

Applying Human Rights and Reducing Coercion in Psychiatry following Service User-Led Education: A Qualitative Study

SUSANNA EVERY-PALMER, LEAH KININMONTH, GILES NEWTON-HOWES, AND SARAH GORDON

Abstract

Despite the imperatives to reduce coercive practices such as substitute decision-making, seclusion, and restraint, the psychiatric profession has struggled to realize these aspirations. Education delivered by people with lived experience of mental distress can help facilitate change. We introduced a service user-led academic program for psychiatry residents focused on promoting human rights and reducing coercive practices in mental health care. Few published reports of such service user-led education exist. In this qualitative study, we analyze data exploring this new program's impact in practice. Four major themes were identified. Service user-led training was challenging but highly valued and prompted a *paradigm shift*, changing residents' thinking. Residents had *so much promise* in their early intentions to reduce coercive practices. However, numerous barriers impeded them from implementing these intentions. *Power differentials* that existed at multiple levels caused residents to experience themselves as "pawns" playing set roles *working under a system* with entrenched hierarchies, resource limitations, legislative frameworks, and public expectations operating to maintain the status quo. The apprenticeship model under which psychiatry residents work is a significant socializing influence. If only the "old paradigm" is modeled and taught, then this hinders more progressive thinking. Service user-led education should be offered more broadly.

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Introduction

Coercive practices such as seclusion are often experienced as highly aversive by service users and cause harm.¹

The United Nations Committee on the Rights of Persons with Disabilities has found that the use of seclusion and various methods of restraint, including physical, chemical, and mechanical restraints, violates the human rights of those experiencing these practices.² The committee has also advised that substitute decision-making—where another person makes a decision on someone else's behalf—should be replaced with supported decision-making, where individuals are supported in making decisions based on their own will and preferences.³

Despite the ethical and human rights imperatives to reduce coercive practices, psychiatry as a profession has struggled to realize these aspirations.⁴ There have been few demonstrable gains in recent decades. In fact, some metrics even suggest that clinical practice is heading in the other direction. In New Zealand, where this study is based, the use of compulsory treatment orders has been increasing and key measures currently indicate that partnerships between consumers and services are declining.⁵ There are wide variations in seclusion usage across mental health inpatient services that cannot be attributed to sociodemographic and clinical factors and are better explained by differences in practice and service delivery across the country.⁶

Many countries are reviewing their mental health laws and replacing them with more human rights-focused approaches. However, legislative change on its own will not drive systemic change.⁷ Internationally, there are viable alternatives to traditional coercive practice that have led to dramatic reductions in seclusion and compulsory treatment.⁸ Such practices require a fundamentally different philosophy that is supported by training and is appropriately resourced.⁹ Leaders and teachers in academic institutions have an essential role in shaping such changes, including through the engagement of service users in the design and delivery of teaching programs.

While the role of service users in coproducing

mental health services has become well established (albeit variably implemented) in North America, the UK, Europe, and Australasia, the equivalent practice of coproducing psychiatric *education*, in which service users are actively involved in the design and delivery of teaching to future psychiatrists, remains in its nascency.¹⁰

The Commission on the Future of Psychiatry (a collaboration between the World Psychiatry Association and the *Lancet* to address priority areas for psychiatry) has strongly advocated for the employment of service user educators as “particularly important to teach the principles of recovery-oriented care and combat negative stereotypes.”¹¹ However, the profession has been slow to adopt this educational practice.¹² There are only a few published reports about service users' involvement in academic psychiatry, which contrasts unfavorably with other mental health professions, such as nursing and social work.¹³ As a contribution to this debate, we have conducted a qualitative analysis considering the impact on practice of the first group of psychiatry residents to participate in a program aimed at supporting sustainable reductions in the use of coercive practices (such as seclusion, restraint, and forced treatment) and promoting supported decision-making. A key component of the program is that it is designed and led by service user academics. Service user academics are scholars who privilege and utilize their lived experience of mental distress and of receiving mental health services to inform their teaching and research activities.

Here we examine the trainees' experiences with the service user-led program and their perceptions of how these experiences affected their clinical practice.

Methodology

Setting

Since 2011, the University of Otago in New Zealand has been progressively developing a mental health academic program, called World of Difference, that is led and delivered by service users. With funding from the country's Health Promotion Agency, in

2017 this program was extended from the education of medical students to also include the education of psychiatry residents. The extension of the program to psychiatry residents was deemed necessary given their specialization in psychiatric practice, the lack of such training having been delivered hitherto, and the expressed interest of the residents in receiving such teaching as part of their training.

