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

ORIGINAL ARTICLE

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The use of coercive mental health care contravenes the principle of voluntary examination and treatment. However, it should be possible assistance.

**Material and Method**

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

**Results**

The study includes interviews that resulted in involuntary hospitalisation (n = 15), coerced observation (n = 2), voluntary hospitalisation (n = 2), and suicide risk and risk for others, and difficult sc

**Discussion**

Latitude should be given for ethical and professional reflection in relation to assessing the use of coercion in daily clinical practice, as well 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, enshrined in the Patients’ and Users’ Rights Act (1). The use of coercion is subject to extensive regulation, and decisions are followed up by 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 he attempted or judged impossible to employ. Particular emphasis must be placed on the strain to which coercion would subject the patient capacity to consent; that is whether he or she can understand relevant information, weigh up various treatment options, and make choice 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 per 2014, the Norwegian Patient Registry received reports of approximately 8,000 involuntary hospitalisations of 5,600 patients. Several studies from Norway and other countries report that low educational levels, low income, weak family ties, limited social support, background appear to increase the likelihood of involuntary hospitalisation (27). Age and gender seem to have less of an impact (28-30). Few studies have attempted to increase the use of coercion (28-30). Cultural attitudes within the organisation (‘this is how we do things here’) may have a large impact on decisions made by healthcare professionals that make decisions over the use of coercion (29-31). The decision-making process is influenced by how those involved interpret ethical dilemmas (31-33).

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 decision who are included in the decision-making process systematically report less perceived coercion (34).

In some emergency interviews, the criteria for coercive mental health care will clearly be fulfilled. In others, it will be apparent that the criteria in many situations it will be unclear whether the correct decision is to use coercion or voluntary measures. In order to develop methods of treatment and to ensure that the decision to use coercion is made as carefully as possible, it is important to consider how to proceed with the decision-making process.

**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 population (5). In 2014, the Norwegian Patient Registry received reports of approximately 8,000 involuntary hospitalisations of 5,600 patients. Several studies from Norway and other countries report that low educational levels, low income, weak family ties, limited social support, background appear to increase the likelihood of involuntary hospitalisation (27). Age and gender seem to have less of an impact (28-30). Few studies have attempted to increase the use of coercion (28-30). Cultural attitudes within the organisation (‘this is how we do things here’) may have a large impact on decisions made by healthcare professionals that make decisions over the use of coercion (29-31). The decision-making process is influenced by how those involved interpret ethical dilemmas (31-33).

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This article concerns emergency interviews at psychiatric outpatient clinics where the possibility of using coercion is considered. We included all decision that coercive mental health care was required. We interviewed doctors and psychologists at several outpatient clinics in Oslo who asked about professional and ethical issues, about any doubt and uneasiness they may have experienced, and about whether they believed 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 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

**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 was considered by 18 psychiatrists, five specialists in clinical psychology, 12 specialty registrars and two psychologists. The outpatient clinics cover both west and east of Oslo. In this article, we have analysed 37 emergency interviews at three psychiatric outpatient clinics where the use of coercive mental health care was considered by 18 psychiatrists, five specialists in clinical psychology, 12 specialty registrars and two psychologists. The outpatient clinics cover both west and east of Oslo.
Use of coercion in mental health care. Ordinal data for the responses of 37 doctors and psychologists to questions about any doubt they might have about issues related to respect, involvement and the patient’s insight into his/her own condition.

<table>
<thead>
<tr>
<th>Question</th>
<th>Not at all</th>
<th>A little</th>
<th>Somewhat</th>
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<tbody>
<tr>
<td>Were you in doubt about your decision? (n = 37)</td>
<td>9</td>
<td>16</td>
<td>10</td>
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<tr>
<td>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)</td>
<td>3</td>
<td>6</td>
<td>5</td>
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<tr>
<td>To what extent did you feel that the patient's views had an impact on the decision? (n = 24)</td>
<td>4</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>To what extent do you think the patient felt that he/she was treated with respect during the emergency interview? (n = 36)</td>
<td>0</td>
<td>3</td>
<td>10</td>
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<td>To what extent did you feel that the patient had an understanding of the situation (disease insight/decision-making capacity)? (n = 37)</td>
<td>8</td>
<td>13</td>
<td>10</td>
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The study has been approved by the Regional Committee for Medical and Health Research Ethics, REC South-East, and all participants have provided informed consent. Statistical analyses were performed using IBM SPSS Statistics, version 21. Kendall’s rank correlation coefficient (Kendall τ) was used to describe the degree of agreement.

**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 district psychiatric centre, in three cases by a general practitioner, and in two by the patient him- or herself. In most cases, various public authorities were involved, including the police, the emergency medical services, and different treatment units within the mental healthcare services – often from various districts. In eight cases, a police report was necessary following a report by relatives, a general practitioner or others to the district medical officer. The police were directly involved in six cases.

