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Exploring the views of people with mental health problems' on the concept of coercion: Towards a broader socio-ethical perspective

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ABSTRACT

In mental health care, coercion is a controversial issue that has led to much debate and research on its nature and use. Yet, few previous studies have explicitly explored the views on the concept of coercion among people with first-hand experiences of being coerced. This study includes semi-structured focus-groups and individual interviews with 24 participants who had various mental health problems and experiences with coercion. Data were collected in 2012–2013 in three regions of Norway and analysed by a thematic content analysis. Findings show that participants had wide-ranging accounts of coercion, including formal and informal coercion across health- and welfare services. They emphasised that using coercion reflects the mental health system's tendency to rely on coercion and the lack of voluntary services and treatment methods that are more helpful. Other core characteristics of coercion were deprivation of freedom, power relations, in terms of powerlessness and 'counter-power,' and coercion as existential and social life events. Participants' views are consistent with prevailing theories of coercion and research on perceived coercion. However, this study demonstrates a need for broader existential and socio-ethical perspectives on coercion that are intertwined with treatment and care systems in research and practice. Implications for mental health policy and services are discussed.

1. Introduction

Coercion in mental health care has been a controversial issue throughout history, leading to many debates on its nature and use (Anderson, 2014). One important challenge that is discussed in research related to coercion's outcome and moral justification is that the concept of coercion (What is coercion?) is poorly understood (Hoyer et al., 2002).

In philosophy and sociology, coercion is often a complex phenomenon that includes both external and internal psychological dimensions (Feinberg, 1986; Wertheimer, 1993). Coercion is characterised by restraining the freedom of choice or possibilities for action that compromises one's autonomy. Coercion may compromise negative freedom from external restraints or positive freedom to express one self, to define and pursue one's goals or to have opportunities to act. Involuntariness is a core aspect of coercion, i.e., when the actor (B) is *forced* to do what he does, despite his own preferences, due to pressure, threats, or conditional offers. This provides no other choice than to subdue his will or actions to the coercer's wishes due to the implied costs of non-compliance. Coercion is also related to power relations, such as powerlessness, or opposing, challenging and potentially removing the power of another through 'counter-power' (Dahl, 1957; Foucault and Faubion, 2001; Weber, 1976). Further, power refers to the stakeholders capabilities and resources, structures and hidden forces that constrain the agenda and its' alternatives, and that is ideological in nature (Lukes, 2005). These power aspects may typically influence B's baseline position and, thus, the possibilities for freely choosing (Anderson, 2014; Feinberg, 1986) and the perceived level of coercion.

Empirical research on patients 'perceptions of coercion in mental health care has also revealed coercion's complexity by expanding the earlier focus on formal legal coercion to include several formal and informal coercive practices in mental health care, and by showing that formal legal status [i.e., voluntary or involuntary admission] does not necessarily correspond to the presence or absence of coercion in the admission process. For example, there may be, 'coerced voluntary admissions' (patients feeling forced to sign in under the threat of involuntary commitment), or 'un-coerced involuntary admissions' (involuntarily

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committed patients who believe or perceived that they are being hospitalised on voluntary basis) (Hoge et al., 1997; Hoyer et al., 2002; Iversen et al., 2002; C. Lidz et al., 1998; Monahan et al., 1995).

Research on perceived coercion has added valuable knowledge to coercion in mental health care. However, the frequent use of quantitative measures has provided few qualitative details on the nature of the reported coercive incidents (Prebble et al., 2014) and, more generally, patients' views on the concept of coercion in mental health care. Further, several health studies in recent years frame treatment objections (often medication) or negative views of coercion as a lack of insight, decision-making capacity, or pathology. Although relevant, this may overlook valid insights or intersubjective truths that could warrant quality-improvement through legal reform, policy development, dialogue with the user(s), and insights that could inform theoretical and moral discussions about what coercion is and when it is justified (Diesfeld and Sjostrom, 2007; Hamilton and Roper, 2006; Lidz et al., 1995). Because the most important reason for justifying and reducing coercion is the patients' interests and because they are most directly affected by coercive acts, their views on coercion – both conceptually and morally – are of pivotal interest. Knowledge of their views is also important to ensure that we are actually talking about the same thing when discussing coercion. Furthermore, this knowledge could contribute to an increased understanding of what is at stake for the patient, what influences perceived coercion, the factors that reduce cooperation, and the advantages or disadvantages of treatment strategies. However, there is sparse research on the views of people who have mental health problems – as meaning-making actors with valid insights and legitimate claims - on the concept of coercion.