The curriculum is conceptualized, developed, and led by service user academics with the support of clinical colleagues within the faculty, and trained service users deliver the teaching. In terms of being service user led, the program has been fully developed, and is fully delivered, by people with lived experience of mental illness who are employed by the university. The approach is based on lessons from social psychology, showing that to provide training to combat mental health stigma and discrimination, mental health service users should be of equal status to trainees, rather than confined to the patient role.¹⁴

The program includes—but extends well beyond—the more traditional approach of solely presenting positive recovery stories in the form of personal testimonies. While such approaches can have value and have been used successfully as a tool for social-political change, they are vulnerable to being coopted or interpreted by others in a manner that can have the opposite of the intended effect in terms of exacerbating stigma and discrimination.¹⁵ The University of Otago didactic teaching incorporates other elements to empower the service user voice and reduce the risk of misinterpretation. These include service user leadership in all aspects of the program, engagement in myth busting, and a focus on behavioral change. These features align with recommendations from other successful antidiscrimination initiatives for health care providers.¹⁶ However, given that the lack of systematic training on human rights as it relates to mental health allows stigma and discrimination to continue in health settings, the program for psychiatry residents also has a strong human rights focus.¹⁷ This is supported by use of resources from the World Health Organization's QualityRights initiative.¹⁸

The program was designed to facilitate the attitudinal shifts and changes in clinical practice required to reduce the use of coercion in psychiatry, such as seclusion, restraint, and forced treatment, and to promote supported decision-making.

Research design

This study was nested within this service user-led education and research program delivered to medical students and psychiatry residents. It was informed by the service user principle of “nothing about us without us.”¹⁹ In line with coproduction principles, service users managed and directed both the intervention and the data collection and analysis processes in collaboration with two of the authors, who have dual roles as practicing psychiatrists and academics.

Data were analyzed using thematic analysis.²⁰ Thematic analysis is an established method for recognizing, analyzing, and reporting emergent patterns within data. Patterns are identified iteratively through careful processes of data familiarization, data coding, theme development, and review.²¹ We used an inductive, realist approach to data analysis, in which we reported the experiences, interpretations, and reality of the residents.²² The inductive approach involves coding the data without forcing it into a preexisting coding frame or the researcher's analytic preconceptions. However, we recognized that an education program for residents led and researched by service users would generate data embedded in the interaction between medical and service user worldviews.

Participant recruitment

Participants were drawn from a pool of 20 psychiatry residents enrolled in the University of Otago's Department of Psychological Medicine's psychiatry course as part of a five-year residency program. We selected residents who were in their first three years of psychiatry training. All had spent at least two years working as junior hospital doctors (“house surgeons”) before entering the residency program. The residents receive teaching from university faculty but are employed by health boards, not by the university.

The teaching program

As part of the World of Difference program, psychiatry residents participated in four hours of didactic teaching and a half-day interactive workshop (delivered to groups of approximately 10 students), both of which were mandatory. They were accompanied by optional monthly one-on-one supervision with a service user (up to eight hours of individual supervision over a year). The latter is described in more depth in a perspective piece written by one of the residents and their service user supervisor.²³

The didactic teaching was largely developed using the World Health Organization QualityRights initiative toolkit.²⁴ This teaching was facilitated by a service user academic (woman, in her 40s, Caucasian) and covered the concepts of recovery, with a particular focus on personal recovery (as opposed to clinical recovery).²⁵ This was supported by the “rethink recovery framework.”²⁶ The teaching explained how stereotypes, prejudice, and discrimination can negatively affect people’s recovery journeys and lead to coercive practices. In terms of human rights specifically, the teaching included a presentation of the four models of disability (charity, medical, social, and human rights); an introduction to human rights generally; an overview of the Convention on the Rights of Persons with Disabilities; an exploration of the formal and informal ways that legal capacity is denied in mental health services; the obligations deriving from article 12 of the convention as informed by General Comment 1 of the Committee on the Rights of Persons with Disabilities, including explication of the distinction between legal and mental capacity, and the requirement to replace substitute decision-making regimes with supported decision-making regimes; and the definition and key principles of supported decision-making. Details on what would be involved in the later interactive workshop were provided to residents at this time.

Three months later, residents participated in an interactive half-day workshop designed to collectively explore and identify practical ways of reducing the use of seclusion, restraint, and other

coercive practices and promoting supported decision-making. The three-month gap between the didactic teaching and the interactive workshops was purposeful in providing time for the residents to consider the potential practical application of the teaching as they engaged in clinical work. The workshops were led by three educators identifying as users of mental health services and included the service user academic who delivered the initial teaching. Two educators were women and one was a man; they were aged in their twenties, forties and sixties; two were Caucasian and one had multiracial ethnicity; and all had personally experienced forced treatment.

In the workshops, residents worked in groups to generate actions regarding (1) what steps they could take personally and in support of their service to reduce seclusion and substitute decision-making, and (2) what steps they could take personally and in support of the service to promote and realize supported decision-making. At the end of the workshop, the participants collectively created a “pledge card” summarizing the actions they had identified. The idea was that the actions were generated and owned by the trainees (rather than being “textbook”), with the aim of increasing participants’ commitment to implementing them. Copies of the pledge cards were provided to all the trainees.

