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Between authoritarian and dialogical approaches: Attitudes and opinions on coercion among professionals in mental health and addiction care in Norway

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ABSTRACT

More knowledge is needed on how to reduce the prevalence of formal and informal coercion in Norwegian mental health care. To explore possible reasons for the widespread differences in coercive practice in psychiatry and drug addiction treatment in Norway, and the poor compliance to change initiatives, we performed a nationwide survey. Six vignettes from concrete and realistic clinical situations where coercive measures were among the alternative courses of action, and where the difference between authoritarian (paternalistic) and dialogical (user participation) practices was explicitly delineated, were presented in an electronic questionnaire distributed to five groups of professionals: psychiatrists, psychologists, nurses, other professionals and auxiliary treatment staff. Non-coercive dialogical resolutions were more likely than coercive authoritative. However, there is a clear professional hierarchy with regard to authoritarian approaches, with the psychiatrists on top, followed by nurses and other professionals, and with psychologists as the least authoritarian. The majority of the respondents sometimes prefer actions that are illegal, which suggests that individual opinions about coercion often overrule legislation. The variation between and within professional groups in attitudes and opinions on coercion is extensive, and may account for some of the hitherto meagre results of two ministerial action plans for coercion reduction.

1. Introduction

The use of coercion in mental health and addiction care raises difficult ethical questions, and the views are moving towards more user participation, patients' rights, and human rights. There is growing evidence on the negative effects of paternalistic attitudes and practice (Kallert, 2008; Steinert, Noorthoorn, & Mulder, 2014; Wynn, 2006), and an increasing trend away from patient needs and towards increased security (Sashidharan & Saraceno, 2017). Over the last ten years the Norwegian health authorities have launched two action plans to reduce the use of coercion and improve quality in mental health and addiction care, but with relatively little effect (Directorate of Health, 2006; Ministry of Health, 2012). Other European countries have also deliberately tried to reduce the use of coercion in care (Steinert et al., 2014). Legislation varies widely between countries, and practice varies, also within countries (Husum, Hem, & Pedersen, in press). Furthermore, Norway with its population of about 5 million inhabitants is one of only few countries with two modes of involuntary admission in psychiatry: one for observation and one for treatment. This makes international comparison difficult. In 2015 there were 3873 approved cases of coercive observation and 3951 approved cases of coercive treatment, with a considerable geographic variation (Pedersen, Hellevik, & Skui, 2016).

The aim of this study is to describe how different professions who work in mental health and substance abuse settings perceive the necessity for use of different coercive measures. Based on six vignettes from concrete and realistic clinical situations where coercive measures are among the alternative courses of action, and where the difference between authoritarian (paternalistic) and dialogical (user participation) approaches is explored, it is the first Norwegian national survey on normative attitudes and opinions and inclinations to use coercive approaches in this field. It is also part of a comprehensive research program on *Mental health care, ethics and coercion,* based at The Centre for Medical Ethics, Institute of Health and Society, Faculty of Medicine, University of Oslo (Center for Medical Ethics, 2017).

2. Method

The Norwegian health care system is organized through four regional and 26 local specialist health care authorities plus 426 municipalities with responsibility for primary health care. We performed an anonymous electronic survey among professionals and treatment staff from all parts of the Norwegian psychiatric and addiction treatment

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system - including hospital-based wards, outpatient clinics (DPS) and municipal services. Ideally we wanted to communicate directly to all potential respondents with the possibility to allocate them to their respective workplaces, but The Norwegian Centre for Research Data (NSD, 2017) advised against identifying the workplaces geographically on a lower level than one of the four regional health authorities. For optimal dissemination of the electronic questionnaires we contacted the five most relevant professional organisations or unions, who through their respective communication systems invited and encouraged members who worked in mental health and addiction care to participate. These were The Norwegian Medical Association (psychiatrists or doctors training in psychiatry, "psychiatrists" in this article), The Norwegian Psychological Association (psychologists working in mental health and substance abuse treatment settings, "psychologists" in this article), The Norwegian Nurses Organization (nurses working in mental health and substance abuse treatment settings, "nurses" in this article), The Norwegian Union of Social Educators and Social Workers (social workers, child welfare officers and social educators working in mental health and substance abuse treatment settings, "other professionals" in this article), and The Norwegian Union of Municipal and General Employees (auxiliary nurses and others working in mental health and substance abuse treatment settings, "others" in this article).

