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Medication-Free Treatment in Mental Health Care:

Characteristics, Justification, and Clinical Outcomes

Dissertation

November 2023

Department of Psychology

Faculty of Social Sciences

Series of dissertations submitted to the
Faculty of Social Sciences, University of Oslo
No. 1012

ISSN 1504-3991

Cover: UiO.
Print production: Graphic center, University of Oslo.

Acknowledgments

The research presented in this thesis was financed by and conducted at Akershus University Hospital from 2017 to 2023. I completed mandatory doctoral training at the University of Oslo.

I would like to express my sincere gratitude to all of the people who made this PhD project possible and who supported me and my work. I want to thank our participants for sharing their thoughts and experiences. I thank all the personnel in the involved treatment services for their invaluable efforts in collecting the data as well as my managers for allowing resources to be spent on this project. I am grateful to my coauthors' valuable assistance and feedback on the papers in this thesis.

My main supervisor, Kristin Sverdvik Heiervang, provided fantastic support throughout this project. Her intelligence, experience, engagement, and empathy were all of utmost value to me. The support from my cosupervisor, Ole Andre Solbakken, was invaluable, especially his help with the statistical issues. My research coordinator Bodil Skiaker gave me some excellent assistance in data management. I am grateful to my sister, Anne Standal, for her invaluable moral support, empathy, and engagement throughout all the time I have been working on this thesis. My friend Guro Brokke Omland was a good companion in the research world and generously included me in her milieu at the university. I am also indebted to Jorun Rugkåsa and Jūratė Šaltytė Benth for their excellent help and guidance in qualitative and statistical analyses, respectively.

Oslo, November 2023

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Abbreviations

ADHD	Attention-deficit/hyperactivity disorder
AII	Affect Integration Inventory
ANOVA	Analysis of variance
CBT	Cognitive–behavioral therapy
CHIME	Connectedness, Hope, Identity, Meaning of life and Empowerment
CI	Confidence interval
CO	Colorado
CSQ	Client Satisfaction Questionnaire
CTO	Community treatment order
DSM	Diagnostic and Statistical Manual of Mental Disorders
ECT	Electroconvulsive therapy
GAF-F/S	Global assessment of functioning, Function scale/Symptom scale
IBM	International Business Machines Corporation
ICD	International Classification of Diseases
ID	Identity
IMR	Illness Management and Recovery
LMM	Linear mixed modeling
MFT	Medication-free treatment
NHO	Næringslivets Hovedorganisasjon [The Confederation of Norwegian Enterprise]
NICE	National Institute of Clinical Excellence
NOU	Norges offentlige utredninger [Norway's Official Reports]
NY	New York
OQ	Outcome Questionnaire
REK	Regional etisk komite [Regional ethics committee]
SINTEF	Stiftelsen for industriell og teknisk forskning ved Norges tekniske høgskole [Foundation for Industrial and Technical Research at the Norwegian Institute of Technology]
SNRI	Selective noradrenaline reuptake inhibitor
SPSS	Statistical Package for the Social Sciences
SSRI	Selective serotonin reuptake inhibitor
STATA	The name Stata is a syllabic abbreviation of the words statistics and data
TAU	Treatment as usual
TX	Texas
UK	United Kingdom
UN	United Nations
US/USA	United States of America
WA	Washington
WAI-SP	Working Alliance Inventory, Short Form, Patient Version
WHO	World Health Organization

Summary

Background: To improve patients' freedom of choice, Norwegian authorities have implemented treatment units devoted to medication-free mental health treatment (MFT). These units are designed to offer alternatives to medication, with the intention of being free from medication pressure and coercion while providing alternative options. This nationwide implementation is historically unprecedented and has been a source of controversy, particularly regarding the knowledge base and the appropriateness of separate units. This thesis illuminates the place for medication-free treatment units in terms of reasons for wanting this kind of treatment service, outcomes compared to treatment as usual (TAU), and the characteristics of this kind of service.

Methods: With a mixed-methods and observational design, we compared an MFT inpatient unit with two ordinary inpatient units according to validated measures of health and treatment experience for 183 participants as well as a dataset of 378 participants on the main outcome measure. In addition, we performed qualitative interviews with five patients and eight staff from the MFT unit.

Results: Our study indicated that patients desired MFT services for several reasons: they had experienced negative effects of medications and found alternatives in ordinary health care to be unavailable. Additionally, their personal values, attitudes, or beliefs influenced their preference for MFT. The health outcomes at the end of treatment were comparable to those of TAU. MFT was characterized by less focus on medications, more focus on psychosocial interventions, more support for choosing a less medication-focused path to recovery, and a more restrictive policy regarding controlled substances. More was expected of patients in terms of both activity and responsibility, which could be experienced as both empowering and/or pressure. Overall measures related to patient influence (e.g., therapeutic alliance, shared decision-making, support for personal recovery) did not differ substantially from TAU. Patients in the medication-free unit reported higher satisfaction with their treatment, which may be linked to a richer

psychosocial treatment program that emphasized patient participation and freedom from medication pressure.

Conclusions: A treatment service characterized by less focus on medications, more focus on psychosocial treatment, and more support for choosing a less medication-focused pathway to recovery could provide treatments with greater patient satisfaction and comparable health outcomes to treatment as usual. The similar health outcomes as those found in TAU were in line with previous investigations of similar undertakings, but this is the first study to compare a Norwegian MFT unit with TAU. Negative medication effects and unavailable alternatives in standard health care were important reasons for why people want such services. We need more knowledge about the long-term outcomes and the cost-effectiveness of different treatment strategies. Shared decision-making is complex; therefore, it is important to understand more about how to create a health-care system that is flexible enough to accommodate individual patients' needs. The present study contributes toward this understanding.

This project is registered in Clinical Trials (ID NCT03499080).

List of Papers

Paper 1

Standal, K., Solbakken, O. A., Rugkåsa, J., Martinsen, A. R., Halvorsen, M. S., Abbass, A., & Heiervang, K. S. (2021). Why patients choose medication-free psychiatric treatment: A mixed-method study of user accounts. *Patient Preference and Adherence*, *15*, 1647–1660. https://doi.org/10.2147/PPA.S308151

Paper 2

Standal, K., Solbakken, O. A., Benth, J. Š., Abbass, A., & Heiervang, K. S. (2023). *Are people worse off in medication-free mental health treatment than in treatment as usual? A noninferiority study of medication-free inpatient treatment in mental health care [manuscript submitted for publication*]. District Psychiatric Center Nedre Romerike, Akershus University Hospital.

Paper 3

Standal, K., Solbakken, O. A., Rugkåsa, J., Halvorsen, M. S., Abbass, A. A., Wirsching, C., Brakstad, I. E., & Heiervang, K. S. (2023). *Medication-free treatment in mental health care: How does it differ from traditional treatment?* Research Square. https://doi.org/10.21203/rs.3.rs-3038199/v2

Introduction

First proposed by Norwegian health authorities in 2009, the nationwide governmental instruction to provide specialist services devoted to medication-free treatment (MFT) is unprecedented and debates have considered its purpose and possible consequences. In the following, I will describe the MFT phenomenon, review the debate in terms of stakeholders' positions and the theoretical landscape, and review the research literature on the outcomes of different treatment options for severe mental disorders as well as the issue of choice and coercion in mental health care. Finally, I will review other treatment paradigms that downplay the role of medication.

Parts of the Introduction and Methods chapters thematically overlap with previous work on the same project (Standal, 2018a, 2018b, 2018c, 2020a, 2020b, 2021a, 2021b; Standal & Heiervang, 2018). Where the similarity to previous work is great, this is referred to explicitly in the text.

The Phenomenon of Medication-Free Treatment

The first known mention of MFT was in a presentation given by a user organization, We Shall Overcome, to a consultative parliamentary hearing in 2008, where they were presented as a measure to reduce coercion in acute care (Nyttingnes & Rugkåsa, 2021; We Shall Overcome, 2008). In 2009, a governmental task force suggested MFT as one of several measures to reduce coercion (Helsedirektoratet, 2009b) and in 2012 it was incorporated into a national strategy to reduce coercion (Det kongelige helse- og omsorgsdepartement, 2010). In 2015, each of the four Norwegian health regions was instructed to provide dedicated medication-free services (Helse- og omsorgsdepartementet, 2015a). The first MFT unit opened in 2015 (NHO Geneo, n.d.) and others followed from 2017 onward.

The purpose of MFT is to ensure that patients in mental health care, as far as clinically justifiable, have the opportunity to choose among various treatment measures, including MFT (Helse- og omsorgsdepartementet, 2015a). Some local protocols in the health regions specify

that patients in the MFT units can use psychotropics if they want (Helse Nord, 2016; Helse Sør-Øst, 2016). User organizations describe that the treatment in such units should be free from medication coercion, pressure, or persuasion (Fellesaksjonen for medisinfri behandling, 2013, February 11).

In this project, “medication-free treatment” (MFT) refers to the development of services related to the aforementioned governmental decision, which has been interpreted by both user organizations and health-care trusts to mean that the provided service is free from medication pressure and coercion, rather than free from all psychotropic medication.

The MFT services are not uniform, but most of them are localized to open inpatient wards that prioritize severe mental disorders (Standal & Heiervang, 2018). Many MFT services are influenced by the recovery tradition (Standal & Heiervang, 2018). As of 2023, only four locations provide MFT in separate treatment units (Fellesaksjonen for medisinfri behandling, 2023, February 7) and three of these units include patients with psychosis and/or bipolar disorders (Fellesaksjonen for medisinfri behandling, 2022, September 3). Earlier investigations of MFT services in Norway indicate that they are characterized by receiving more psychosocial treatment (Øvernes, 2019) and requiring more resources (Oedegaard et al., 2022; Wærness, 2019). Staff members experience a shift in emphasis toward using less medication (Wærness, 2019) and an increased focus on patient participation (Wærness, 2019; Øvernes, 2019), patients’ responsibility for their own health, and group treatment and processes aimed to advance patients’ recovery (Wærness, 2019). Some staff have reported challenges in aligning the medication-free mandate with the treatment guidelines, legal framework, and available resources (Oedegaard et al., 2022). They have also described key success factors, such as collaborating on holistic and personalized health promotion, which includes having enough time to focus on the individual. These factors are achieved to varying degrees in different treatment units (Beyene et al., 2023). Patient interviews reveal experiences of increased responsibility and freedom, a less pathologizing language, being seen as humans as opposed to being labeled,

more unity between users and personnel, and improved involvement of family, friends, and networks (Bjørgen et al., 2020).

Most inpatients in mental health care receive medications (Bjerkan et al., 2009), but there are indications that about half would be interested in an MFT alternative (Heskestad et al., 2019). Clinician accounts of patients' reasons for wanting MFT include side effects, fear of long-term harm, not feeling ill, not feeling need for antipsychotics, stigma, lack of effect, delusions, and outside pressure or recommendations (Øvernes, 2019). Patient accounts include wanting a service with less focus on medication and diagnoses, learning to cope without medication, and escaping the negative side effects of medication (Bjørgen et al., 2020).

The Debate About Medication-Free Treatment Units

Stakeholders' Positions

The decision to implement MFT units has been controversial. Nyttingnes and Rugkåsa (2021) summarized the stakeholders' main concerns as including medication coercion rates (i.e., Health Ministry), patient autonomy (i.e., supporters), and evidence-based treatment (i.e., critics). The Norwegian Health Ministry has posited the importance of MFT for reducing coercion rates and rectifying patients' negative experiences. The user coalition (Fellesaksjonen for medisinfri behandling) and MFT supporters have similar positions to the Health Ministry, but their critique of current care practices has been more pronounced. These critics have highlighted that separate units are necessary to offer real treatment choice and avoid coercive environments and argue that the MFT label is necessary to enable reluctant patients to access treatment, MFT's critics posit that there is no relevant evidence that justifies MFT, but strong evidence for the efficacy of antipsychotics. On the one hand, treatment without scientific evidence is ethically dubious and reluctance to receive medication can be driven by lack of insight. On the other hand, the critics consider that the current services provide room for patients' choice and treatment of nonresponders. Therefore, they mainly criticize the promotion of MFT as a separate health-care service. Accordingly, the separate MFT wards and the MFT label create an

unwanted divide between biological and psychosocial treatments, which might create "antipsychiatric islands" and stigmatize the use of medication (Nyttingnes & Rugkåsa, 2021).

Theoretical Landscape

According to Nyttingnes and Rugkåsa (2021), several discursive positions can be identified in the MFT debate, including biomedical, psy, antipsychiatry, recovery, social justice, pharmaceutic critical, and bureaucratic positions. I will describe the medical tradition and the recovery tradition more in depth, as these are salient forces in the field of MFT.

The Medical Model and Related Concepts In the literature, many related models are considered medical models (Huda, 2019; Mechanic, 1999; Wampold, 2001), biomedical paradigms (Ekeland, 2011), Kraepelinian/neo-Kraepelinian psychiatry (Bentall, 2003; Klerman, 1978), abnormal psychology (Seidman & Di Iorio, 2015), and the paternalistic medical model (Bentall, 2009). The common factor among these models is that they put assessment and classification of problems at the center of the clinical decision-making.

According to Huda (2019), the medical model involves assessing a patient and then making decisions and interventions based on this assessment, followed by monitoring the response to these interventions by further assessment, which may lead to changes in decisions and interventions, and so on in a cycle of assessments, interventions, and assessment of the effect of interventions. Classification of problems patients present is seen as essential for clinical practice to acquire and recall knowledge to inform clinical care and to allow communication between health-care professionals. Therefore, diagnoses are at the center of the clinical decision-making. Such models are also described as emphasizing specific dysfunctions (Wampold, 2001) and discrete disease entities (Ekeland, 2011; Klerman, 1978) with identifiable courses (Mechanic, 1999), discontinuity from the normal (Klerman, 1978; Mechanic, 1999; Seidman & Di Iorio, 2015), context-free universality (Ekeland, 2011; Mechanic, 1999; Seidman & Di Iorio, 2015), and the expert role of the health-care professional (Bentall, 2009). These depictions tend to have a biological emphasis (Bentall, 2009; Ekeland, 2011; Klerman, 1978;

Mechanic, 1999; Seidman & Di Iorio, 2015), but may also be applied to other etiologies (Engel, 1977; Wampold, 2001). Drug treatment is often considered an essential first-line intervention due to the clinical perspective of medications as specifically targeting the biological imbalances responsible for disorders (Bentall, 2009; Rose, 2003).

Newer proponents of the medical model (Huda, 2019) recognize that diagnoses are not clearly separate units sharply separated from normality with clear causal mechanisms or proven detectable differences in structure or process. However, these proponents still argue that diagnoses have predictive utility with useful information about the range of likely outcomes and effectiveness of different treatments, which may overlap but differ in terms of their probabilities according to other diagnostic constructs.

Many contemporary health-care professionals adhere to a biopsychosocial medical model (Engel, 1977) that emphasizes avoiding the reduction of illnesses to single underlying medical abnormalities. Instead, it considers the fully manifested experience of the illness, influenced by a multitude of biological, psychological, or social factors. This perspective is contrasted with a “biomedical model,” which prioritizes underlying medical abnormalities. Nevertheless, the clinician’s assessment of the patient’s illness remains crucial in deciding on appropriate treatments. Hence, this model is still connected to the broader definitions of a medical model. Moreover, it has been argued that the health-care field’s adoption of a biopsychosocial model has not led to a marked widened scope in practice. For instance, there is still a significant bias in favor of biomedical or neuroscientific explanatory paradigms (Benning, 2015).

Nonetheless, emphasizing the health-care professional’s assessment and classification for choosing the right treatment prioritizes their expert role and universal criteria that sets this tradition apart from traditions that emphasize individuality and contextuality.

Recovery Tradition Among the Norwegian MFT units, the recovery approach seems the most widespread (Standal & Heiervang, 2018) and its traditional values are also evident in the MFT debate (Nyttingnes & Rugkåsa, 2021). This approach has been characterized using the acronym CHIME (Slade et al., 2012), which refers to a focus on Connectedness, Hope, Identity, Meaning of life and Empowerment. The recovery tradition focuses on personal recovery, which is a process of recovery that is individually defined and experienced. In contrast, clinical recovery is located within an illness frame of understanding and specifies universal recovery criteria for symptomatic and functional improvement (Slade et al., 2008). The recovery tradition also highlights that clinical recovery is heterogeneous, which objects to Kraepelin's pessimistic view of the course of schizophrenia, among others. In addition, the recovery tradition emphasizes providing treatment services based on the views of individual patients rather than professional priorities. Although recognizing that medications can be an important treatment option (Mueser & Gingerich, 2011), proponents of the recovery tradition stress that it is just one of many options and the job of health-care services is not to ensure that patients take medication, whatever the cost (Slade, 2009). Slade et al. (2008) proposed the following litmus test as to whether health-care services are recovery-oriented: that is, services in which all patients are prescribed medication, in which the term "compliance" is used, in which the reasoning bias is present of attributing improvement to the medication and deterioration to the person, and in which contact with and discussion about the patient revolves around their medication issues, are not recovery-focused health-care services.

There is a tension within the recovery tradition regarding individualism, which has been the most criticized feature (Price-Robertson et al., 2017). The recovery tradition positions itself as an alternative to a "traditional approach" among others by shifting weight from professional accountability and control, which rewards passivity and compliance, to personal responsibility and self-management (Slade, 2009). Several authors have criticized the recovery tradition for placing all responsibility for change on the individual, which obfuscates environmental conditions

(Harper & Speed, 2012; Price-Robertson et al., 2017; Recovery in the Bin et al., 2019). Stickley and Wright (2011) note a shift in the literature, wherein some dissenting voices stressed that recovery is not the responsibility of the individual, but that mental health services and communities more generally share the responsibility. The user organization, “Recovery in the Bin,” distinguishes between the initial grasroots recovery movement and a newer co-opted recovery version in line with neoliberalism (Recovery in the Bin et al., 2019). Similarly, Price-Robertson et al. (2017) have proposed relational recovery, which highlights humans as interdependent relational beings. The empowerment dimension in the recovery tradition has been depicted as a focus on personal responsibility, control over life, and focusing upon strengths (Slade et al., 2012). However, empowerment can also be conceptualized as a collective political struggle for the rights of underprivileged groups (Askheim & Starrin, 2007), which entails raising awareness about connections between the individuals’ own lives and external societal conditions, as well as that others in the same circumstances may experience the same issues (Askheim, 2007). Instead of aiming to achieve the kind of “insight” that allows individuals to see the error of their ways and adjust their conduct accordingly, Smail (2005) suggests aiming for "outsight," wherein the causes of distress are demystified, and individuals' responsibility for their condition is put into its proper perspective.

Shared Decision-Making in Health Care

There is a continuum ranging from different degrees of user involvement to both informal and formal coercion. It is not uncommon for patients to experience coercion outside of formal coercion regimes, both specifically regarding medication (Blindheim, 2020; Newton-Howes & Stanley, 2012; Norvoll & Pedersen, 2016; Nyttingnes et al., 2016; Stasiulis et al., 2022) and treatment more generally (Færden et al., 2020; Hotzy & Jaeger, 2016; Newton-Howes & Stanley, 2012; O'Donoghue et al., 2014; Prebble et al., 2015). Approximately 20% of voluntarily admitted patients perceive that they are subject to some measure of force during their treatment (Prebble et al., 2015).

The Norwegian legal framework currently defines the following consequences of severe mental disorder as criteria for formal coercion: that is, the likely significant worsening of prognosis without intervention in combination with lacking decision-making capacity, or threat to own or others' safety (Mental Health Care Act, 1999a). In addition, patients have the right to participate in choices between clinically justifiable alternatives (Patient and User Rights Act, 1999b). The right to access specialist services is further regulated by evaluations of the expected utility of interventions and reasonable costs in relation to the expected utility (Prioritization Regulation, 2000).

There is widespread agreement that formal coercion is only legitimate in exceptional circumstances, according to principles of proportionality, necessity, and subsidiarity. Some argue for an absolute prohibition of coercion, as some fundamental rights should be nonnegotiable (Chieze et al., 2021). Mighty international organizations, such as the World Health Organization (WHO) (2021) and the United Nations (UN) (2006), call for eliminating practices that restrict individuals' right to make decisions for themselves and to have those decisions respected by others (i.e., in their legal capacity), such as involuntary admission and treatment. Some scholars consider informal coercion to be just as ethically illegitimate as formal coercion, sometimes even more so due to its concealed nature (Chieze et al., 2021).

Investigations of user involvement have found a low degree of involvement in both the wider health system from an observer perspective (Couët et al., 2015) and in mental health care from the perspective of patients (De las Cuevas & Peñate, 2014; Haugom et al., 2022; Royal College of Psychiatrists, 2014; Ådnanes et al., 2021) and in health personnel and services reporting of what has been done and offered (Haugom et al., 2020; Royal College of Psychiatrists, 2014; Ådnanes et al., 2021). Patients with psychosis report that having treatment choices is important (Haugom et al., 2022; Oedegaard et al., 2020), but among patients with schizophrenia, there are indications that less than half are adequately involved in their treatment decisions (Royal College of Psychiatrists, 2014).

Patients experience pressure to take medication as a common form of informal coercion (Norvoll & Pedersen, 2016) and patients with non-positive attitudes to medication perceive lower degrees of involvement in treatment decisions (De las Cuevas & Peñate, 2014). Low patient satisfaction has been reported regarding their influence on the choice of medication in acute wards (Færden et al., 2020). There are reports that medication discussions are challenging for patients with psychosis (Bjornestad et al., 2019; Blindheim, 2020) and they may not be offered any alternatives to medication (Haugom et al., 2022). Feeling that use of medication was not their choice may lead to patients wanting to quit medication (Bjornestad et al., 2019).

The literature on compulsory community treatment orders (CTOs), where medication coercion is typically an essential focus, indicates that CTOs had no beneficial impact on admission rates (Barbui et al., 2021; Barnett et al., 2018). Findings for other outcomes are scarce (Barnett et al., 2018; Kisely et al., 2017). People receiving compulsory treatment are found less likely to be victims of crime, but show no benefit to their social functioning or quality of life (Kisely et al., 2017). There are mixed results for impact on service use (Barnett et al., 2018; Kisely et al., 2017) and limited data on the effects of coerced medication specifically (Jardim et al., 2021; Steiro et al., 2018).

There is little research on effects of informal coercion (Hotzy & Jaeger, 2016; Sirotich et al., 2021). Patients' experiences of coercion are not uniformly negative, but varied and complex (Canvin, 2016; Silva et al., 2023). Patients may experience coercion as care and protection against the negative effects of their illness or as a violation of their rights and autonomy, leading to a feeling of loss of control and powerlessness (Silva et al., 2023). A review of informal coercion found attitudes were quite positive among health-care professionals as well as patients, at least when informal coercion was applied according to various aspects of patient care, such as respect for the patient's autonomy, procedural fairness, and communication transparency (Hotzy & Jaeger, 2016). However, more general investigations of perceived coercion often find that patients associate them with negative effects (Aguilera-Serrano et al., 2017; Norvoll &

Pedersen, 2016; Tingleff et al., 2017). The level of perceived coercion during admission has been found to be negatively associated with patient satisfaction (Færden et al., 2020), but not with improvement after 1 year (O'Donoghue et al., 2017). Interventions aimed at fostering shared decision-making among patients with mood disorders have been found to improve satisfaction, depression outcomes, and adherence (Samalin et al., 2018).

Health-care professionals are typically found to have a self-perception of practicing shared decision-making (Haugom et al., 2020; Seale et al., 2006). In practice, however, this happens to varying degrees (Haugom et al., 2020; Quirk et al., 2012) and their understanding of what shared decision-making entails in practice may differ (Haugom et al., 2020). For example, not using medication may not be presented as an option (Haugom et al., 2020) or they may strategically withhold information about the adverse effects of medication (Seale et al., 2006). Even in supposedly recovery-oriented services, medication choices may be restricted to which kind of medication to take and patients may be subject to leveraging, withholding of information, and being held responsible for their recovery in ways largely defined and dictated by others (Stasiulis et al., 2022).

Professionals in both MFT (Oedegaard et al., 2022) and TAU practices (Seale et al., 2006) report experiencing dilemmas with shared decision-making about medication for severely ill patients, particularly in relation to patients deemed to have compromised insight (Oedegaard et al., 2022; Seale et al., 2006), but also in relation to the treatment guidelines, legal framework, and available resources (Oedegaard et al., 2022).

Morant et al. (2016) summarized the unique features of contemporary mental health-care systems that present challenges to shared decision-making as forms of coercion, questions about insight and capacity, a short-term and risk-averse service culture that prioritizes relapse avoidance over the potential harm of long-term medication use, reliance on biomedical models of mental illness that prioritize medication and medical expertise over other treatment strategies, dominance of a disease-targeting model for psychiatric medication that may obscure alternative

explanations, professional pessimism about long-term prognosis, lack of prescriber confidence about reducing or stopping medication, the relationships of psychiatry with the pharmaceutical industry, psychiatry's (and medication's) broader societal role in regulating behavior, and resource limitations that reduce regular contact with psychiatrists. Because of these challenges, Morant et al. (2016) argued that decision-making about psychiatric medication is better understood in a broader sense that moves beyond the microsocial focus of medical consultations. Similarly, Baker et al. (2013) pointed out that psychiatrists will need professional and organizational support that recognizes that genuinely sharing decisions also requires sharing responsibility and risk.

Treatment Outcomes With and Without Medication

One of the most controversial points in the MFT debate is the evidence base for treatment with and without medication (Røssberg, 2016a; Aarre, 2014). Downplaying pharmacotherapy has been most controversial regarding psychosis and severe affective disorders, where medication traditionally has a strong standing (Helsedirektoratet, 2009a, 2012, 2013; NICE Guideline, 2022).