Data collection

Approximately five months after the workshop, residents who provided written informed consent to participate in the qualitative evaluation ($n=11$) joined one of two focus groups ($n=4$ and $n=7$) to discuss their experience in the program and how they had been implementing their “pledges” in practice. The focus groups lasted three hours each and occurred at a hospital training facility between March and November 2018.

The rationale for using focus groups was to encourage open discussion among participants. With focus groups, the researcher facilitates or moderates a group discussion among participants. Unlike interviews, the researcher takes a peripher-

al, rather than a center-stage, role in the discussion. This technique is based largely on group dynamics and synergistic relationships among participants to generate data.

The focus groups were conducted by a female service user academic with a postgraduate psychology qualification. She was in her twenties and had experience facilitating focus groups. She was not involved in delivering the teaching or analyzing data. The reasons for this were to protect confidentiality; to separate the roles so as to avoid bias; and to make use of personnel from the service user team with strengths in different areas. The facilitator was selected as someone with whom there were no existing power dynamics with the residents; she did not have any employment, supervisory, or teaching relationships with them and was the same age or younger age than many. She used a semistructured interview schedule with open-ended questions supplemented with more targeted questions for deeper exploration. The discussions were recorded and transcribed verbatim.

Researcher background

LK and SG are service user academics, and SEP and GNH are academic psychiatrists. All authors have interests in coproduction. As service user academics, LK and SG base their academic work on service user-led and coproduced research with authentic service user leadership in all developmental stages. They are open about their lived experience of mental illness and use that to inform their research and teaching.

Data management and analysis

The data were initially analyzed by LK, SEP, and GNH, none of whom had been involved in delivering the teaching or data collection to protect confidentiality. The transcripts were de-identified prior to analysis so that none of the named researchers knew which residents participated, protecting their anonymity. The researchers independently read and coded the transcripts, and identified emergent themes, before comparing findings.

LK led the qualitative analysis, undertaking initial coding (open coding) on a line-by-line basis

using NVivo Qualitative Data Analysis software (version 12), with subsequent analysis exploring the relationships between codes so as to develop higher-order concepts. Care was taken to ensure that this interpretation of data was undertaken from within a service user worldview, whereby such interpretation is informed primarily by a lived experience of mental distress and service use.

SEP and GNH undertook independent analyses. The analyses were then compared to identify whether there were any divergent views between the service user and clinically focused perspectives in order to enrich the overall analysis and ensure triangulation.

The relationships between and within emerging categories were explored. Overarching higher-order themes were developed through discussion and debate between the four authors. We went through four iterations of integrating, refining, and writing up the merging theories, using constant comparative methods and negative case analysis. This was to increase the credibility and trustworthiness of the concepts extracted and to enrich the depth of analysis.

Ethics

All participants provided their written informed consent. The study was granted ethics approval by the University of Otago's Human Ethics Committee (D17/386).

Funding source

Funding for this study was provided by the New Zealand Health Promotion Agency (grant number 6192).

Results

Eleven residents (two women and nine men) with a median age of 32 years (+/- 5 years) participated in this study. Three residents were in their first year of psychiatry training, and eight were in their second or third year. They reported varying ethnicities, which we do not describe due to their being potentially identifying. The illustrative quotations included in this paper are accompanied by their participant code in brackets (e.g., [#1]).

The major themes identified from the focus groups were as follows:

- Service user-led training prompted a *paradigm shift* and changed thinking.
- Residents *had so much promise* in their early intentions to be less restrictive but often felt thwarted in enacting these aspirations.
- *Power differentials* persisted at many different levels and impeded change.
- Residents felt trapped and constrained *working under a system*. Services and society need to be different to achieve further progress.

Theme one: A paradigm shift

Service user-led training was considered powerful and engendered deep reflection—many participants reported coming away with a new paradigm. They felt that sessions presented an alternative perspective from the biomedical model that predominated at medical school and within their working environments. Insights into how it feels to experience coercive practice were considered particularly powerful in motivating residents to pursue approaches that promoted people’s right to self-determinism and reduced coercion wherever possible.

I personally have come away from the previous sessions we had with [the service user educators] and I've really felt they have been quite powerful and have shaped my practice in a positive way, and definitely trying to promote the least restrictive means as much as possible. [#1]

Residents felt that the training helped them think more carefully about human rights principles. They reported becoming more conscientious in formulating management plans *with* (rather than about) service users and incorporating supported decision-making where possible. The training provided skills and confidence in using supported decision-making.

