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Coercive mental health care – dilemmas in the decision-making process

ORIGINAL ARTICLE

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BACKGROUND

The use of coercive mental health care contravenes the principle of voluntary examination and treatment. However, it should be possible for persons at acute risk to receive imperative health assistance.

MATERIAL AND METHOD

After evaluating 37 emergency interviews in psychiatric outpatient clinics where the use of coercive mental health care was considered, interviews were conducted with psychiatric triage clinicians.

RESULTS

The study includes interviews that resulted in involuntary hospitalisation (n = 15), coerced observation (n = 2), voluntary hospitalisation (n = 14) and follow-up by the outpatient clinic (n = 6). Important factors in assessing the use of coercion were the severity of psychotic symptoms, suicide risk and risk for others, and difficult social circumstances. Three-quarters of psychiatric triage clinicians were in some degree of doubt, and 16 out of 37 experienced uneasiness during the assessment. With a view to enhancing the patient's perception of having been met with respect, the triage clinicians emphasised the need for the patient's opinion to be heard. Where the triage clinicians were in doubt, a number of professional and ethical issues were highlighted in the process of reaching a decision.

DISCUSSION

Latitude should be given for ethical and professional reflection in relation to assessing the use of coercion in daily clinical practice, as well as training in measures to reinforce patients' experience of participation during the interview.

Coercive mental health care is an exception to the fundamental principle that examination and treatment should be voluntary. In Norway, patient self-determination and autonomy are enshrined in the Patients' and Users' Rights Act (1). The use of coercion is subject to extensive regulation, and decisions are followed up by dedicated control commissions. A serious mental health disorder must be present, and one must consider whether there is an imminent and serious risk to one's own

or another's life or health (2). Voluntary treatment options must be attempted or judged impossible to employ. Particular emphasis must be placed on the strain to which coercion would subject the patient. One must evaluate whether the patient has the capacity to consent; that is whether he or she can understand relevant information, weigh up various treatment options, and make choices tailored to his or her own situation (3). The patient must be given the opportunity to express his or her views. Often many factors must be taken into account as part of a complex holistic assessment.

To ensure that persons at acute risk receive essential health care, section 7 of the Norwegian Health Personnel Act requires healthcare personnel to provide emergency healthcare assistance (4). To determine whether there is a need for coercive mental health care, the patient must be examined by a doctor or psychologist who is independent of the ward to which admission is being considered. The examination can be performed by a general practitioner, Accident and Emergency doctor or, as in our study, a triage clinician in a psychiatric outpatient clinic. Based on the information from this examination and their own observations, the healthcare professional responsible for the decision (a psychiatrist or specialist in clinical psychology employed by the inpatient institution) must make an independent judgement within 24 hours as to whether the conditions for coercive mental health care have been fulfilled (4).

Use of coercion in Norway

In Norway, there are marked geographical and institutional differences in the use of coercive mental health care, which do not seem to be explicable in terms of differences in patient populations (5). In 2014, the Norwegian Patient Registry received reports of approximately 8 000 involuntary hospitalisations of 5 600 patients (6).

Several studies from Norway and other countries report that low educational levels, low income, weak family ties, limited social support, problematic substance abuse and an ethnic minority background appear to increase the likelihood of involuntary hospitalisation (7). Age and gender seem to have less of an impact (8, 9). Few available beds and low levels of staffing are also associated with increased use of coercion (8, 9). Cultural attitudes within the organisation ('this is how we do things here') may have a bearing, as may paternalistic attitudes among professionals that make decisions over the use of coercion (10, 11). The decision-making process is influenced by how those involved interpret the legal criteria for use of coercion (12), as well as by ethical dilemmas (3, 13, 14).

A key aim of an emergency psychiatric interview is to ensure that the patient feels as far as possible that he or she is participating in the decisions made. Patients who are met with respect and who are included in the decision-making process systematically report less perceived coercion (15).

