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GUEST EDITORIAL

Coercion in mental healthcare: different perspectives, similar concerns and a united call for action

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Recently I had a conversation with my daughters about Nelson Mandela. They had been watching television and simply did not believe that he and others were segregated and locked up simply because they were black, and that many were killed for the same reason. They were incredulous that this occurred in my lifetime and was allowed to go on (I found them checking later on the computer!). Our conversation went on to homosexuality and gender identity issues, with the same result. I remember having a similar sense of outrage and incredulity myself visiting the national civil rights museum in Memphis, the site of the murder of Martin Luther King in 1968.

Soon after this discussion I saw the report by Human Rights Watch (HRW, 2016) about the treatment of many people with mental illness in Indonesia and in particular the use of *pasung*. *Pasung* is an overarching term applied to various forms of restriction, such as chaining, tying, shackling and locking in outbuildings, animal sheds or similar. It was outlawed in 1977 but persists to this day. The Indonesian government estimates that 18 000 people are currently subject to such measures.

My charity work has brought me into contact with many such cases. They do not respect geography and represent an affront to human dignity. They are a clear form of discrimination and exclusion. The three thematic papers in this issue approach the use of coercive measures from different perspectives – of people experiencing coercion, their family carers and those who deliver services.

The causes of the use of *pasung* and related 'interventions' are complex and variable. They include lack of resources, absent, ignored or overly coercive legislation and the value different cultures place on the rights of the individual as compared with the rights of the community (Molodynski *et al*, 2016). Shame and stigma are key toxic ingredients in the formula too. Indonesia is an interesting example in these respects, as it is in the G20 and has a vibrant economy on a number of measures. Although the HRW report primarily highlights institutional care (and rightly), the majority of containment happens within families. It is not borne out of anger or hate but out of a combination of desperation, the absence of effective treatments and/or a desire to keep a loved one safe. The issue of coercion resulting from limited care provision is apparent in all continents, especially but not exclusively in low- and middle-income countries (Alem & Manning, 2016).

In the first paper, Rugkåsa & Canvin sensitively explore these issues for families, highlighting the central dilemma of wanting to support a loved one and see them do well while respecting their wishes and autonomy as far as possible. They look at examples and evidence from diverse sources and areas of the world to bring out universal themes.

In the following article, Rose and colleagues examine those same issues from the point of view of

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the person receiving care, with a focus on in-patient care and experiences of physical and chemical restraint. They include the results of a recent survey that gives a troubling snapshot of the ongoing issues in British mental healthcare today. While practices in British psychiatry may be less dangerous and less overtly coercive than elsewhere, it is clear that many patients are traumatised by their experiences. The article concludes by looking at some remedies that could improve the experience of in-patient care in general and reduce the use of coercive measures in particular, such as alterations to rigid daily routines, improved communication and co-production on wards. While containment is sometimes unavoidable for safety reasons and the 'least bad' course of action, any measures to reduce the need for it must be welcome.

The third paper, authored from three continents, attempts to draw together some of the key international themes regarding coercion. It focuses on societal structures, individual beliefs, the lack of legislation or lack of enforcement of it, and the crucial role of economic factors.

There is such scale, diversity and complexity that it seems almost impossible to find a way through. However, the same was undoubtedly true of apartheid (who can forget those newsreels from the townships in the 1980s?), racial discrimination and homophobia. With all these, significant progress is being made. In mental healthcare, too, there are things that can undoubtedly be done to begin to change things and specific remedies that can help. Recently a major pharmaceutical company announced that it will be relaxing its patents to allow poorer countries to manufacture and use its products cheaply (GlaxoSmithKline, 2016). If other companies acted similarly, this could lead to a significant increase in the availability of effective modern medications in poorer countries, which could reduce distress and burden for a large number of people. Many low-income countries are implementing legislation and have ratified the United Nations Convention on the Rights of Persons with Disabilities. Service user groups in many countries have increasingly powerful voices. Our knowledge of what works and what does not work in terms of treatment is improving. Crucially, more governments are waking up and realising the waste of human potential that this neglect of mental healthcare and ongoing exclusion and coercion represent. On a global scale, such abuses represent a stain on societies and an unnecessary economic waste. On an individual level they must be a tragedy beyond words – for the person and for the family. The photographs and descriptions in the HRW report make this clear. I hope that in 20 years my daughters (among others) will be talking to their utterly incredulous children about how people with mental health problems used to be chained up – wouldn't that be something worth making changes for?

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THEMATIC PAPER

Mental health, coercion and family caregiving: issues from the international literature

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This article summarises current knowledge about two aspects of family care for people with mental illness: potentially pressurising or coercive aspects of family life; and family carers' experiences of being involved in coercive service interventions. There is a paucity of studies on these topics, especially outside Europe, North America and Australasia, and further research is recommended.

Caregiving within families forms part of normative cultural expectations everywhere. In many parts of the world, where health systems are non-existent or limited, family members may be the sole source of help for people with mental illness. Where services do exist, family members are often involved in delivery. Their role is increasingly written into mental health policy and law, which often specify a role for caregivers in compulsory

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