[People] may lack the capacity to decide where they need treatment, but they do have capacity to decide

what treatment or certain aspects of that treatment. [#5]

Even somebody who might seem completely delusional and really seriously psychotic can still have input. [#6]

[The teaching] has definitely made me think more. If I'm doing a seclusion review or thinking about the Mental Health Act, I'm now being really careful about thinking through every aspect, and from the client's perspective as well. So, it has been a really positive thing. [#11]

Interestingly, residents made observations that the service user teaching had helped reduce their anxieties around risk.

[If] you're giving that person the opportunity to ... take control of their care [and] if I've made a plan with a patient that they are making decisions about and making their own decisions, and if I've given my best assessment and made recommendations [then] ... if something were to go wrong, I'd feel less personally responsible. [#5]

This sort of training has made me more comfortable with the idea of allowing people to make unwise decisions. [#6]

Participants recognized that some senior clinicians were “inclined to a more paternalistic approach” [#5], using compulsory treatment as an expedient way of enforcing the preferred plan in the name of “best interests” rather than engaging in shared decision-making. Previously, residents may have imitated this approach as “usual practice,” but they described now finding it troublesome and striving to do things differently. They felt that it had been “quite easy to just get swept along with the culture of what the people around you are doing” [#6] but that they were now better equipped to challenge the status quo.

Residents reported that with experience and consistently repeated messages, they were getting better at enacting these paradigm shifts.

I think what I'm doing more is appropriately framing the individual's experience so that it makes

sense in their eyes ... From a personal and practice point of view, I think we're doing that a lot better. [#3]

I'm just getting better at that [supported decision-making] through experience I think. [#1]

Residents reported that this different way of practicing as presented through the workshops helped them feel that their work was “of more of value to the people, the clients, that I work with” [#5].

Theme two: “We had so much promise”

While participants supported using less restrictive measures wherever possible, they did not find it easy to realize this in practice. The acute inpatient unit and after-hours management of psychiatric emergencies were particularly challenging environments and situations. Participants experienced a sense of shame and guilt about failing to implement their good intentions.

We had so much promise ... these ideas [on the pledge cards for reducing the use of seclusion] are good, but we have failed to implement a lot of them, especially in the inpatient environment. [#1]

I always feel a sense of failure when someone comes up to me and says, “Doctor I just got one of the people in seclusion” ... It's like, you haven't done enough to stop them from being so unwell that they end up in seclusion. [#2]

Residents felt that their decisional authority after hours was nominal, in conflict with the goals on their pledge cards that they had been optimistic about achieving.

It's hard for us in our position, particularly on call, to eliminate seclusion. [#5]

They described the tensions between an ideal world (where restrictive practices are neither needed nor in existence) and the realities of operating in a complex system, with multiple players and the specter of risk hanging over them.

We have to rely on the feedback given by the nursing staff because they are the ones who are managing

the patient in the ward. So if they say, “I think there is a potential risk related to this patient,” then we have to rely on that information ... I've never been consulted on whether they should start seclusion or not. I've only ever been called saying, “Can you review this person in seclusion?” [#7]

Overall, participants thought it was difficult to envision a country where coercive practices such as seclusion could be completely eliminated. This was because of concerns about safety, systemic factors, and societal views.

“In principle” aims of minimizing seclusion and promoting least restrictive approaches were ubiquitous within participants' workplaces, but services varied in their capacity and commitment to implement these goals. It was noted as a source of pride that in at least one inpatient unit, staff exhausted all other alternatives before considering seclusion.

I think [the staff on the inpatient unit] do a really good job. I'm really proud of it. The way they go about really just leaving seclusion as a last resort. [#1]

However, this was not a consistent experience, and many felt that there were both cultural and systemic factors that made the elimination of restrictive practices difficult, if not impossible, giving rise to the subsequent themes.

Theme three: Power differentials

Participants used the word “power” many times, but on deep analysis this was a spurious and elusive power, characterized largely by its absence. The underlying theme was not in fact power but rather powerlessness.

Residents thought that service users lacked power and viewed themselves as wielding power.

At the end of the day, regardless of how well you engage someone, or how well you thought you've formed that relationship, there'll still be that “you've got the power to put me on medication or to force me to have this”—and no matter what, there's still a power dynamic. [#2]

The residents felt, however, that they had very little actual power to challenge the status quo. They were acutely aware of their role as “trainees.” For context, residents cycle through six-month training rotations, so are usually the newest staff members on a team. Every three months, reports on each resident’s progress, completed by their supervisors and informed by multidisciplinary team members, are submitted to the College of Psychiatry. These reports help determine whether the residents achieve a “pass” or “fail” for each rotation. Consequently, residents experience pressure to be seen as a good team member by their new colleagues. Participants reported feeling transient, insignificant, and vulnerable in relation to the “bosses” (certified psychiatrists and managers). This meant that they were reluctant to challenge established practices.