Thus, drawing on the above discussions, this paper aims to deepen our understanding of coercion in mental health care by exploring the concept of coercion from the perspectives of people who have first-hand experiences of being coerced. Further, based on the findings, we will argue for the need to develop a broader socio-ethical understanding of coercion. Finally, implications for research and mental health policy will be discussed.

2. Method

2.1. Study context and design

Mental health care in Norway is publicly funded and organised as ‘specialised health services’ – i.e. hospital trusts (hospitals and outpatient clinics) and as ‘community health services’ (general practitioners, local emergency- and home-care). Formal coercion is mainly performed within specialised health services, while community health services request involuntary hospitalisation. National statistics show relatively stable use of coercion over time. However, great variation among the hospital trusts in the use of coercion, points to different local practices (Bremnes et al., 2014).

The study is part of a large-scale project in Norway called, ‘Mental health care, ethics and coercion’ (PET), which started in 2011. This project was inspired by discourse ethics (Habermas, 1990) and aims to explore ethical challenges in relation to using coercion and user participation, from all stakeholders' perspectives.

This study used a qualitative design with individual- and group interviews across various user' and patient'- settings. Focus group interviews were chosen as the primary method to gather empirical data because group interactions can stimulate open democratic discussions about coercion (Agar and MacDonald, 1995). Individual in-patient interviews were used as a supplement.

2.2. Sample and data collection

Three, semi-structured, focus group interviews were conducted with 5–7 participants in eastern, central and northern Norway. Additionally, individual interviews were conducted with three in-patients from a psychiatric rehabilitation ward and two users who contacted us to share their views and experiences. Focus group participants were recruited and interviewed between November 2012 and May 2013, and individual interviews were completed in March and August of 2013.

The sample consists of 24 adults who have various mental health problems and coercion experiences; ten women and fourteen men, between 22 and 60 years of age. Marital and employment statuses varied, and many participants were receiving disability pensions. Participants told about mental health problems, such as psychosis, bipolar disorder, pre-natal psychosis, schizophrenia, depression and substance abuse. They had experienced involuntary commitment, forced medication, seclusion, restraints and coercive treatment in the community. Experiences varied from one recent episode to episodes years' earlier, to multiple and extensive use of coercive measures over several years. Many participants were still using services, and at least two participants were on coercive treatment in the community at the time of the interview.

2.3. Recruitment and data collection

A combination of purposive and convenience sampling was used due to challenges finding participants. Inclusion criteria were adults with first-hand experience of coercion interested in and able to attend long group interviews. Participants were mainly recruited through the *National Centre for Knowledge through Experience* (NCKE) and its network of users and user organisations. First, researchers (first author) presented the study at ongoing user-led workshops about alternatives to coercion. Then, several key users who served as ‘gate-keepers,’ locally distributed the information letter, thereby contributing to a ‘snowball-sample’ of participants. In-patients who were recruited from a hospital participating in the larger research project (PET) were included to ensure sufficient variation.

The focus group interviews occurred in a meeting room in a user-organisation's office, a county house and a hotel. They were 3 h in length and included lunch and short breaks. Individual interviews occurred in the hospital's visiting room or the researcher's office and lasted from 25 to 60 min. An interview guide was finalised by the two authors after being reviewed by the PET research group and users who collaborated in the recruitment process. The individual interviews were conducted by one researcher (the first author) and the focus group interviews by two researchers. One researcher (the first author) was the moderator and ensured that all voices were heard. The researchers supplemented each other for alertness to the group dynamic, participants' well-being and follow-up questions. The interview guide included the following main questions: What is coercion? (The main question for this paper); Is coercion right or wrong, and why?; Are there alternatives to coercion?; and What are your views on participating in care? Participants were encouraged to illustrate their views with concrete examples and experiences.

In all focus group interviews the atmosphere and discussions were good. All participants actively participated. Most participants found that the interviews were meaningful and that sharing their experiences was perceived as social support, even though some participants found it tiring. However, given the potential burden for recollecting heavy experiences, we safeguarded by seeking advice from experienced users and the NCKE. Additionally, the user organisations were a social security net. Afterwards, all participants