prevention of violation, promotion and protection of their rights.

What are the barriers to achieving these standards?

4.1 Refusal to consent and incompetency to consent are included in the section on 'admission under special circumstances' in the MHA 1987. It has been strongly criticized that 'competence' has not been defined in the purview of the MHA. In the MHA, there is no separate provision for forced treatment. Involuntary treatment is thus presumed to be authorized under the section on admission under special circumstances and involuntary admission. As a 'mentally ill' person is defined as a person who needs treatment because of his mental disorder, it is commonly extrapolated that under Sections 19 and 20, it is the psychiatrist's duty to treat the mentally ill person. In other words, the clauses of the Act do not set out or help to resolve the dilemmas that treating clinicians face. Specific guidelines, thresholds or criteria as to the circumstances where involuntary treatment or admission is justified are woefully missing from the existing MHA.

4.2 Other barriers to achieving the expected standards include

- Lack of awareness in the patient (or the family) about the treatment and the outcomes to be achieved.
- The assumption that mental illness is always and necessarily accompanied by lack of capacity.
- The lack of provision for advanced planning (including advanced directives) in the event of future incapacity, compulsory admissions and treatment in patients with severe mental illness.
- Continuing prevalence of perceived coercion and negative approaches to lack of compliance, including threats and other forms of leverage.
- Lack of resources, which encourages therapeutic impatience and coercion.
- Lack of training and support to clinical staff on safe management of disturbed behavior and treatment refusal

- Lack of adequate advocacy and representation of patients' wishes

What measures are needed to overcome these barriers?

5.1 The initial phase to achieve a reduction of coercive measures and coercive leverage involves:

Raising awareness

Benchmarking, using validated tools to count and document coercive measures

Agreeing a definition of restraint and other coercive measures.

Definitions

6.0 We recognize the following definitions:

6.1 The term "violence and/or coercion against person with mental illness" means an act of violence that results in, or is likely to result in, physical, sexual, economical or psychological harm or suffering to person with mental illness, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.

6.2 Physical restraint: direct physical contact between persons where force is positively applied against resistance, either to restrict movement or mobility or to disengage from harmful behavior displayed by an individual.

6.3 Chemical restraint: involves the use of medication to restrain. It differs from therapeutic sedation in that it does not have a directly therapeutic purpose but is primarily employed to control undesirable behavior.

6.4 Mechanical restraint involves the use of equipment. Examples include specially designed mittens in intensive care settings; everyday equipment, such as using a heavy table or belt to stop the person getting out of their chair; or using bedrails to stop a person from getting out of bed. Controls on freedom of movement – such as keys, baffle locks and keypads – can also be a form of mechanical restraint.

6.5 Environmental restraint involves buildings designed to limit peoples' freedom of movement, including locked doors, electronic key pads, double door handles and baffle locks.

6.6 Seclusion is an important sub-type of environmental restraint. It is defined as 'placing of a person, at any time and for any duration, alone in an area with the door(s) shut in such a way as to prevent free exit from that area'.

6.7 Psychological restraint includes constantly telling a person not to do something, or that doing what they want to do is not allowed, or is too dangerous. It may include depriving a person of lifestyle choices by, for example, telling them what time to go to bed or to get up. It might also include depriving individuals of equipment or possessions they consider

necessary to do what they want to do, for example removal of walking aids, glasses, outdoor clothing or keeping the person in nightwear with the intention of preventing them from leaving.

6.8 Broadly speaking, the need to use restraint, particularly physical restraint, arises from two distinct circumstances: those which are *planned* and those which are *unplanned*.

6.8.1 *Unplanned physical restraint* refers to those incidents requiring restrictive physical interventions which are unforeseen and unexpected. Under these circumstances immediacy does not allow time to plan ahead. Staff are guided by best practice guidelines and training.

6.8.2 *Planned physical restraint* refers to restrictive physical interventions which have been planned via risk assessment and where there is an expectation that predicted circumstances are likely to occur. There is time for planning and restraint plans are structured and documented in health care records.

