RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

POSITION STATEMENT PS05/26

Coercion and other forms of restrictive practice:

Compliance with human rights

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1. Purpose of the statement

The Royal College of Psychiatrists is committed to ensuring that mental healthcare is delivered safely, effectively, and with full respect for human rights. The College's priority is to uphold the dignity and autonomy of patients, and to seek to minimise the use of coercion and any other form of restrictive practice, while also navigating the complex clinical realities that are often encountered in psychiatric practice.

The need for a College Position Statement is also reinforced by the World Health Organization (WHO), along with the United Nations Office of the High Commissioner for Human Rights, publishing a guidance document on "Mental Health, Human Rights and Legislation".[1] This guidance, produced by the WHO's Mental Health, Brain Health and Substance Use (MSD) team, aims "to promote human rights in mental health" and "proposes steps towards establishment of mental health services that are respectful of human dignity."

The College recognises that its stance on legal capacity does not align entirely with some of the broad principles articulated in the WHO document but does align with the position taken by other bodies within the United Nations, such as the Human Rights Committee and the United Nations Subcommittee for Prevention of Torture.[2] This Position Statement also aims to clearly articulate the College's view on coercion and other forms of restrictive practice, and to outline how it aligns with relevant human rights principles as articulated in the European Convention on Human Rights (ECHR).[3]

Throughout this statement, the term 'coercion' is referring specifically to lawful detention, involuntary admission, involuntary treatment or restrictive measures such as seclusion or limits on movement, employed by trained mental health professionals in accordance with current legislation accompanied by rigorous safeguards. The use of these practices, which may be perceived as coercive by an individual regardless of their mental capacity to consent, must always be viewed as an intervention of last resort, justified only to prevent serious harm to the individual or others. "Last resort" should always require consideration of less restrictive interventions or alternatives, balancing the risk of serious harm against the restriction of autonomy via the proposed intervention. Any such plan must be individualised, multidisciplinary and documented clearly as to rationale, necessity and proportionality with regular review and access to advocacy, as well as a clear strategy around ending any restrictive measure. Such a review should also examine the clinical outcome, patient experience, treatment-related harm and harm associated with delayed or unavailable care.

This document thus aims to act as a guide for medical students, psychiatric trainees, and established clinicians in their practice. It also serves to provide the public and society with a clear understanding of the College's position on these crucial ethical and human rights issues, which are of paramount importance to UK psychiatry.

2. Why it is needed

This Position Statement addresses a critical need for clarity among psychiatrists at the interface of care where the consistency between clinical decisions and human rights principles can appear to be challenged. The recent international guidance from the WHO presents a view that is, in some key areas, inconsistent with the considered legal and ethical framework within which UK psychiatrists must operate. Furthermore, the College considers that its approach is, on proper analysis, consistent with the UN Convention on the Rights of Persons with Disabilities (CRPD).

For instance, the WHO's assertion of "zero tolerance" towards coercion and its stance that "no person shall be subjected to any limitation of their legal capacity"[4] conflicts with the ECHR's recognition that competing rights may, as a last resort, necessitate temporary interventions which may be considered to be coercive.

The ECHR is considered a "living document" and is interpreted constantly by the European Court of Human Rights, ensuring its principles remain relevant to evolving healthcare challenges. The case law of the European Court of Human Rights, which considers international human rights treaties such as the UN Convention on the Rights of Persons with Disabilities, represents a coherent analysis of the difficult balances that are at play in the mental healthcare context.

This ensures that practitioners can provide safe, effective, and rights-respecting care without being misled by a partial or somewhat narrow interpretation of human rights principles, which could in turn lead to preventable harm or a failure to meet legal obligations under the ECHR.

The tension between competing rights is central to the ECHR and is a core part of the College's position. The most relevant rights in this context are:

- **Article 2: Right to Life.**
  This article obliges states to take all practicable steps to secure the lives of individuals, especially when faced with a real and immediate risk to life. This may include involuntary measures to prevent suicide or self-harm.