We are temporary staff [others nod in agreement] so we don't have a say over bigger things like training and budgeting. It's just not our place. [#8]

Nurses were seen as having a lot of influence over trainees. For example, seclusion is initiated by nursing staff and then a resident is called to conduct a clinical review and to recommend continuation or termination of seclusion.

A lot of the tension is with, if I can say so, with the nursing staff, who have worked there for what can sometimes feel like decades and have their own way of doing things and the way they like things. Which often tend to be quite restrictive measures. [#1]

Residents felt that being called to review nurses’ seclusion decisions was often a rubber-stamping exercise in which they were expected to support their more experienced nursing colleagues who had initiated the seclusion.

I mean, we're all so junior here that we at least try to and are encouraged to be subservient in some degree to the nurses because they have so much more experience than we do. [#2]

I realized more and more ... how insignificant I am and how much I am governed by the bosses,

the charge nurses; I'm a pawn. I'm definitely trying to promote the least restrictive means as much as possible ... [but] it's met with a lot of resistance, almost to the point of abuse from some of the charge nurse managers ... and they can really make my life difficult if they want to. [#1]

Some residents also experienced the same power dynamic with the psychiatrists, finding it difficult to express their own opinions.

I basically got abused and bullied into doing what [the on-call psychiatrist] wanted me to do. And you're so vulnerable as a registrar [resident] because that person can then be your supervisor in the next run. [#2]

Theme four: Working under a system

Participants felt that it was unfair to ask clinicians to change their coercive practices in high-risk environments without commensurate systemic and structural changes that would support this.

I wish we could change things; we definitely want good for clients. But certainly, we have to work under a system, in a system. And the barriers are there. That's what I feel. [#7]

The key barriers identified included a lack of time and resources, as well as societal attitudes toward risk.

The inpatient services in which the participants were working were experiencing high occupancy and frequent bed shortages. Most inpatient service users were experiencing acute distress. Participants had identified giving people adequate time as a key tool for supported decision-making, but in practice they found implementing this very difficult.

You've got limited time, especially if you're working with other people. I just had a massive argument in [the emergency department] last week for seeing patients too slow. You know and then they're like, "Oh, you have three more to see." And you're like, "But I'm seeing one patient at a time!" So, it's quite difficult. [#7]

In terms of collaboratively formulating advance

directives, participants said that this took a lot of time—time that they simply did not have. Participants repeatedly used descriptors such as “difficult,” “struggle,” and “barrier” in relation to the concept of time and resources.

Yeah, it can be quite galling when we're told to spend more time with everyone. And that we need to invest more and more. And you can't argue against that because we all know we should, but the reality is we can't [due to resourcing constraints] ... And that's quite difficult for us to balance. [#6]

Residents also complained about insufficient time to write directly to clients to record shared decision-making, despite the obvious benefits of such approaches.

[Supported decision-making] actually takes an awful lot of effort and time on both the team's part and the client's part to do this. [#7]

Residents thought that those unwell enough to require seclusion often did not have the capacity to regulate behavior or make informed decisions, particularly if acutely psychotic, manic, or suffering from drug intoxication or withdrawal. In relation to use of the Mental Health Act, residents felt that it was sometimes the only way to treat someone who might not acknowledge they needed treatment—and that it was what colleagues and the public expected.

Indeed, residents reported that public expectations rested heavily on them. They considered that the public had low tolerance for mental illness, unusual behavior, and risk within the community and that the responsibility for managing these factors was perceived to sit squarely with psychiatric services. The corollary was that adverse outcomes involving mentally unwell people were generally viewed as service or clinician failings. Participants thought that eliminating seclusion and forced treatment would require changes in public opinion and legislation. Mental well-being needed to be conceptualized as a societal responsibility, not just something to be “dealt with” by mental health services. This required further investment in

community-based services to support people and changes in public opinion.

Mad people used to exist in civilization without being incarcerated or followed up with legislation. And then if we're going to deconstruct that we'll actually be reverting back. [#2]

Discussion

This service user teaching is anchored in the recovery paradigm and human rights model of disability advocated by the Convention on the Rights of Persons with Disabilities, and it is interesting that participants saw this training as providing a distinct (yet valuable) alternative view to the rest of their psychiatry training. This suggests that traditional pedagogy has not caught up with more modern practices.

Psychiatry residents felt the teaching affected their thinking about the human rights of those they treat and changed the way they wanted to practice. Consistent with findings reported in other studies, the residents felt that having the human rights-focused messages repeated over time led to incremental improvements in their clinical practice.²⁷ Although their desire to implement least restrictive practices for those experiencing mental distress increased, they identified numerous barriers that prevented them from achieving this goal. They considered that the “fact” of mental illness and diminished capacity meant that the need for coercive practices persisted. However, they also believed that if services were better resourced and society became more tolerant, the need for coercive practice would diminish.