In some emergency interviews, the criteria for coercive mental health care will clearly be fulfilled. In others, it will be apparent that the criteria for use of coercion have not been met. However, in many situations it will be unclear whether the correct decision is to use coercion or voluntary measures. In order to develop methods for evaluation and decision-making that may help to reduce the use of coercion, and to ensure that the decision to use coercion is made as carefully as possible, it is important to consider how to proceed in situations where it is not clear what the correct course of action might be.

This article concerns emergency interviews at psychiatric outpatient clinics where the possibility of using coercion is considered. We included both interviews that did and did *not* result in the decision that coercive mental health care was required. We interviewed doctors and psychologists at several outpatient clinics in Oslo who performed such emergency interviews. They were asked about professional and ethical issues, about any doubt and uneasiness they may have experienced, and about whether they believed patients felt involved in the decision-making process and that they had been met with respect.

The aim of the study was to reveal the factors that influence decisions made by psychiatric triage clinicians regarding the potential use of coercion. We focused on the following questions, assessed from the point of view of the decision-maker:

- What considerations form the basis for a decision regarding whether or not coercion is required?
- What, if any, dilemmas, doubt and uneasiness do you experience during these interviews?
- What factors are important for patients to feel that they are involved in the decision-making process and that they have been met with respect?

Material and methods

In this article, we have analysed 37 emergency interviews at three psychiatric outpatient clinics where the use of coercive mental health care is considered. The interviewees comprised 18 psychiatrists, five specialists in clinical psychology, 12 specialty registrars and two psychologists. The outpatient clinics cover both western and eastern districts of Oslo. The triage clinicians were interviewed by experienced psychiatrists or specialists in clinical psychology. The participants were recruited on a continuous basis, whereby all those who performed emergency interviews were asked if the interview had involved evaluating the need for coercive treatment. The interviews lasted up to one hour. A questionnaire was used featuring statements with quantitative response options plus the opportunity to expand on responses in greater depth. The questionnaire was developed in collaboration with '*Tvangsforsk*', the Norwegian Research Network on Coercion in Mental Health Care. A selection of key questions is reproduced in Table 1. The questionnaire is available from the first author upon request.

Table 1

Use of coercion in mental health care. Ordinal data for the responses of 37 doctors and psychologists to questions about any doubt they may have experienced in their decision, and about issues related to respect, involvement and the patient's insight into his/her own condition

Question	Not at all	A little	Somewhat	Much	Very much
Were you in doubt about your decision? (n = 37)	9	16	10	2	0
To what extent do you think the patient felt that he/she was allowed to express his/her opinions in the emergency interview? (n = 35)	3	6	5	11	10
To what extent did you feel that the patient's views had an impact on the decision? (n = 24)	4	4	2	9	5
To what extent do you think the patient felt that he/she was treated with respect during the emergency interview? (n = 36)	0	3	10	16	7
To what extent did you feel the patient had an understanding of the situation (disease insight/decision-making capacity)? (n = 37)	8	13	10	6	0

The study has been approved by the Regional Committee for Medical and Health Research Ethics, REC South-East, and all participants have provided written consent.

Statistical analyses were performed using IBM SPSS Statistics, version 21. Kendall's rank correlation coefficient (Kendall tau-b) was used to calculate the correlation between ordinal categorical variables.

Results

Of the 37 emergency psychiatric interviews, in nine cases the need for intervention was reported by relatives, in nine cases by an acute care team, i.e. an ambulatory out-of-hours service at a district psychiatric centre, in three cases by a general practitioner, and in two by the patient him- or herself. In most cases, various public agencies were involved – including Accident and Emergency, the police, and different treatment units within the mental healthcare services – often from various districts. In eight cases, a compulsory medical examination had been deemed necessary following a report by relatives, a general practitioner or others to the district medical officer. The police were directly involved in five of the 27 emergency interviews for which this was recorded.

Almost all of the patients evaluated displayed acute psychosis (31 of 37), while 13 were deemed at risk of suicide. Fifteen of the 37 interviews led to involuntary hospitalisation of the patient. Of the remainder, 14 ended in voluntary hospitalisation and two in hospitalisation with coerced observation. Six patients were not hospitalised, but received appointments for outpatient follow-up.