Comparisons between psychosocial and pharmacological treatments typically find equivalence regarding depression (Breedvelt et al., 2021; Cuijpers et al., 2023; Cuijpers et al., 2020; Kappelmann et al., 2020; Leichsenring et al., 2022). Few scholars have examined alternatives to medication for psychosis and bipolar disorder (Cooper et al., 2020; Lichtenberg, 2011; Swartz et al., 2018) and there are somewhat mixed findings regarding psychodynamic treatment for psychosis (Cooper et al., 2020; Huhn et al., 2014; Lichtenberg, 2011). In reviews regarding psychosis, some have compared treatment paradigms where medication was either absent or deemphasized, and these reviews found largely equivalent outcomes to Treatment as Usual (TAU). However, the conclusion drawn is that more research is needed (Cooper et al., 2020; Lichtenberg, 2011). For unipolar depression, several psychosocial treatment alternatives have been found to have adequate evidence (Leichsenring et al., 2015; NICE Guideline, 2022;

Parikh et al., 2016). Combined treatment is often found to be slightly superior to either treatment alone (Cuijpers et al., 2020; Leichsenring et al., 2022), although some reviews have found psychosocial monotherapy to be equal to combined treatment (Caselli et al., 2023; Cuijpers et al., 2023; Furukawa et al., 2021).

Established pharmacological agents showed symptomatic improvement compared to placebo in the short term (Cipriani et al., 2018; Goes, 2023; Leichsenring et al., 2022; Leucht et al., 2017). In the depression literature, the clinical significance of antidepressant treatment effects has been questioned (Jakobsen et al., 2020; Pies, 2012; Yapko, 2013). In the bipolar literature, evaluations of the strength of the evidence for medication vary considerably (Butler et al., 2018; Helsedirektoratet, 2012; Kadakia et al., 2021; Morsel et al., 2018; Pfennig et al., 2013).

Studies of long-term effects of pharmacological treatment have limitations and show mixed findings, hence long-term use is controversial (Alvarez-Jimenez et al., 2016; Arikan et al., 2023; Baghai et al., 2012; Belge et al., 2023; Correll et al., 2018; Goff et al., 2017; Hengartner, 2020; Moncrieff et al., 2020; Smedslund et al., 2018; Suvisaari et al., 2018; Zipursky et al., 2020). In unipolar depression, psychosocial treatment may have an advantage in the long term (Cuijpers et al., 2023; Cuijpers et al., 2020; Furukawa et al., 2021; Health Quality Ontario, 2017; Hollon et al., 2021; Qaseem et al., 2016; Spielmans et al., 2011; Voderholzer & Barton, 2016; Winter & Barber, 2013). Evidence for pharmacological maintenance treatment relies heavily on discontinuation trials, a method that has been criticized for withdrawal confounding (Cosci et al., 2020; Hengartner, 2020; Moncrieff, 2009; Moncrieff et al., 2020). Pharmacotherapy can have a wide range of undesirable and adverse effects (Bai et al., 2020; Cai et al., 2023; Ceraso et al., 2020; Correll et al., 2018; Croatto et al., 2023; Davies & Read, 2019; Hengartner, 2020; Horowitz et al., 2021; Jakobsen et al., 2020; Levenberg & Cordner, 2022; Moncrieff et al., 2020; Sinyor et al., 2020) that must be weighed against their positive effects. Even though there have been relatively few developments in the field of psychotropics in recent years, psychedelic-assisted treatment is currently resurging as a treatment paradigm showing promising but

preliminary findings (Bender & Hellerstein, 2022; Kisely et al., 2023; Ko et al., 2023; Luoma et al., 2020; Reiff et al., 2020).

Other Medication-Reduced Paradigms

Although medication has been central in western medicine's treatment of severe mental disorders since the 50s (Sohler et al., 2016) there have been several initiatives counter to this trend. Some of the most well-known are Chestnut Lodge (1920–2000) (McGlashan & Carpenter, 2007), Kastanjebakken (1977–2000) (Hauff et al., 2002), Soteria (1969–ff) (Calton et al., 2008; Mosher, 1999), and Open Dialogue (1980s–ff) (Seikkula et al., 2006). Common elements of these initiatives include their emphasis on relationships (Bergström et al., 2018; Hauff et al., 2002; Kafka, 2011; Mosher, 1999; Waugaman, 2019), flexibility and adaptation, a supportive environment, and finding meaning in individuals' experiences (Bergström et al., 2018; Kafka, 2011; Mosher, 1999; Waugaman, 2019). Although none of these treatments ban medications, they use them more sparingly than in traditional health care and believe that other elements are more central to patients' long-term improvement.

A current trend in medication-reduced treatment paradigms is the establishment of so-called deprescribing services specifically aimed at supporting patients' withdrawal from their dependence on prescribed medicines (Cooper et al., 2023). Support for deprescribing is specifically mentioned in some local MFT protocols in Norway (Helse Sør-Øst, 2016; Helse Vest, 2016). Cooper et al. (2023) identified such services in several Western countries working with patients prescribed a range of psychotropic medications. The most common practices were: i) tapering medications gradually and hyperbolically; ii) prioritizing patient preference and flexibility around tapering decisions; iii) incorporating lived experience leadership and knowledge into services; iv) providing psychosocial support for patients, such as psychological therapy, emotional support, and coping strategies for withdrawal symptoms. They emphasized the need for a holistic approach due to the complexity and difficulty of distinguishing withdrawal from relapse and the lack of official guidance on withdrawal, as well as the need to challenge

medication beliefs that have been prevalent in mainstream mental health care, such as the chemical imbalance theory (Cooper et al., 2023).

Aim of the Thesis

The overarching aim of this thesis is to examine the place for MFT units in mental health care, which is explored in terms of reasons for wanting this kind of treatment service, outcomes compared to TAU, and identification of its core characteristics.

Theme of the First Paper

Paper 1 posed Research Question 1: Why do people want MFT? People's reasons for choosing these treatment services illuminate their utility.

Theme of the Second Paper

Paper 2 posed Research Question 2: What is the outcome for people receiving MFT services compared to people receiving TAU? The answer to this question gives an indication of the consequences of MFT for health outcomes.

Theme of the Third Paper

Paper 3 posed Research Question 3: What characterizes a MFT service compared to TAU? The answer to this question shows what these treatment units might add to traditional health care.

Taken together, these three papers elucidate the place for MFT units in terms of the purpose they serve for users, consequences for important outcomes, and what they add to traditional TAU.

Methods

Theoretical Perspectives

My theoretical perspectives in this project were previously described by Standal (2021b). Using a mixed-methods design demands a point of view wherein qualitative and quantitative methods are compatible, which can take the form of an aparadigmatic stance, wherein methods and paradigms are seen as independent of each other, stances where paradigms are seen as compatible (e.g., the multiple paradigms or dialectical theses), or a paradigm that encompasses both quantitative and qualitative approaches (i.e., the single paradigm thesis). The most common paradigm in mixed-methods research is pragmatism, but other paradigms are also present within this tradition (Tashakkori et al., 2021).

My own paradigmatic stance draws on critical realism. Realism entails the ontological notion that there is a real world that exists and acts independently of our knowledge or beliefs about it but is in principle knowable and changeable. Critical realism entails a reflexivity about the conditions of possibility for thought or language to represent something outside itself. It differs from empiricism in theorizing knowledge as a social process that involves variable "means of representation" (Benton & Craib, 2011). In other words, critical realism unites the ontological conception of the existence of an objective realm of causal determinants with epistemological relativism. Concepts of truth and falsity are preserved as constraints upon our theories; however, our theoretical constructs are only "reasonable posits" about the real world (Isaac, 1990). Furthermore, one attempts to penetrate behind or below the surface appearance of things to uncover their generative causes, often termed "depth" realism to distinguish it from "empirical" realism (Benton & Craib, 2011). Reality is seen as stratified in layers where higher levels are subject to the laws of more basic levels without being reducible to them (Benton & Craib, 2011; Isaac, 1990). Higher levels can also impact more basic levels (Benton & Craib, 2011). The separation of the ontological and epistemological in critical realism arguably makes it open for methodological diversity. Hence, data are seen not merely as phenomena of interest in

themselves, but as evidence for real phenomena and processes not available to direct observation (Wiltshire, 2018).

From Theoretical Perspectives to the Choice of Methods

The Hindu parable of the blind men and the elephant (Meister, 2016) can be used to explain the implications of different world views. In this parable, each of the men touch different parts of the elephant, hence they all describe the elephant differently. In an ontological realist perspective, there is an elephant existing independently of the blind men's perception and they may touch the same elephant. In an epistemological relativist perspective, the men can never be sure they have perceived the whole elephant; therefore, their view may be more or less biased and lack important parts of the picture. In a critical realist perspective, it is possible for the men to get a fuller and more accurate picture of the elephant by exploring it from multiple angles, which is important since there is one real elephant existing and acting in their real world. Employing a mixed-methods design allows us to obtain a fuller picture of the characteristics of and justifications for MFT.

Methods and Rationale

Setting

The setting for this study was one MFT unit and two TAU units under a general university hospital in the metropolitan Oslo area in Norway. The hospital has a catchment population of 500,000 and serves both urban and rural communities. The medication-free unit is representative of such services for most common characteristics (Standal & Heiervang, 2018). It was officially opened as a medication-free unit on March 1st, 2017, and had been in operation for about 1 year at the start of data collection. The characteristics of the units are shown in Table 1.

Table 1

Characteristics of the Included Treatment Units

	Medication-free unit	Neighboring TAU unit	Distant TAU unit
Target population	People aged >18 years in need of voluntary inpatient mental health care. Exclusion criteria were active addictions, acute suicidal behavior, or acute aggressive/violent behavior		
	People with psychosis and bipolar disorder wanting MFT are prioritized	Patients needing transfer from the acute ward are prioritized	
Organizational placement	Neighboring wards under the same leadership		Different regions under the same hospital
Treatment program	Recovery-oriented treatment (Slade et al., 2012) incorporating the Illness Management and Recovery (IMR) treatment program (Mueser & Gingerich, 2011). Elements from the traditions of the affect consciousness model (Monsen & Monsen, 2000), a feedback-informed framework (Miller et al., 2015), Open Dialogue (Seikkula & Arnkil, 2013), and techniques from basal exposure therapy (Hammer et al., 2018).		Cognitive milieu therapy, network meetings, counseling and diverse group activities
Weekend policy	A 5-day unit in which patients go home for the weekend	A 7-day unit, but the main rule is that the patients go home for the weekend	A 7-day unit
Treatment duration	Typically 8 weeks	Varied, mean 4 weeks	Varied, typically 6–8 weeks
Ordinary treatment places	7	9	14

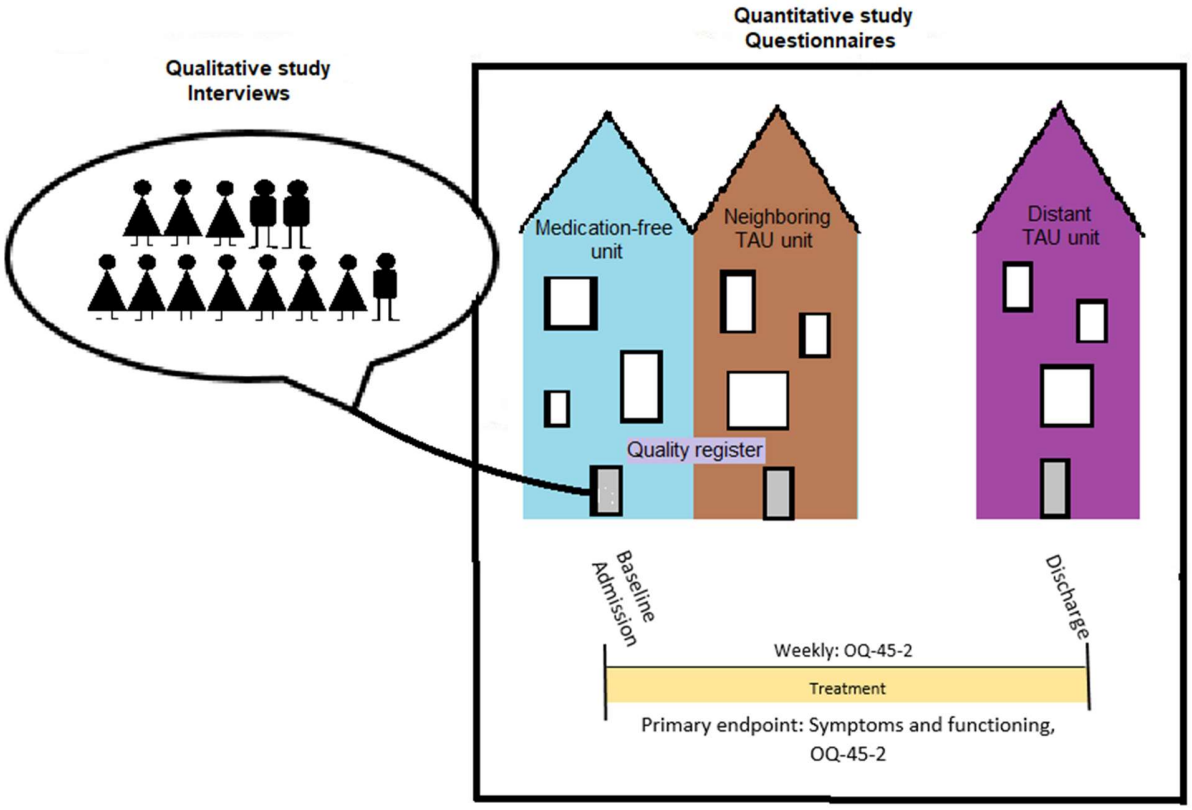
Choice of Setting. The research project was initiated by the hospital management, which made choosing the hospital's local medication-free unit and the neighboring unit natural and convenient. We decided to recruit a second comparison unit at another location, both to increase the speed of data collection, and because we expected spillover effects among the two colocalized wards. The naturalistic setting was considered necessary for capturing this new and unexplored kind of treatment service. Since the mandate was vaguely defined, many factors, such as population or treatment characteristics, were unknown or in the making.

Design

The mixed-method design was observational and pragmatic within a naturalistic treatment setting. We compared a MFT inpatient unit with ordinary inpatient units on validated and tailor-made measures. In addition, we performed qualitative interviews with patients and staff from the medication-free unit. Responses to the main outcome measure were collected from two overlapping samples: namely, the research project participants (Sample R) and a local quality register comprising two units (Sample Q). An overview of the study can be seen in Figure 1.

Figure 1

Project Overview

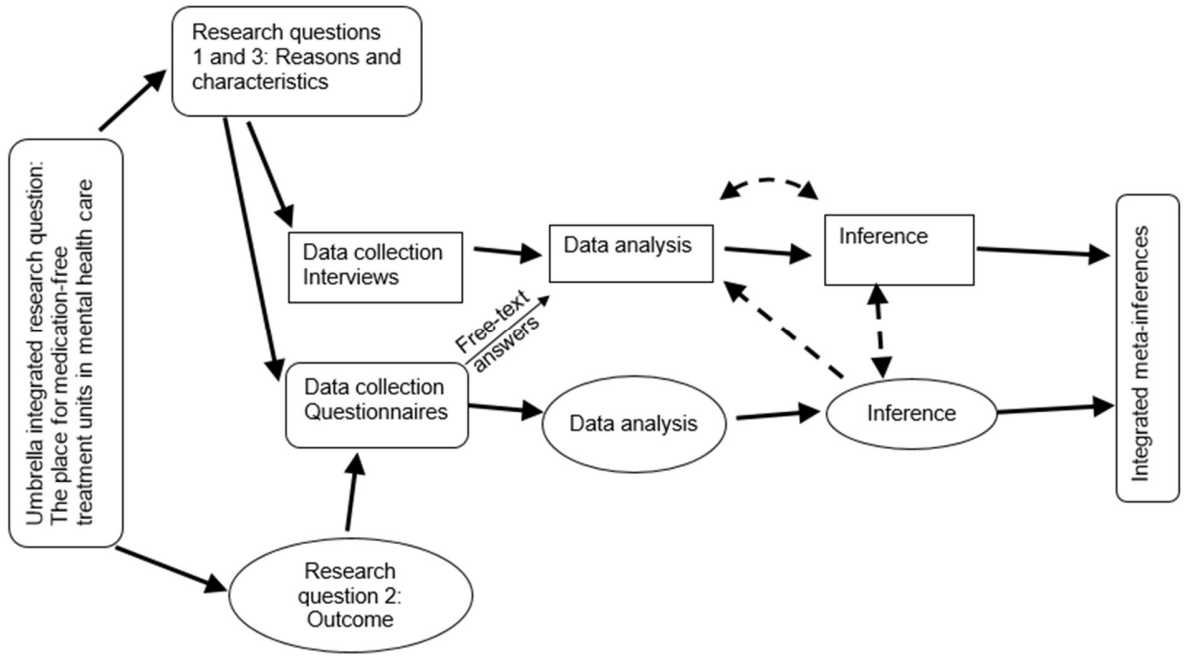


According to the terminology of Tashakkori et al. (2021), our overall mixed-methods design is parallel, signifying that the gathering of qualitative and quantitative data occurred independently of each other. The multisample design implies that the different data strands were collected from different individuals. Points of integration occurred during the analysis and inference stages. In mixed-methods studies, integration refers to the explicit conversation between (or interrelation of) the quantitative and qualitative components of a mixed-methods study (Plano Clark, 2019). We integrated the findings into meta-themes or meta-inferences based on what the inferences from the two sets of analyses indicate when taken together (Tashakkori et al., 2021).

Figure 2 illustrates the design following Tashakkori et al.'s (2021) model.

Figure 2

Mixed-Method Design



Note. Square boxes, qualitative; round boxes, quantitative; and dotted lines, feedback loops.

Design Choice The main reason we chose a mixed-methods design for this study was the complexity of the studied phenomenon. As described above, the phenomenon of "medication-free treatment units" has unclear boundaries when compared to TAU. The explorative potential of the qualitative approach, as well as including several approaches illuminating the same questions, seemed useful for capturing this new phenomenon. This mixed-methods design also seemed a suitable way for strengthening our inferences. We reckoned that integrating quantitative and qualitative approaches would provide a test of corroboration as well as complementarity. Moreover, the design enables both comparison to TAU, for which the standardized aspects of the quantitative approach are well suited, as well as an exploration of the unique aspects of this setting. The parallel design was chosen due to time restrictions.

The design had to be observational because freedom of choice is an essential goal for the MFT units. We could not control the independent variable by randomizing people to MFT or TAU; however, it is important to understand the consequences of offering alternatives and letting people choose, especially in terms of the concerns about compliance and need for coerced treatment.

Recruitment and Data Collection

This study was pilot-tested with regards to the practical procedures in week 47 and 48 of 2017. We made adjustments for better feasibility in dialogue with the treatment units and their patients. Table 2 presents an overview of the sampling procedures and data collection.

Table 2

Sampling Procedures and Data Collection

Dataset	Sample R	Sample Q	Patient interview sample	Staff interview sample
Units included	All three	MFT and neighboring TAU	MFT	MFT
Consent required	Yes	No	Yes	Yes
Other inclusion criteria	Patients on a planned stay during the recruitment period capable of completing forms in Norwegian. The exclusion criteria were emergency stays, self-referral admissions, which are shorter stays not following the standard treatment program, or inability to participate (e.g., being unable to complete forms in Norwegian)			Milieu personnel employed for a year at the time of inclusion, working full time and mainly during the day
Inclusion periods	May 2018 to April 2020, and September 2020 to March 2021, with an intermittent break due to the pandemic. Only one of the two TAU continued recruiting patients after the break	June 2017 to May 2022, but we excluded the data from the medication-free unit in the period from April to June 2021 due to a temporary shift to outpatient treatment caused by the pandemic	January to March 2018	
Sampling procedures	All eligible patients were asked for consent by treatment staff upon admission	OQ-45.2 responses were gathered as part of the treatment	All eligible patients were asked for consent by treatment staff upon admission	Purposive sampling
Data collection	Forms filled out by patients and their clinicians during the treatment period	Forms filled out by patients during the treatment period	Audio-recorded semi-structured interviews face-to-face with staff and patients with a duration of 50–60 minutes	
Sample size goal/attained	224/183	224/378	8/5	8/8
Response rate	46.2%	55.9%	Not relevant	
Types of data included	All questionnaire data	Only OQ-45.2	Audio and transcripts of interviews	

Note. OQ = Outcome Questionnaire, MFT = Medication-free treatment, TAU = Treatment as usual

Recruitment Power calculations were made according to the principles described by Julious (2004) using the Sealed Envelope power calculator for a continuous outcome noninferiority trial. We assumed a standard deviation (SD) of 15 points for the primary outcome variable (OQ-45 total distress) with a noninferiority limit of 5 points (i.e., allowing for detection of a small differential effect size between treatments). We set the statistical power at 0.80 and the one-sided significance level at 0.05. Calculations based on these assumptions yielded a total required sample size of 224. The required sample size was reached in Sample Q, but not in Sample R. Recruitment for Sample R was more greatly affected by the pandemic than for Sample Q because it required more resources.Posthoc sensitivity calculations regarding power indicate we were able to detect about medium size effects in sample R .

Recruitment for research questionnaires (i.e., Sample R) and patient interviews was done via patients' main clinician on the included wards. These clinicians had routines for informing all eligible patients about the research project and giving them consent forms to deliver within their first week of treatment. OQ-45.2 responses were collected from all patients as part of their treatment and stored in the quality register (i.e., Sample Q). We had a goal of recruiting about eight participants for each interview sample, as this was deemed a suitable size for obtaining useful data for a mixed-methods design. Recruitment for staff interviews was done purposively through their leaders. The staff delivered their signed consents to the interviewer, while patients delivered their signed consents to the nurse station.

Inclusion and Exclusion Criteria These criteria are described in Table 2. The inclusion criteria for patients were intended to capture the widest possible range of people with standard treatment stays that were comparable across units. The inclusion criteria for staff were intended to capture people with experience both before and after the introduction of MFT who had much patient involvement and could be anonymized. As previously described by Standal (2021b), we chose to include only one type of staff role—namely, milieu personnel—for the following

reasons: The feasibility of presenting anonymous results due to the limited number of individuals in other roles, the fact that these individuals had worked on the ward before the implementation of MFT (unlike psychologists and doctors who were all new), and the considerable time this group spent with their patients.

Data Collection The data collection was between methods for the most part, that is, separate data (e.g., questionnaires versus semi-structured interviews) were gathered for quantitative and qualitative analyses. However, one questionnaire contained both closed alternatives analyzed quantitatively and free text analyzed qualitatively.

The questionnaire data were collected by having patients and their clinicians fill out questionnaires at specific intervals during the treatment stay. We tried to fit the data collection into clinical routines as much as possible. For this reason, we arranged for some measures to be used both clinically and for research (see Table 4). The data used clinically were stored in the quality register.

Two members of the research group performed semi-structured face-to-face interviews with the participants. The audio-recorded interviews lasted 50–60 minutes. All participants were interviewed on the ward, and patients were interviewed toward the end of their stay.

Choice of Means for Data Collection The questionnaire format was chosen because it is an efficient way to collect large amounts of data (Judd et al., 1991) and we considered most of the population of interest would be able to answer the questionnaires. Using semi-structured interviews to collect data for qualitative analyses was considered suitable because we wanted to assess participants' inner experiences and thoughts about the subject (Blaikie, 2010). Hence a flexible interview format that both addressed important themes but also allowed for participants to express their individual concerns was considered suitable.

Recording and Data Transformation The interviews were audio-recorded. Audio files were transcribed verbatim by two coauthors. The questionnaire data were gathered on paper. Sample R was plotted by a research coordinator and research assistants, who also performed

quality checks of random samples regarding the plotting accuracy. Plotting was done using EpiData software (v. 2.2.2, EpiData, Buenos Aires, Argentina) and the files were then transferred to SPSS software (v. 26-29, IBM SPSS, Armonk, NY, USA).