Each organisation sent e-mails with a link to the electronic questionnaire to those members who according to their membership registers worked in relevant mental health settings, a total of 15,576 professionals (Table 1).

Since all answers where anonymous, it was not possible to send individual reminders, but the respondents seem fairly representative, with the necessary power for our analyses. The questionnaire link was open between June 16 and December 17, 2014.

2.1. Variables

2.1.1. Vignettes

The survey was built around six vignettes with clinical dilemmas, suggesting from two to five more or less authoritative/coercive action alternatives (see frame below). All respondents completed all six vignettes. The vignettes were based on descriptions of ethically challenging situations taken from focus group interviews with staff (Hem, Molewijk, & Pedersen, 2014), suggestions from a reference group that also included user representatives, and the researchers' previous knowledge and experience. On two vignettes (D and E) some of the suggested action alternatives were illegal, but this was not signaled in the questionnaire. The questionnaires were in Norwegian. For the purpose of this article, the vignettes with their action alternatives, as well as the relevant questions and answers, were translated and back-translated between Norwegian and English. The complete questionnaire (in Norwegian) can be obtained from the authors upon request. "The vignettes with their action alternatives are depicted in Box 1:

2.1.2. Demographic and control variables

In addition to profession (psychiatrist/MD, psychologist, nurse, other profession, other) the following categorical variables were included: sex, age-group (20–29, 30–39, 40–49, 50–59, 60+), years of experience (< 2 years, 2–5 years, 5–10 years, 10–15 years, > 15 years), regional health authority (RH South-East, RH West, RH Central Norway, RH North), treatment setting (psychiatry, addiction treatment), and whether the respondent was formally responsible for local coercion decisions (pertains to psychiatrists and psychology specialists only).

2.2. Statistical procedures

After having assessed the frequencies of the different action alternatives, including the verbatim suggestions, the alternatives were dichotomized into *dialogical* (usually with some degree of user participation) and *authoritative* (usually paternalistic), and the six binary variables were used as responses in six multivariable logistic models. We also calculated a *global authoritative score* by summing across all six vignettes, ranging from 0 (no authoritative actions on any of the six vignettes) to 6 (authoritative actions on all six vignettes). The distribution of this variable was close to normal, with mean 2.16 and SD 1.185.

Frequency tables, logistic regression models and error bar graphs are used for group comparisons, mainly between professions where statistically significant differences are shown either with *p*-values from chi-squared tests in contingency tables or with odds ratios with not overlapping 95% confidence intervals (fractions and means) or not including 1.0 (logistic regression models). SPSS version 24 was used for all analyses.

2.3. Ethical approval

The survey was approved by The Norwegian Centre for Research Data (NSD, 2017).

Table 1
Distributing organisations, recipients and respondents.

Organisation/union	Professions	Recipients (N = 15,576) Column percent	Respondents (N = 1160) Column percent with 95% CI *Row percent (response)*
The Norwegian Medical Association	Psychiatrists and psychiatrists in training	1812 (12%)	211 (18 (16–20)%) *11.6%*
The Norwegian Psychological Association	Selected licensed Psychologist	3928 (25%)	258 (22 (20–24)%) *6,6%*
Norwegian Nurses Organisation	Nurses working in psychiatric and addiction treatment settings	4659 (30%)	233 (20 (18–22)%) *5,0%*
Norwegian Union of Social Educators and Social Workers	Social workers Child welfare officers Social educators	2313 (15%)	286 (25 (23–28)%) 12,4%
Norwegian Union of Municipal and General Employees	Auxiliary nurses and others	2864 (18%)	172 (15 (13–17)%) *6,0%*
All		15,576 (100%)	1160 (100%) *7.5%*