In 18 of the emergency interviews, contact was established with relatives as part of the assessment. In 13 of these, the relatives believed that the patient should be hospitalised, in ten cases under coercion if necessary. There was good agreement between relatives and the individual conducting the interview regarding the need for hospitalisation. The patient was admitted in 11 of 13 cases in which the relatives requested hospitalisation. Two of the three interviews in which the relatives did not want hospitalisation resulted in outpatient follow-up without admission.

As shown in Table 1, nine of the 37 psychiatric triage clinicians said that they had no doubts about their decision. Three-quarters of healthcare personnel who considered the use of coercive care were thus in doubt to a greater or lesser degree.

Various sources of doubt

Factors that affected the outcome of the emergency interview were the severity of the patient's psychotic symptoms, the risk of suicide or of harm to others, and the patient's social situation. The latter included, for example, whether the patient lived alone and whether he or she had supportive relatives. In cases of voluntary hospitalisation, the risk of suicide was a key source of doubt. In cases where there was no doubt regarding the use of coercive mental health care, psychotic symptoms and danger to others were key factors in the decision.

The psychiatric triage clinicians were asked to describe when and why they were in doubt, the different options that were available, and the basis for their final decision. These reflections are shown for three patients in Box 1.

Box 1 Case vignettes where psychiatric triage clinicians experienced doubt regarding coercive mental health care.

Patient A had probable prodromal symptoms of a severe mental disorder. However, it was very uncertain whether he or she was psychotic and what role substance-related issues were playing in the patient's current condition. The patient had a deficient social network and an unstable living situation. He/she expressed no preferences, either with respect to hospitalisation, medical treatment or follow-up at an outpatient clinic. The goal was to establish contact with outpatient services over the longer term, but doubts remained as to whether outpatient treatment would be sufficient at the present time. Ethical issues regarding the balance between insight and autonomy were highlighted. The final decision was for voluntary outpatient follow-up.

Patient B had severe psychotic symptoms, but had excellent support from competent relatives. Possible alternatives were close follow-up with new initiation of drug treatment versus hospitalisation. Key factors in the final decision to opt for voluntary outpatient follow-up were the combination of supportive relatives and the strain that hospitalisation would place on the patient.

Patient C had severe mental illness and a difficult living situation. The patient's social situation was complicated and marked by conflict. The patient's mother was very concerned that the patient would attempt suicide. The person conducting the emergency interview considered there to be a strong correlation between the patient's social situation and worsening of his/her symptoms. The final decision was that coerced hospitalisation was necessary.

Some of the psychiatric triage clinicians experienced doubts early in the interview process, but these faded as the patient's psychotic symptoms and/or suicide risk became more apparent. For others, doubts resolved after they were able to establish a good relationship with the patient that made communication easier.

One of the interviewers described a patient who downplayed his/her situation while information from those who knew the patient clearly indicated that he/she should be hospitalised. The decision-maker struggled to establish a rapport with the patient at the start of the interview, but this did improve. A calming of the situation led to the decision to opt for outpatient follow-up.

Reasons for the decisions made

Box 2 shows various factors that helped determine whether coercive mental health care or voluntary follow-up was chosen.

Box 2 Factors that, according to the person conducting the emergency interview, influenced the decision on coercive mental health care versus voluntary follow-up

FACTORS THAT ARGUED FOR COERCIVE MENTAL HEALTH CARE:

- Severe and rapid deterioration in functioning with psychosis and suicide risk
- Previous serious suicide attempts
- Serious psychotic symptoms that appeared disabling
- Threat to the life and health of others
- Required for his/her own protection
- Expectation of improvement upon hospitalisation

FACTORS THAT ARGUED FOR VOLUNTARY FOLLOW-UP:

- Patient responded positively to the proposed interventions
- Patient-therapist relationship was strengthened during the emergency interview
- Patient seemed to have insight into his or her situation
- Importance of establishing trust and allegiance to the hospital
- Overall evaluation supported voluntary treatment rather than coercion

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Alternatives to coercion

Several of those who conducted emergency interviews that resulted in involuntary hospitalisation described alternatives that they wished had been available, but which were not. Several said that ambulatory care at home might have made it easier to assess the patients' functional and self-care capacities. However, many others stated that they did not think there were any alternatives that would have been appropriate in the situation in question.