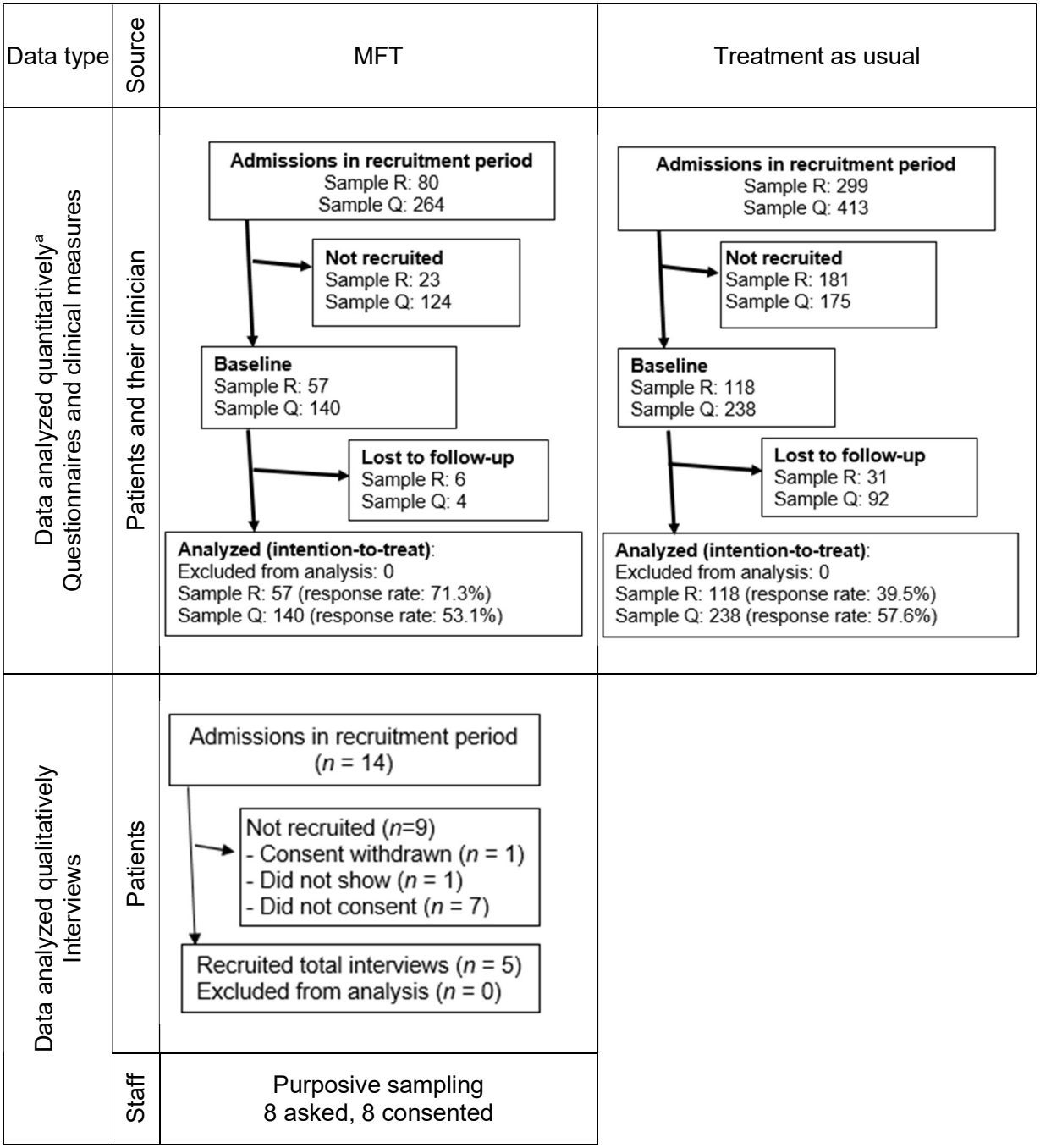
Sample Q was plotted into Excel software (v. 16.0, Microsoft, Redmond, WA, USA) by staff on the treatment units for clinical use and later transferred to SPSS software. I checked the SPSS files according to procedures for screening and cleaning the data described by Pallant (2016). In addition, I checked the consistency between answers on overlapping questions (e.g., medication and drug use). Impossible or unlikely values were checked against the paper scheme and patient journals when possible. Psychotropic drugs were grouped according to the Norwegian Medication Handbook (Foreningen for utgivelse av Norsk legemiddelhåndbok, n.d.). Missing data were retrieved from patient journals when possible (e.g., diagnoses, medications, global assessment of functioning [GAF] scores until 2020, treatment length). For the OQ-45, missing items were replaced using the expectation–maximization method in Sample R, and according to clinical scoring guidelines in Sample Q. Items in the OQ-45 in the main dataset seemed to be missing at random at the baseline and treatment termination but not at intermittent time points, as shown in paper 2. In Sample R, missing values at discharge were imputed using the longitudinal nature of the OQ-45 to generate predicted estimates at discharge within each group by using linear mixed modeling (LMM) with random intercepts for patients and fixed effects for weeks.

Samples

Figure 3 shows the participant flow.

Figure 3

Participant Flow Chart



Note. Admissions in the recruitment period were derived from anonymous statistics from the electronic patient journals containing stays in the units during the recruitment period but excluding emergency admissions and self-referral admission stays. Not recruited refers to

patients admitted during the recruitment period who did not consent or were unable to participate for any reason.

[a]The numbers are based on responses to the main outcome measure (OQ-45.2)

As shown, the recruitment for the research questionnaire sample from the medication-free unit was good with a response rate > 70% and somewhat lower in the other questionnaire conditions. Above half of those eligible declined to participate in the patient interviews, which resulted in a sample of five participants. According to informal discussions with the recruiters, the reasons for declining interviews were that there was too much going on and patients felt overwhelmed when considering also participating in the research project.

Questionnaire Samples As shown in Table 3, participants from MFT units were a little younger, fewer used psychotropics at baseline, and they scored slightly worse on the Affect Integration Inventory (AII-42) at baseline than the TAU group. Otherwise, the mental health at baseline did not differ substantially. MFT participants had treatment stays about twice as long, a larger reduction in psychotropic medication dose during treatment, and lower doses of antidepressants and antipsychotics by treatment end than the TAU group. A descriptive comparison with the available statistics on all admissions during the recruitment period (shown in paper 2 and 3) showed that Sample R was fairly representative, except that persons with psychosis and personality disorders were underrepresented by around 10% in the TAU. .According to power calculations shown in paper 3, sample Q is able to detect small effects whereas sample R is able to detect about medium effects.

Table 3

Characteristics of the Questionnaire Samples

Variables		Sample	*n* (each group)	Statistics	MFT	TAU	Difference between regimens p-value
Gender	Female		183 (59 + 124)	*n* (valid %)	42 (71.2)	72 (58.1)	0.087[a]
	Male				17 (28.8)	52 (41.9)	
Age		R	183 (59 + 124)	M (SD)	38.6 (13.1)	43.7 (12.9)	**0.013**[b]
CTOs			163 (58 + 105)	*n* (valid %)	1 (1.7)	5 (4.8)	0.324[a]
Treatment duration (weeks)			182 (59 + 123)	M (SD)	8.9 (2.2)	4.7 (2.2)	**<0.001**[b]
Psychotropics	Use of psychotropics,		183 (59 + 124)	*n* (valid %)	46 (78.0)	113 (91.1)	**0.008**[a]
	Dose change		182 (59 + 123)	M (SD)	−0.4 (1.2)	0 (1.2)	**0.040**[b]
	End dose: Anxiolytics/hypnotics		182 (59 + 123)		0.4 (0.8)	0.4 (0.7)	0.947[b]
	End dose: Antidepressants		182 (59 + 123)		0.5 (0.8)	0.9 (1.0)	**0.004**[b]
	End dose: Hyperkinetic disorders/ narcolepsy medication		182 (59 + 123)		0.1 (0.3)	0.0 (0.2)	0.697[b]
	End dose: Antipsychotics		182 (59 + 123)		0.2 (0.4)	0.5 (0.8)	**0.001**[b]
	End dose: Mood stabilizers		182 (59 + 123)		0.2 (0.4)	0.3 (0.6)	0.183[b]
Diagnoses	Psychosis		182 (59 + 123)	*n* (valid %)	9 (15.3)	12 (9.8)	0.277[a]
	Bipolar		182 (59 + 123)		8 (13.6)	20 (16.3)	0.636[a]
Mental health at baseline	OQ-45.2	Q	175 (57 + 118)	M (SD)	99.3 (21.1)	96.1 (23.1)	0.372[b]
			282 (111 + 171)		99.1 (21.0)	95.3 (27.9)	0.198[b]
	AII-42		173 (56 + 117)		4.1 (1.2)	4.5 (1.2)	**0.045**[b]
	GAF-S	R	177 (58 + 119)		52.1 (8.6)	50.8 (6.3)	0.252[b]
	GAF-F		177 (58 + 119)		49.8 (8.5)	50.9 (6.6)	0.324[b]

Note. MFT = medication-free treatment; TAU = treatment as usual; CTO = Community treatment order; dose = number of defined daily doses according to WHO; OQ = Outcome questionnaire; AII = Affect integration inventory; GAF-S/F = Global assessment of functioning, function and symptoms scale

[a]χ^2 test

[b]independent samples *t*-test

Patient Interview Sample

Two patient participants were men and three were women. They ranged in age from 25 to 50 years, and included people born in Norway and elsewhere. One of the participants had

never used psychotropic medication. The rest had attempted to stop taking psychotropic medications, either during the current stay or previously. Four of the five patient participants were not taking medication at the time of the interview. The patients mentioned the following medication groups: selective serotonin reuptake inhibitors (SSRIs), serotonin and noradrenalin reuptake inhibitors (SNRIs), anxiolytics, hypnotics, antipsychotics, and beta-blockers. Four patients had previously ever been admitted to an open psychiatric ward. Their diagnoses were not recorded to protect their anonymity.

Staff Interview Sample

Seven of the eight participating staff were women and one was a man. Five were nurses or assistant nurses and the other staff had other professional backgrounds, which we did not report for confidentiality reasons. They had an average of 14 years' experience in mental health care and 12 years in this treatment unit, ranging from a few years to several decades.

Data

Table 4 provides an overview of all data used in this PhD thesis, specifying sources and timing.

Table 4

Overview of data

	Baseline	Weekly during treatment	End of treatment
Patient	- OQ-45-2[a, b] - AII-42[b] - Medsupport question 7[c] - Reasons MFT - Age - Gender - CTO - Medication use	- OQ-45-2[a,b]	- OQ-45-2 - Collaborate - CSQ-8 - Medsupport question 7 - WAI-SP - INSPIRE - Treatment received - Interviews with patients on medication-free unit
Clinician	Clinician - Medication use - GAF		Clinician - Medication use - Diagnoses - Treatment received
Staff	- Interviews with staff on medication-free unit		
Patient journal	- Anonymous statistics from patient journal for analysis of response rate and representativeness: number of admittances, lengths of admittances, main diagnoses, gender and age		

[a]Obtained from both sample R and Q, overlapping data

[b]Also used clinically

[c]Regarding treatment received 6 months prior to admission

Data Collected from Questionnaire Sample. Reliability of multi-item scales using Cronbach's α ranged from .899 to .956.

Primary Outcome: Severity of Symptoms and Functioning. The Outcome Questionnaire-45 (OQ-45.2) was developed to track outpatients on a weekly basis. It measures symptom distress, interpersonal functioning, and contentment with social role functioning, areas widely recognized as the essential ingredients of interest when assessing patient improvement. The questionnaire is considered suitable for patients with a wide range of diagnoses, sensitive to change over a short period of time, and brief and easy to administer (Lambert et al., 2001). Support has been found regarding construct and concurrent validity (Amble et al., 2013; Lambert et al., 1996), ability to discriminate between clinical and nonclinical samples, and detection of

changes in distress during treatment (Lambert et al., 1996). The Norwegian version was found to have adequate reliability (i.e., internal consistency and test–retest) and concurrent validity (Amble et al., 2013). As the factor structure on the OQ-45 is questionable (Amble et al., 2013; Mueller et al., 1998), we used the total score.

Affect Integration Inventory. The Affect Integration Inventory 42 (AII-42) is a short version of AII, a medium-length (112 items) self-rated assessment instrument that endeavors to measure capacities for experience and expression of nine affect states. These are important parts of the affect integration construct, the capacity to utilize affects for personal adjustment. Solbakken et al. (2017) have found satisfactory reliability (i.e., internal consistency), sound internal structure, and associations with external criteria, indicating good convergent and discriminant validity.

Function and Symptoms. The GAF scale is one of the axes in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) from DSM-III-R (Karterud et al., 1998) until DSM-5. The multiaxial system was discarded in DSM-5 (Kress et al., 2014). From 1998 to 2020, Norwegian health authorities recommended all health institutions to use a minimum set of basic data, which included a split version of GAF called S-GAF (Karterud et al., 1998; Lie, 2019). Patient scores are ranged on two scales from 0–100 regarding their symptoms and functioning. While the psychometric properties of GAF are disputed (Kress et al., 2014; Lie, 2019), the measure is short, widely applied, and was mandatory in hospitals at the start of the recruitment period.

Working Alliance Inventory. The short form patient version of the Working Alliance Inventory (WAI-SP) is a measure of therapeutic working alliance that assesses three aspects of collaborative purposive work in therapy (i.e., bond, task, and goal), as well as a general factor. (Tracey & Kokotovic, 1989). The WAI has been found to have adequate internal consistency and reliability, and is correlated with a variety of counselor and client self-reported outcome measures and other relationship indicators, indicating convergent, concurrent, and predictive

validity (Horvath & Greenberg, 1989). Validity is further supported by finding a factor structure in line with the definitions in the literature (Tracey & Kokotovic, 1989).

Being respected for not wanting medication. Medsupport is a questionnaire about the perceived quality of help and information regarding medication (Drivenes et al., 2020). In this article we use question 7 from the original version ("('I have been respected for my wish not to use medication'). For this question, we also included ratings of treatment 6 months before admission for both groups combined to indicate the prevalence in mental health care more broadly.

Staff Support for Personal Recovery. The INSPIRE support scale (Version 3) assesses perceived staff support for personal recovery domains considered important to the individual. The scale has demonstrated adequate psychometric properties regarding convergent validity and internal consistency reliability (Williams et al., 2015), but the factor structure is disputed (Šaltytė Benth et al., 2023; Williams et al., 2015).

Collaboration Between Patients and Staff. CollaboRATE is a 3-item measure for three core shared decision-making tasks: (1) explanation about health issues, (2) elicitation of patient preferences, and (3) integration of patient preferences into decision-making processes (Barr et al., 2017). Adequate discriminative and concurrent validity, excellent interrater reliability, and sensitivity to change have been reported (Barr et al., 2014) as well as the reliability of ranking clinician performance across administration modes (Barr et al., 2017).

Satisfaction with Treatment. The Client Satisfaction Questionnaire-8 (CSQ-8) is an eight-item questionnaire for measuring patients' global satisfaction with health-care services. The CSQ-8 has been shown to correlate well with the longer version (i.e., CSQ-18) and has shown good psychometric qualities regarding internal consistency, attendance, remainer–terminator status and greater client-reported symptom reduction (Attkisson & Zwick, 1982). Validation of the CSQ-8 in a Norwegian mental health-care setting has found support for validity

and reliability with a high internal consistency and a small to moderate relationship with change in symptom severity, but with possible ceiling effects (Pedersen et al., 2022)

Treatment Received. At the end of treatment, patients are given a form adapted from Ruud and Reas (2002) regarding what treatments they received during their stay and related benefits. The clinicians are given a form adapted from Ruud et al. (2006) regarding the treatment provided including a question about the duration of treatment (i.e., number of weeks).

Background Data. Data on age, gender, CTOs, diagnoses (International Classification of Diseases, 10th revision [ICD-10]), and medication use were obtained from questionnaires completed by the research participants and their clinicians. Anonymous hospital statistics about the treatment units regarding number of admittances, lengths of admittances, main diagnoses, gender and age were collected from hospital registers for investigation of representativeness and response rates.

Request for Medication-Free Treatment and Reasons. A questionnaire to patients about whether they wanted MFT and why (i.e., alternatives and free text) was administered at baseline.

Data Collected From Interview Samples An interview guide for patient interviews was developed collaboratively by the authors of Paper 1 and was inspired by a previous study of medication-free services (Ødegaard, 2018). We selected questions that we considered to facilitate patients' descriptions of their understanding and expectations of MFT and their attitudes about this treatment approach, as well as whether and why MFT was important for them, how the treatment compared with their other treatment experiences, and whether and how they experienced the shared decision-making process. The questions were formulated with a direct approach to the areas of interest and examples were elicited when possible. The semi-structured format included follow-up questions to be asked when something was unclear or of interest for a deeper exploration. One pilot interview was performed, leading to minor adjustments in the formulation and order of questions.

An interview guide for staff interviews was developed collaboratively by the authors of Paper 3 and Odd Arne Tjersland, Brakstad's supervisor. We selected questions with the potential to illuminate how staff participants view, understand, and experience the medication-free mandate compared with more traditional approaches. The interviewer deliberately followed the participants' lead to a large extent to capture their concerns but also made an effort to address the main themes from the guide during the interviews.

Analyses

Quantitative Analyses

Numerical questionnaire data were analyzed using IBM SPSS Statistics (v. 26-29; IBM SPSS) software for all papers and STATA (v. 17; StataCorp, College Station, TX, USA) software was also used for Paper 2. The descriptive data were reported as frequencies and percentages or means (M) and SDs, as appropriate. Paper 1 contained only descriptive statistics, whereas paper 2 and 3 contained more advanced test that are discussed below. The significance level was set to 0.05 for all analyses.

Our project employed the following parametric tests: *t*-tests, one-way between groups analysis of variance (ANOVA), multiple regressions, and LMM for continuous variables; as well as the nonparametric χ^2 test for categorical variables.

Assumptions of Parametric Tests The assumptions of parametric tests include a continuous dependent variable, randomly sampled independent observations, a normal distribution of residual scores on the dependent variable, and homogeneity of variances. (Kéry & Hatfield, 2003; Pallant, 2016). In addition, the regression models require assumptions regarding sufficient sample size according to the number of variables, no singularity (i.e., one independent variable was actually a combination of other independent variables) or multicollinearity (i.e., independent variables are highly correlated), no extreme outliers, and assumptions of linearity and homoscedasticity of variances (Pallant, 2016). The noninferiority analysis in Sample R was amenable to LMM, since we obtained repeated measures as well as information about the total

treatment duration. LMM allows for relationships that are not strictly linear and data that have dependency (He & Lao, 2018), and is relatively robust regarding violations of distributional assumptions (Schielzeth et al., 2020). This analysis was deemed suitable because it allows for modeling individual-level trends over time and can use all available data due to its flexible treatment of time (Kwok et al., 2008).

Our samples are much larger than 30; therefore, violations of normal distributions should not cause major problems (Pallant, 2016). However, the distributions were assessed graphically by inspecting the histograms in Paper 2 and by sensitivity analyses without outliers in Paper 3.

The common statistical assumption of random sampling from the population was violated due to the following conditions: only selected units participated in the study, the research project participants were required to provide their informed consent and they had to be capable of being interviewed and/or completing forms in Norwegian. This violation is common in real-life research (Pallant, 2016). However, as previously pointed out by Standal (2021a), according to Frick (1998), a process-based interpretation may make more sense. That is, the research claim is not about the relation between our sample and a hypothetical population of interest, but rather about the *reason* for the differences observed in our sample. According to a process-based interpretation, statistical tests establish findings that only apply to the tested subjects. These findings can be used to support more general claims via induction.

The assumption of homogeneity of variance was corrected with Levene's test when using *t*-tests. In ANOVAs, the Brown-Forsythe test was employed for scewed variables violating Levene's test and Welch test was employed for non-scewed variables violating Levene's test. This assumption was not violated in the other analyses.

The assumption of independence of observations may not be fulfilled since the patients were treated in a group setting. However, in inpatient treatment, the group dynamic can be considered reflective of the intervention, as various treatment regimens may foster different dynamics, and the increase in social support is a significant aspect of inpatient treatment.

However, there is a chance that individuals with an unusual impact on the group may randomly influence some patient cohorts.

Multiple regression models have restrictions on the number of variables that can be included in relation to sample size for maintaining generalizability (Pallant, 2016). As the details of the regression models were worked out after data collection, we chose the number of covariates according to sample size to exceed 10 cases per variable.

Singularity was not an issue. Multicollinearity was assessed using correlation analysis. Standard residual diagnostic tests were performed on level one (i.e., variation between time points) and level two (i.e., variation between patients). Homoscedasticity of variances and linearity was judged by scatterplots between the standardized residuals and fitted values. No substantial violations were found.

Assumptions of Nonparametric Tests The χ^2 test was used for categorical variables. This is a nonparametric test that compares the observed frequencies or proportions of cases that occur in each categories with the values that would be expected if there was no association between the two variables being measured (Pallant, 2016). The χ^2 test requires the lowest expected frequency in any cell to be five or more, which was fulfilled in most comparisons. There were too few clinician reports from the distant TAU unit to run all ward level comparisons regarding treatment with medication. We had sufficient reports from patients on the same matter.

Paper 2 The noninferiority analysis was performed for both Samples R and Q, whereas the multiple linear regression and diagnostic subgroup analysis was performed for only Sample R. These data analyses were based on the intention-to-treat principle, except for the sensitivity test specified. The primary outcome, namely, general psychological distress according to the OQ-45.2, was assessed before, during, and at the end of treatment.

The primary noninferiority analysis assessed the difference between the groups in changes from baseline to discharge on the OQ-45.2 using a two-sided 90% confidence interval

(CI) from independent samples t-tests against a noninferiority margin of −5 points. Identical analyses were performed on both datasets. In Sample R, the missing values at discharge were imputed by employing session-by-session data from OQ-45.2 and generating the predicted estimates at discharge within each group using LMM with random intercepts for patients and fixed effects for weeks. Sample Q included no information about treatment length nor designated endpoint measure; therefore, we used the first and last obtained measure as the start- and endpoint. The last measure was typically delivered 1 week before discharge. In cases with only one assessment, the last observation was carried forward. In addition, as a test of sensitivity, a noninferiority analysis of Sample Q was also performed after excluding cases with only one assessment, since these were unevenly distributed among the conditions (92 TAU vs. 4 MFT), while this was true for a total of only eight cases in Sample R).

A multiple linear regression model including patients with no missing data for the covariates was estimated to explore the association between outcomes and preselected covariates (e.g., medication use, treatment duration, age, gender, psychosis, and bipolar diagnosis) in Sample R. The outcomes among those with either psychosis or bipolar diagnosis were compared between regiments using independent samples t-tests in Sample R.

Paper 3 The differences between groups were identified using independent sample t-tests (sample characteristics) and one-way between groups analysis of variance (ANOVA) (treatment characteristics) for continuous variables and $\chi 2$ tests for categorical variables. Although our interest was in differences between regimens, we also performed supplemental ward level analyses to more robustly assess the degree to which medication-free treatment stands out. We expected there could be spill-over effects between the neighboring wards. Sensitivity analyses without outliers were performed to assess the impact of outliers. We performed posthoc sensitivity calculations with the program G*Power v. 3.1 (Faul et al., 2009) on the nonsignificant results indicating that we had adequate power to detect about medium sized differences.

Qualitative Analyses In Paper 1, the qualitative interview data were analyzed using thematic analysis (Braun & Clarke, 2006) and in Paper 3, a combination of thematic analysis and systematic text condensation (Malterud, 2012) was employed.

Thematic analysis involves flexible stepwise analysis wherein, after familiarization, the data are first coded in terms of their basic meaning units and these codes are then sorted into broader themes (Braun & Clarke, 2006).

As the interviews were performed by other research group members, analysis approaches suitable for completed data collection were the most feasible. In line with a critical realist perspective, my aim was to grasp the participants' actual thoughts and experiences, rather than study how they talked about or construed their experiences in the research setting. Hence, I considered thematic or interpretative phenomenological analyses as possibly relevant approaches instead of more discursive approaches. Braun and Clarke (2006) recommended thematic analysis as the first qualitative method for analysis that researchers should learn because it provides core skills that will be useful when conducting many other forms of qualitative analysis. In addition, my interest in each individual's experiences was more as a means for arriving at patterns and themes across or independent of individuals, rather than each experience in themselves. Therefore, I judged thematic analysis as being a good place to start. Later in the process, I supplemented thematic analyses with the systematic text condensation technique (Malterud, 2012) to aid the carving out of themes across patients and staff.

I used the NVivo program (v. 12-14, Lumivero, Denver, CO, USA) to support the analyses. I first read the transcripts and listened to the audio files to both familiarize myself with the material and check whether I agreed with how the interviews were transcribed and whether the audio aided my understanding of the material. I made a few minor changes to the transcripts. I then predominantly coded the transcripts inductively, which meant that I tried to code the data without trying to fit it into a preexisting coding frame or my analytic preconceptions (Braun & Clarke, 2006). I grouped the codes under my research questions while I was coding, but also

coded things that did not readily fit under my questions. I chose to do it this way because I reckoned that I might not immediately see what could be relevant and I might find some connections at a later stage of the analysis. I then focused on the research questions of each paper. I collated the codes into themes under each research question, which were then refined hermeneutically. The codes were sorted into broader themes separately for the patient and staff data. Considering Paper 3, the data in each theme were then condensed into artificial quotations that contained the meanings from the original quotes (Malterud, 2012). These condensates from the patients and staff were combined into higher-level themes through an iterative process that involved the coauthors. Disagreements were resolved by going back to the transcripts and discussing and reflecting upon them among the coauthors. Ultimately, I made the final decision given that it could be accepted by the project leader and coauthors. Finally, I revisited the transcripts to check whether the final themes resonated with the data.

A common challenge for both research questions that were addressed qualitatively was that the MFT concept appeared to not be clearly delineated. The MFT units can be understood as spearheading a desirable development for mental health care in general which is improving shared decision-making, especially regarding medications. All patients in mental health care have the right to choose MFT as long as it is clinically justifiable (Helse- og omsorgsdepartementet, 2015b). Patients in MFT units can use medication if they wish and if it is justifiable clinically (Helse Nord, 2016; Helse Sør-Øst, 2016). Therefore, it is not necessarily a clear-cut difference in what kind of treatments patients may receive from MFT or TAU and it remains an empirical question how much their treatment conditions differ in practice. Hence, the MFT concept functions as a “sensitizing concept” in our study (Blumer, 1954). According to the sensitizing tradition, researchers set out with a loosely defined concept that is refined during the course of their research (Blaikie, 2010). Hence, the characteristics of MFT are explicitly our object of study in Research Question 3. Therefore, I approached this issue somewhat differently in Papers 1 and 3. In Paper 1, my initial focus was broad, addressing Research Question 1:

'Why do people choose MFT?' I explored individuals' reasons for coming to the medication-free unit, their concerns upon arrival, and experiences that could shed light on these concerns. Initial findings were that it was not possible to clearly separate reasons for wanting MFT from other reasons in the interviews (e.g., wanting specific treatment elements), as the participants considered all these reasons to be intertwined. However, the quantitative findings showed that the majority reported medication-related reasons, which is close to the core of the mandate for MFT services. Hence, medication issues were considered important. We decided to narrow our focus to the concerns and experiences explicitly related to psychotropic medication to illuminate the reasons that could be readily attributed to the official mandate of MFT units. In Paper 3, Research Question 3 focuses on what MFT is compared with TAU services. Therefore, I chose a more inclusive approach, where all distinguishing features of the MFT units were included in the findings. These features were discussed later regarding whether and how they might be linked to the medication-free mandate.

