Consensus Research AI Query: What are the effects of coercive mental health treatment?

Coercive mental health treatment, which includes practices like involuntary admission, seclusion, restraint, and forced medication, is a controversial topic due to its potential negative effects on patients' mental health and dignity.

Negative Effects on Mental Health

Worsening Mental Health: Coercive measures have been shown to worsen mental health outcomes. Patients exposed to such measures had higher Health of the Nations Outcome Scale (HoNOS) scores at discharge, indicating poorer mental health compared to those not exposed. Restraint had the most significant negative impact, followed by forced medication and seclusion. (1)

Emotional and Psychological Impact: Patients often describe coercive treatment as humiliating and oppressive, which can erode self-confidence and trust in their own feelings and thoughts. This can lead to feelings of humiliation and oppression, likened to imprisonment by totalitarian systems. (2)

Limited Clinical Benefits: While coercive measures can sometimes reduce immediate aggressive behaviors, they often negatively impact therapeutic relationships, engagement with mental health services, and can increase self-stigma. (3, 4)

Physical Harm and Risks

Physical Harm: Coercive measures can lead to physical harm, including injuries and, in severe cases, death. Commonly reported harms include cardiac arrest and venous thromboembolism during restraint. (6)

(Cont'd)

Ethical and Quality of Care Concerns

Ethical Dilemmas: The use of coercion raises ethical concerns about the loss of patient dignity and autonomy. It is often seen as a last resort when other less restrictive measures fail. (4,9)

Quality of Care: Coercive practices are linked to poorer quality of mental health care, as they can negatively affect patient outcomes and the therapeutic environment. (9)

Conclusion:

Coercive mental health treatment is associated with negative mental health outcomes, physical harm, and ethical concerns. These findings highlight the need for alternative approaches and interventions to reduce the use of coercion in mental health care, emphasizing the importance of patient dignity and autonomy.

References

Baggio, S., Kaiser, S., Huber, C. G., & Wullschleger, A. (2024). Effect of coercive measures on mental health status in adult psychiatric populations: a nationwide trial emulation. *Epidemiology and Psychiatric Sciences*, *33*, e35.

Aims: Healthcare staff use coercive measures to manage patients at acute risk of harm to self or others, but their effect on patients' mental health is underexplored. This nationwide Swiss study emulated a trial to investigate the effects of coercive measures on the mental health of psychiatric inpatients at discharge.

Methods: We analysed retrospective longitudinal data from all Swiss adult psychiatric hospitals that provided acute care (2019–2021). The primary exposure was any coercive measure during hospitalization; secondary exposures were seclusion, restraint and forced medication. Our primary outcome was Health of the Nations Outcome Scale (HoNOS) score at discharge. We used inverse probability of treatment weighting to emulate random assignment to the exposure.

Results: Of 178,369 hospitalizations, 9.2% (n = 18,800) included at least one coercive measure. In patients exposed to coercive measures, mental health worsened a small but statistically significant amount more than in non-exposed patients. Those who experienced at least one coercive measure during hospitalization had a significantly higher HoNOS score (1.91-point, $p < .001$, 95% confidence interval [CI]: 1.73; 2.09) than those who did not experience any coercive measure. Results were similar for seclusion (1.60-point higher score, $p < .001$, 95% CI: 1.40; 1.79) and forced medication (1.97-point higher score, $p < .001$, 95% CI: 1.65; 2.30). Restraint had the strongest effect (2.83-point higher score, $p < .001$, 95% CI: 2.38; 3.28).

Conclusions: Our study presents robust empirical evidence highlighting the detrimental impact of coercive measures on the mental health of psychiatric inpatients. It underscores the importance of avoiding these measures in psychiatric hospitals and emphasized the urgent need for implementing alternatives in clinical practice.