The theme of power—or rather powerlessness—came through strongly. Residents entered the program naïve but enthusiastic with “so much promise” but consequently found their autonomy to effect change to be illusory. They often perceived themselves as hapless “pawns” playing set roles within a flawed system. Entrenched hierarchies, resource limitations, legislative frameworks, and public expectations operated to maintain the status quo. The residents appreciated that this powerless-

ness extended well beyond them, impacting most heavily on service users, the most vulnerable actors in the system.

Strengths and weaknesses

The strengths of this study include an in-depth analysis of the views and experiences of psychiatric residents collected half a year after participating in a service user-led education program. There are few published examples of service user-led educational programs in psychiatric education, and we are not aware of any that have also been evaluated or researched by service users.

More than half of the first tranche of residents to undergo the teaching program elected to participate in this research, providing good representation. The data were collected by a research assistant who was not involved in teaching, assessing, or working with the residents, allowing residents to speak openly about their experiences.

As is the nature of qualitative studies, our data are hypothesis generating and cannot provide “proof” of the benefits or limitations of service user teaching, but merely an account of personal experiences. The methodology and scope of the study did not allow us to observe delayed effects among the participants or ripple effects on their environments.

In line with constructivist theory, we recognize that the service user status, age, and gender of the researchers will have interacted with the experiences, knowledge, and demographics of the participants, influencing both the data generated and the coding framework applied.²⁸ As noted by Virginia Braun and Victoria Clarke, qualitative data are not coded in an epistemological vacuum.²⁹ Other research teams with different worldviews may have elicited different data or interpreted the same data in a different way.

Interestingly, our participants were uniformly positive about the value of the teaching program; their struggles were with enacting the learnings rather than with accepting the underpinning philosophy. This warrants discussion. In our experience, service user-led education in psychiatry often engenders more diverse responses than those elicited from the residents. Some other learners

have found service user-led teaching confronting, with the spectrum of responses including resistance, defensiveness, and withdrawal. We did not detect these responses—either overtly or subliminally—in this population. This may be due to population characteristics: our residents were relatively young and early in their career, a number had previous exposure to service user-led teaching through our medical student program, and the interview panel for their residency program had included a service user and questions about recovery. However, we acknowledge that our focus group methodology may have contributed to some of the uniformity. Although we had a neutral facilitator skilled at eliciting different viewpoints, it is possible that residents did not want to reveal dissenting minority views to their peers. Furthermore, residents who did not like the program may have selectively declined to participate in the research. Hence, we may not have elicited the full spectrum of views.

Implications

Arguably, one of the necessary mechanisms to connect the intervention to actual outcomes is the government’s support in terms of an active commitment to its obligations under the Convention on the Rights of Persons with Disabilities. At the start of this program, there was no such explicit governmental support for the changes required for compliance with the convention. However, this has recently changed, with the New Zealand government having accepted and prioritized the recommendations of a recent inquiry to repeal and replace the country’s mental health legislation to reflect modern approaches to human rights, supported decision-making, and informed consent.³⁰ The first stage has involved the government publishing guidelines on how to apply human rights, recovery approaches, and supported decision-making under the current Mental Health Act.³¹ The actual repeal and reform of that act is going to involve a longer-term process. However, it has also been identified that legislative change on its own will not drive systemic change.³² The results of the present study support that and provide insights into the issues that such systemic change is going

to need to address and involve, as discussed in the next section.

Next steps

Data should be collected to appraise whether attitudinal changes correspond to changes in practice in the medium to long term. It is also imperative to canvas the views of service users. What is their experience working with mental health staff who have undergone training such as that provided in the World of Difference program? Do such programs result in appreciable changes in practice from their perspective?

Service user-taught programs could be expanded to include skills development and an introduction to alternative practices as modeled and endorsed by fellow practitioners internationally. Trainees could be allocated to mentors who are skilled in alternatives to coercion.

Education should include the presentation of alternative approaches to care, such as those enacted in Trieste, Heidenheim, and Soteria.³³ Such education shows not only *that* there are different ways of engaging with service users but also *how* to implement these methods. This can overcome the lament that there are no alternatives.

No matter the level of skill and knowledge that is built, the organizational structures within which new clinicians operate can serve to undermine their best efforts. For example, it is much harder to find alternatives to restrictive practices when insufficient time is allocated to supported decision-making, when there is insufficient staffing to accommodate de-escalation, or when suboptimal facilities create environments that feed frustration and aggression.³⁴

The example of Trieste shows that an integrated, community-based approach can be effective not only from a financial perspective but also in achieving population benefits such as reducing suicide and acute admissions, increasing employment, and reducing the number of people requiring forensic services.³⁵ Such a change requires education and commitment throughout the organizational system, with sustained leadership identified as a key factor in changing the culture in the use of restric-

tive practices.³⁶

The World of Difference program was designed to promote practice in psychiatry that is nondiscriminatory and that upholds the human rights of service users. Psychiatry residents participating in this inaugural program reported developing alternative perspectives from the biomedical model that they saw as predominant in their working environments. Correspondingly, they described wanting to work in less restrictive ways and generated thoughtful ideas about how to put this desire into practice. However, they felt that their good intentions were often thwarted by societal and structural factors: environments and people who resisted such change.