Integration of Results The integration of qualitative and quantitative findings was informed by the approaches of Farmer et al. (2006); O'Cathain et al. (2010); Tashakkori et al. (2021) and Schoonenboom and Johnson (2021). We compared findings from different sources to investigate their convergence, divergence, or complementarity. Visual aids, including joint displays, were used to depict, juxtapose, and analyze the data (Schoonenboom & Johnson, 2021; Tashakkori et al., 2021). Consequently, these aids were used to formulate integrative statements across all results.

I first analyzed the quantitative and qualitative data separately but allowed the analyses of each strand to inform each other. These analyses were conducted in parallel and the interchanging influences could go both ways, which mostly manifested as exemplified above regarding delineating Research Question 1. I then produced visual displays for all the themes addressed or identified in the data and the findings from each strand. I compared the findings to identify whether they seemed to corroborate, diverge from, or complement each other. I

developed integrative statements or meta-themes from these analyses, that is, I described the findings to reflect the analysis of all data seen in relation to each other.

Reflexivity

Reflexivity is a form of critical thinking that aims to articulate the contexts shaping research processes and subsequently the knowledge produced (Lazard & McAvoy, 2017). As previously described by Standal (2018c), critical realism implies that totally neutral, objective interpretations are impossible, regardless of how detached the researcher might be. To make sense of my own perceptions, I must construct interpretations of the data using my experiences and mentalization. My horizon of understanding is my tool, but it also represents my limitation; that is, I can examine my horizon, but not be outside of or independent of it. My position as an ontological realist means that there is a truth to which my interpretations can more or less correspond; therefore, my perspective can be biased. Being aware of what influences my thinking alleviates these obstacles, although they are never eradicated completely.

My preunderstanding

I was initially positive about strengthening alternatives to medication because I have experienced some therapeutic milieus in mental health care as being too dogmatic about this issue. I have experienced that people can have varied responses to psychotropics. My university training in psychology has shaped me in a direction that is less medically oriented than many hospital milieus. Having been exposed to these tensions in the field of mental health has given me an understanding of some of the forces that may be at play in the processes that culminated in the establishment of MFT. As I often have found myself in opposition to a more medical perspective in addition to initially supporting the MFT initiative, I must be aware of my possible biases in that direction. However, I may also be shaped by the medical paradigm that has strongly influenced Western cultures. The Western medical tradition acknowledges human limitations to a greater extent than some of its alternatives, providing one way to alleviate individuals' burden by offering refuge into a 'sick role' (Klerman, 1978). I have been skeptical of

approaches that strongly stress individual responsibility, as some parts of the recovery tradition have been criticized for (Harper & Speed, 2012; Price-Robertson et al., 2017; Recovery in the Bin et al., 2019), agreeing that these approaches may become unbalanced. My clinical experience and knowledge more generally have further alerted me to the importance and complexities involved in forming therapeutic alliances. This knowledge has alerted me to explore the feelings of being on the same page and being supported in the chosen paths, as well as the significance of values, attitudes, and beliefs.

Social Influences

I was employed as a developer and adviser at the inpatient treatment unit (i.e., the MFT unit and neighboring TAU unit) from July 2016 to April 2017 and was involved in the planning process for developing the MFT unit. I am currently still employed in the same department of the hospital. As previously described by Standal (2018c), according to Brannick and Coghlan (2007), insider academic research is commonly considered problematic because various issues, such as personal stake, substantive emotional investment in the setting, and asymmetrical power relations may distort the data collection (Anderson & Herr, 1999). Brannick and Coghlan (2007) argued that the insider stance can be turned into a resource through a process of reflexive awareness, which can enable us to articulate our tacit knowledge that has become deeply segmented because of our socialization within the organizational system of health-care services.

Having worked at the treatment units for a short time places me in a position somewhere between insider and outsider perspectives. My continued work within the organization provides me with insider knowledge about the broader context of the health-care services. This perspective may offer a richer background for understanding the data and has helped me pinpoint some important questions for which we need answers (Standal, 2018c). As I worked in the units for such a short period and the MFT unit has evolved a lot since my time, I do not feel any personal ownership of the MFT program. However, having a personal relationship with

people working in the studied units may make it harder for me to consider the data critically. Therefore, I had to be reflexive about considering this potential bias when conducting my research.

Managing Personal and Social Influences

I have taken care to reflect on possible influences from early on in the research process and seize opportunities to discuss my research in different milieus and environments. I have followed the MFT debate and tried to understand different positions within the debate and their scientific and ethical foundations, as well as expose my own positions to counterarguments. I have been cognizant of what roles I take within the organization, such as not being the one who decides which patients receive MFT during the data collection. I have discussed the modes of data analysis and interpretations of the data among my coauthors. The statistician was not involved in the milieus where MFT was discussed. Otherwise, most coauthors shared a positive inclination toward MFT, but were from different professions, positions, and locations. When any questions or disagreements emerged, I took care to revisit the data to check my interpretations, which were discussed and reflected upon among the research team.

Ethical Considerations

The research study was approved by the Regional Committee for Ethics in Research (REK, 2017/1056/REK Sør-Øst B), as well as by the Privacy Ombudsman at Akershus University Hospital (17-134). This study was performed in accordance with the ethical standards laid down in the 1964 Declaration of Helsinki and its later amendments. All participants in the research project gave their informed consent prior to their inclusion in the study, including their participation and publication of their data. The quality register did not require informed consent or REK approval but was approved by the Privacy Ombudsman at Akershus University Hospital (25-2018), including approval for the publication of anonymous results.

This project contributes to the improvement of health-care services for people with mental illnesses. However, some patients may experience the data collection as a burden, while

others may view it positively. Some of the data were also actively used for clinical purposes; hence, the data collection can therefore be said to benefit each participant directly. While the data collection did take some time away from clinicians' clinical work, we strove to hold this interference with usual processes to a minimum.

The recruitment of patients through clinicians was performed for feasibility but may entail ethical dilemmas since these clinicians are in a position of power relative to their patients. Hence, we took care to instruct the clinicians that their patients' consent must be given freely and made it clear that consenting or declining to participate in the research project would not have any consequences for them, including their treatment. This was also explained clearly in the informed consent forms. While staff recruitment through their leaders entails similar ethical dilemmas, the staff gave their final informed consent to their interviewers; therefore, they could withdraw from the research project without involving their leaders. We also took care that no one working on the wards had access to the raw data to protect their anonymity.

Questions about health and treatment experiences have the potential to stir up difficult feelings. The interviews with patients were intentionally performed during their admission to the hospital so that they could easily access support from health-care professionals if needed. Likewise, the initial questionnaires were completed during patient admission, but the follow-up questionnaires were sent to their homes. This way, patients could become familiar with the questionnaires during their admission, presumably reducing the risk of any negative reactions. All participants had the opportunity to contact the researchers to ask questions and could withdraw from the research project at any time.

Results

Here, I briefly summarize the three papers included in this thesis.

Paper 1

This paper examined why patients chose medication-free services. Forty-six participants completed the questionnaires, and five participants were interviewed in a mixed-method design integrated with a concurrent triangulation strategy that applied thematic analysis and descriptive statistics. The paper included data from the patient interview sample and questionnaire sample R from the MFT unit.

The results drawn from Paper 1 indicated that negative effects of medications and unavailable alternatives to medication in ordinary health care were important reasons for the desire for MFT. These negative effects included emotional flattening, feeling “zombielike” or “less human,” feeling empty and tired, having suicidal thoughts, and beginning to abuse the medicine. Difficulty in obtaining alternatives to medication included experiences with pressure, lack of alternatives, not being respected for not wanting medication, and needing help with medication withdrawal. The use of medications may also conflict with the patients’ personal values, attitudes, or beliefs, including notions of recovery in conflict with medication use (e.g., dialogic and containing relationships with health-care providers, belief in better therapeutic processes without medication) and the meaning attached to not using medication (e.g., strength, acceptance, wanting to cope in other ways, worries).

In conclusion, this study has expanded our understanding of the emerging demand for separate MFT units. The research highlights a perceptual gap between service users and critics of MFT regarding the availability of medication-free treatment for those who desire it. These findings may contribute to the diversification of treatment options in mental health-care services. Mental health clinicians are encouraged to communicate all treatment alternatives to their patients and to be mindful of the potential impact of power imbalances in their interactions.

Paper 2

Paper 2 assessed whether MFT is noninferior to ordinary TAU and explored the role of various covariates, including medication use. The analyses were conducted using both questionnaire datasets: Sample R (n = 59 + 124) and Sample Q (n = 140 + 238). In Sample R, we explored how various treatment and patient factors were associated with the outcomes.

The results showed that the participants improved substantially in both regimens. The changes in Sample R did not differ significantly between MFT or TAU, but the lower bound of a two-sided 90% CI was beyond the noninferiority margin of −5 points. In Sample Q, overall analyses showed that MFT was superior, while the sensitivity analyses with dropouts removed showed that MFTwas noninferior. The medication data showed no substantial associations with outcomes.

In conclusion, supporting people in a less medication-oriented recovery process appears to not lead to inferior short-term treatment outcomes among this patient population, which may reassure health-care professionals in their efforts to enable their patients' freedom of choice and help patients choose between treatment options.

Paper 3

Paper 3 examined what characterized treatment in the MFT unit using a mixed-method design including questionnaire data from both regimens in Sample R (*n* = 59 + 124), patient interviews (*n* = 5) and staff interviews (*n* = 8).

The results indicated that both patients and staff perceived the core features of MFT to involve reduced medication use and a greater emphasis on alternative forms of treatment compared to TAU. Additionally, patients reported having more flexibility to reduce or avoid medication use. The staff also understood the mandate to encompass a more restrictive use of controlled substances traditionally regarded as being addictive. Our findings suggested that the staff participants had developed a greater belief in the potential for MFT but acknowledged that the withdrawal of medications from patients with mental health issues is complex and not

straightforward. Another feature that distinguishes MFT from TAU is the higher expectations of patients regarding activity and assuming responsibility, which may be more indirectly related to the medication-free mandate. For patients, this emphasis could be linked to a stronger sense of purpose and was experienced as helpful, but it could also be perceived as a type of pressure and lack of understanding. Patients in the MFT unit reported greater satisfaction with their treatment, potentially associated with the richer psychosocial treatment program focusing on patient participation and freedom from pressure to use medication. While the overall extent of patient influence, such as shared decision-making, therapeutic alliance, or perceived support for personal recovery, did not substantially differ from TAU, our detailed investigations revealed the nuances described above.

In conclusion, our findings provide insights into how MFT services might work and show that it could be a viable alternative for people uncomfortable with the current medication focus of mental health-care services. The core features of MFT involve less use of medication, a greater focus on psychosocial aspects in the recovery process, and more room for patients to reduce or avoid medication than in TAU. Patients in the MFT ward reported feeling more supported in choosing a medication-free path, even as their medication was carefully withdrawn, and the staff participants were aware of the related risks and complexity. Patients reacted differently to increased demands; therefore, clinicians should be reflective in considering the individual–relational dimensions in MFT services.

Discussion

Taken together, the research project described by this thesis shows that a treatment service characterized by a reduced focus on medications, a greater focus on psychosocial treatment, and more support in reducing medication use than TAU can provide treatments with greater patient satisfaction and without detrimental consequences, at least in the short run. Patients want such services because of the negative effects of medications and unavailable alternatives to medication in ordinary health care. Medication use may also conflict with the patients' personal values, attitudes, and beliefs.

Discussion of the Findings

Patient Choice

Our findings suggest that MFT services can positively impact patients' perceived support for choosing a path with less medication. However, in comparison to TAU, we identified no substantial differences in general measures of shared decision-making, therapeutic alliance, and support for recovery. Qualitative insights indicated that a stricter policy regarding controlled substances, along with increased expectations for patient participation and assuming responsibility, may have diverse impacts on patients' feelings of empowerment or influence. Consequently, the current form of MFT aligns with the core goal of enhancing patients' freedom to reduce or not use medication. However, their overall experience of shared decision-making appears comparable to traditional TAU.

Compared to the literature, the scores from our instruments measuring shared decision-making, therapeutic alliances, support for recovery, and satisfaction seem comparable (within 2 SDs) to scores normally found in transdiagnostic samples among mental health-care populations (Attkisson & Zwick, 1982; De las Cuevas et al., 2020; Hersoug et al., 2009; Nguyen et al., 1983; Pedersen et al., 2022; University of Nottingham, n.d.). The mean satisfaction score of 28.5 for the MFT unit was on the higher side compared with 23.7–27.09 in the literature (Attkisson & Zwick, 1982; Nguyen et al., 1983; Pedersen et al., 2022), which was significantly better than

traditional TAU in our study. Hence, we concluded that satisfaction and support for medication-free recovery were higher than normal in the MFT unit, but more generally, the level of support and shared decision-making was normal. Previous research has uncovered problems in shared decision-making in several contexts (Couët et al., 2015; De las Cuevas & Peñate, 2014; Haugom et al., 2020, 2022; Royal College of Psychiatrists, 2014; Ådnanes et al., 2021); hence, researchers should probably strive for increased shared decision-making in mental health services. The freedom of choice is valuable in its own right and is probably also conducive to improving treatment outcomes through improving therapeutic alliance. There is widespread agreement that patients' freedom of choice should not be limited unduly.

However, it is commonly acknowledged that individuals' freedom ends when it begins to impact other people's rights (Vida Estacio, 2009); therefore, there will always be limits to choice. As mentioned previously, Norwegian law defines limits regarding patients' choices adressing the clinical justification for treatment measures and criteria for prioritizing specialist services (Mental health care act, 1999a; Patient and user rights act, 1999b; prioritization regulation, 2000). These limits are related to both proper spending and the distribution of health-care resources, as well as to avoiding harm to patients. These concerns are also evident in debates about the role of medication in mental health-care services. The debate further encompasses questions about whether and when it is fruitful to challenge patients' and societal attitudes toward mental health-care treatments.

Clinically Justifiable Treatments That Avoid Harm: The debate about the outcomes of different treatment paradigms

Our main outcome result is in line with general investigations that found small differences between standard pharmacological treatments and psychosocially focused treatment regimens (e.g., pure or medication-reduced regimens) (Breedvelt et al., 2021; Cooper et al., 2020; Cuijpers et al., 2023; Cuijpers et al., 2020; Kappelmann et al., 2020; Leichsenring et al., 2022; Lichtenberg, 2011). However, regarding the associations between medication use and

outcomes, we found small but significant associations with higher antidepressant dosages and greater improvement on the OQ-45 (main outcome) scores in the total sample when controlling for other psychotropic groups, dosages, overall dose changes, treatment duration, presence of psychosis or bipolar diagnosis, age, and gender. This result contrasts with a study from a different MFT unit that found that patients who chose to come off their medication had better outcomes (Hammer et al., 2018). The dosages for anxiolytics/hypnotics, antipsychotics, mood stabilizers, or medication for hyperkinetic disorders/attention-deficit/hyperactivity disorder (ADHD), and narcolepsy were not independently associated with any outcome variables in our study. Due to the small group sizes, the certainty regarding the magnitude of associations with covariates is uncertain, and as a result, the presented results should be approached with caution.

Our research project extends the literature by providing further indications that there are viable alternatives to TAU considering the place for medication in mental health care, which is a research area with scant and disputed evidence for the most serious disorders (Cooper et al., 2020; Lichtenberg, 2011; Swartz et al., 2018).

To our knowledge, this research project is the first to compare the Norwegian medication-free initiative with TAU. Although the knowledge of alternatives to medications for severe disorders is still scarce, the current medication-focused paradigms also have problems. For example, the long-term effects of medications are controversial and show mixed findings (Alvarez-Jimenez et al., 2016; Arikan et al., 2023; Baghai et al., 2012; Belge et al., 2023; Correll et al., 2018; Goff et al., 2017; Hengartner, 2020; Moncrieff et al., 2020; Smedslund et al., 2018; Suvisaari et al., 2018; Zipursky et al., 2020) and their side effects are well-known (Bai et al., 2020; Cai et al., 2023; Ceraso et al., 2020; Correll et al., 2018; Croatto et al., 2023; Davies & Read, 2019; Hengartner, 2020; Horowitz et al., 2021; Jakobsen et al., 2020; Levenberg & Cordner, 2022; Moncrieff et al., 2020; Sinyor et al., 2020) and important issues for patients (Bjørgen et al., 2020; Øvernes, 2019). In addition, severe mental disorders pose significant

health burdens despite the efforts of current treatment regimens (GBD 2017 Disease and Injury Incidence and Prevalence Collaborators, 2018), which calls for humility regarding what approaches are best for individual cases as well as allowing a broader range of approaches.

Reasonable Costs and Gains

Also related to the debates about understanding the knowledge base are questions about reasonable costs in relation to gains. Oedegaard et al. (2022) found that health-care personnel experience resource distribution as a dilemma for their care of patients receiving medication-free treatments because they were perceived to need more psychosocial follow-up than patients receiving TAU care. In our study, the medication-free unit had twice as long treatment stays; however, the length of stay at the medication-free unit was due to a fixed program. The Board of the Norwegian Psychiatric Association (2023a) recently asserted that “to allow oneself” to get well without medication in situations where medication could make recovery faster is a luxury that is hard to defend considering its societal costs: “In a global sustainable solidarity perspective, arguments against psychotropics probably have no role. We also must ask if this is a sustainable choice for our society, in spite of our welfare arrangements” (my translation). However, although more psychosocial treatment may be more costly in the short term, it is possible that this picture changes over the long term, since increasing patients’ treatment options may improve therapeutic alliances, which is associated with improved outcomes (Wampold & Imel, 2015). In addition to monetary health-care costs, the costs of patients’ experiences with side effects and the negative effects of medications must also be considered. Cost considerations are also impacted by the view of mental illnesses. In the Norwegian debate, it has been pointed out that learning to cope with feelings has important value for individuals and society (Karterud, 2023). If one believes that feelings have a function and meaning, the way one deals with them has broader implications than merely alleviating symptoms. As stated by Karterud (2023), feelings are linked to norms and morals; consequently, a liberal democratic society necessitates citizens with high affect consciousness. In our study,

patients' experiences with medication included emotional flattening, feeling "zombielike" or "less human," feeling empty and tired, having suicidal thoughts, and abusing the medicine. One can imagine that these negative experiences have great costs for both individuals and society.

Taken together, the ultimate balance of costs and gains is uncertain and probably highly individual. Given that medications may have high costs for individual patients, alternatives should be made available.

When Should Patients' Attitudes be Challenged?

One might argue that patients' attitudes and perceptions regarding their treatment should not merely be considered ad notam, but practitioners should actively engage with and, at times, challenge these attitudes. Therapeutically, healthcare professionals may challenge beliefs and attitudes considered dysfunctional if they have established a therapeutic alliance with their patients that allows for such work. Moreover, one could argue that challenging some patients' attitudes is necessary, as these attitudes may be rooted in the harmful influences of illness, societal pressure, or simply scientific misconceptions.

Patients' perceived lack of insight or decision-making capacity often poses dilemmas for health-care personnel in shared decision-making processes (Oedegaard et al., 2022; Seale et al., 2006; Yeisen et al., 2019). The rationality of the patients' beliefs has been an argument for ethically justifying paternalistic actions (Szmukler, 1999). In addition, subjects' decision-making capacity is an important consideration in humanitarian laws of coercion (Helse- og omsorgsdepartementet, 1999a). The term 'insight' is often defined as the patient's recognition of having a psychiatric disorder and their awareness that treatment could be helpful. (De las Cuevas & de Leon, 2020), whereas decision-making capacity has been defined as a person's ability to make informed decisions about receiving health care or participating in health-care research (Ursin, 2020). These are thorny issues because the act of determining the quality of another person's insight may itself be infused with paternalism and there is high risk of a circular situation wherein disagreement with health-care personnel is taken as evidence for lacking

capacity for consent. Indeed, some operationalizations of insight include patients' self-assessment of their need for treatment with medication (Hirsch et al., 2021). According to user experiences, the patients' wish to receive MFT has been used as an argument for their lack of capacity for consent (Lund & Borchgrevink, 2016). Similarly, a patient's perspective of the lack of benefits from medication was used as an argument in a ruling by the Norwegian Supreme Court (Norsk Høyesterett, 2018). It is highly problematic to use a subject's agreement with a specific course of action as an argument for that subject's capacity for consent. However, patients may sometimes hold beliefs more universally regarded as harmful delusions, such as being dictated by voices not to receive help. Exploring, or alleviating the consequences of such beliefs can be important. Regarding more forceful measures, such as medication coercion, the Norwegian legislature currently requires a high probability for the positive effect of coerced medication (Helse- og omsorgsdepartementet, 1999a), which has been argued is not justified for psychotropic medications (NOU 2011: 9, 2011). This brings us back to the debate about outcomes in the literature.

A debate about "pill shaming" has surfaced recently in Norway, where The Board of the Norwegian Psychiatric Association (2023b) has asserted that there is a serious problem of societal shaming around using medication for mental disorders. In our study, the most prevalent reasons for wanting to receive MFT were the negative effects of medication and difficulty obtaining alternative treatments. Some patients associated not using medications with being strong. One interpretation of this finding may be that patients consider using medication as a sign of weakness. If their medication otherwise has beneficial effects, such attitudes may not be fruitful and may even be part of a repressive mindset. Likewise, less value-laden perceptions, such as concerns about long-term effects, could be addressed with facts. As elaborated in the introduction, however, the "facts" in this matter are subject to controversy and lack of firm evidence. Negative side effects are the most frequent reason patients want MFT. These are experiences individuals have to deal with every day, and I would argue that the person living

with them is the one closest to determining their meaning for one's life. Our findings are in line with several investigations that distinguish MFT units from TAU because of their focus on individual responsibility (Bjørgen et al., 2020; Wærness, 2019). Our study obtained descriptions of increased expectations for participation, hard work, and a more demanding treatment regimen in general. Some patients seemed to find this focus empowering, whereas others experienced this as pressure and a lack of understanding. There are differing perspectives on challenging patients regarding assuming responsibility or working hard, and these differences are mirrored in the tensions within and around the recovery tradition concerning its individual and relational dimensions. (Harper & Speed, 2012; Price-Robertson et al., 2017; Recovery in the Bin et al., 2019; Stickley & Wright, 2011). As noted in paper 3, the underlying question of the place for individual responsibility is fraught with philosophical and political issues, and hard to pinpoint empirically. However, it is important to undertake continuous reflections on how different positions affect and shape interactions with different patients, including their shared decision-making opportunities. Our findings indicate that patients may find it difficult to express their needs and wishes when they go against the expectations of the treatment culture, whether related to their medication adherence or assuming responsibility and working hard. Hence, reflexivity is crucial for avoiding pitfalls in either direction.

Controversy Around Separate Units

Critics of separate MFT units have feared that these units may enforce patients' negative attitudes toward medication (Røssberg, 2016a) and may become "antipsychiatric islands" within the health-care system (Røssberg, 2016b). A one-sided focus on one treatment paradigm to the exclusion of other paradigms in health care would be detrimental to the patients' choices (Helse Sør-Øst, 2014). These critics acknowledge that pitfalls in either direction are problematic (Røssberg & Andreassen, 2019), but promote integration rather than plurality of services.

User organizations have argued that integrated services would not work because medication-free options are not recognized alternatives in traditional health care (Helmikstøl,

2014). Hence, they do not believe that these treatment paradigms could coexist in harmony because the mainstream paradigm is too dominant. This observation is mirrored in research on shared decision-making and informal coercion in health care, where pressure for medication use seems more widespread than the failure to offer medication (Bjornestad et al., 2019; Blindheim, 2020; Haugom et al., 2022; Newton-Howes & Stanley, 2012; Norvoll & Pedersen, 2016; Nyttingnes et al., 2016; Stasiulis et al., 2022). For example, findings from a health-care region where MFT is more integrated into regular services in the form of designated courses indicated that the staff struggled to resolve dilemmas, such as correspondence to treatment guidelines, which is a theme that was not evident in our study (Oedegaard et al., 2022). Patients in MFT were perceived to make choices that were at odds with the recommendations, such as wanting to discontinue medication after experiencing several psychotic episodes. The Norwegian guidelines for psychosis recommend offering pharmacological treatments with maintenance for at least 2 years for schizophrenia, but also stress that the appropriate treatment should be based on individuals' choices and priorities (Helsedirektoratet, 2013). Both guidelines for psychosis and bipolar disorder state that patients who want to receive MFT should be respected as far as possible (Helsedirektoratet, 2012, 2013). Therefore, it is not obvious to me that the current form of MFT conflicts with the Norwegian guidelines. However, the experienced discrepancy between MFT and the guidelines may be understood in the light of a wider cultural framework as described by Morant et al. (2016), where the many messages within the mental health-care system besides guidelines indicate the necessity for medication-based treatment for severe mental disorders. Therefore, staff from separate MFT units may experience less conflict regarding their standards of care, as they can build a health-care culture that differs from mainstream care.