2. **Nyttingnes, O., Ruud, T., & Rugkåsa, J. (2016). 'It's unbelievably humiliating'—Patients' expressions of negative effects of coercion in mental health care. *International journal of law and psychiatry*, *49*, 147-153.**

Abstract

Purpose:

Some patients criticize coercive mental health treatment using extremely strong words. This may be connected to poor therapeutic relationships and unfavourable treatment outcomes, so a better understanding of this criticism is warranted.

Methods:

Data consisted of detailed notes from 15 all-day dialogue seminars on coercion and voluntariness in Oslo, Norway from 2006 to 2009. Very dissatisfied patients and ex-patients were a central voice through the seminars. To gain a better understanding of their negative experiences of coercion, we conducted a stepwise qualitative thematic analysis of the seminar notes, with a mix of inductive and deductive coding followed by focused coding and analytic induction.

Results:

Coercive care was described in strong terms, such as humiliation and Nazism. To explain this, we suggest a model of two pathways towards such strong language: (i) Participants understood their symptoms as mental crises following trauma or spiritual problems, and perceived involuntary medication to harm rather than help. Some found that their complaints were dismissed as lack of insight. (ii) Minor incidents were experienced as coercive, such as being ‘defined’ by the medical model, receiving repeated negative remarks and feeling one needed to succumb to get care. The accumulated effect could be experienced as eroding self-confidence and trust in their own feelings and thoughts.

Conclusion:

Involuntary medication and dismissal of patient perspective, combined with the accumulated effects of minor negative incidents, can explain the feelings of humiliation, oppression and the use of metaphors such as imprisonment by totalitarian systems. Our model can help explain such patient reactions seen in clinical practice and the literature.

3. **Luciano, M., Sampogna, G., Del Vecchio, V., Pingani, L., Palumbo, C., De Rosa, C., ... & Fiorillo, A. (2014). Use of coercive measures in mental health practice and its impact on outcome: a critical review. *Expert review of neurotherapeutics*, *14*(2), 131-141**

Although coercive measures have always been part of the psychiatric armamentarium, the ethical dilemma between the use of a “therapeutic” coercion and the loss of patients' dignity is one of the major controversial issues in mental health research and practice. The aims of the present review are to explore the existing literature on predictors of use of coercive measures and to explore the relationship between coercive measures and patient outcome. A literature search was conducted using MEDLINE, PsychyINFO, Scopus, Web of Knowledge and the Cochrane Database. In all selected papers, references were cross-checked to identify other possible eligible papers. The use of coercive measures was predicted by patients' clinical and socio-demographic features, staff characteristics and ward-related factors. Coercive measures have only a limited impact on patients' clinical and social outcome. At the current level of knowledge, coercion is still a controversial issue in mental health practice. Only few studies with a solid methodology have been carried out. Large multicenter and rigorous studies, with long-term follow-ups, are highly needed.

4. **Lohmann, S., Cowlishaw, S., Ney, L., O'Donnell, M., & Felmingham, K. (2024). The trauma and mental health impacts of coercive control: A systematic review and meta-analysis. *Trauma, Violence, & Abuse*, *25*(1), 630-647.**

Coercive control is an under researched type of intimate partner violence (IPV). The aims of this review were to (a) synthesize all available evidence regarding associations with coercive control and mental health outcomes including post-traumatic stress disorder (PTSD), complex PTSD, and depression; and (b) compare these with associations involving broader categories of psychological IPV. Primary studies which measured associations of coercive control with PTSD, complex PTSD, depression, or other mental health symptoms, were identified via a systematic search of electronic databases (PsycINFO, Medline, CINAHL, Scopus). Eligible studies involved observational designs and reported associations between coercive control and mental health outcomes, among participants who were at least 18 years old. Studies were published in peer-reviewed journals and English language. Random-effects meta-analyses were used to synthesize correlational data from eligible studies. The search identified 68 studies while data from 45 studies could be included in the meta-analyses. These indicated moderate associations involving coercive control and PTSD (r = .32; 95% confidence interval [.28, .37]) and depression (r = .27; [.22, .31]). These associations were comparable to those involving psychological IPV and PTSD (r = .34; [.25, .42]) and depression (r = .33; [.26, .40]). Only one study reported on the relationship between coercive control and complex PTSD and meta-analyses could not be performed. This review indicated that coercive control exposure is moderately associated with both PTSD and depression. This highlights that mental health care is needed for those exposed to coercive control, including trauma-informed psychological interventions.