Standardization and benchmarking

7.1 Standardization describes the attempt to develop guidelines, improve safety, develop training and analyze benchmarking results. Guidelines should be developed regionally or nationally. They should be based on evidence and they should be practical in the Indian context. Existing evidence-based guidelines from Betsi Cadwaladr University Health Board, for example, can be used as a template for adaptation. Guidelines for restraint and rapid tranquilization will improve safety and avoid idiosyncratic practice. Staff training on the reduction of coercive measures (including control and restraint training that emphasizes physical restraint as the intervention of last resort) was fundamental and effective measure in parts of Europe. The comparisons of benchmarking results have been another important tool in Europe. This allows the identification of areas where practice is outside of the norm, which can then be prioritized for intervention.

Rights and responsibilities

8.1 There is an ongoing and appropriate debate over the tension between the rights of patients who refuse medication in contrast to the benefits of restoration to normal functioning through involuntary treatment.

8.2 Notwithstanding this debate, persons with mental illness are entitled to the equal enjoyment and protection of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.

8.3 States should condemn violence against persons with mental illness and should not invoke any custom, tradition or religious consideration to avoid their obligations with

respect to its elimination. States should pursue by all appropriate means and without delay a policy of minimizing violence and coercion against persons with mental illness. States should exercise due diligence to prevent, investigate and, in accordance with national legislation, punish acts of violence against person with mental illness, whether those acts are perpetrated by the State or by private persons.

8.4 A balance has to be struck between patients' autonomy and the suffering that no treatment may cause. The Hawaii declaration of the World Psychiatric Association provided guidelines for treating a patient who cannot express his or her own wishes regarding treatment and cannot see what is in his or her best interest because of their psychiatric illness. The guidelines suggest that compulsory treatment may or should be given provided it is done in the best interests of the patient. Patients should be encouraged to participate as fully as possible in all decisions about their care.

8.5 The role of the family in caring for the mentally ill in India needs due consideration. The family in India plays a major role in health seeking for its constituents. Any intervention planned for the patient should take into account the family's considerable influence over many aspects of patient management, including outpatient consultation and continuing care.

8.6 A thorough assessment of the patient's decision-making capacity should take place before coercive measures are considered. Decision-making capacity can and should be improved by means such as repeated discussion of information, group sessions, videotapes and computer programs, and involvement of family members.

8.7 Mental health clinicians should be trained in skilled communication that is two-way, open, repeated, empathic, and accommodative. Along with communication, detailed documentation is necessary to explain why a particular action (e.g., involuntary treatment or seclusion/restraint, etc.) was felt necessary under the specific circumstances.

8.8 Facilities should be available for advanced planning for the possibility of future incapacity, for example, by the use of joint crisis plans and advance directive. This can help reduce compulsory admissions and treatment in patients with severe mental illness, and may affect the amount of perceived coercion.

8.9 The doctrine of the 'least restrictive alternative' ('least' in terms of modality, severity, and duration of the action taken) should be used. Positive approaches, such as persuasion, should be the strategies of choice and negative approaches, such as threats should be avoided.

8.10 Professionals should be explicit about what they doing and why, should allow patients to tell their side of the story, and should seriously consider this information.

8.11 Health care providers and hospitals should implement strategies for effective staff training on management of aggression and violence safely for staff and patients. This needs to include evidence based and safe de-escalation, as well as restraint techniques.

Long term plans/goals

9.1 The most important 3 long term goals are:

1. Active involvement of patients in decisions made about them
2. When coercive measures are necessary, they should be undertaken by trained staff in a safe manner.
3. Long term reduction in prevalence of coercive measures

9.2 In order to achieve these goals health care providers will need to develop strategic plans. Benchmarking, regular analysis of data, regional, national and international comparisons and transparency can help to raise awareness and allows key stake holders to prioritize funding where deficiencies are identified. An agreed definition of restraint allows better communication without misunderstandings between various stakeholders. Organizational strategies will be needed to implement training and raise awareness. This will need support from a senior level in stakeholder organizations. Raising awareness amongst patients and their families will be an important aspect of a national strategy.