Our findings of patients' reasons for wanting to access medication-free services are in line with previous investigations regarding their experiences with the side effects or negative effects of medication (Bjørgen et al., 2020; Øvernes, 2019), as well as their values, attitudes,

and beliefs regarding learning to cope without medication (Bjørgen et al., 2020), wanting less focus on medication as well as diagnoses (Bjørgen et al., 2020), and concerns about the long-term effects of medication (Øvernes, 2019). In addition, we found that half the participants listed medication pressure in ordinary services as a reason for wanting MFT and more than 60% mentioned either pressure or lack of alternatives in ordinary health-care services. Some of these reasons may be independent of the organization of the health-care services, such as negative medication effects, while other reasons indicate that these patients found it hard to access MFT in regular health-care services, which is especially pertinent regarding these patients' experiences with medication pressure and the lack of options, but may also be relevant to the focus of treatment regimens. For example, contextual psychotherapy models stress the importance of a cogent explanation and concomitant therapeutic tasks (Wampold & Budge, 2012). Therapists' allegiance is also found to be highly associated with positive outcomes (Wampold & Imel, 2015). Treatment cultures are typically formed around therapeutic approaches as well as in institutions and workplaces. Group-based approaches and inpatient treatment, in particular, demand close coordination and cooperation; therefore, there is a stronger need for health-care professionals to be 'on the same page.' This may result in robust treatment cultures characterized by high consistency and allegiance, which can benefit patients. On the one hand, there may be limits to which treatment paradigms can be integrated in one treatment unit without either the treatment rationale becoming fragmented and unclear or one approach repressing the other. On the other hand, very specialized units may increase the risk of individual patients falling between services. Our findings add to the literature indicating that the medication-focused paradigm is dominant in regular health-care services, which makes it difficult for patients with severe mental disorders to access alternative care. The medication-free unit offers an alternative paradigm wherein they feel more supported in this matter. This supports the notion that systemic changes are necessary to improve shared decision-making practices related to medication, whether through the establishment of dedicated units or other means.

Methodological Considerations

In the following, I will discuss the methodological issues deemed most central to our study regarding its reliability, dependability, and validity.

Reliability or Dependability

In both quantitative and qualitative research, reliability and dependability concern consistency in descriptions, measurements, or recordings. (Tashakkori et al., 2021). The reliability of a measure is defined as the extent to which it is free from random error components (Judd et al., 1991). Some of the most common ways to assess reliability are across different occasions (i.e., test–retest reliability), across internal items (i.e., internal consistency reliability) (Judd et al., 1991), and between different raters (i.e., interrater reliability) (Gisev et al., 2013). In our samples, all multi-item measures had a Cronbach's α above .80, which indicates good internal consistency. As described in the Methods section, our standardized clinical measures have mostly been found to have adequate reliability in previous research.

Current diagnostic systems have made progress in the reliability of mental diagnoses (Faravelli et al., 2012; Kendell & Jablensky, 2003). In research studies, interrater reliability has been found to be mostly moderate to substantial for various ICD-10 diagnoses, but this reliability might be different in routine clinical practice (Huda, 2019).

The concept of dependability in qualitative research is used as an analog for reliability in quantitative research. This concept is concerned with the extent to which a phenomenon can be tracked or explained consistently across different contexts (Tashakkori et al., 2021). In our study, inferences from the interview data were strengthened by interpretive agreements. Some coauthors delved deeply into the qualitative material in their masters' theses, while others were supervisors of those theses. Hence, several members of our research group were deeply familiar with the interviews and condone the inferences drawn.

Validity

Quantitative researchers have defined validity as the approximate truth of an inference, which is considered a matter of degree (Shadish et al., 2002). The concept of validity is used in both quantitative and qualitative research (Mason, 2002; Shadish et al., 2002; Yardley, 2015), although trustworthiness is sometimes used as a qualitative substitute (Tashakkori et al., 2021) that is more in line with constructivist approaches (Denzin & Lincoln, 2011). Constructivist researchers reject the coupling of validity to truth because of their perspective of reality as being multiple and constructed rather than singular and tangible. In this view, trustworthiness becomes a matter of persuasion and more dependent on having practiced good science than being right (Sandelowski, 1993). My position within critical realism means that I aim to approach truth; therefore, Shadish et al. (2002) definition is applicable.

With an observational design, selection effects pose threats to internal validity. that is, the ability to make inferences about whether the observed covariation between treatments and outcomes reflects a causal relationship (Shadish et al., 2002). Hence, it is uncertain whether observed differences in outcome (or lack thereof) reflect the effects of different treatment regimens. However, our findings indicate that the patients were quite similar in terms of their mental health at baseline, which indicates no systematic differences regarding this important confounder.

Selection effects may also threaten the transferability of inferences, such as the degree to which research conclusions can be applied to other similar settings, people, time periods, contexts, and theoretical representations of the construct (Tashakkori et al., 2021). Since patients on the MFT ward are prepared in advance to see if the treatment program may suit them, they may be considered as a more select group, motivated for this treatment regimen, rather than MFT more generally. On the other hand, the observational design increases transferability by studying how MFT is actually conducted in the clinic, with the patients who actually receive MFT in real life.

Construct validity concerns to what extent the constructs of theoretical interest are successfully operationalized in research (Judd et al., 1991). As mentioned earlier, the phenomenon of MFT has quite fluid boundaries with TAU. Therefore, The MFT characteristics are made the object of our study and MFT is treated as a “sensitizing concept” (Blumer, 1954). However, the treatment units may differ in a number of ways that cannot be related to the medication-free mandate, which is important to consider when generalizing the results to other settings with MFT. However, our mixed-methods design enables an in-depth exploration of the characteristics that can aid such generalization.

We also aimed to capture several phenomena with the help of standardized measures. As outlined in the Methods section, most of these measures have tested psychometric properties, including adequate criterion validity.

Self-report, clinician ratings, and interview data are vulnerable to demand characteristics; therefore, the perceived expectations in the setting may influence the participants’ responses (Orne, 1962). However, the presence of a comparison group and in-depth interview data with more nuances and a richer context for interpretation alleviate this issue to some extent.

The validity of mental diagnoses is disputed (Bentall, 2003; Faravelli et al., 2012). Although current mental diagnostic systems mostly specify behavioral symptoms without implying anything about their origin or treatment (Atkinson et al., 1996), this descriptive function is often considered dependent on some correspondence to how mental health symptoms cluster together in the real world (Bentall, 2003). Kendell and Jablensky (2003) proposed that a condition for descriptive (i.e., syndromal) diagnoses to be considered valid was that the syndrome could be demonstrated to be an entity separated from neighboring syndromes and normality by a zone of rarity. On the other hand, if the category’s defining characteristics are more fundamental underlying biological abnormalities, clear qualitative differences must exist between these defining characteristics and those of other conditions with a similar syndrome. Neither criteria has been established widely in current mental diagnoses (Faravelli et al., 2012;

Huda, 2019; Insel et al., 2010). However, some argue that diagnoses can be useful despite not being valid (Huda, 2019; Kendell & Jablensky, 2003). In our context, it is interesting for our subject matter how people labeled with, for example, a diagnosis of psychosis or bipolar disorder, fare in and experience MFT, regardless of the validity of the label, because these people are often met with a treatment regimen that stresses the importance of medication.

As previously described by Standal (2021b), we saw a need for a tailor-made questionnaire to address the specific phenomenon and questions explored in this study. We designed the questionnaire to explore reasons for wanting to receive MFT for this study. We have only pilot-tested the questionnaire; therefore, more optimal ways of framing the questions and choice of categories may exist. Nevertheless, the open-ended aspect of this questionnaire is considered to alleviate this issue to some degree (Standal, 2021b). A sequential design might have been more optimal for this part of the study; hence, we could use the qualitative responses to perfect the questionnaire. But this would have delayed the data collection, and it proved challenging to obtain enough participants. Possible improvements could have included response options that encompass notions of recovery and the meaning of medication use. In hindsight, I would have worded the introduction question differently (“were you referred to a MFT service?”) because it could be interpreted in different ways (i.e., intentionally being referred for MFT or being referred to a unit that happened to be medication-free). The intention was to single out patients who were referred for other reasons (hence, they were not relevant to this questionnaire). In hindsight, it may have been better to simply start by asking if the questionnaire respondents wanted to receive MFT. The questions could then have been made applicable for participants in the comparison wards as well, who may not have been referred to the MFT unit. Nevertheless, the existing version of the questionnaire can still be employed to evaluate participants' responses regarding their desire for MFT.

The sample size may pose threats to the statistical conclusion validity in the quantitative material, i.e., the conclusions reached, or inferences drawn about the extent of the relationships

between variables (Statistics Solutions, n.d.). While the statistical power is good for the main outcome measure in Sample Q, we had insufficient statistical power to perform complex subgroup analyses due to the smaller Sample R, which limits the interpretation of the influence of the included covariates. Post-hoc sensitivity calculations regarding power indicate we were not able to detect effects below medium size in sample R. Sample R from the medication-free unit is highly representative for the local unit due to its high response rate, which is a strength. The response rates for the other questionnaire samples were lower, and we have indications that many users with psychosis may not be included, which must be considered. Nevertheless, the sample characteristics were otherwise similar to more complete data from hospital statistics.

Regarding the qualitative samples, the patient interview sample was on the smaller side and there may be important patient experiences that were not represented in our interviews. However, the interview data were complemented by questionnaire data for many themes. Considering the staff interview sample, as explained in the Methods section, we included only one type of staff role for several reasons. Hence, we only have the perspective of milieu personnel.

The inferences in our mixed-methods design were strengthened by triangulation; that is, the combination and comparison of multiple data sources, data collection and analysis procedures, research methods and inferences that occurred at the end of the study (Tashakkori et al., 2021).

Future Perspectives

It is important to study long-term outcomes for different treatment strategies, as the current knowledge is ambiguous and uncertain (Alvarez-Jimenez et al., 2016; Arikan et al., 2023; Baghai et al., 2012; Belge et al., 2023; Correll et al., 2018; Goff et al., 2017; Hengartner, 2020; Moncrieff et al., 2020; Smedslund et al., 2018; Suvisaari et al., 2018; Zipursky et al., 2020). In addition to observational studies of patients who choose different options, it is

important to have more randomized controlled experiments using psychosocial treatment paradigms for severe mental disorders that are followed up over time.

It is also important to study the status and development of patient influence and shared decision-making around treatment choices in general and medication use in particular. To improve shared decision-making in mental healthcare at large, one could examine the attitudes of mental health professionals toward medication-free treatment, identify potential barriers to its implementation and develop strategies to address these barriers and promote the integration of medication-free options into standard care. Factors that contribute to patient satisfaction in medication-free treatment could be investigated in more detail and across units to identify specific aspects of psychosocial treatment that are most valued by patients.

Resource requirements are also an important topic for future studies. In the studied MFT unit, medications were replaced with more psychosocial treatments in both their length and intensity. However, longer and more intensive psychosocial treatment is not inherently opposed to the use of medication. Nonetheless, staff reports indicate that patients receiving MFT require more resources (Oedegaard et al., 2022; Wærness, 2019). Therefore, it is important to explore this issue in a wider framework considering health service use and welfare needs over time.

Conclusion and Implications

A treatment service characterized by a reduced focus on medications, a greater focus on psychosocial treatment, and more support in reducing medication use compared with TAU can provide greater patient satisfaction and improvements in their mental health comparable to ordinary treatment in the short run. This is in line with previous investigations of similar undertakings. However, our study is the first to compare a Norwegian medication-free unit to TAU. Patients desire to receive such services because of negative effects of medications and unavailable alternatives to medication in ordinary health care. In line with previous research, we found that patients may experience interactions with health-care professionals about medications challenging in traditional health-care services. Medication use may also conflict with

their personal values, attitudes, or beliefs. The patients feel more supported in choosing a less medication-focused pathway to recovery in the MFT unit; therefore, these units can contribute to increasing patient autonomy in this area.

Our findings add to previous MFT investigations by distinguishing MFT from traditional TAU due to its more extensive psychosocial interventions, less reliance on medications, and greater focus on individual responsibility.

We need more knowledge about the long-term outcomes and cost-effectiveness of different treatment strategies. Shared decision-making for patients with mental health issues is complex and we need greater clarity about how to create a health-care system that is flexible enough to accommodate individual patients' needs.

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Patient Preference and Adherence

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ORIGINAL RESEARCH

Why Service Users Choose Medication-Free Psychiatric Treatment: A Mixed-Method Study of User Accounts

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Purpose: Medication has been a central part of treatment for severe mental disorders in Western medicine since the 1950s. In 2015, Norwegian Health Authorities decided that Norwegian health regions must have treatment units devoted to medication-free mental health treatment to enhance service users' freedom of choice. The need for these units has been controversial. The aim of this study was to examine why service users choose medication-free services. This article examines what purpose these units serve in terms of the users' reasons for choosing this service, what is important for them to receive during the treatment, and what factors lay behind their concerns in terms of medication-related views and experiences.

Methods: Questionnaires were answered by 46 participants and 5 participants were interviewed in a mixed-method design integrated with a concurrent triangulation strategy applying thematic analysis and descriptive statistics.

Results: Negative effects of medications and unavailable alternatives to medication in ordinary health care were important reasons for wanting medication-free treatment. Medication use may conflict with personal values, attitudes, and beliefs.

Conclusion: This study broadens the understanding of why the demand for separate medication-free units has arisen. The findings may contribute to making medication-free treatment an option in mental health care in general. To this end, clinicians are advised to communicate all treatment alternatives to service users and to be mindful of the effect of power imbalances in their interactions with them.

Keywords: mental health care, medication-free, choice, psychotropics

Introduction

Medication has been a central part of treatment for severe mental disorders in Western medicine since the 1950s.[1] However, medication adherence has been a challenge. A recent review found 49% of service users with severe psychiatric disorders were not adherent to their psychotropic medication.[2] Nonadherence can be related to interactional factors between service users and health care professionals[2–8] or their families and friends,[5,6,8] side effects/negative effects of medication,[2,3,5–8] and service users' beliefs, attitudes, and perceptions.[2,4–8] There is also evidence of some correlations with service user characteristics like "lack of insight",[2,4–7] comorbidity,[2,6] severity of pathology,[5,8] positive symptoms and grandiosity,[5] lower quality of life/wellbeing,[8] psychological reactance and internal locus of control.[8] Sociodemographic factors show mixed results,[2,5,6,8] although

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Received: 24 February 2021
Accepted: 2 June 2021
Published: 23 July 2021

some find correlations on age,[2,6] unmarried status,[6] male gender,[6] low education level,[2,6] and unemployment.[2] Service user accounts have shown experiences of one-way relationships wherein service users do not experience use of medication as their own choice, which leads to termination of medication.[3] This corresponds to findings showing that service users can experience the boundary between voluntary and coerced medication as blurred.[9,10] Poor service user involvement is also reflected in a study of mental health professionals' experiences with shared decision-making with service users with psychotic disorders, concluding that shared decision-making is practiced to only a limited extent with this group.[11] Involuntary medication has been found to be a particularly problematic form of coercion in service users' experience.[10]

The majority of admitted service users in mental health care are treated with medication. A report indicates 88% are treated with medication, of whom 13% are medicated against their will. Additionally, 1% indicate they want medication but are not receiving it.[12] Although there have been treatment programs in more recent times with less use of medication,[13,14] a nationwide governmental instruction to provide specialist services devoted to medication-free treatment, such as that which was introduced in Norway in 2015, is unprecedented.

In 2009 a governmental task force suggested medication-free treatment as one of several measures to reduce coercion,[15] and in 2012 it was incorporated in a national strategy to reduce coercion.[16] In 2015, each of the four health regions was instructed to provide dedicated medication-free services.[17] The first unit opened in 2015,[18] and others followed from 2017 onward.

The Norwegian Ministry of Health and Care did not specify what was meant by a medication-free treatment unit other than what can be inferred from descriptions of its purpose. The Ministry simply refers to the aim that service users in mental health care shall, as far as clinically justifiable, have the opportunity to choose between different treatment measures, including medication-free treatment.[17] A coalition of user organizations lobbying for medication-free treatment describes it as freedom from coercion, pressure, or persuasion regarding medication.[19] Medication-free treatment is further interpreted in local protocols of the health regions, where it is made clear that service users in the "medication-free" units can use psychotropics if they want to.[20,21] Medication-free treatment must be deemed clinically justifiable,[17] which excludes service users formally subjected to involuntary medication.

In this article, "medication-free treatment" (MFT) refers to services developed as a result of the aforementioned governmental decision and which seem to be interpreted by both user organizations and health trusts to mean that the service is free from medication pressure and coercion, rather than free from all psychotropic medication.

As of 2018, MFT was offered in 25 locations in Norway.[22] The services are not uniform, but the most common characteristics are the following: inpatient, open wards, prioritizing individuals with severe mental disorders, and influenced by a recovery tradition.[22,23]

Some initial studies and audits have been conducted of these services. Clinician accounts of service users' reasons for wanting MFT include side effects, fear of long-term harm, not feeling ill, not feeling need for antipsychotics, stigma, lack of effect, delusions, and outside pressure or recommendations.[24] Service user accounts include wanting a service with less focus on medication and diagnoses, learning to cope without medication, and escaping negative side effects of medication.[25] Health care professionals' attitudes to MFT seem to vary. A qualitative study shows some are critical, considering MFT as lacking scientific evidence, that that it reflects the wish of a minority of service users, or that MFT might not be necessary because service users already are perceived to have a crucial involvement regarding medication.[26] These arguments disputing the need for dedicated MFT units are also found in the public debate.[27,28] A quantitative investigation shows health care professionals are positive overall (68%, rising to 90% after a conference on the subject).[24] However, clinicians report that for a substantial proportion of their psychosis service users (22%), MFT would not be clinically justifiable.[24] Service users report medication discussions as sometimes challenging in general mental health care.[9] There are indications that about half the population in inpatient units would be interested in an MFT alternative.[29] Service users with psychosis in MFT report that having choices about treatment is important.[30]

Because the need for MFT units is controversial, the MFT mandate does not require service users to go off medication, and MFT wards may have several other features that might be attractive to service users, it is important to examine whether medication-issues are important for the users. This will illuminate whether the units are utilized in line with their intended purpose, as well as deepen the understanding of this eventual purpose. The

reasons service users in MFT treatment have for wanting MFT have not yet been examined in detail. This is the topic of the present study, and we were particularly interested in exploring their medication-related views, concerns, and experiences.

Method

Setting

The context in this study was an MFT unit that is part of a general hospital in the metropolitan area of Oslo. The hospital has a catchment population of 500,000, containing both urban and rural communities. This medication-free unit is an inpatient unit for voluntary admissions within the recovery tradition prioritizing severe mental illness; hence, it is fairly representative of MFT services in Norway.

The target group for this MFT unit is described as service users over age 18 with severe mental disorders that are traditionally treated with medication but who want MFT. Service users with psychosis and bipolar disorders are prioritized. The level of care is intermediate, targeting a population with low functioning or prior treatment resistance (i.e. not having responded to several known treatments, including drug treatment). Service users with active addictions, suicidal behavior or aggressive/violent behavior are excluded. Service users must be willing to participate in the treatment program, and motivation and effort are highlighted on the web pages.[31]

The treatment program has an overarching umbrella of recovery including the program illness management and recovery (IMR).[32] The recovery tradition has been characterized using the acronym CHIME.[23] This entails a focus on Connectedness, Hope, Identity, Meaning of life, and Empowerment. The treatment program further incorporates focus on affect, feedback, and communication from the traditions of the affect consciousness model,[33] a feedback informed framework,[34] open dialogue,[35] and techniques from basal exposure therapy.[36]

The treatment program lasts eight weeks and there are seven service users on the ward at any given time. It is organized as a "5-days-unit" where service users go home for the weekends.

Design

This article is part of a larger study, described in full at ClinicalTrials.gov (Identifier NCT03499080). Because the subject matter is a new and relatively unexplored type of treatment service where opinions and perceptions are diverse, we chose an exploratory design to address our research agenda.

The design consists of mixed methods, containing qualitative thematic analyses of interviews and open-ended questionnaire responses, as well as quantitative descriptive analyses of questionnaire data from service users and their clinicians on the ward. Quantitative and qualitative data collection and analysis were done in parallel and were integrated in the analysis using a concurrent triangulation strategy.[37]

The purpose of using mixed methods was to increase validity and completeness by comparing results from different methods, thereby transcending the shortcomings of each. The qualitative materials add depth and an opportunity for the participants to express themselves in their own words, thereby allowing for the discovery of themes not previously considered. The quantitative material indicates how representative the themes are within our context.

Inclusion Criteria

Eligible service users were those on planned stay in the recruitment period who were deemed capable of being interviewed and/or filling out forms in Norwegian and who consented to participation. The wards also include emergency stays and user-controlled stays that are shorter and do not follow the ordinary treatment program.

Sampling Procedures

The recruitment period for the questionnaire study was 22.5 months, from May 2018 to April 2020, whereas for interviews it was three months, from January to March 2018. Service user flow can be seen in Figure 1. Therapists had standardized routines for informing service users about the project and handed out information and consent forms at the beginning of each admission. Questionnaires used in this study were to be completed within the first week of their stay.

Data Collection

Questionnaire data was collected by having service users and their clinicians fill out questionnaires at specific intervals during the treatment stay.

ARM performed semi-structured interviews face-to-face with participants. The interviews lasted 50–60 minutes and were audio-recorded. Service users were interviewed on the ward toward the end of their stay.

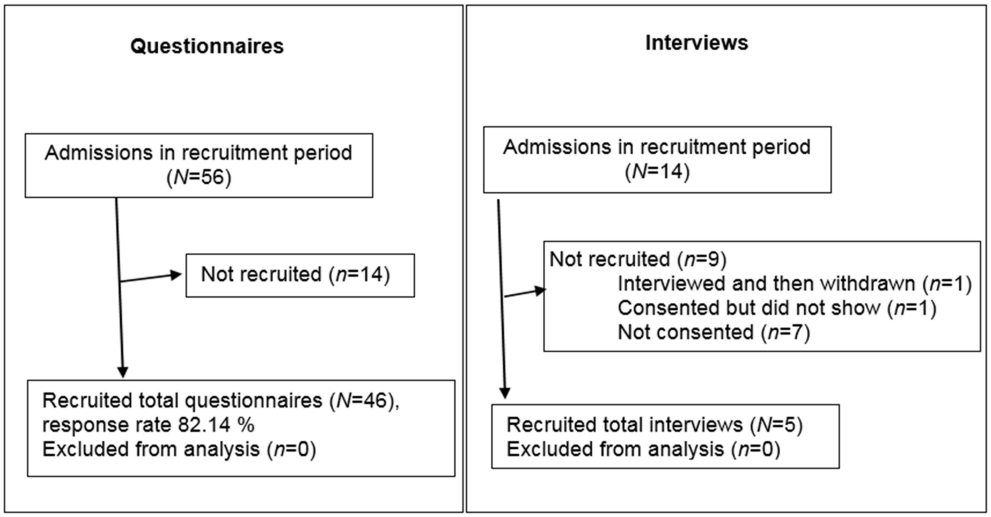

Figure 1 Participant flow.

Measurements

Translated versions of questionnaires and interview guide can be found in Supplemental Material B–D.

Reasons for Wanting MFT

Because service users might be admitted to hospital for various reasons, service users in MFT were asked whether they were referred specifically for MFT. Respondents were asked who had wanted the referral to MFT with multiple-choice answers (self, next of kin, health professional, others). Those who replied that they had wanted it themselves were asked to indicate why it was important to them based on the following multiple-choice alternatives: 1= Having felt pressure to use medication, 2= Experienced lack of alternatives to medication, 3 = Use of medication does not fit my understanding of my problems, 4 =Negative experiences with effects and/or side effects of medication and 5= Other (open-ended). The first three alternatives were thought to illuminate possible reasons for the need for dedicated units, whereas the fourth is more about the medication itself.

Being Respected for the Wish Not to Use Medication

To assess the degree to which participants thought they were respected for their medication preferences in the treatment received in the 6-month period prior to the present stay, they were asked to indicate on a 5-point Likert scale their agreement with the statement "I have been respected for my wish not to use medication." This question was taken from the Medsupport instrument.[38]

Sample Characteristics

Participants provided information on age, gender, and current use of psychotropic medication. Clinicians completed main diagnoses, current use of psychotropics, and details of type of psychotropics. To calculate response rate and assess how representative our sample was among all those using the MFT-unit in the study period, we accessed anonymous statistics from the electronic service user journals for all service users in the MFT unit during the study. Information included age, gender, and diagnoses for all planned regular stays at the unit during the recruitment period, excluding readmissions within 30 days.

Interview Guide

An interview guide was developed in collaboration between KS, ARM, MSH, and KSH, and was based on the literature and a previous study of medication-free services.[39] Topics included users' understanding of and expectations regarding MFT and attitudes toward this treatment approach, as well as whether, and why, MFT was important for them, how the treatment compared to other treatment experiences, and whether they experienced shared decision making.

Analyses

Numerical questionnaire data were analyzed using SPSS (version 26) and described by frequencies and percentages or means and standard deviations (SD) as appropriate. Valid percentage was reported if not otherwise specified. Psychotropic drugs were grouped according to the Norwegian medication handbook (Norsk legemiddelhåndbok). The answers to open-ended questions were analyzed thematically with the same strategy as for the interviews (see below). The program NVivo was used. In the integrated results only medication-related themes were compared, as these were the focus in the interviews.