5. **Kersting, X. A., Hirsch, S., & Steinert, T. (2019). Physical harm and death in the context of coercive measures in psychiatric patients: a systematic review. *Frontiers in psychiatry*, *10*, 400.**

Background: For centuries coercive measures in psychiatry have been means of averting acute danger. It has been known for almost as long that these measures can lead to harm or even death to those affected. Over the past two decades the topic has increasingly been the subject of scientific discussion and research. While the legal and ethical preconditions for coercive measures in psychiatry as well as epidemiological studies on their incidence and patients' subjective experiences have increasingly come into focus, research on possible adverse events has lagged behind. To our knowledge there is no systematic review on the

harmful or even fatal physical adverse effects of coercive interventions in psychiatry.

Methods: We searched the databases PubMed and CINAHL for primary literature with a search string based on the PICO framework including key words describing different psychiatric diagnoses, coercive measures, and harms.

Results: In total, 67 eligible studies (mainly case reports and case series) of very heterogeneous quality were included. Two RCTs were found reporting position-dependent cardiac deterioration, but were, however, carried out with healthy people and were characterized by a small number of cases. Death was the most frequently reported harm: cardiac arrest by chest compression in 14 studies, cardiac arrest by strangulation in 9, and pulmonary embolism in 8 studies. Further harms were, among others, venous thromboembolism and injuries. Injuries during physical restraint were reported in 0.8–4% of cases. For other kinds of coercive interventions, there are no sufficient data. Venous thromboembolism occurred in a considerable percentage of cases during mechanical restraint, also under prophylaxis. The most commonly reported coercive measure was restraint, distinguishing in mechanical restraint (43 studies), physical restraint (22 studies), bedrails (eight studies), vest restraint (7 studies), and chair restraint (6 studies). Forced medication was explicitly mentioned only in two, but seems to have occurred in nine studies. Six studies included seclusion.

Conclusion: Coercive measures can lead to physical harm or even death. However, there is a significant lack of data on the incidence of such adverse events related to coercive interventions. Though reported anecdotally, physical adverse events during seclusion appear to be highly underresearched.

6. **Barbui, C., Purgato, M., Abdulmalik, J., Caldas-de-Almeida, J. M., Eaton, J., Gureje, O., ... & Thornicroft, G. (2021). Efficacy of interventions to reduce coercive treatment in mental health services: umbrella review of randomised evidence. *The British Journal of Psychiatry*, *218*(4), 185-195.**

Background: Coercive treatment comprises a broad range of practices, ranging from implicit or explicit pressure to accept certain treatment to the use of forced practices such as involuntary admission, seclusion and restraint. Coercion is common in mental health services.AimsTo evaluate the strength and credibility of evidence on the efficacy of interventions to reduce coercive treatment in mental health services.

Protocol registration: https://doi.org/10.17605/OSF.IO/S76T3.MethodSystematic literature searches were conducted in MEDLINE, Cochrane Central, PsycINFO, CINAHL, Campbell Collaboration, and Epistemonikos from January 2010 to January 2020 for meta-analyses of randomised studies. Summary effects were recalculated using a common metric and random-effects models. We assessed between-study heterogeneity, predictive intervals, publication bias, small-study effects and whether the results of the observed positive studies were more than expected by chance. On the basis of these calculations, strength of associations was classified using quantitative umbrella review criteria, and credibility of evidence was assessed using the GRADE approach.ResultsA total of 23 primary studies (19 conducted in European countries and 4 in the USA) enrolling 8554 participants were included. The evidence on the efficacy of staff training to reduce use of restraint was supported by the most robust evidence (relative risk RR = 0.74, 95% CI 0.62–0.87; suggestive association, GRADE: moderate), followed by evidence on the efficacy of shared decision-making interventions to reduce involuntary admissions of adults with severe mental illness (RR = 0.75, 95% CI 0.60–0.92; weak association, GRADE: moderate) and by the evidence on integrated care interventions (RR = 0.66, 95% CI 0.46–0.95; weak association, GRADE: low). By contrast, community treatment orders and adherence therapy had no effect on involuntary admission rates.