This declaration was made and ratified by the Indian Forensic Mental Health Association" (IFoRMHA) and European Violence in Psychiatry Research Group (EViPRG), 1st February 2013, in Mysore, Karnataka, India

European Faculty

Dr Roger Almvik

President, European Violence in Psychiatry Research Group (EViPRG)
Research Director, St. Olav's University Hospital, Forensic Dpt. Brøset, Centre for Research & Education in Forensic Psychiatry, Trondheim, Norway

Prof Peter Lepping

Centre for Mental Health and Society
Consultant Psychiatrist and Associate Medical Director, BCULHB, North Wales
Visiting Professor Glyndŵr University Wrexham, UK

Prof Rob Poole

Co-Director: Centre for Mental Health and Society, Professor of Social Psychiatry School of Social Sciences, Bangor University, Honorary Consultant Psychiatrist BCULHB, North Wales, UK

Prof Catherine Robinson

Co-Director: Centre for Mental Health and Society, Professor of Social Policy Research, School of Social Sciences, Bangor University, UK

Prof Tilman Steinert

Director of Research and Education
Vice Medical Director, Centres for Psychiatry Südwürttemberg, Ulm University, Germany

Dr Brian Tehan

Assistant Medical Director and Consultant Anaesthetist, BCULHB, North Wales, UK

Prof Richard Whittington

Health & Community Care Research Unit (HaCCRU), Institute of Psychology, Health and Society,
Liverpool University, UK

Prof Joy Duxbury

Professor of Mental Health Nursing, School of Health, University of Central Lancashire, UK

Prof Dirk Richter

Nursing Research Professor, Health Section, Bern University of Applied Sciences, Switzerland

Dr Frans Fluttert

Senior Researcher, Assistant Professor, Molde University College, Norway
Research Supervisor, Centre for Forensic Psychiatry, Oslo University, Norway

Dr Roland van der Sande

Senior Lecturer, Master of Advanced Nursing Practice Mental Health Program
Utrecht University of Applied Science, Faculty of Health, the Netherlands

Mr Simon Pyke

Associate Chief of Staff, Mental Health and Learning Disability Clinical Program Group, BCULHB,
North Wales, UK

Indian Faculty

Prof Raveesh. B. N

Prof & Head, Department of Psychiatry, Mysore Medical College & Research Institute, Mysore.

Dr Suresh Badamuth

Additional Professor, Department of Psychiatry, NIMHANS, Bengaluru.

Dr H Chandrashekar

Professor & Head, Department of Psychiatry, Bangalore Medical College & Research Institute, Bengaluru.

Prof B N Gangadhar

Department of Psychiatry, NIMHANS, Bengaluru.

Dr Mahesh R

Director & Consultant Psychiatrist, Spandana, Bengaluru.

Dr Senthil Kumar Reddi

Assistant Professor & Coordinator-Emergency Psychiatry and Acute Care, NIMHANS, Bengaluru.

Dr Anil Kumar

Assistant Professor, Dept of Psychiatry, Mysore Medical College & Research Institute, Mysore.

Dr Dhananjaya

Consultant Psychiatrist, ESI Hospital, Bengaluru.

Dr A Jagadish

Consultant Psychiatrist, Abhaya Hospital, Bengaluru

Dr P Venkataraya Bhandary

Medical Superintendent & Consultant Psychiatrist, A.V.Baliga Hospital, Udupi.

Dr Murali Krishna

Welcome Fellow, Consultant Psychiatrist, HMH, Mysore

Dr M S Narendra Kumar

Assistant Editor, Indian Journal of Psychological Medicine, IPS South Zone.

Organizations that support this declaration

Indian Psychiatric Society, Karnataka State Branch

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