The interview data were subject to thematic analysis[40] This is a flexible stepwise qualitative analysis method wherein the data, after familiarizing, are first coded according to the most basic meaning units of interest and then analyzed into broader themes.[40] Audio files were transcribed verbatim by ARM and coded and sorted with the program NVivo by KS. Initially, KS reviewed the transcripts doing predominantly inductive coding of the interviews. The coding was grouped according to the research questions in the total study.[41] Our initial focus was service users' reasons for coming to the MFT unit, their concerns on arrival, and experiences that may illuminate these concerns. These codes were grouped into themes. A theme was a concern explicitly expressed by at least one participant. In line with the concurrent triangulation strategy, findings from both quantitative and qualitative methods guided the analysis in a hermeneutic fashion. Initial findings were that the MFT concept was not sharply delineated for participants, and the quantitative finding that the majority reported medication-related reasons led us to conclude that medication-related reasons were important, but it was not possible to clearly separate them from other reasons in the interviews. We therefore narrowed the focus to concerns and experiences explicitly related to psychotropic medication to shed light on reasons that could be attributed to the official mandate of MFT units.

KS coded and grouped the data and drafted the findings. KSH and JR reviewed the transcript material constituting the final themes. KSH, ARM, MSH, and JR read transcripts and gave input into the analysis and interpretation.

Integration of Results

The integration was done by a between-method triangulation,[42,43] adjusted to the present study. Herein we investigated convergence, divergence, and complementarity in the results, leading to meta-themes across all results. Results were compared regarding the meaning of themes, whereas prominence was assessed only in the quantitative material.

Ethics

The study was conducted in accordance with the Declaration of Helsinki and approved by the Regional Committee for Ethics in Research (2017/1056/REK sør-øst B.), as well as by the Privacy Ombudsman at Akershus University Hospital (17–134). Participants gave written, informed consent prior to participation. All participant names are pseudonyms, and the consent includes publication of anonymous results.

Results

Participant Flow

As shown in Figure 1, the questionnaire response rate was more than 80%, whereas about half of the potential subjects declined to participate in interviews. According to the therapists in informal discussions, the reasons for declining interviews were that there was much going on and it felt overwhelming for the service users to take part in research as well at this point.

Participants

Questionnaire Sample

In the questionnaire group, 68.57% were women and the rest were men. The majority (71.74% reported by service users, 73.91% reported by clinicians) used psychotropics at baseline. The most common psychotropic group was antidepressants (31.25% of prescribed medications), antipsychotics (27.50%), and anxiolytics/hypnotics (22.50%). The mean age was 37.85 (SD 12.94). Only one participant reported having an outservice user commitment order. Diagnoses were diverse, with the most common ones being psychosis, bipolar disorder, non-bipolar affective disorder, and personality disorder (14.89% each). Compared to all those using the MFT unit in the study period, our research sample seems reasonably representative with respect to age, gender, and diagnoses (Supplemental Material A).

Interview Sample

As can be seen in Figure 1, five interviews were included in the analysis; two of these participants were men and three were women. In the article, female pseudonyms were used for all participants to protect anonymity. Ages ranged from 25 to 50 years and the sample included people born

in Norway and elsewhere. One of the participants had never used psychotropic medication. The other four had tried to withdraw from such medication, either during the current stay or earlier. Four of the service users were completely off medication at the time of interview. Collectively, participants discussed experience with SSRIs, SNRIs, anxiolytics, hypnotics, antipsychotics, and beta-blockers. Four of the five service users had previously been admitted to an open psychiatric ward. Details of diagnoses and other demographic variables were not recorded to protect anonymity. In three of the five cases (Anita, Bella, and Diana) MFT was described as someone else's suggestion, while two (Cecilie and Elise) described it as their own initiative. One participant, Anita, said the medication-free mandate was unimportant to her. All except Anita stated that they wanted MFT and had concerns explicitly about quitting or not using medication.

Questionnaire Results

Table 1 gives an overview of findings from the questionnaire about reasons for wanting MFT. We have focused on participants indicating that MFT was their own wish.

Negative effects of medication was the most common alternative chosen as reason for wanting MFT. Around 90% listed at least one medication-related reason. Of the total 46 participants, including those who had not initiated MFT themselves, 78.26% wanted MFT and stated medication-related reasons.

Experience with being respected for not wanting to use medication in the last six months prior to this treatment stay is shown in Table 2. As shown, experiences were varied. Of those who found the question applicable about half agreed with the statement that they felt respected in their decision to not use medications in the 6-month period prior to the MFT treatment; 15.63% disagreed.

Table 1 Questionnaire About Reasons for Wanting MFT

		All		**Participants Wanting MFT (n=38)**				
		N	**% of 46**	**n**	**% of 38**			
Wanted MFT total		38	82.61	38	100			
Want MFT for medication-related reason, incl. free text		36	78.26	36	94.74			
Not own wish		5	10.87					
Not answered question of who wanted MFT		3	6.52					
Total		46	100			**Subgroups of Questions** % Chosen Either of These		
Reasons for wanting MFT	Negative effects/side effects	26	56.52	25	65.79			89.47
	Experienced pressure about using medication	20	43.48	19	50.00	63.16	78.95	
	Lack of alternatives to medication	16	34.78	16	42.11			
	Conflicts with my understanding of my problem	16	34.78	13	34.21			
	Other reason	9	19.57	8	21.05			
				Free text (n 17): - Negative effects of medication - Having experienced pressure or coercion - Understanding of problem - Worries about medication - Belief in a better therapeutic process without medication - Finding other ways to cope than medication - Help with withdrawal - Other aspects of the treatment			

Notes: Bold box contains the results that are our main focus: from patients indicating MFT was their own wish.

Table 2 Answers to the Question: "I Have Been Respected for My Wish Not to Use Medication" in the 6 Months Prior to Admittance

Response Alternatives	n	Valid %		% of Applicable	
Strongly disagree	2	4,44	11,11	6,25	15,63
Disagree	3	6,67		9,38	
Neutral	10	22,22	22,22	31,25	31,25
Agree	10	22,22	37,78	31,25	53,13
Strongly agree	7	15,56		21,88	
The question is applicable	32	71,11			
The question does not apply	13	28,89			
Total valid	45	100,00			
Missing	1				
Total	46				

Notes: Orange shade: disagree and strongly disagree, green shade: neutral, grey shade: agree and strongly agree.

Interview Results

Findings Affecting the Analysis: The MFT-Concept Has Unclear Borders

Although participants stated that they wanted MFT and had concerns explicitly about stopping or not commencing medication, there was not necessarily a clear distinction for them between MFT and other factors. Cecilie put it like this when asked if MFT was important to her:

> Well …, it was … it was partly that it was medication-free, that was what … I did not think … I had not sort of separated IMR and medication-free treatment. I saw it as the same.

The MFT mandate seemed abstract and some struggled to answer questions about how they understood MFT and were reticent about what difference it made. However, the same participants also expressed both wanting MFT and having clear concerns regarding medication. For example, Diana said she had "no idea" whether she thought shared decision-making would be handled as well on a ward that was not MFT but expressed feeling safer from being involuntarily medicated in MFT. This finding, together with the quantitative finding that 94.74% of those wanting MFT reported medication-related reasons, led to us focusing on service users' explicit medication-related reasons for wanting this treatment. Other themes were also present, but it was hard to determine whether they were regarding treatment in general, other aspects of the ward, or were implicitly related to MFT.

Interview Themes Illuminating Reasons for Wanting MFT

As shown in Figure 2, we divided themes from the interview data into two broad areas: being medication-free and

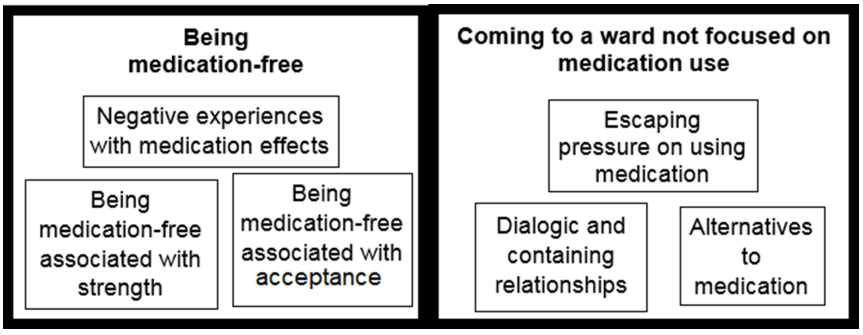

Figure 2 Interview themes illuminating reasons for wanting MFT.

coming to a ward not focused on medication use, both with subthemes as described below.

Being Medication-Free

Being medication-free was expressed as a key motivation for being at the MFT unit in the sense of wanting to withdraw medication during the stay, consolidate previous withdrawal, or simply avoid starting medication. This was connected to the subthemes (i) negative experience with medication effects, (ii) an association between being medication-free and being strong, and (iii) acceptance of themselves without medication.

All the informants reported some negative experience with medication effects, mainly psychotropic medication. There were, however, reports of benefits of sleep medication. Experiences included emotional flattening, feeling "zombielike" or "less human," feeling empty and tired, having suicidal thoughts, and developing abuse of the medicine.

Along with negative experiences with medication, there were also expressions of an association between being medication-free and being strong. Elise put it like this " … for me personally, it has been very important to avoid medication. Because I wanted to go the hard route." Diana described using a "happy pill" as defeat. Anita expressed a view that the choice of MFT depends on, among other things, "how strong you are."

Some participants explained the wish for MFT as wanting to achieve acceptance of themselves without medication, as Elise expressed it, without "chemical modifications." This implies a notion of the unmedicated self as the real self. Elise said, in connection with being cautious about medication, that "I want to live as the person I am, for better or worse." Diana described how the medicines promoted and legitimized her defense against emotions that made her feel worse:

> My challenges on the outside have been to put a lid on all emotions. So all my emotions have sort of been fused …. And that has given me anxiety. And I was afraid that if I was put on medication again, that it would just like … that it would be okay to continue covering up my emotions. And repressing emotions sort of was okay because the medications were on my side regarding that. So I needed to be challenged on experiencing my emotions and tackle things. Experiencing standing up for myself, to feel that I exist and to have a voice.

Coming to a Ward Not Focused on Using Medication

Coming to a ward with another focus was expressed as important in the sense that other wards lacked alternatives to medication, in the MFT unit the participants could escape medication pressure, and there were expectations of relationships with health care professionals characterized more by dialogue and containment when there was no medication focus. Diana said it was important to her that the ward was not focused on medication use. Similarly, Elise said that she would have been skeptical if the ward was not medication-free, and Cecilie viewed the MFT ward as an interesting approach for someone like her who did not want to use medication.

Searching for alternatives to medication was expressed by, for instance, getting tools to tackle challenges that they have not gotten elsewhere. For example, when Elise was asked whether she previously had wanted such a service, she said:

> That I have thought those times I have been on [ward x] because, as I said, on [ward x] it is more for stabilization. Ehh … that will do for a while, but when you don't get the tools you get here … then it becomes a little hopeless. So to speak.

Similarly, Cecilie described her motivation like this:

> I came here to learn a tool for managing my life further on. I had no need to come here and be "in storage". (…) if I had had that need, I would not come here, I think.

Cecilie had experienced a strong focus on medication in other services and sometimes that had been the only help she had been offered. When asked if she previously had thought about wanting treatment with less focus on medication, she responded:

> Not really. It has never really, like, been heard about or talked about. There has never been a focus on that for me. They've had two, or three really, diagnoses that they've touched on but that are now removed and that really were, the only treatment I have received for those has been medication.

Cecilie seemed to search for an explicit service focus on the opportunity to become medication-free. She was surprised that medication was such a prevalent topic in the IMR handouts at the MFT unit. When asked about how the service could be improved, she said:

> Perhaps it could have been more in focus so people had been a little more … (…) aware that it is possible to do it without medication. Interviewer: So more focus on what medications do to you and how it is possible to manage without? Cecilie: Yes. And focus on that it is at least possible to try without, at least give it a chance. And there is not much focus on that, directly, in the [IMR] modules we've had until now.

Escaping medication pressure was an issue. Diana and Elise directly expressed this was a reason for wanting MFT. Overall there were mixed experiences with discussing medication practices in other treatment settings. Diana expressed feeling safer when being admitted at the MFT unit because the possibility of coerced medication was absent:

> … this was not a place where I needed to stress about them wanting to medicate me involuntarily. And that made me calmer when I was admitted, because I understood they worked in another way here.

Diana discussed her experiences of medication pressure when she had been in a vulnerable situation, and her arguments against the professionals had fallen short:

> There was a very strong pressure. I was very insecure about myself, was very low in confidence … It is hard to oppose medication when you sort of feel your arguments don't float.

She also said that her previous psychiatrist had been angry with her for being determined about not wanting medication. Elise said her wish not to use medication had been respected but attributed this in large part to her being strong and knowledgeable about her rights.

Elise: The experience I have had on (ward x) among other things it was more like … how shall I put it … they did not pressure, but it was more like, you felt this was what they wanted all along, and … but then you are informed. And you know they can just forget about that legal option [ie, the use of the Mental Health Act], at least regarding medication.

Cecilie similarly described that her attempts at stopping her medication had been accepted in previous treatment because she was so determined: " … I do not think they really wanted to take the fight." While not agreeing she was directly supported, she was nevertheless guided in stopping her medication and she expressed overall satisfaction with the help she received. When on medication, on the other hand, she experienced a lack of follow up regarding medication effects, dosage, continued need for medication, and the effect on her blood pressure. She felt that this lack of follow up contributed to her starting to misuse the medication.

There were descriptions of recovery notions of dialogic and containing relationships with health care professionals that were seen to be at odds with focus on medication. Elise said that she had no faith that medication would solve her problems and that she believed more in talking therapies. She said she would have been skeptical if the ward was not an MFT unit, as she believed "chemical adjustment should not be necessary." She made a connection between medication and focus on clinical assessment, rejecting both:

Elise: I do see now that by simply making a diagnosis many [clinicians] have moved on from those 90 or several hundred questions that you have to go through over 4 hours or whatever it is. And I find that positive because many years ago I listened to a family therapist called Jesper Juul [A public figure in Scandinavia], and he was very opposed to assessments. And he said something to me that has stuck with me since that lecture, and that is that all psychologists must learn to talk to people.

Interviewer: Yes, that is very important.

Elise: Yes, it has stuck with me all the way. And that is why I have been so adamant in keeping away from medication. And therefore I am very positive about what I see now, which is about to change.

It seems that reliance on medication was at odds with her understanding of recovery, and that she expected more room for talking therapy as opposed to assessment and medication on the MFT unit. Similarly, Diana associated "not being laid flat" with medication as being given room for expressing feelings. Diana expressed that it was important for her to

Diana: … meet a therapist who actually accepted that I wanted to get in touch with my emotions.

Interviewer: Yes, have you previously experienced that that was not accepted?

Diana: I have. I have many experiences, bad experiences in health care. And that too … it was important to me not having to use medication, it was important for me to have a space where I could develop a little more contact with myself and connect the brain a little to the body and understand what goes in with me when emotions take over.

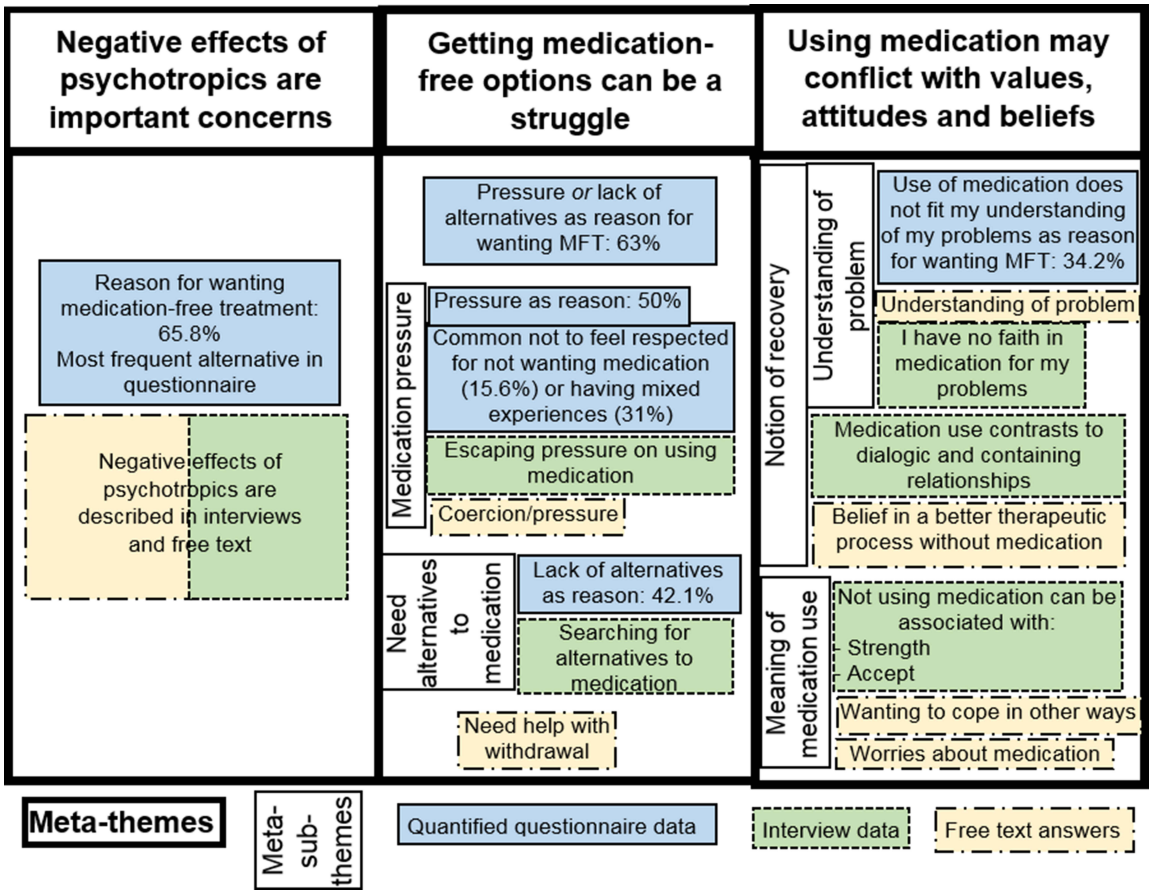

Figure 3 Integrated results.

Integrated Results

We found no direct dissonance between the findings from the questionnaires and the interviews. We found widespread agreement and some complementary findings leading to three meta-themes, as shown in Figure 3. Negative effects of medications was the most prevalent reason chosen in the questionnaire for wanting MFT, and this theme was also present in open-ended questions and interviews, strengthening this as an important issue for participants. Experiences with pressure, lack of alternatives, not being respected for not wanting medication, and needing help with withdrawal can be reasonably subsumed under the heading that getting medication-free alternatives can be a struggle. Finally, values, attitudes, and beliefs conflicting with using medication were expressed in all the data sources. The questionnaire results showed a large minority (34.21%) indicated that reliance on medication does not fit their understanding of their problem, a theme also present in the interviews and open-ended questions. The qualitative results indicated a broader theme of notions of recovery in conflict with medication use (dialogic and containing relationships with health care providers, belief in a better therapeutic process without medication). In addition, qualitative findings indicated the meaning attached to not using medication (strength, acceptance, wanting to cope in other ways, worries) may be at odds with using medication.

Discussion

A majority of participants reported that MFT was their own desire and stated reasons that were related to the intended purpose of MFT (78.26%). Important reasons seem to be the negative effects of medication, struggle with getting alternatives in ordinary health care, and medication use conflicting with values, attitudes, and beliefs. Together with previous findings,[29] our study demonstrates

the presence of a desire for MFT as an alternative to mainstream treatment services. This contradicts the views of MFT as representing the wish of only a minority of service users.[26] It also contradicts the view that service users already have a crucial impact on choice regarding medication.[26]

Side effects or negative effects of medication were an important issue for our participants, which is in line with previous research.[2,3,5–9,24] It was the most frequently chosen reason for wanting MFT both in our questionnaire (65.79%) and in Øvernes[24] interviews with clinicians (39%).

Our study shows that getting medication-free options can be a struggle in mainstream mental health care and that medication use may conflict with values, attitudes, and beliefs. This may explain why the wish for dedicated units for MFT has arisen. Service users search not just to avoid medication but for services in which medication plays a less central role. Pressure to use medication and lack of alternatives are concrete obstacles for service users not wanting medication. In addition, a shared understanding of the nature of their problem, the notion of the recovery process, and the meaning of using medication can be important elements of a therapeutic alliance.

Service-related factors such as experiencing pressure to take medication or lack of alternatives were a large part of the reasons for wanting MFT (63.16%). Lack of respect for not wanting medication was a common experience in recent treatment, and it can be difficult to quit medications without help. As shown by Yeisen, Bjørnestad, Joa, Johannessen, Opjordsmoen,[26] some clinicians consider MFT unprofessional, unscientific, harmful, and unethical. Service users report strong informal pressure for medication during previous admissions, mirroring the staff sentiments found by Yeisen, Bjørnestad, Joa, Johannessen, Opjordsmoen.[26] Notably, one of our interviewed participants seeking alternatives conveyed that medication was the only thing she had been offered, and alternatives had never really been discussed. Some of our interviewed participants who said they had been respected simultaneously conveyed that the respect was due to their own determination, strength, and/or knowledge. That is, even when agreeing to having been respected, they often conveyed an element of struggle. Our findings regarding these struggles correspond to previous qualitative research showing that discussing medication with professionals can be difficult.[3,9] Further, quantitative research has found relationships between negative interactions with health care workers and not taking medication.[2–8]

Service users' right to choose medication-free alternatives is limited by whether it is considered clinically justifiable.[44] Therefore, mental health professionals still have defining power as to who is offered this option. Interestingly, critics of MFT have objected to both the safety of MFT as well as the notion that this alternative is not sufficiently available at present. Critics have questioned the need for MFT, saying there are already alternatives, for example, for people with psychosis being treated in ordinary health care.[27] Yeisen, Bjørnestad, Joa, Johannessen, Opjordsmoen[26] found many psychiatrists believed service users had a crucial impact on treatment choice and, accordingly, on adherence to medication.

Taken together, our findings support that although experiences are varied, a large proportion of service users had previous experience being disrespected for not wanting medication, and more than half of the service users report experiencing pressure to take medication or lack of alternatives to medication. This sheds important light on why the need for MFT units has arisen. It also highlights gaps in perception of reality among service users and health care professionals regarding the availability of options. As Blindheim[9] has pointed out, health care professionals might not be sufficiently aware of the impact of power imbalance in communication about these issues.

Participants' understanding of their problem, notions of recovery, and meaning attached to using medication were sometimes at odds with using psychotropics. Understanding of the problem was indicated as a reason for wanting MFT by 34.21%. MFT was associated with more dialogical and containing relationships in contrast to being assessed and medicated or "laid flat." Belief in a better therapeutic process without medication, wanting to cope without medication, and associations between strength, acceptance, and being medication-free were also themes in the qualitative material. Previous research has found associations with freedom and not using medication.[5] Taken together, these themes may be seen as wanting to be treated more as a subject and/or feeling more as a subject in their lives; in contrast, medication is associated with objectification. In our view, there is no necessary connection between medication and objectification. This association may be understood in light of the above-mentioned experiences with pressure regarding medication. There may also be correlations between emphasis on medication and a more authoritative stance

that has to do with traditions within the mental health field.[45] Additionally, one might imagine that the act of taking a substance that is supposed to affect a person's thoughts and feelings in itself may collide with feeling in charge of the self. In previous research, involuntary medication has been described as a particularly invasive form of coercion.[10]

Strengths and Limitations

Our study was an exploratory study of one fairly typical medication-free unit. Mixed methods provide the opportunity for more in-depth knowledge of the influences at play in this context, which facilitates theoretical generalization as well as triangulation of results obtained with different methods.

The downside of the local nature of the study is that data from different contexts are not available. What service users want or expect to get out of MFT might be influenced by unique characteristics of the local medication-free unit in comparison to available alternatives and how this is presented to the service users via referrers, media, the medication-free unit, or other sources. For example, focus on motivation, effort, and empowerment might attract service users with certain attitudes and values or shape their narrative. How this translates to health care services at large must be inferred through theoretical generalization, including comparison of contexts and other research findings.

The response rate for questionnaires was high (82.14%), strengthening the representativeness of our sample in this context. There might be biases in selection for interviews, given that about half of service users declined the interview. From what is known about reasons for declining, we might have missed out on reports from the most distressed service users. The interview sample is on the smaller side because of difficult recruitment and so might not be saturated. The open-ended questions section of the questionnaire compensates somewhat for this.

There is the possibility that participants may feel they have to justify being on a medication-free ward when asked about this, even though their anonymity is protected. The exploration of this issue from different angles (interviews, different questionnaires, open-ended questions) may reduce this risk.

Conclusions

The majority of service users coming to the medication-free ward in our study confirm this was their own wish and give reasons in line with the goals of the government and user organizations. The findings demonstrate that these service users want an alternative to mainstream medication treatment. Negative effects of medications and difficulty in obtaining alternatives are important reasons for wanting this kind of service. Some also believe that taking medications does not fit with their concept of their problem and recovery. Our study highlights a gap in perception of the status quo between service users and critics of MFT regarding whether treatment without medication is perceived as available by service users who want this.

Future Implications

According to government authorities, service users have the right to choose MFT everywhere in mental health care as long as it is clinically justifiable.[46] To make this option a reality, clinicians are advised to be mindful of communicating alternatives as well as the effect of power imbalances in their interactions with service users who disagree with them so that the medication-free choice does not become a struggle. The presence of informal pressure indicates potential for more shared decision making within the boundaries of what is considered clinically justifiable. It also indicates the need to further clarify these boundaries and the potential of medication-free alternatives.