- **Article 3: Prohibition of Inhuman or Degrading Treatment.**
  This not only provides a strict framework for admission and treatment but also imposes positive obligations on states to take practical steps to prevent individuals suffering the consequences of non-admission or non-treatment.

- **Article 5: Right to Liberty and Security.**
  This places strict safeguards around the deprivation of liberty and emphasizes that such measures should only be used as a last resort, as outlined in mental health legislation such as the Mental Health Act 1983.

- **Article 8: Right to Respect for Private and Family Life**.
  While this guarantees the right to autonomy, it does not provide a license for states to abandon individuals in the name of autonomy, especially where their decision-making abilities are impaired by a mental health condition.

The case law of the European Court of Human Rights has consistently examined these tensions and refined its approach, never prioritizing one right at the expense of others.[5] This approach is a key part of the College's position.

The College's stance on legal capacity and informed consent is consistent with this case law. It offers a slightly different approach to that taken in the WHO document, which states that "no person shall be subjected to any limitation of their legal capacity".[4] The College's view is that in some situations where an individual's mental functioning is profoundly impaired, for example, during an acute psychotic episode, their ability to decide treatment may be compromised. In such instances, temporary interventions with rigorous safeguards may be necessary to prevent serious harm and are justifiable under Articles 2 and 3 of the ECHR.

Furthermore, the College's approach is consistent with the UN Convention on the Rights of Persons with Disabilities (CRPD),[6] which places great emphasis on the concept of dignity, a term cited 17 times in the Convention.[7] This is particularly relevant when a patient's stable, deeply held beliefs and values are threatened by a treatment refusal caused by a severe mental health condition.[8] When implemented with appropriate safeguards, involuntary treatment can be seen as supporting or giving effect to a person's true or authentic will and preferences.[8]

In the recent case of Spivak v Ukraine,[9] the European Court emphasised that when compulsory medical measures are considered necessary, they must be subject to rigorous oversight to prevent potential abuse and to ensure that the interference with personal autonomy is proportionate and justified. It is essential that the treatment provided is appropriate and necessary. While the CRPD position on informed consent was considered, the Strasbourg court did not accept the proposition that all treatment must always be consensual: other rights may be in play. However, the court will now scrutinise frameworks governing treatment when informed consent is not possible, as well as how they comport with the facts of the individual case.

The College considers that its position in this regard is also consistent with the approach of the ECtHR in Rooman v Belgium,[10] which expressly considered the obligations imposed by the CRPD. The Court stressed that persons detained on grounds of mental disorder are entitled to be provided with a suitable medical environment accompanied by real therapeutic measures, and that the provision of appropriate treatment is relevant to the lawfulness of their continued detention. This may include specialised psychological treatment. Other relevant aspects of treatment may include supportive nutrition, family involvement, and adequately resourced community, intensive and inpatient care.

The College also recognizes a major need for ongoing research on alternatives to coercive measures, aligning with its support for programmes like the 'Reducing Restrictive Practice' initiative[11] and similar developments.[12]

3. The College's position

The College's key message to its members and external partners is that a nuanced, human rights-based approach is essential for modern mental healthcare. The College fully supports the principles of patient autonomy, dignity, and recovery, but it firmly rejects a rigid, absolutist interpretation of rights that ignores the complex human realities of severe mental illness.

The College's core position is defined by the following principles:

- **Balancing competing rights:**

  A rights-based framework should consider the entire spectrum of human rights, including those that are in tension. For example, while Article 5 places strict safe-guards on the deprivation of liberty, Articles 2 and 3 impose positive obligations to prevent serious harm. Protecting an individual from severe, potentially life-changing harm may, on occasion, require measures that limit liberty. The College's stance, supported by the case law of the European Court of Human Rights, is to advocate for a careful and continuous balancing of these rights, rather than the prioritization of one at the expense of others.

