

a humanistic frame⁶. Ties between psychiatry, public health and social sciences need to be strengthened.

There are no simple solutions. Debates may be uncomfortable, but they could open new opportunities and roles for psychiatry. The shift would diminish the “formal power” currently afforded to psychiatrists. Yet, there could be multiple benefits in shifting the profession from a tutelary to a facilitative role, including unlocking funds currently used for coercion and addressing important issues of image and reputation. It should be in the interests of psychiatry as a medical profession to substantially reduce its reliance on coercion, and to spread such a message to its members worldwide.

A rights-based approach can provide a pathway to the future of mental health care we want for all. The CRPD can be used to promote the investment of human and financial resources into a broad spectrum of support to drastically reduce non-consensual measures with a view to their elimination. It offers a framework to achieve social justice, attain the highest standard of health care, and strengthen governance of health and social services.

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Practical strategies to end coercive practices in mental health services

Mental health has become a global imperative. Increasing coverage of treatment options and support services is crucial. However, without deep reflection and change in paradigm about the types of services being provided, we risk reproducing some of the poor outcomes and dissatisfaction that we see in high-income countries, stemming from overmedicalization, overuse and inappropriate use of medications (and their negative impacts, for example, in terms of metabolic disturbance, sexual dysfunction, premature mortality) and human rights violations associated with involuntary admission, forced treatment, seclusion and restraint¹⁻³.

Promoting human rights in mental health *must* go hand-in-hand with efforts to scale-up services in countries, and mental health strategies and interventions must be firmly grounded in a human rights approach⁴.

The Convention on the Rights of Persons with Disabilities (CRPD) sets out key obligations on countries to end practices based on force, coercion and substitute decision making in mental health, and instead requires that practices be based on people's will and preferences or on

the best interpretation of their will and preferences^{5,6}.

Coercive practices are particularly challenging to change, since they are commonly accepted in society, seen as necessary to protect persons from harm, and are firmly cemented and sanctioned in law and policy across all countries. This despite the absence of evidence for their effectiveness, and the available evidence demonstrating that practices such as seclusion and restraint actively cause harm to physical and mental health, and can lead to death⁷.

G. Szmukler⁸ argues that there are exceptions where, in the interest of promoting people's autonomy, it becomes necessary to utilize involuntary interventions, and that a person's ability to make a decision should be a decisive factor in determining whether forced admission and treatment is a legitimate response. Below, we set out our disagreement with this position and also address some specific points raised by the author.

First, denying a person who is blind the right to drive is not the same as denying a person, whose decision making capacity is impaired, the right to decide on his/her admission and treatment. A person

who is blind is objectively so, and cannot drive a car. On the other hand, determining that a person's decision making is impaired is subjective. Furthermore, there is no objective way that a health or other professional can know what is best for the person, because preferences are themselves subjective. The professional does not have the same history, experience or knowledge as the person concerned about what he/she finds helpful in his/her recovery.

The underlying issue in the scenario outlined by Szmukler is not the denial of the right to drive, but rather understanding that the function of driving is first and foremost the possibility to get from A to B. A person who is blind will be primarily interested in the freedom of movement that driving affords, rather than the act of driving itself. Thus, while the act of driving may not be a guaranteed right, creating the necessary accommodations to enable him/her to get from A to B, on an equal basis with others, is an obligation under international human rights law.

Similarly, in the case of someone whose decision making is affected, the obligation is to support him/her to make his/her own decisions on an equal basis with

others. This support may mean helping the person to access relevant information, understand and weigh up the benefits and negative effects of treatment, and support him/her to assert and communicate his/her decisions and choices.

If a person is unable to communicate his/her decisions directly, these should be based on the best interpretation of his/her will and preferences. Best interpretation can be determined, for example, by drawing upon a trusted support person or network to help interpret what the person would want in the current situation, based on what is already known about him/her (e.g., his/her views, beliefs, values in life)⁹.

Alternatively, one can refer to a person's advance directive, containing information about his/her will and preferences should he/she be unable to communicate decisions sometime in the future. However, there are cases in which a person, who expressed a particular wish at Time 1, expresses a contrary will and preference at a later time. In such scenarios, Szmukler questions which preference should be respected. In fact, advance directives can include an "Ulysses clause", which enables people to state that any objections they may express "in the moment" should be overruled in favor of the written directive. This also allows options for people using services who report that they are in favor of involuntary treatment. However, even with a Ulysses clause, it is important to consult a support network to validate the final decision where discrepancies have arisen.

In situations where there are no support persons or advance directive available (or when an advance directive is not clear), sufficient time should be allowed for a person to make his/her decision in a safe, non-coercive environment. If there is no life threatening urgency to the situation, then decisions can be deferred to such a time that the person is able to express his/her will and preference. And even if there is urgency, one is still obliged to interpret what the person's will and preference might be, based on information that one has at hand.

In these situations it is possible that errors are made, and that decisions based

on the best interpretation turn out not to be in line with a person's will and preferences. In these situations it is essential that the experience serves as a learning opportunity to gain a deeper understanding of the person's wishes, how best to support him/her moving forward, and to prevent such incidents from re-occurring. In the aftermath of such situations, it is useful to encourage the person to develop or update advance directives and to help him/her to identify trusted persons/networks to support him/her by interpreting his/her will and preferences in the future if necessary.

In addition to achieve long-term sustainable change, policy and law will need to reflect the practice changes described above. Many recently formulated laws around mental health contain substantial provisions about "managing" the "exceptional" use of involuntary admission and treatment, as well as seclusion and restraint. However, the system of exceptions has not worked even when there have been stringent rules and restrictions about their use. Furthermore, the endless debate about what is "exceptional" has served to hinder progress and productive dialogue both at national and international levels. Energies should instead be concentrated on looking at a way forward and at strategies and solutions to promote the right of people to receive quality care and support in line with the CRPD.

Change will be required at multiple levels, including knowledge, attitudes and practices of professionals, families and others towards supporting people in their decision making, providing services that operate without force, that promote rights, recovery, and people centered care and support, and redefining policy and law so that these move beyond a narrowly focused biomedical approach in order to fully embrace a human rights approach that addresses the social determinants of mental health, and emphasizes support instead of coercion.

WHO QualityRights has developed training and guidance tools to enable national stakeholders to integrate CRPD rights into their practices¹⁰. The initiative is also developing best practice guidance identifying and providing the evidence

for community based services that operate without coercion, respond to people's needs, support recovery, and promote autonomy and inclusion. The initiative is also at the early stages of discussing new guidance for human rights oriented policy and law in line with the CRPD.

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