Data Sharing Statement

Raw data cannot be shared because of privacy regulations.

Acknowledgments

We thank our participants for sharing their thoughts and experiences. We thank all the personnel involved in the treatment services for their invaluable efforts in gathering data. We especially thank the former leader of the hospital department at Åråsen Wenche Brandtzæg Nikolaisen for allocating resources to this project, the former leader of the inpatient treatment units at Åråsen Anders Skogen Wenneberg for supporting the project, research coordinator Bodil Skiaker for help with data management, assistant Shko Nagmadin Karim and Pia Jensen for plotting of data, Jorunn Iversen and Gunn Borgen for help in coordinating the data collection at the Myrvegen inpatient unit, Camilla Kvaase and Lene Paulsen for important roles in the data collection at Åråsen inpatent units, and Jill Arild for providing the user perspective as our user representative.

Funding

The study was funded by Akershus University Hospital.

Disclosure

The authors report no conflicts of interest in this work.

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Supplemental material A: Sample characteristics

Our research sample, compared to all registered users in hospital statistics during the recruitment period, where available.

Table A1.

Main diagnoses at baseline

Main diagnosis reported by clinicians, grouped by researchers	Research sample		All registered*	
	n	Valid %	*n*	Valid %
Psychosis F20-F29	7	15,2	9	16,07
Bipolar disorder F30-F31	7	15,2	9	16,07
Personality disorders F60-61	7	15,2	10	17,86
Affective disorder, non-bipolar F32-F39	6	13,0	7	12,50
Anxiety F40-41	6	13,0	5**	8,93
Trauma/stress F43	5	10,9	6	10,71
Hyperkinetic disorder F90	4	8,7	4	7,14
Dissosiation F44+ F48.1	1	2,2	2	3,57
Somatoform disorders F45	1	2,2	1	1,79
Eating disorders F50	1	2,2	1	1,79
Pervasive developmental disorders F84	1	2,2	0**	0
N valid	46		56	
Missing	0			

**Hospital statistics from the study period among planned and ordinary stays excluded readmittances within 30 days.*
**Our research sample and hospital statistics are drawn from different sources (questionnaires versus electronic journal). There may be errors or differences in registration, explaining instances in our research sample seemingly not included in overall statistics.

Table A2.

Psychotropic medications prescribed at baseline

Medication groups*	***n*** **Medications in use**	**%** **of medications in use**
NLH 5.3 Antidepressants	25	31.25
NLH 5.2 Antipsychotics	22	27.50
NLH 5.1 Anxiolytics and hypnotics	18	22.50
NLH 6.1 Antiepileptics	7	8.75
NHL 9.1 Histamine H1-antagonists	6	7.50
NLH 5.5 Mood stabilizers	2	2.50
Total	80	

**Excludes medications grouped as "other" or "don't know" by clinicians (included somatic medications)*

Table A3.

Age

	Research sample	All registered*
Mean	37,85	37,46
Median	34,00	
SD	12,94	
Minimum	62	
Maximum	19	
N Valid	46	56
Missing	0	

**Hospital statistics from the study period among planned and ordinary stays excluded readmittances within 30 days.*

Table A4.

Gender

	Research sample		All registered *	
	n	Valid %	*n*	Valid %
Male	14	30,43	20	35,71
Female	32	69,57	36	64,29
N valid	46	100,00	56	
Missing	0			

**Hospital statistics from the study period among planned, ordinary stays excluded readmittances within 30 days.*

Supplemental material B: Questions from self report questionnaire used in this study Translated from norwegian

General introduction to the entire questionnaire

Questionnaire at beginning of treatment about you and your treatment in the last 6 months

The questions are about background information, what is important for you, and treatment received in the last 6 months (before your current admission). Please check the best answer for each question. **Only one answer per question, unless otherwise specified.**
Regarding questions about your therapist or service provider, think of those involved in treatment of your mental health in the period.
This form is used only in research, and your therapist will not see your answers.

Questions used in this Study
Being respected for the wish not to use medication

Have you received help with psychotropics the last 6 months? *Please check one box for the most suitable answer.*

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Not applicable
7 I have been respected for my wish not to use medication.	☐	☐	☐	☐	☐	☐

Reasons for wanting MFT

Your agenda
1. Were you referred for medication-free treatment?*

□ 1 Yes □ 2 No □ 3 Don't know

**Medication-free inpatient units is a government measure initiated by user organizations. The goal is to ensure that patients get real alternatives to medication for mental disorders (psychotropics), as well as to gather experience with alternatives to medication. Therefore, the unit's main focus is on psychosocial treatment. Patients who are referred to this unit will not be subjected to persuasion or pressure regarding medication and will get help finding other coping strategies. One can choose not to use psychotropics even though it is recommended in current guidelines as long as the treatment in total is clinically justifiable. One can also use psychotropic medication if desired.*

If Yes:
2. Who wanted medication-free treatment? (Multiple choices possible)
□ 1 Self □ 2 Next of kin □ 3 Health professional □ 4 Others

If Self:
3. Why was this important to you? (Multiple choices possible)
□ 1 I have felt pressure to use medication
□ 2 I experience lack of alternatives to medication
□ 3 Use of medication does not fit my understanding of my problems
□ 4 I have had negative experiences with effects and/or side effects of medication
□ 5 Other
Describe:

Sample characteristics

Birth year: _____

Gender
☐ 1 Male ☐ 2 Female ☐ 3 Other

Are you under an outpatient commitment order?
☐ 1 Yes ☐ 2 No

Use of medication for mental illness

☐ I use no medications
☐ I use medications

General ending to the entire questionnaire

Please check that you have answered all questions.
Thank you for giving us important information!

Supplemental material C: Questions from clinician questionnaire used in this study Translated from norwegian

General introduction to the entire questionnaire

Questionnaire for clinician at treatment start
The questionnaire is filled out on the basis of all information one has about and obtains from the patient. Please fill in the top text on each page so each page is adequately marked in case of separation.

Questions used in this article

Sample characteristics

Use of medication for mental illness (indication)

☐ The patient uses no medication
☐ The patient uses medication (fill in below about all current prescribed medications)
Depot medicine for injection: _____ Dose: _____ mg Interval: _____ days
Whether use of depot is voluntary: ☐ Voluntary ☐ Involuntary

Current prescribed medications (at admission):

Current diagnoses:

Main diagnosis (ICD-10):

End of the entire questionnaire

Please check that you have answered all questions.
Thank you for giving us important information!

Supplemental material D: Interview guide
Translated from norwegian

Part one: Reasons for medication-free treatment

1. This ward is called a “medication-free inpatient ward”. What does this term mean to you?
2. When did you first hear about this phenomenon?
3. Before you came, how did you picture you would notice the difference between a medication-free ward and an ordinary ward?
4. How did you first hear about this ward?
5 What was important to you when being referred for this admission?

Was it important for you to come to a medication-free ward?

If yes	If no
6. Why was this important to you? 7. Do you have any experiences contributing to this being important for you? Would you like to share some of these? 8. How long have you wanted such a service?	6. What do you think about the ward being medication-free? 7. If you could choose freely between medication-free and and ordinary ward, all else being equal (treatment offer, duration, waiting time, persons, own reasons etc.) what would you have chosen? a. Why?

Part two: Experience of medication-free treatment

9. All in all, what do you think about your stay here on the MFT-ward?
   - What have you been most satisfied with during the stay?
   - What have you been least satisfied with during the stay?
   - If you had met another man or woman who was in need of mental health care, would you recommend this ward?
10. If you have been admitted to another inpatient ward earlier (including this ward before it became an MFT-ward), what would you say is the biggest difference between tjhose wards and this one?
11. If you during your stay have chosen to not use medication or reduce medication, what has this been like?
   - Do you think you have gotten help in working with your problems in other ways (than taking medications)?
   - Have you gotten alternatives/help you have not gotten elsewhere?
   - Do you feel supported in tackling your challenges without medication?
12. During your stay, do you feel you have had influence on your treatment? (decide, affect, participate, be heard)
   - Do you feel you have had enough influence, or would you have preferred more?
   - *If much influence:* Do you think this opportunity to decide would be as good on a ward that was not medication-free?
14. If you should give an advice to us working here for the treatment to be better, what would it be?
15. If you could choose exactly the treatment you wanted, what would you choose?

If time left:

1. Do you feel your thoughts about choices and needs regarding treatment is taken into consideration by therapists (Therapists in general, not just the pones you have met)

2. What kind of experiences do you have from conversations about treatment choices? Some say they do not dare to tell all about how they feel, because they are afraid they will not get to choose the treatment they want, but may be forced to take medicines, or even involuntary admitted. Do you have such thoughts?

II

II

III

III

Medication-free treatment in mental health care

How does it differ from traditional treatment?

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Declarations

Ethics approval and consent: The study was conducted in accordance with the Declaration of Helsinki and approved by the Regional Committee for Ethics in Research (2017/1056/REK sør-øst B.) and the Privacy Ombudsman at Akershus University Hospital (17–134). Participants gave written, informed consent before participation. All participants' names are pseudonyms, and consent includes the publication of anonymous results.

Consent for publication: Not applicable.

Availability of data and materials: The datasets generated and/or analyzed during the current study are not publicly available due to privacy regulations. The data contain health information and may be indirectly identifiable, hence are regarded as personal sensitive data. We do not have permission to share them outside of the research group.

Trial registration: This study is registered at ClinicalTrials.gov (NCT03499080), date 17/04/2018.

Competing interests: The authors declare that they have no competing interests.

Funding: Akershus University Hospital. The role of the funding body was to set the main theme (medication-free treatment) and provide salary and general working conditions.

Authors' contributions: KS, KSH, and OAS planned the project and initiated the data collection. AA consulted in planning the project. IEB made the staff interview guide in collaboration with KS and KSH, and interviewed staff. CW transcribed the staff interviews. MSH supervised the student (not the author) who interviewed and transcribed the patient interviews. KS analyzed the data and drafted the manuscript. JR supervised the qualitative analyses. OAS supervised the quantitative analyses. KSH was the project leader and supervised KS closely throughout the process. All authors critically reviewed and agreed on all versions of the article and the journal to which the article will be submitted. All authors agree to take responsibility and be accountable for the contents.

Publications and preprints: Themes and formulations under the introduction and method sections may overlap with previous publications on the same project [1-3], since the same project has investigated several research questions [2,3] and we have previously written about the same phenomena and presented our project [1]. However, results of our investigation of characteristics of medication-free treatment have not been published previously. A preprint is uploaded on Research Square.

Acknowledgements: We thank our participants, all the personnel at the involved treatment services, leaders and support personnel in the project. We especially thank Wenche Brandtzæg Nikolaisen, Anders Skogen Wenneberg, Bodil Skiaker, Camilla Kvaase, Lene Paulsen, Astrid Tiltnes, Svein Mossige, and Odd Arne Tjersland.

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IEB, CW, and Astrid Tiltnes have each written their master's theses on the interview material. Public availability of their theses has been postponed until late 2023 to allow for the planned publication of articles on the research material.

Abstract

Background: Norwegian authorities have implemented treatment units devoted to medication-free mental health treatment nationwide to improve people's freedom of choice. This article examines how medication-free treatment differs from treatment as usual across central dimensions.

Methods: The design was mixed methods including questionnaire data on patients from a medication-free unit and two comparison units (*n* 59 + 124), as well as interviews with patients (*n* 5) and staff (*n* 8) in the medication-free unit.

Results: Medication-free treatment involved less reliance on medications and more extensive psychosocial treatment that involved a culture of openness, expression of feelings, and focus on individual responsibility and intensive work. The overall extent of patient influence for medication-free treatment compared with standard treatment was not substantially different to standard treatment but varied on different themes. Patients in medication-free treatment had greater freedom to reduce or not use medication. Medication-free treatment was experienced as more demanding. For patients, this could be connected to a stronger sense of purpose and was experienced as helpful but could also be experienced as a type of pressure and lack of understanding. Patients in medication-free treatment reported greater satisfaction with the treatment, which may be linked to a richer psychosocial treatment package that focuses on patient participation and freedom from pressure to use medication.

Conclusion: The findings provide insights into how a medication-free treatment service might work and demonstrate its worth as a viable alternative for people who are not comfortable with the current medication focus of mental health care. Patients react differently to increased demands and clinicians should be reflexive of the dimensions of individualism–relationism in medication-free treatment services. This knowledge can be used to further develop and improve both medication-free treatment and standard treatment regarding shared decision-making.

Trial registration: This study was registered with ClinicalTrials.gov (Identifier NCT03499080) on 17 April 2018.

Keywords: medication-free, mental health care, psychotropics, choice

Introduction

Since 2015, all Regional Health Trusts in Norway are required to provide medication-free treatment to people with mental disorders within the structure of dedicated units. This has resulted from an instruction by the Ministry of Health [4], which is unprecedented worldwide.

The official aim of medication-free units is that, as far as clinically justifiable, patients should have the opportunity to choose whether they want medication as part of their treatment [4]. The policy emerged partly from the lobbying by a coalition of user organizations that viewed medication-free treatment as a means to avoid coercion, pressure or persuasion related to medication [5]. Local protocols of the health regions have clarified that patients treated in medication-free units may use psychotropics if they wish [6,7].

In this article, medication-free treatment refers to services developed in response to the governmental decision mentioned above. Medication-free treatment is interpreted to mean that the service is free from medication pressure and involuntary treatment with medication, rather than free from all use of psychotropic medication.

Medication has been a central part of treatment for severe mental disorders in Western medicine since the 1950s [8], but only about half of patients with a severe psychiatric disorder adhere to their medication regimen [9]. The World Health Organization (WHO) has recently criticized mental health care internationally for being too restricted to a biomedical model of illness that places psychotropic drugs at the center of treatment [10]. Referring to the United Nations Convention on the Rights of Persons with Disabilities (CRPD) [11], the WHO has called for eliminating involuntary admission and treatment [10].

Historically, other initiatives for the treatment of severe mental disorders have explicitly prioritized the psychosocial component over medication. Some of the most well known are Chestnut Lodge (1920–2000) [12], Kastanjebakken (1977–2000) [13], Soteria (1969–ff) [14,15], and Open Dialogue (1980s–ff) [16]. Common elements are the emphasis on relationships [13,14,17-19], flexibility and adaptation, a supportive environment, and finding meaning in the person's

experiences [14,17-19]. These treatments vary in therapeutic intensity [14,17,19,20]. Although none of these treatment ban medications, they typically use them more sparingly than in traditional health care and believe that other elements are more central to long-term improvement [12-15,18,19].

By 2018, medication-free treatment was offered at 25 locations in Norway [1]. The services are not uniform, but the most common characteristics are that treatment is provided within inpatient open wards, patients with a severe mental disorder are prioritized, and the treatment is influenced by a recovery-oriented tradition [1,21].

The recovery approach is characterized by a focus on connectedness, hope, identity, meaning of life, and empowerment (CHIME) [21]. The recovery tradition focuses on personal recovery: that is, a recovery process that is defined and experienced individually as opposed to clinical recovery that is located within an illness frame of understanding. This approach also highlights that clinical recovery is heterogeneous and does not follow a set course of illness. The recovery tradition emphasizes that treatment services should be based on the views of individual patients rather than on professional priorities [22]. Although medications are recognized as important treatment options within the recovery approach [23], this approach has criticized traditional services for handling the medication issue dogmatically [22].

Earlier investigations of medication-free treatment services in Norway indicate that these services offer more psychosocial treatment [24] and require more staff resources [25,26] compared with standard treatment. Staff experience an increased focus on client participation [25] or shared decision-making [24] and using less medication, and an increased focus on patients' responsibility for their own health, group therapy, and processes to facilitate recovery [25]. Staff sometimes find it challenging to balance a patient's needs with treatment guidelines, the legal framework, and available resources [26]. Patient interviews reveal experiences of increased responsibility and freedom, a less pathologizing language, being seen as humans as opposed to being labelled, greater unity between users and staff, and improved involvement of family, friends and their network [27].

There is an ongoing debate about whether such units provide something new and are needed [28,29]. To our knowledge, no articles in peer-reviewed journals have reported a broad investigation into the characteristics of medication-free units compared with traditional treatment. The characteristics of current medication-free treatment regimens and differences from those of traditional services should be explored in greater detail.

The aim of the present study was to investigate the characteristics of medication-free treatment as compared with traditional approaches. Using quantitative data, we compared the provision and experience of treatment in a medication-free unit with that in treatment-as-usual units at the same level of care. We used qualitative interviews with patients and staff at the medication-free unit to explore their views and experiences of how the medication-free unit compared with other relevant experiences.

Materials and Methods

Setting

The setting for this study was one medication-free unit and two standard care (treatment as usual or TAU) units under a general university hospital in the metropolitan Oslo area in Norway. The hospital has a catchment population of 500,000 and contains both urban and rural communities. The medication-free unit is representative of such services for most common characteristics [1]. The unit officially opened as a medication-free unit on 1 March 2017 and had been in operation for about 1 year at the start of data collection. The characteristics of the units are shown in Table 1.

Table 1 Characteristics of the included treatment units

	Medication-free unit	Neighboring TAU unit	Distant TAU unit
Target population	People aged >18 years in need of voluntary inpatient mental health care Exclusion criteria: active addictions, acute suicidal behaviour or acute aggressive/violent behaviour		
	People with psychosis and bipolar disorder wanting medication-free treatment are prioritized	Patients needing transfer from the acute ward are prioritized	
Organizational placement	Neighboring wards under the same leadership		Different regions under the same hospital
Treatment programme	Recovery-oriented treatment [21] incorporating the treatment programme Illness Management and Recovery (IMR) [23]. Elements from the traditions of the affect consciousness model [51], a feedback-informed framework [52], open dialogue [53] and techniques from basal exposure therapy [54].		Cognitive milieu therapy, network meetings, counselling and diverse group activities
Weekend policy	A 5-day unit in which patients go home for the weekend	A 7-day unit, but the main rule is patients go home for the weekend	A seven-day unit
Treatment duration	Typically, 8 weeks	Varied, mean 4 weeks	Varied, typically 6–8 weeks
Ordinary treatment places	7	9	14

Design

The design was for a preplanned parallel multi-sample mixed methods [30], observational and pragmatic study within a naturalistic treatment setting. The point of integration between the quantitative and qualitative methods was mainly in the analysis stage. We compared the medication-free unit with TAU using validated measures and questionnaires to ascertain the extent of psychosocial treatment, treatment with medication, and formal assessments; measures of patients' experiences of treatment in terms of their satisfaction, shared decision-making, alliance, support for personal recovery, help with medication and respect for their not wanting to use medication. We also analyzed the results of interviews with staff and patients about the medication-free unit in which participants compared their experiences of the unit with

other relevant work/treatment experiences. For staff, this focused on the ward before becoming a medication-free unit, and for patients, this mostly related to other treatment experiences.

The purpose of using multi-sample mixed methods was to obtain a more nuanced perspective of the relevant phenomena. A parallel design was deemed feasible and adequate. The main reason mixed methods was deemed suitable in this study was the complexity of the phenomenon of study. The phenomenon of medication-free treatment units has unclear boundaries toward treatment as usual. The explorative potential of the qualitative approach, as well as having several approaches illuminating the same questions, seemed useful for capturing this new phenomenon. It also seemed a suitable way to strengthen our inferences. We reckoned that integrating quantitative and qualitative approaches would provide a test of corroboration and complementarity. Moreover, the design enables both comparison with treatment as usual, for which the standardized aspects of the quantitative approach are well suited, and exploration of unique aspects of this setting.

Criteria for inclusion and exclusion

The inclusion criteria for patients were intended to capture the widest possible range of people on standard treatment stays that were comparable across units. Eligible patients were patients on a planned stay during the recruitment period who were deemed capable of being interviewed and/or completing forms in Norwegian and who consented to participate. The exclusion criteria were emergency stays and self-referral admissions, which are shorter stays that do not follow the standard treatment program, or inability to participate (being unable to be interviewed or complete forms in Norwegian).

The inclusion criteria for staff were intended to capture people with experience both before and after the introduction of medication-free treatment who had much patient involvement and were possible to anonymize. Eligible staff were milieu personnel who had been employed for ≥1 a year at the time of inclusion and who were working full time and mainly during the day.

Sampling procedures

The recruitment periods for the questionnaires were from May 2018 to April 2020 and September 2020 to the end of March 2021, with a break in between because of the Covid-19 pandemic. Only the neighboring TAU unit continued recruiting patients after the break. Data for all patients were collected during their treatment stay. Interviews were conducted from January to March 2018. Staff were purposively sampled through leaders at the unit and were informed and asked for consent by the interviewer. Patients were recruited through therapists who distributed information and consent forms at the beginning of each admission.

Regarding the questionnaire sample, power calculations were made for the primary outcome variable (OQ-45–2) of the larger study described in Heiervang [31], yielding a required sample size of 224. For this article, we did posthoc sensitivity calculations with the program G*Power [32] on the nonsignificant results indicating that we had adequate power to detect about medium sized differences (supplement, table S9-11). All nonsignificant results were below medium in size. Hence there may be below medium sized differences that could have been detected in a larger sample.

. We had a goal of recruiting about eight participants for each interview sample, as this was deemed a suitable size for forming part of a mixed methods design.

Data collection

We piloted the study routines in which we also gathered feedback from participants regarding questionnaires and interview guides. Questionnaires and clinical measures were completed by patients or their clinicians during the treatment period. One author (IEB) and another psychology student performed semi-structured individual face-to-face interviews with staff and patients, respectively. The interviews lasted 50–60 minutes and were audio-recorded.

Overview of the data

An overview of the data is presented in Table 2.

Table 2 Overview of the data

Topic	Data	Source	Timing	Data type
Sample characteristics	Age, gender, CTO and medication use	Patient	Baseline	Questionnaire
	Diagnoses (ICD-10) and medication use	Clinician	Baseline and end of treatment (diagnoses)	
	Number of admittances, lengths of admittances, main diagnoses, gender and age at included units during recruitment period for investigation of representativeness and response rate.	Patient journal	Independent of treatment timeline	Statistics
Psychosocial treatment	Psychosocial treatment, mean intensity	Clinician	End of treatment	Questionnaire
	Number of psychosocial treatment elements	P&C		
	Treatment duration (weeks)	Clinician		
Psychotropic medication	Received treatment with medication	P&C		
	Dose change during treatment	Clinician		
Assessment	Received assessment	P&C		
Staff thoughts and experiences of treatment	Interview data	Milieu personnel	Independent of treatment timeline	Semi-structured interview
Patients experience	Being respected for not wanting medication (M7)	Patient	End of treatment	Clinical measure
	WAI (Alliance)			
	CSQ (Satisfaction)			
	Collaborate (Shared decision- Inspire support (Support for personal recovery)			
	Interview data			Semi-structured interview

Note: P = patient, C = clinician, M7 = MedSupport question 7, WAI = Working alliance inventory, CSQ = Client satisfaction questionnaire

Questionnaires

Questions were completed by patients or their clinician, as indicated in Table 2.

Medications were grouped according to the Norwegian Medication Handbook [33].

Questions on treatment received are adapted to the present context from forms developed by a certified research institute [34,35]. Otherwise, questions are derived from a larger study on a similar patient group with minor modifications. Translated versions of questionnaires can be found in the Supplement, figure S1-10.

Standardized clinical measures

Table 3 shows the standardized clinical measures used in this study.

Table 3 Measures of treatment experiences obtained by patient report

Measure	Description	Range Worst → best
The Client Satisfaction Clinical measure-8	This instrument is an eight-item clinical measure for measuring a patient's global satisfaction with services. It has been shown to correlate well with the longer version, CSQ-18 and has shown good psychometric qualities regarding internal consistency, attendance, remainer–terminator status and greater client-reported symptom reduction [55].	8→32
INSPIRE Support version 3	This instrument measures perceived staff support for personal recovery domains considered important to the patient. The scale has adequate psychometric properties [56].	0→100
Working Alliance Inventory, short form (WAI-SP)	This instrument is a shorter form of the WAI that assesses three aspects of the collaborative purposive work in therapy, bond, task and goal, as well as a general factor [57].	1→7
Being respected for not wanting medication (question 7 from MedSupport)	Medsupport is a questionnaire about the perceived quality of help and information regarding medication [58]. In this article we use question 7 from the original version ('I have been respected for my wish not to use medication'). For this question, we also included ratings of treatment 6 months before admission for both groups combined to indicate the prevalence in mental health care more broadly (Table 8).	1→5
Collaboration between patient and staff: CollaboRATE	This instrument is a three-item measure of shared decision-making. CollaboRATE assesses three core shared decision-making tasks: (1) explanation about health issues, (2) elicitation of patient preferences and (3) integration of patient preferences into decisions [59]. It has been found to have adequate psychometric properties in both simulated [60] and clinical [59] settings. A mean score is calculated when all three items are answered.	0→9

Interview guides

An interview guide for patient interviews was developed in collaboration between a student and authors KS, MSH, and KSH, and was based on the literature and a previous study of medication-free services [36]. Topics included patients' understanding and expectations of medication-free treatment and attitudes about this treatment approach, as well as whether, and why, medication-free treatment was important for them, how the treatment compared with other treatment experiences, and whether, and how, they experienced shared decision-making. An interview guide for staff interviews was developed in collaboration between KS, IEB, and KSH. Topics included how staff participants view, understand, and experience the medication-free mandate compared with more traditional approaches. Translated versions can be found in the Supplement.

Analyses

Analyses were mainly parallel track analyses, meaning that quantitative and qualitative analyses were conducted separately first, and findings were then integrated. However, the different strands were allowed to talk to each other, and some crossover track analysis occurred in the integration phase.