- **Informed consent as the ideal, but not always possible:**

  The College's view is that mental health care should be delivered based on informed consent wherever possible, in line with the approach to physical health care. However, the College also maintains that equality in mental healthcare must not be interpreted so rigidly as to ignore the realities of impairment of mental functioning.[4]

- **Impairment of decision-making:**

  This may arise across a range of clinical contexts, including dementia, delirium and eating disorders; in older adults, frailty, multimorbidity and heightened vulnerability to adverse effects should also inform the necessity, proportionality and choice of any restrictive intervention, particularly where pharmacological measures are considered. In some circumstances, for example, when a patient is experiencing an acute psychotic episode or because of dementia or delirium, adherence to the principle of informed consent is not possible (the patient being unable to give such consent). In such circumstances, temporary and proportionate limitations on their legal capacity may be ethically justifiable.

  This may also be necessary to preserve life in cases of eating disorder, like severe anorexia nervosa. The College's view is that such limitations, when implemented with rigorous safeguards, are necessary to protect the patient's fundamental human rights - particularly the Right to Life (Article 2), freedom from inhuman or degrading treatment (Article 3) or serious life-changing harms - or in some cases, necessary to protect the fundamental rights of others.

- **Legislative alignment:**

  The College acknowledges the complexity that arises where a person who is deemed to have mental capacity refuses treatment, particularly concerning the risk they pose to others. The current legislative framework in the UK, such as the Mental Health Act 1983 in England & Wales, permits compulsory treatment in

certain circumstances even where capacity is present. The College's position, which prioritizes autonomy and the balancing of rights in line with evolving human rights jurisprudence, will continue to inform its work with legislators as they review and reform capacity-based mental health law in the four nations of the UK.

- **Proportionality, safeguards, and accountability:**

  Any intervention involving involuntary treatment or restrictive measures (including where the risk is primarily to others) must be employed proportionately. The College insists that all such measures must be implemented within a framework of strict accountability.

  This includes multidisciplinary assessments, the views of persons who know the patient well, transparent record-keeping, and robust, independent judicial or tribunal oversight to ensure that interventions are continuously scrutinized for their necessity and proportionality.[13] It is also the College's view that this approach helps to avert a slide into human rights abuses.

- **Integrated and person-centred care:**

  The College advocates for a balanced model of care that integrates robust, community-based services with specialized, modern, and human rights-compliant inpatient facilities. The College strongly supports the move away from institutionalization but recognizes that inpatient care remains essential for managing acute episodes and ensuring patient safety.

  The College also supports the concept of Advance Choice Documents[12] as an essential tool for empowering individuals to make decisions about their care, ensuring their will and preferences are respected even when they may not have the decision-making capacity to express them. This fosters autonomy and aligns with Article 8 of the ECHR, which safeguards individuals' rights to private and family life. Advance planning may also support the person's ability to exercise their legal capacity as endorsed by the UN Committee for the Rights of Persons with Disabilities.[14]

4. Recommendations for action

The College's detailed position is designed not only to guide psychiatrists but also to catalyse change in the wider system. The College therefore calls on external partners, including government bodies, legislators, policy makers, and other healthcare organizations, to support these aims by taking the following concrete actions:

a. Promote comprehensive, cross-sectoral reforms

A holistic approach to mental health requires coordinated reforms that extend well beyond the confines of the healthcare sector. The College advocates for a focus on the broader social determinants of mental health, such as housing, education, employment, and social inclusion, which are critical for achieving lasting improvements in mental health outcomes. This approach aligns with the ECHR, which has increasingly interpreted existing articles to indirectly protect certain aspects of economic and social rights, particularly through the lens of rights like the right to private life (Article 8).

This can also be seen in the approach of the Scottish Mental Health Law (Scott) Review which includes a Human Rights Evaluation including consideration of the person's ability to enjoy their economic, social, cultural and environmental rights.[15] The College recommends the implementation of collaborative initiatives between healthcare, social services, the justice system, and community organizations to ensure individuals receive comprehensive, integrated support that fosters recovery and well-being.

b. Support research and innovation to reduce coercion

The College is of the view that a focus on innovation for patient benefit is key to maintaining positive standards of care and treatment. The College strongly supports the need for research into alternatives to coercive measures. Policymakers and funding bodies are urged to prioritize funding for programmes like the successful Mental Health Safety Improvement Programme, which was closely involved in the national effort to reduce restrictive practices across 38 wards in England.[11]

