Table 1. Overview of development projects and quality assurance work for reducing the use of coercion and improving its quality

DECENTRALISED SPECIALISED SERVICES AND MUNICIPAL HEALTH SERVICES:

***Using a psychiatric ambulance instead of police, including**:*

- increasing professional competence in ambulance services by including mental health nurses with relevant experience and personal suitability for securing patients
- placing greater emphasis on using time, information and dialogue with patients and family members
- placing greater emphasis on negotiating with patients and avoiding the use of physical force or mechanical restraints

Increasing consciousness among physicians in local emergency units of their decision-making practices regarding involuntary hospitalisation, including:

- using comparative statistics and medical case summaries from hospitals
- offering individual feedback and guidance from the head physician for physicians who have frequently made administrative decisions regarding involuntary hospitalisation that have been overruled by the hospital psychiatrist
- requiring stricter use of legal criteria for committals
- increasing the availability of voluntary alternatives for patients requiring help who would receive limited or no benefit from hospitalisation in acute wards

Securing well-grounded decision-making processes and conducting culture work at district psychiatric centres, including:

- establishing a team of head psychiatrists who emphasise minimal and proper use of coercion
- establishing a tradition of cooperation to secure decision-making processes regarding coercion
- developing a work culture focusing on staff attitudes toward patients and consciously avoiding unnecessary paternalism and restrictions
- creating voluntary solutions by improving staff members' negotiating skills
- increasing emphasis on cooperative and participative ways of working with patients, including decision-making regarding medication

HOSPITAL SERVICES:

Developing strategic policy programmes to reduce coercion in the hospital trust or locally, including:

- expanding and reorganising decentralised and community-based services to 'redirect the stream of acute hospitalisation'
- requiring collegial discussions before using coercion in order to avoid arbitrary decision-making
- regularly running courses to increase staff competence in health legislation
- regularly having debriefings with patients after using mechanical restraints

Reducing seclusion and/or increasing the therapeutic value of seclusion by using more dynamic and less custodial ways of conducting seclusion, including*:*

- increasing individual and flexible 'stimulus-modelling'
- increasing individualised and flexible use of restrictions and house rules
- increasing activities and time spent outdoors
- improving dialogue with patients and increasing patient participation
- increasing the 'treatment-content' of seclusion by establishing a treatment team for patients and promoting a more active role for the psychiatrists/psychologists in assessments and follow-up with secluded patients and in information sharing
- increasing staff competence in dealing with psychosis, distress and aggression
- decreasing unfounded and stereotypical staff views of patients as dangerous

Therapeutic management of aggression (TMA), including:

- increasing focus on staff attitudes and milieu therapy
- requiring regular courses and training for the staff
- placing greater emphasis on prevention and coping skills regarding anger, aggression and disturbed behaviour
- increasing humane and respectful use of physical force and mechanical restraints
- attempting to conduct retrospective conversations with patients after a coercive episode

Staff (work force) development, including:

- having a stricter recruitment policy to ensure that staff members are suited to work with psychiatric patients
- changing the treatment philosophy, such as to have more acknowledging approaches to patients
- changing staff attitudes, for example, towards patients or the use of limit-setting and coercion
- increasing staff consciousness and ability to endure the urge to use coercion, thus waiting longer before intervening with coercive measures
- increasing staff competence and reflexivity through teaching and supervision, particularly in acknowledging ways to communicate with patients
- increasing use of experienced nurses and therapists as role models

Closer follow-up of patients by psychiatrists or psychologists, including:

- using an experienced head psychiatrist, who believes in the limited use of coercion, in the hospital emergency unit to evaluate the need for involuntary hospitalisation
- encouraging closer collaboration between therapists and other personnel in the care of restrained or forcibly medicated patients
- scheduling more frequent inspection of patients by physicians/psychiatrists during seclusion and use of restraints