Experienced uneasiness

In all, 16 of the 37 psychiatric triage clinicians stated that they found the interview uncomfortable to a greater or lesser degree. Sources of uneasiness included doubt over the decision, time pressure, lack of familiarity with the patient, pressure from the individual normally responsible for the patient's treatment to opt for hospitalisation, and disagreement with the emergency department. Two of the healthcare personnel interviewed felt that their own safety was threatened. One cited police intervention as a source of uneasiness, and believed the situation could lead to the patient feeling that he/she had been treated with disrespect.

Respect

The psychiatric triage clinicians were asked to describe the basis for their impression of whether the patient felt that he or she had been met with respect (Table 1). The majority emphasised the importance of giving the patient thorough information and of taking the time to listen to the patient's views in a supportive environment. They also stressed the importance of conveying to the patient that they understood his or her situation. Striving to build a good relationship is vital.

There was a strong correlation between whether the psychiatric triage clinicians felt that the patient had been met with respect and whether they felt that the patient had been allowed to express his or her views (Kendall's tau-b = 0.63; p-value <0.001; n = 35). In the assessments, there was also a correlation between the patient's insight into their illness and the extent to which this insight influenced the decision (Kendall's tau-b = 0.62; p-value: <0.001; n = 24). Although several of the triage clinicians felt that patients who were admitted for coercive mental health care/observation were treated with less respect, there were exceptions. One individual knew the patient well beforehand and spent a long time talking to him/her. The patient was judged to have been treated with a great deal of respect, even though the final decision was for involuntary hospitalisation.

In cases where the police were involved, the triage clinicians believed that patients were far less likely to feel they had been met with respect. Nevertheless, several described their collaboration with the police as good, saying that the police 'calmed the situation down', were 'helpful and responsive', and 'behaved in a friendly, flexible, and calm manner'. The police were most likely to be involved in those situations that were the most unpredictable and serious.

Professional and ethical dilemmas

Box 3 shows professional and ethical dilemmas experienced by psychiatric triage clinicians, categorised after the decision had been taken.

Box 3 Professional and ethical dilemmas that were considered as part of the decision-making process

UPON VOLUNTARY HOSPITALISATION

- The patient had recently had an episode of psychosis but was not considered psychotic during the interview. How could one ensure that the patient would be safeguarded if he/she failed to take care of him/herself?
- The patient was psychotic, but with recent disease onset. Use of coercion could undermine the establishment of trust and teamwork that is important for long-term follow-up
- There was a lack of essential background information about a suicidal patient, and the patient provided little information

UPON COERCED OBSERVATION

- Awareness that the receiving unit had a different view of the situation to one's own

UPON HOSPITALISATION FOR COERCIVE MENTAL HEALTH CARE

- The patient had previously been receiving coercive outpatient mental health care, but this had been discontinued. There were now doubts as to whether this was the right decision, as the patient had subsequently experienced a severe decline in function

- The desire to respect the patient's autonomy conflicted with the need to use coercion to safeguard a patient who had shown self-neglect
- Assessing the degree of manic symptoms in the patient was difficult, and the patient showed little cooperation during the interview. However, there was also doubt as to whether sufficient effort had been made as required by law to persuade the patient to consent to voluntary treatment
- Those who knew the patient described symptoms of psychosis, but the patient disguised the symptoms so that they only became apparent after a long interview

UPON VOLUNTARY OUTPATIENT FOLLOW-UP

- The patient had paranoid delusions, and hospitalisation was considered beneficial. The patient's opposition to hospitalisation was key to the decision to opt for outpatient follow-up
- The patient would struggle to comply with outpatient treatment, but the emergency ward strongly objected to hospitalisation
- Parents wished for hospitalisation of their adult offspring, but a comprehensive assessment led to a decision for outpatient follow-up

Discussion

The purpose of this study was to reveal the factors that psychiatric triage clinicians regard as important when they consider the use of coercive care. Important factors in the assessment were the severity of psychotic symptoms, risk of suicide and danger to others, and difficult social circumstances. In cases of doubt, the triage clinicians considered various professional and ethical issues as part of the decision-making process. They highlighted the ethical dilemma that inevitably accompanies the coerced treatment of a person who has not expressed a wish for such assistance.