Our participants are enmeshed in a paradigm collision—the conflicts in their experiences represent a microcosm of the larger debate occurring between the service user worldview and the traditional clinical worldview in psychiatry. The apprenticeship model under which residents work is a significant socializing influence. If only the “old paradigm” is modeled and taught, then this will hinder more progressive thinking, particularly in relation to the application of human rights in practice. As a consequence, education of the type profiled here needs to reach people at all levels throughout the service, from policy makers to managers to multidisciplinary clinicians—with service users placed squarely at the center.

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References

1. A. Mellow, A. Tickle, and M. Rennoldson, “Qualitative systematic literature review: The experience of being in seclusion for adults with mental health difficulties,” *Mental Health Review Journal* 22 (2017), pp. 1–15; T. Brannelly, “An ethics of care transformation of mental health service provision: Creating services that people want to use,” in J. Wintrup, H. Biggs, T. Brannelly, et al. (eds), *Ethics from the ground up* (London: Red Globe Press, 2019), p. 17.
2. Committee on the Rights of Persons with Disabilities,

Guidelines on article 14 of the convention on the rights of persons with disabilities: The right to liberty and security of persons with disabilities (New York: United Nations, 2015).

3. P. Gooding, "Supported decision-making: A rights-based disability concept and its implications for mental health law," *Psychiatry, Psychology and Law* 20/3 (2013), pp. 431-451; Committee on the Rights of Persons with Disabilities, General Comment No. 1: Article 12; Equal Recognition before the Law, UN Doc. CRPD/C/GC/1 (2014).

4. Committee on the Rights of Persons with Disabilities (2014, see note 3); Health Quality and Safety Commission New Zealand, *Zero seclusion: Towards eliminating seclusion by 2020* (Wellington: Health Quality and Safety Commission, 2018).

5. New Zealand Ministry of Health, *Office of the director of mental health annual report 2016* (Wellington: Ministry of Health, 2017); New Zealand Ministry of Health, *The Mental Health Act and human rights: A discussion document* (Wellington: Ministry of Health, 2017); New Zealand Health and Disability Commissioner, *New Zealand's mental health and addiction services: Monitoring indicator update 2017 & 2017/18* (Wellington: Health and Disability Commission, 2019).

6. J. Lai, A. Jury, J. Long, et al., "Variation in seclusion rates across New Zealand's specialist mental health services: Are sociodemographic and clinical factors influencing this?," *International Journal of Mental Health Nursing* (2019), pp. 288-296; A. O'Brien, "Community treatment orders in New Zealand: Regional variability and international comparisons," *Australasian Psychiatry* (2014), pp. 352-356.

7. New Zealand Health and Disability Commissioner (see note 5); New Zealand Mental Health and Wellbeing Commission, *He Ara Oranga – mānuka takoto, kawea ake: Upholding the wero laid in he ara oranga* (Wellington: Mental Health and Wellbeing Commission, 2020).

8. R. Mezzina, "Community mental health care in Trieste and beyond: An 'open door–no restraint' system of care for recovery and citizenship," *Journal of Nervous and Mental Disease* (2014), pp. 440-445; M. Zinkler, "Germany without coercive treatment in psychiatry: A 15 month real world experience," *Laws* 5/1 (2016), p. 15; J. Bola and L. Mosher, "Treatment of acute psychosis without neuroleptics: Two-year outcomes from the Soteria project," *Journal of Nervous Mental Disease* 191/4 (2003), pp. 219-229.

9. M. Zinkler and S. von Peter, "End coercion in mental health services: Toward a system based on support only," *Laws* 8/3 (2019), p. 19.

10. E. Omeni, M. Barnes, D. MacDonald, et al., "Service user involvement: Impact and participation; A survey of service user and staff perspectives," *BMC Health Services Research* 14/1 (2014), pp. 1-13; C. Burr, K. Rother, L. Elhilali, et al., "Peer support in Switzerland: Results from the first national survey," *International Journal of Mental Health Nursing* 29 (2020), pp. 212-223; S. Lawn, "Integrating service

user participation in mental health care: What will it take?," *International Journal of Integrated Care* 15 (2015), p. e004; S. Soklaridis, A. de Bie, R.B. Cooper, et al., "Co-producing psychiatric education with service user educators: A collective autobiographical case study of the meaning, ethics, and importance of payment," *Academic Psychiatry* 44 (2020), pp. 159-167.