Such initiatives are essential for advancing patient-centred care and finding new ways to reduce the need for coercive measures, while still being able to act to prevent serious harm where necessary. Service users, as well as carers, should play a significant role in such research.

c. Collaborate with developments in capacity-based mental health law

Autonomy is a key principle in mental health care and is being increasingly recognised as such in the European Court of Human Rights and in UN Human Rights treaties. The ECHR recognises mental capacity in relation to Article 8.[5] In the UK a move towards mental capacity-based law (that covers both physical and mental conditions) has been adopted in Northern Ireland as a mechanism to recognise and enhance patient autonomy.

The College is collaborating with such developments (for example it has set up a working group on opportunities and challenges for a mental capacity-based law in the 4 nations of the UK).

The College calls on external partners to collaborate similarly to address outstanding questions, for example:

1. How can assessments of mental capacity be improved?
2. Should mental capacity-based law only apply to over 16s?
3. Should mental capacity principles only apply to risk to self, or can they also apply to risk to others?

d. Ensure stringent accountability and oversight

Accountability is an indispensable pillar in the delivery of mental health care. The College is in favour of the continued strengthening of legal and governance frameworks to ensure that all restrictive and coercive measures are subject to robust, independent review. Legal safeguards, including independent judicial or tribunal oversight as required by the ECHR (Articles 2, 3, and 8), ensure that any restrictions are continuously scrutinized for their necessity and proportionality.[13] Transparent record-keeping and accessible avenues for appeal or redress are non-negotiable to prevent any potential abuse of power.

e. Uphold the right to community-based care with appropriate inpatient support

The College supports the shift from large-scale institutionalization and advocates for community-based services as the foundation of modern mental health care. These services offer the benefits of reducing stigma, promoting social inclusion, and maintaining crucial connections with family and local support networks, consistent with the rights to independent living seen in Article 19 of the CRPD.[16] However, the College is also in favour of a balanced model that recognizes the continued need for specialized inpatient care during acute episodes.

Whilst these principles apply across all ages, additional safeguards are required for children and young people. There should be no absolute prohibition on admitting children or adolescents to appropriate psychiatric units. Such an absolute prohibition would fail, thus failing to address the needs of young people experiencing severe and acute crises, potentially leaving them at greater risk of harm. This would amount to discrimination, as it would deprive children and young people access to essential medical and nursing care and treatment. In such circumstances, inpatient care should be delivered in dedicated, age-appropriate environments with specialized child and adolescent mental health teams, always taking the young person's views into account in line with the UN Convention on the Rights of the Child.[17]

However, decisions around admission and any imposed restrictions must be informed by an assessment of the young person's competence or capacity, including Gillick competence in under-16s where applicable. The ability to rely upon parental consent, where applicable, must remain within the lawful scope of parental responsibility and must not be used to bypass safeguards available under mental health legislation, including timely access to tribunal review. For children in care, the respective rights

and responsibilities of the child, parents and relevant local authority, including who holds parental responsibility, must be considered under the Children Act 1989 or corresponding legislation across the UK. Family involvement should be sought as per best practice but should not automatically be assumed to be protective in all circumstances. Autistic children and those with intellectual disabilities require further rigorous scrutiny of any proposed admission and restrictive measures, supported by Care, Education and Treatment Reviews in England and appropriate best-interests processes where applicable. Shortages of suitable inpatient beds must not dilute these safeguards or justify inappropriate placements.

f. Facilitate full and effective participation

The College recommends that the voices of patients with lived experience and their families be actively included in shaping mental health policy, research agendas, and individual care plans. This is not only a democratic principle but also a practical one reinforcing the participatory rights outlined in Article 10 of the ECHR.

These recommendations are designed to build a mental healthcare system that is not only legally robust and ethically sound, but also compassionate, innovative, and focused on the well-being and dignity of every individual, ensuring that a slide into human rights abuses is averted.

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