Conclusions: Different levels of evidence indicate the benefit of staff training, shared decision-making interventions and integrated care interventions to reduce coercive treatment in mental health services. These different levels of evidence should be considered in the development of policy, clinical and implementation initiatives to reduce coercive practices in mental healthcare, and should lead to further studies in both high- and low-income countries to improve the strength and credibility of the evidence base.

7. **Aragonés-Calleja, M., & Sánchez-Martínez, V. (2022). Current state of research on coercion in mental health: umbrella review protocol. *Journal of Psychosocial Nursing and Mental Health Services*, *60*(10), 49-55.**

In recent years, international organizations, professionals, and representatives of mental health service users have expressed the need to regulate, limit, and even eliminate coercive measures in psychiatric treatment. The main objective of the current review is to provide a comprehensive synthesis of existing evidence on coercion in mental health care through a protocol for an umbrella review of systematic reviews. This protocol was designed according to the Joanna Briggs Institute guide for methodological development, conduct, and reporting of

umbrella reviews. To minimize bias in the process, two independent reviewers selected the studies to be included, extracted, and synthesized; analyzed the data; and assessed risk of bias of each review. The review protocol was reported according to the Preferred Reporting Items for Systematic Reviews and Meta-Analysis Protocols guidelines. This review offers a comprehensive compilation of systematic reviews on coercion developed to date. Coercion causes adverse physical and psychological effects and is an emotional stressor for individuals with psychiatric diagnoses and health care workers. Characterization of coercion across care settings, its impact on clinical outcomes, the perception of those involved, and how coercion could be reduced will also be discussed.

8. **Salize, H. J., & Dressing, H. (2005). Coercion, involuntary treatment and quality of mental health care: is there any link?. *Current Opinion in Psychiatry*, *18*(5), 576-584.**

Summary:

Research activities are remarkably few in number, especially considering the frequency of involuntary measures and the controversial perception or discussion of these measures among the persons concerned, professionals, or a wider public. Many basic research questions still remain to be adequately addressed, such as the long-term effects of involuntary treatment.

9. **Aragonés-Calleja, M., & Sánchez-Martínez, V. (2024). Evidence synthesis on coercion in mental health: An umbrella review. *International Journal of Mental Health Nursing*, *33*(2), 259-280.**

Abstract

Coercion in mental healthcare is ubiquitous and affects the physical health, recovery and psychological and emotional well-being of those who experience it. Numerous studies have explored different issues related to coercion, and the present umbrella review aims to gather, evaluate and synthesise the evidence found across systematic reviews. The protocol, registered in the International Prospective Register of Systematic Reviews (PROSPERO registration number: CRD42020196713), included 46 systematic reviews and meta-analyses of primary studies whose main theme was coercion and which were obtained from databases (Medline/PubMed, PsycINFO, EMBASE and CINAHL) and repositories of systematic reviews following the Preferred Reporting Items for Systematic reviews and Meta-Analyses guidelines. All the reviews were subjected to independent assessment of quality and risk of bias and were grouped in two categories: (1) evidence on specific coercive measures (including Community Treatment Orders, forced treatment, involuntary admissions, seclusion and restriction and informal coercion), taking into account their prevalence, related factors, effectiveness, harmful effects and

alternatives to reduce their use; and (2) experiences, perceptions and attitudes concerning coercion of professionals, mental health service users and their caregivers or relatives. This umbrella review can be useful to professionals and users in addressing the wide variety of aspects encompassed by coercion and the implications for professionals' daily clinical practice in mental health units. This research received funding from two competitive calls.