11. D. Bhugra, A. Tasman, S. Pathare, et al., "The WPA-Lancet Psychiatry Commission on the future of psychiatry," *Lancet Psychiatry* 4 (2017), pp. 775-818.

12. B. Happell, L. Byrne, M. McAllister, et al., "Consumer involvement in the tertiary-level education of mental health professionals: A systematic review," *International Journal of Mental Health Nursing* 23 (2014), pp. 3-16; S. Agrawal, C. Kalocsai, P. Capponi, et al., "'It was great to break down the walls between patient and provider': Liminality in a co-produced advisory course for psychiatry residents," *Advances in Health Sciences Education* 26 (2021), pp. 385-403; S. Agrawal, P. Capponi, J. López, et al., "From surviving to advising: A novel course pairing mental health and addictions service users as advisors to senior psychiatry residents," *Academic Psychiatry* 40 (2016), pp. 475-480.

13. Soklaridis et al. (see note 10); Agrawal et al. (2016, see note 12); Happell et al. (2014, see note 12).

14. P. Corrigan and D. Penn, "Lessons from social psychology on discrediting psychiatric stigma," *Stigma and Health* 54 (2015), pp. 765-776.

15. L. Costa, J. Voronka, D. Landry, et al., "'Recovering our stories': A small act of resistance," *Studies in Social Justice* 6 (2012), pp. 85-101; J. Voronka, "Storytelling beyond the psychiatric gaze," *Canadian Journal of Disability Studies* (2019), pp. 8-30; L. Ashton, S. Gordon, and R. Reeves, "Key ingredients—target groups, methods and messages, and evaluation—of local-level, public interventions to counter stigma and discrimination: A lived experience informed selective narrative literature review," *Community Mental Health Journal* 54 (2018), pp. 312-333.

16. S. Knaak, G. Modgill, and S. Patten, "Key ingredients of anti-stigma programs for health care providers: A data synthesis of evaluative studies," *Canadian Journal of Psychiatry* 59 (2014), pp. 19-26.

17. Human Rights Council, *Mental Health and Human Rights: Report of the United Nations High Commissioner for Human Rights*, UN Doc. A/HRC/34/32 (2017).

18. World Health Organization, *WHO QualityRights tool kit to assess and improve quality and human rights in mental health and social care facilities* (Geneva: World Health Organization, 2012).

19. J. Charlton, *Nothing about us without us: Disability oppression and empowerment* (Berkeley: University of California Press, 1998); V. Billingham, "Through the patient's eyes," Salzburg seminar session 356 (1998).

20. V. Braun and V. Clarke, "Using thematic analysis in psychology," *Qualitative Research in Psychology* 3 (2006), pp.

77–101.

21. Ibid.
22. M. Patton, *Qualitative evaluation and research methods*, 2nd edition (Newbury Park: Sage, 1990).
23. S. Gordon and M. Higgins, “The perspectives of a service user academic and a psychiatric trainee on engagement in supervision,” *Irish Journal of Psychological Medicine* 37 (2020), pp. 141–145.
24. World Health Organization (2012, see note 18).
25. M. Slade, M. Amering, M. Farkas, et al., “Uses and abuses of recovery: Implementing recovery-oriented practices in mental health systems,” *World Psychiatry* 13/1 (2014), pp. 12–20.
26. M. Slade, *100 ways to support recovery: A guide for mental health professionals* (London: Rethink, 2009).
27. Ashton et al. (see note 15).
28. K. Charmaz, “Constructionism and the grounded theory method,” in J. Holstein and J. Gubrium (eds), *Handbook of constructionist research* (New York: Guilford Press, 2008), pp. 397–412.
29. Braun and Clarke (see note 20).
30. Mental Health and Wellbeing Commission (see note 7); R. Patterson, M. Durie, B. Disley, et al., *He Ara Oranga: Report of the Government inquiry into mental health and addiction* (Wellington: New Zealand Government, 2018).
31. New Zealand, *Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act* (1992).
32. Patterson et al. (see note 30).
33. Mezzina (see note 8); Zinkler (2016, see note 8); Bola and Mosher (see note 8).
34. G. Jenkin, J. McIntosh, and S. Every-Palmer, “Fit for what purpose? Exploring bicultural frameworks for the architectural design of acute mental health facilities,” *International Journal of Environmental Research and Public Health* 18/5 (2021), p. 2343.
35. Mezzina (see note 8).
36. M-H. Goulet, C. Larue, and A. Dumais, “Evaluation of seclusion and restraint reduction programs in mental health: A systematic review,” *Aggression and Violent Behavior* 1/34 (2017), pp. 139–146; J. N. Scanlan, “Interventions to reduce the use of seclusion and restraint in inpatient psychiatric settings: What we know so far a review of the literature,” *International Journal of Social Psychiatry* 56/4 (2010), pp. 412–423.