Reduction of coercion in psychiatric hospitals: how can this be achieved?

Beate Wild, Cinara Paul, and Hans-Christoph Friederich*

Department of General Internal Medicine and Psychosomatics, University Hospital Heidelberg, Heidelberg, Germany

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The percentage of coercive measures used in psychiatry widely varies between countries, settings, and patient groups.[1] Complete data collected in a federal state of Germany showed that in 2016, 6.7% of patients treated in psychiatric hospitals had experienced coercive measures.[2] The use of coercion is always a controversial subject as it overrides fundamental rights of the patients.[3] In recent years, there have been various legal and clinical movements toward reducing the use of coercion.[4]

In the current issue of *The Lancet Regional Health – Europe*, Steinert and colleagues present the PreVCo study,[5] a two-armed multisite Randomised Controlled Trial (RCT) from Germany that investigated the efficacy of the implementation of recommendations derived from the 2018 high-quality guidelines of the German Association of Psychiatry (DGPPN) for reduction of coercion in psychiatry.[6] Altogether, 54 psychiatric wards were included in the study and randomly allocated to an intervention and a waiting control group. The wards of the intervention group chose 3 out of 12 recommendations for implementation. At baseline, control and intervention group received an initial workshop led by trained implementation consultants. Only in the intervention group, the consultants then maintained close contact with the managers of the ward teams and conducted three additional workshops. At the end of the study, the use of coercive measures (seclusion, restraint, forced mediation) had strongly decreased in both groups (45% in the intervention group; 28% in the control group). However, no differences between intervention and waiting control group were noted regarding the primary outcome, the median number of coercive measures used per bed and month (median number for the intervention group in the final study period: 0.53 (interquartile range, IQR = 0.59); for the control group: 0.71 (1.08)).

First, it is important to emphasize that the PreVCo study succeeded in the implementation of three out of 12 guideline recommendations. From the perspective of the RCT rationale it could be inferred that the intervention was not effective because it did not lead to a significant reduction of coercive measures (compared to the control group). However, in both groups, the use of coercive measures was considerably reduced – which could be potentially because the ward teams of both conditions received an initial awareness workshop regarding the rating and use of coercive measures. So, in terms of clinical relevance the PreVCo trial was effective. Therefore, it could be concluded that single components of the intervention (or their combination) such as (1) focusing more on the prevention of coercion by running interactive workshops for ward teams, (2) introducing fidelity rating instruments, or (3) providing support and feedback by implementation managers could lead to a reduction of coercive measures.[7]

The reduction of coercive measures in the control group is one reason for the non-significant result of the RCT. A second reason could be that a prerequisite for participation was a written declaration of support by the hospital management. The wards of the study sample thus probably belonged to clinics led by motivated managers, already sensitized for the subject - which could be reflected by the low baseline median numbers of coercive measures used per month and occupied bed (0.96 for the intervention and 0.98 for the control group). At baseline, the median number of admissions per ward and month was 37.3 in the control and 45.3 in the intervention group. This leads to a much lower percentage of patients who experienced coercion compared to the 6.7% reported in the complete survey from 2016.[2] If the wards involved were already sensitized to the topic, then only a small effect was to be expected (which could not be detected by the calculated sample size). Besides, the complete survey found a strikingly high variance in prevalence of coercion between hospitals in the same federal state, which may arise due to differences in structure, but also due to different attitudes towards coercive measures of the hospital management and staff.[2] This implies that the study sample was selected – which is nearly always the case in RCTs and raises the question of which study design could be more appropriate to reach out to hospitals that present with more problems or lower motivation to reduce coercion.

A third reason for the non-significant result could be that the implementation of three recommendations was not sufficient. Also, the chosen recommendations substantially varied across the intervention wards. Perhaps, a fully tailored model would not be the optimal one in this context. It should be evaluated which particular recommendations were strongly correlated with reduction in coercive measures. The recommendations with the

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*Corresponding author. Department of General Internal Medicine and Psychosomatics, University Hospital Heidelberg, 69120 Heidelberg, Germany.

E-mail address: beate.wild@med.uni-heidelberg.de (B. Wild).

highest impact on reduction of coercion could then be core recommendations of an advanced intervention program.

In conclusion, it appears to be possible to reduce coercion in psychiatric hospitals by various intervention approaches directed at the wards – such as staff training,[8] risk assessment, but also complex interventions.[9] The cost of these interventions is not that high compared to the damage that coercive measures can cause. Future clinical and research programs should find a way to also address hospitals with high prevalence of coercion and less resources to change.

Contributors

BW wrote the main part of the commentary, CP and HCF wrote smaller parts. CP did the literature search. All authors discussed and revised the commentary.

Declaration of interests

The authors declare no conflict of interest.

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