Several of the triage clinicians who were interviewed were in doubt as to whether voluntary hospitalisation of the patient would be sufficient. Patients could appear ambivalent during the interviews, making it uncertain whether they would remain in the ward or discharge themselves prematurely. Moreover, it was sometimes unclear whether it would be possible to establish proper follow-up at home. Some were in doubt as to the severity of the patient's symptoms, for example, to what degree he or she was psychotic. Other respondents experienced substantial pressure from the patient's relatives regarding the need for hospitalisation, while having little prior knowledge of the patient's situation themselves. In general, there was good agreement between the opinions of the relatives and those of the triage clinicians regarding the need for hospitalisation.

One triage clinician stated that there would always be room for doubt in emergency interviews because the interviews provide only a snapshot of the situation. The course of a patient's illness may fluctuate, however, with periods of severe functional deterioration. As a result, such interviews are often challenging.

When considering whether or not the patient felt they had been met with respect, the triage clinicians placed particular emphasis on whether the patient had been given the opportunity to express his or her opinions. This has been shown in several other studies (3, 16, 17, 18). There was also a strong correlation between beliefs about whether the patient had insight into his or her illness and those about whether the patient had been included in the discussion. In a further article under preparation, we will highlight the patients' experiences and impressions of the same interviews. We will look at whether they consider they were treated with respect during the interview and whether they felt they were able to influence the decision. We will also examine to what extent these impressions differ from those of the clinicians.

Patients subjected to coercive care may sometimes say afterwards that they consider the hospitalisation to have been necessary. Nevertheless, they will often maintain their negative view of the use of coercive care and continue to feel that they were subjected to unfair, disrespectful

and/or humiliating treatment (19). Use of coercion is in general associated with reduced user satisfaction (20).

Involving the patient in the decision-making process is not only a professional but also a legal obligation. According to the amendment of the Norwegian Mental Health Care Act, 1 September 2017, patients with the capacity to provide consent may refuse help from the mental healthcare services, unless they pose an immediate and serious risk to themselves or to the lives or health of others (2). The patient's right to make choices with respect to his or her own mental health, including those that therapists consider to be bad choices, is to be strengthened. If the patient is considered capable of providing consent, coercion may not be used to impose treatment. Self-harm that does not endanger a person's life, or discontinuation of antipsychotics with an associated risk of relapse, are examples of such situations. Our study was conducted prior to the amendment. It will be interesting in future studies to investigate the consequences of the amendment for emergency assessment interviews that involve decisions regarding the use of coercion.

The psychiatric triage clinicians in our study highlighted measures that can be used to help include the patient in the decision-making process: Set aside enough time. Give the patient an opportunity to talk about his or her situation and to express his or her views and any disagreement. Try to establish a good rapport and alliance with the patient. Spend time explaining the reasons for your actions, take things slowly, repeat important questions and build a framework of care. Listen and take the patient seriously. Explore actively and clearly the patient's own experiences and impressions.

One limitation of the study is that standardised methods were not used for qualitative analysis of transcribed interviews. The outpatient clinics involved were also from a limited geographical area.

Performing an emergency assessment is challenging, especially when it is unclear whether coercive or voluntary treatment is the correct choice. Extensive demands are placed on the ability of psychiatric triage clinicians to include the patient in the decision-making process. A key question is whether the doctors and psychologists that perform these interviews receive sufficient, systematic education and training in methods for reducing the patient's experience of uneasiness, loss of integrity, and powerlessness related to assessment of their need for coercive mental health care. In our opinion, too little is known about the quality of provision in this area by educational institutions, and this is an important topic for further research. It is interesting to note that many of the triage clinicians stated that the interview in this study was helpful in providing them with an opportunity to reflect on the process. In everyday clinical practice too, there should be latitude for ethical and professional reflection around the emergency psychiatric interview.

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