Almost all of the patients evaluated displayed acute psychosis (36 of 37), while three were deemed at risk of suicide. Fifteen of the 37 interviews were done in voluntary hospitalisation and two in hospitalisation with coerced observation. Six patients were not hospitalised at all. In 18 of the emergency interviews, contact was established with relatives as part of the assessment. In 13 of these, the relatives believed that coercion was necessary. There was good agreement between relatives and the individual conducting the interview regarding the need for hospitalisation. The police were involved in eight cases, and in two cases, a diagnosis was made by a district psychiatrist, in three cases by a general practitioner, and in two by the patient him- or herself. In most cases, various public authorities were involved.

**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 in the patient’s current condition. The patient had a deficient social network and an unstable living situation. He/she expressed no preference for treatment or follow-up at an outpatient clinic. The goal was to establish contact with the outpatient services over the longer term, but doubts were sufficient at the present time. Ethical issues regarding the balance between insight and autonomy were highlighted. The final decision was recorded.

**Patient B** had severe psychotic symptoms, but had excellent support from competent relatives. Possible alternatives were close follow-up hospitalisation. Key factors in the final decision to opt for voluntary outpatient follow-up were the combination of supportive relatives and the patient's wish to avoid hospitalisation. The police were involved in five cases, and in two cases, a diagnosis was made by a district psychiatrist, in three cases by a general practitioner, and in two by the patient him- or herself. In most cases, various public authorities were involved.

**Patient C** had severe mental illness and a difficult living situation. The patient’s social situation was complicated and marked by conflict. The patient had severe mental illness and a difficult living situation. The patient’s social situation was complicated and marked by conflict. The diagnosis of severe mental illness and a difficult living situation was complicated and marked by conflict. The police were involved in 15 cases, and in two cases, a diagnosis was made by a district psychiatrist, in three cases by a general practitioner, and in two by the patient him- or herself. In most cases, various public authorities were involved.

**Box 2 Factors that, according to the person conducting the emergency interview, influenced the decision on coercive mental health care.**

**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
Discussion

The purpose of this study was to reveal the factors that psychiatric triage clinicians regard as important when they consider the use of coercion in cases of doubt, the triage clinicians regard as important. They highlighted the ethical dilemma that inevitably accompanies the coerced treatment of the patient that they understood his or her situation. Striving to build a good relationship is vital. 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 the patient's relatives regarding the need for hospitalisation, while having little prior knowledge of the patient's situation turned out to be 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.

**UPON VOLUNTARY HOSPITALISATION**
- The patient had previously been receiving coercive outpatient mental health care, but this had been discontinued. There were no alternatives that would have been appropriate in the situation in question.
- Assessing the degree of manic symptoms in the patient was difficult, and the patient showed little cooperation during the interview. There was also a strong correlation between beliefs and the patient's views regarding the need for hospitalisation.

**UPON COERCED OBSERVATION**
- The patient had previously been receiving coercive outpatient mental health care, but this had been discontinued. There were no alternatives that would have been appropriate in the situation in question.
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**UPON VOLUNTARY OUTPATIENT FOLLOW-UP**
- The patient had paranoid delusions, and hospitalisation was considered beneficial. The patient's opposition to hospitalisation was a result of the desire to respect the patient's autonomy conflicted with the need to use coercion to safeguard a patient who had shown signs of incapacitation.
- Those who knew the patient described symptoms of psychosis, but the patient disguised the symptoms so that they only became apparent at a later stage.

One triage clinician stated that there would always be room for doubt in emergency interviews because the interviews provide only a snapshot of the patient's condition. 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 than the police as good, saying that the police 'calmed the situation down', were 'helpful and responsive', and 'behaved in a friendly, flexible manner' in those situations that were the most unpredictable and serious.

**Factors that argued for voluntary follow-up rather than coercion**
- The patient responded positively to the proposed interventions.
- The patient-therapist relationship was strengthened during the emergency interview.
- The 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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Patients subjected to coercive care may sometimes say afterwards that they consider the hospitalisation to have been necessary. Nevertheless, use of coercive care and continue to feel that they were subjected to unfair, disrespectful and/or humiliating treatment (19). Use of coercive 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 2017, patients with the capacity to provide consent may refuse help from the mental healthcare services, unless they pose an immediate threat to 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 considered capable of providing consent, coercion may not be used to impose treatment. Self-harm that does not endanger a person's life, associated risk of relapse, are examples of such situations. Our study was conducted prior to the amendment. It will be interesting in future research 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 or 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 all reasons for your actions, take things slowly, repeat important questions and build a framework of care. Listen and take the patient serious possibility to talk about his or her situation and to express his or her views and any disagreement.

One limitation of the study is that standardised methods were not used for qualitative analysis of transcribed interviews. The outpatient care area.

Performing an emergency assessment is challenging, especially when it is unclear whether coercive or voluntary treatment is the correct course of action. Psychiatric triage clinicians to include the patient in the decision-making process. A key question is whether the doctors and psychologists in the hospital system are capable and agree with reducing the patient's experience of uneasiness, loss of integrity, and powerlessness relating to their 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 issue to focus on in future research in this area.

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LITERATURE


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