Quantitative analyses

Cronbach's alpha for internal consistency reliability for all multi-item measures was >.80 (details are shown in the Supplement, Table S5). Numerical questionnaire data were analyzed using IBM SPSS Statistics (version 26) and are reported as frequency and valid per cent (valid %) or mean (M) and standard deviation (SD) as appropriate. Psychotropic drugs were grouped according to the Norwegian Medication Handbook (Norsk legemiddelhåndbok)[33]. Differences between groups were identified using independent sample *t* tests (sample characteristics) and one way between groups analysis of variance

(ANOVA) (treatment characteristics) for continuous variables and chi-squared tests for categorical variables.

Although our interest was in differences between regimens, we also performed ward level analyses (supplement, tables S1–4) to more robustly assess the degree to which medication-free treatment stands out. We expected there could be spillover effects between the neighboring wards. Sensitivity analysis without outliers was performed to assess the impact of outliers.

Qualitative analyses

The qualitative interview data were analyzed using a combination of thematic analysis [37] and systematic text condensation [38]. Thematic analysis involves flexible stepwise analysis wherein, after familiarization, the data are first coded in terms of basic meaning units and these codes are then sorted into broader themes [37]. Audio files were transcribed verbatim and coded and sorted using the program NVivo 14.23.1.(38). Initially, KS reviewed the transcripts using predominantly inductive coding of the interviews, and the coding was grouped according to the research questions of the overarching project [31]. Given that the medication-free mandate is not sharply delineated from TAU, all distinguishing features of this unit were included in the findings. Relationships with the mandate were discussed in the discussion part. The codes were then sorted into broader themes separately for patients and staff data. The data in each theme were then condensed [38], and these condensates from the patients and staff were combined into higher-level themes through an iterative process involving KSH, JR, MSH, IEB, and CW. Finally, we revisited the transcripts to check whether the final themes resonated with the data.

Integration of results

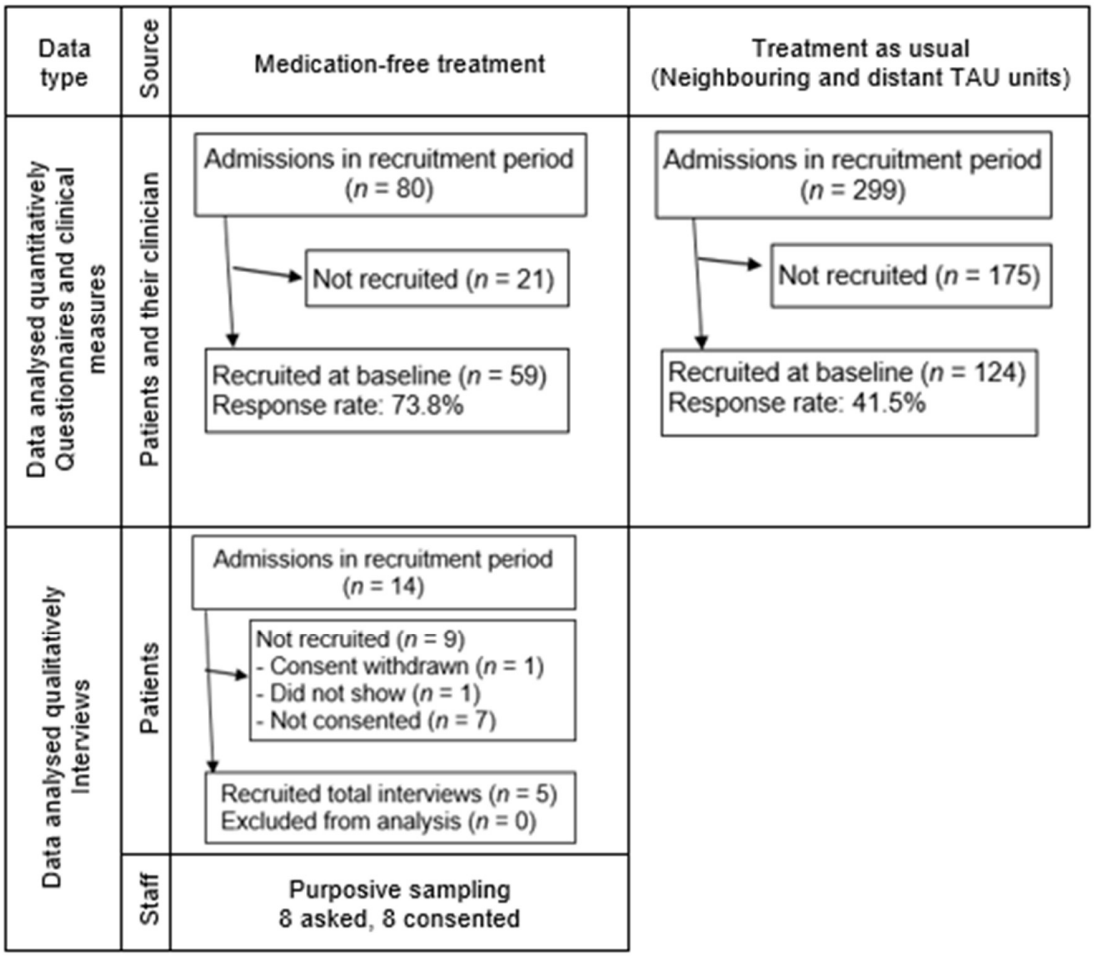
The qualitative and quantitative data were integrated with the help of joint displays, which are regarded as a way to depict, juxtapose, and analyze data [30,39]. Joint displays compare qualitative and quantitative data and can be used to provide integrative statements [30]. Rows were used for the overall issues addressed or identified in the data, and columns were used for the quantitative and qualitative results. We investigated convergence, divergence and complementarity in the results and used these analyses to develop integrative statements across all results. In this process, the qualitative data were revisited to determine if they could further illuminate quantitative findings, allowing for some crossover track analysis. For example, the finding of higher patient satisfaction in medication-free treatment guided an investigation in the qualitative material of which changes were positively regarded by the patients.

Results

Participant flow chart

Figure 1 shows participant flow.

Figure 1 Participant flow



Note. Admissions in the recruitment period = anonymous statistics from the electronic patient journals containing stays in the units during the recruitment period but excluding emergency admissions and self-referral admission stays. Not recruited = patients admitted during the recruitment period who did not consent or were unable to participate for any reason.

Questionnaire sample

Sample characteristics are summarized and compared between regimens in table 4.

Table 4 Sample characteristcs

Variable		*n* (each group)	Statistics	MFT	TAU	*p* value, difference between
Gender	Female Male	183 (59 + 124)	*n* (valid %)	42 (71.2) 17 (28.8)	72 (58.1) 52 (41.9)	.087[a]
Age (years)		183 (59 + 124)	M (SD)	38.6 (13.1)	43.7 (12.9)	**.013**[b]
CTO		163 (58 + 105)	*n* (valid %)	1 (1.7)	5 (4.8)	.324[a]
Use of psychotropics, baseline		183 (59 + 124)	*n* (valid %)	46 (78.0)	113 (91.1)	**.008**[a]
Diagnos	Psychosi	182 (59 + 123)	*n* (valid %)	9 (15.3)	12 (9.8)	.277[a]
	Bipolar	182 (59 + 123)		8 (13.6)	20 (16.3)	.636[a]
Mental health at	OQ-45–2	175 (57 + 118)		99.3 (21.1)	96.1 (23.1)	.372[b]
	AII-42	173 (56 + 117)	M (SD)	4.1 (1.2)	4.5 (1.2)	**.045**[b]
	GAF-S	177 (58 + 119)		52.1 (8.6)	50.8 (6.3)	.252[b]
	GAF-F	177 (58 + 119)		49.8 (8.5)	50.9 (6.6)	.324[b]

Note. MFT = medication-free treatment, TAU = treatment as usual, OQ = Outcome Questionnaire, AII = Affect Integration Inventory, GAF-F/S = Global Assessment of Functioning, function scale and symptom scale, **bold text** = statistically significant

[a] χ^2 test

[b] Independent-samples *t* test

[b] Independent-samples *t* test

According to mental health measures, participants in both conditions scored above clinical cut off on OQ-45–2 [40], in the moderate- to severe pathology range on GAF [41] and below normal range on affect consciousness [42]. Diagnoses were diverse, the most common being affective disorders (42 %), trauma/stress-disorders (14.4 %), personality disorders (13.3 %), and psychosis (11.6 %) (supplement, table S8). Fewer participants in medication-free treatment used psychotropics at baseline (78 % versus 91.1 %). This research sample seems representative when compared with other sources for admissions during the recruitment period on available demographics (supplement, tables S6 and S7).

The exception was for some diagnostic groups in the TAU group, in which patients with psychosis and personality disorders were underrepresented by 10.2% and 9.2%, respectively, compared with the hospital statistics.

Patient interview sample

Two patient participants were men, and three were women. To protect their confidentiality, female pseudonyms are used for all participants in the quotations presented here, and we do not report on their diagnoses. They ranged in age from 25 to 50 years, and included people born in Norway and elsewhere. One participant had never used psychotropic medication. The rest had attempted to stop taking such medication, either during the current stay or previously. Four of the five patient participants were not taking medication at the time of the interview. Medication groups mentioned were selective serotonin reuptake inhibitors (SSRIs), serotonin and noradrenalin reuptake inhibitors (SNRIs), anxiolytics, hypnotics, antipsychotics, and beta-blockers. Four had previously been admitted to an open psychiatric ward.

Staff interview sample

Seven staff participants were women, and one was a man. We have used female pseudonyms to protect anonymity. Five were nurses or assistant nurses, and the others had other professional backgrounds, which we do not report for confidentiality reasons. They had an average of 14 years' experience in mental health care and 12 years in this treatment unit, ranging from a few years to several decades.

Treatment characteristics

Quantitative analyses of comparative treatment characteristics: treatment elements, type and magnitude

Table 5 Psychosocial treatment received, medication-free treatment versus TAU

	Source	MFT			TAU			Anova		η^2
		n	M	SD	*n*	M	SD	F(B,W)	*p* value	Point estimate (95% CI)
Treatment duration (weeks)		59	8.9	2.2	123	4.7	2.2	147.2 (1, 180)	**.000**	0.45 (0.35;0.53)
Psychosocial treatment, mean intensity 1→5[c]	C	56	2.5	0.2	71	2.2	0.4	21.4[a,b] (1, 121)	**<.001**[b]	0.13 (0.04; 0.25)
Number of psychosocial treatment elements received		56	9.8	1.4	71	8.6	2.2	14.1[a,b] (1, 120)	**<.001**[b]	0.09 (0.02;0.20)
	P	49	10.5	2.6	84	9.4	3.1	4.5 (1, 131)	**.036**	0.03 (0.00; 0.11)

Note. *N* = 183 (MFT, *n* = 59; TAU, *n* = 124), MFT = medication-free treatment, TAU = treatment as usual, C = clinician, P = patient, **bold text** = statistically significant,), B = Between groups df, W = Within groups df, c = clinician reported, p = patient reported
[a]Asymptotically F distributed
[b] Welch test for non-scewed variables violating Levene's test for homogeneity of variance
[c]1: None, 2: less than once a week, 3: 1–2 times a week, 4: 3–4 times a week, 5: ≥5 times a week

Participants in the medication-free treatment had about twice as long treatment stays and a higher mean intensity of psychosocial treatment elements with a large[43] effect size (η^2 0.13–0.45 on regimen level comparison). Regarding the number of psychosocial treatment elements received, although the regimen level analysis indicated more elements in medication-free treatment than in TAU, there was no clear pattern at the ward level (supplement, table S1–2).

Findings on treatment with psychotropics and assessment are displayed in table 6.

Table 6 Treatment with psychotropics and assessment for the medication-free treatment versus TAU

		MFT			TAU			Chi-square-test regimen			
	Source	*n* valid	*n* received	Valid %	*n* valid	*n* received	Valid %	χ^2	*p* value	Phi	df
Received medication treatment	C	56	43	76.8	69	66	95.7	9.9	**.002**	0.3	1
	P	46	25	54.4	75	75	91.5	23.8	**<.001**	0.4	1
Received assessment	C	55	32	58.2	70	48	68.6	1.4	.23	0.1	1
	P	48	31	64.6	82	64	78.1	2.8	.095	0.1	1
								Anova			
			M	SD		M	SD	F(B,W)	*P* value	η^2 Point estimate (95% CI)	
Dose[a] change, all psychotropics	C	59	–0.44	1.20	123	–0.04	1.2	4.3 (1, 180)	**.040**	0.02 (0.00; 0.08)	

Note. *N* = 183 (MFT, *n* = 59, TAU, *n* = 124), MFT = medication-free treatment, TAU = treatment as usual, C = clinician, P = patient, **bold text** = statistically significant, B = Between groups df, W = Within groups df,
[a]Dose = DDD: defined daily dose according to the WHO

Fewer patients in the medication-free treatment group received treatment with medication by medium sized [44] effects (phi 0.3–0.4 for regimen level comparisons). Regimen level analyses showed a larger reduction in the medication dose during treatment in MFT. However, the effect size was below medium [43] and differences were not significant at the ward level.

Patients' experience of admission rated according to various dimensions

Table 7 shows patients experiences of the admission overall, and table 8 shows details of the question about being respected for not wanting medication.

Table 7 Patient-rated experiences of admission to medication-free treatment versus TAU

		Range worst → best	MFT				TAU				Anova		
			M	SD	*n* valid	Not applicable	M	SD	*n* valid	Not applicable	F(B,W)	p	η^2 Point estimate (95% CI)
Satisfaction (CSQ-8)		8→32	28.5	3.5	48		26.5	4.3	86		8.0 (1, 132)	**.006**	0.06 (0.01; 0.15)
Support for personal recovery (Inspire support)		0→100	72.4	14.7	48		68.5	15.9	86		2.0 (1, 132)	.161	0.02 (0.00; 0.08)
Shared decision -making (CollaboRATE)		0→9	7.6	1.3	47		7.2	1.7	81		1.9 (1, 126)	.173	0.02 (0.00; 0.08)
Alliance (WAI-SP)		1→7	5.6	1.0	51		5.5	1.0	86		1.1 (1, 135)	.301	0.01 (0.00; 0.06)
Being respected for not wanting medication (M7)	All	1→5[c]	4.8	0.5	37	11	3.9	1.2	34	49	18.4[a,b] (1, 46)	**<.001**[b]	0.22 (0.07; 0.37)
	No CTO		4.8	0.5	36	11	3.9	1.1	30	49	17,1[a,b] (1, 37)	**<,001**[b]	0.24 (0.08; 0.40)

Note. *N* = 183 (MFT, *n* = 59, TAU, *n* = 124), MFT= medication-free treatment, TAU = treatment as usual, CTO = community treatment order, M7 = MedSupport question 7, **bold text** = statistically significant,), B = Between groups df, W = Within groups df, c = clinician reported, p = patient reported

[a]Asymptotically F distributed

[b] Brown-Forsythe test for scewed variables violating Levene's test for homogeneity of variance

[c] MedSupport: 1: strongly disagree, 2: disagree, 3: neutral, 4: agree, 5: strongly agree

Table 8 I have been respected for my wish not to use medication (MedSupport question 7) details

			Admission								Treatment in the last 6 months before admission			
			MFT				TAU				All			
	Answers	Included	*n*	Valid %	% of applicable		*n*	Valid %	% of applicable		*n*	Valid %	% of applicable	
Disagree	Strongly disagree	all	0	0	0	0	2	2.4	5.9	14.7	11	6.6	11.8	25.8
	Disagree		0	0	0		3	3.6	8.8		13	7.8	14.0	
Neutral	Neutral		2	4.2	5.4	5.4	4	4.8	11.8	11.8	26	15.6	28.0	28.0
Agree	Agree		4	8.3	10.8	94.6	14	16.9	41.2	73.5	28	16.8	30.1	46.2
	Strongly agree		31	64.6	83.8		11	13.3	32.4		15	9.0	16.1	
	Does not apply		11	22.9			49	59.0			74	44.3		
Total valid *n*			48				83				167			
Disagree	Strongly disagree	not on CTO	0	0	0	0	1	1.3	3.3	13.3	9	6.0	10.7	25.0
	Disagree		0	0	0		3	3.8	10.0		12	7.9	14.3	
Neutral	Neutral		2	4.3	5.6	5.6	3	3.8	10.0	10.0	25	16.6	29.8	29.8
Agree	Agree		4	8.5	11.1	94.4	13	16.5	43.3	76.7	25	16.6	29.8	45.2
	Strongly agree		30	63.8	83.3		10	12.7	33.3		13	8.6	15.5	
	Does not apply		11	23.4			49	62.0			67	44.4		
Total valid *n*			47				79				151			

Note. *N* = 183 (MFT, *n* = 59, TAU, *n* = 124), MFT = medication-free treatment, TAU = treatment as usual

Participants in the medication-free treatment group were more satisfied with their treatment, as measured by the CSQ-8; the effect size was medium [43] (η2 0.06). They were also more likely to feel respected for the wish not to use medication, both when including all patients and only those without a community treatment order (CTO); the effect sizes were large [43] (η2 0.22–0.24). No patients in the medication-free treatment reported not being respected for their wish not to use medication. The experience of not being

respected was more common in the 6 months before admission than during admission in the included units.

Supplemental analyses of outliers and ward level trends

Sensitivity analyses without outliers did not change the results of the analyses.

Visual inspection of ward level patterns for spillover-effects (supplement, tables S1 and S3) shows the neighboring TAU ward was mostly more similar to the other TAU ward than to Medication-free ward. Regarding receiving assessment the pattern may indicate spillover effects with the two neighboring wards being more similar in doing less assessment than the distant TAU. There were no substantial effects on ward level (table S4).

The oneway between groups analysis of variance on ward level shows statistically significant differences in patient satisfaction $F(2, 131) = 4.0$, being respected for not wanting medication $F(2, 26) = 6.9$, treatment duration $F(2, 179) = 84.6$, and intensity of psychosocial treatment $F(2, 44) = 12.6$. Effect sizes calculated using eta squared was medium ([43]) for satisfaction (0.06), and large ([43]) for being respected for not wanting medication (0.22) and treatment duration (0.49). Post-hoc comparisons using the Tukey HSD test indicated that MFT differs from both comparison wards in higher patient satisfaction (M = 28.5, SD = 3.5), to a greater extent being respected for not wanting medication (M = 4.8, SD 0.5), and longer duration of treatment (M = 8.9 weeks, SD 2.2). Regarding categorical variables, there is significantly less treatment with medication on medication -free unit compared with both comparison wards on patient report and neighboring TAU ward on clinician report, with medium to large [45] effect sizes (Cramer's V 0.3–0.5). Distant TAU ward had insufficient clinician reports to be compared.

Hence, medication-free treatment robustly distinguishes itself from both wards regarding satisfaction, duration, intensity of psychosocial treatment, extent of treatment with medication, and being respected for not wanting medication.

Qualitative analyses of comparative treatment characteristics

In the qualitative analyses, both patients and staff expressed that the notion of medication-free treatment was somewhat ambiguous and that the name seems more "radical" than its manifestation in practice (i.e., that medications are not prohibited). The border between mandate and specific content on this ward (e.g., the Illness Management and Recovery (IMR) program) was unclear and how the medication-free mandate unfolded in practice, as compared with other approaches, was often difficult to depict. However, as shown below, both patients and staff described medication-free treatment overall as involving less use of medication and a greater focus on other forms of treatment, as well as increased availability of options for patients to reduce or not use medication. Staff also understood the mandate to encompass a more restrictive use of controlled substances, which are traditionally regarded as addictive.

Medication-free treatment promotes less reliance on medication during the recovery process

Both patients and staff reported that, in medication-free treatment, medication played a less central role in the recovery process and patients had greater support to reduce or not use medication. Patient participants reported they were now being listened to regarding medication issues, which contrasted with some of their previous experiences in other units in which they had experienced pressure to use medication:

> (…) I notice a huge difference between him and other doctors (…) he doesn't give a lot of medications. On the other ward, it was like "tell us if you need Imovane [sleeping pill]" or "say if you need …", and I am like, "No thanks, I'm fine." While

here, [name of the doctor] is very like “no” because he wants to try other things first. And I think that is very good. (Bella, patient)

Staff described that the purpose of the unit was to provide patients the opportunity to manage their condition without using medication, especially those with a severe disorder for which staff would previously have had concerns about reducing their use of medication. However, this change had not been straightforward because reducing or discontinuing medication needs to be balanced against the risk of increased symptoms, and a careful approach is needed:

I am quite glad that patients can come in, and even if they have, ehm, a serious diagnosis, they can look at which medications are good for them and try to taper. And one has tapered medication for some patients but increased again because some develop psychosis or something else, and one tries to make changes carefully. (Beatrice, staff)

Staff could experience conflict between the patient’s wishes and the potential for worsening of the patient’s disorder:

At the same time we experienced she got more symptoms and delusions, and some of the other inpatients started to act differently, they showed a lot of care for this person, but we received feedback that, ehm, there were strange things at times (…) So we tapered as far as possible, together with the person, and it was sad to hear she was admitted to the acute ward a week after discharge. (…) She called the ward shortly after discharge saying she had gotten the wrong medications home and believing we had poisoned her and, I experienced that unsettling. (…) she wanted to taper more. (…) But I think we managed to create a good cooperation that that was not wise here and now (…) And that she perhaps should maintain the current dose a while longer. (…) she did not experience her

> symptoms as dangerous or unpleasant, she felt she got in touch with something good, and actually wanted to be there. (Donna, staff)

Staff described that, with medication-free treatment, they were more restrictive in prescribing controlled substances. Some believed it is important for patients to learn to manage their disorder without such substances because medication only removes the symptoms and not the problem. It was experienced as problematic when patients come to a medication-free ward with the intention of withdrawing from the use of controlled substances but change their mind after admission:

> …there were instances where we had people who wanted controlled substances, and we don't think that belongs on a medication-free ward (…) Now is their opportunity to really tackle this without (…) That is what is the purpose of our ward. (Gina, staff)

Staff participants sometimes perceived a conflict between the restrictive stance and avoiding the patient either suffering, compromising/disgracing themselves, or being in a state in which it is difficult to form an alliance.

Some staff participants described the idea of reducing medication for serious disorders as new and challenging, but they increasingly observed that it is possible. Some noted that working in the medication-free treatment unit had increased their awareness of potential overmedication in more traditional approaches. Those who said that their attitudes had not changed in this regard also described themselves as having been critical of the prominence of medication in psychiatry from before the implementation of medication-free treatment.

Medication-free treatment promotes a wider range of psychosocial treatment activities

Both patient and staff participants discussed the greater availability of psychosocial treatments and improvements in the treatment program. They believed that a greater focus on alternatives to medication is inherent to the mandate. Patient and staff participants described that patients are offered alternatives to medication to manage difficult feelings, such as talking through and receiving explanations:

> More important alternatives than taking that pill. (…) it is dialogue. To talk things through. Focus on relaxation, focus on just feeling what happens in the body. And they [staff] are very good at explaining what actually happens physically in the body (…) When you have anxiety or when you are afraid or sad, or happy for that matter. In addition, the psychologists here are very good at… explaining why we have the different feelings. So, it becomes more logical why I react as I do because the feelings are actually made for different purposes (…) And it is so good to hear that, because then I sort of understand why I react as I do. In another way. (Diana, patient)

Staff noted that medication-free treatment is more tangible, active, and longer lasting. They described a more personal approach in group settings, which helped to foster group cohesion and experiences of community, recognition, and mutual learning. Before medication-free treatment was initiated, patients were discouraged from discussing their treatment with each other. However, the staff perceived that the culture within the unit was changing toward more openness. This may be reflected in patients' experiences of having more room to express their feelings and to hear staff participants' perspectives on their emotional reactions.

Staff described positive feedback from patients:

> This IMR program, of course, is something that works, I feel. (…) It is a concrete tool that the patient works with (…) So I would say it is for the better. (…) In my experience, they have been very satisfied, those we have had again here. They say this should have come 20 years ago. (…) [They have] been in the system so many years, and nothing has worked, it has sort of been vague. (…) those two here now, they said this will be the last time, the last admission. So, that says a lot, it was quite moving to hear this. (Anna, staff)

The treatment is more demanding

All participants described the program as more intense and with higher expectations of patient participation, individual responsibility, and hard work than in other approaches. “it is actually quite a high pressure. (…) as I say to the patients, when you are here for 8 weeks you are actually at school” (Beatrice, staff). “Here, the crucial difference is that there is a lot of work. And that is a big advantage” (Elise, patient).

The theme of the high demand was not explicitly related to the medication-free mandate, and some staff participants related it to the recovery approach. Staff participants described that their role now had changed in that they were expected to take a step back and leave more work to the patient. Greater emphasis on group work meant less routine one-on-one contact between members of staff and patients. this also meant that patients needed to utilize the group setting for support or else initiate contact with the staff themselves. Staff participants regarded it as important that patients take responsibility for asserting their need for support, just as they would have had to outside the hospital setting. A similar attitude of needing to work harder and assuming more responsibilities was observed to affect the work of staff. However, they described this as more mixed than what was the case for patients; for example, the tasks were more demanding in some areas whereas other aspects of their work had become easier.

Patient participants described that other experienced inpatient settings involved greater emphasis on relaxation, and some expressed it had felt like being in “storage.” Several patients described the increased demands and higher level of activity in medication-free treatment as largely positive. Some connected this to a stronger sense of purpose and agency and described that the degree of pressure resulting from these expectations increased the likelihood of following through. However, some also experienced that this led to too much pressure and that they received insufficient support in asserting their individual needs.

Among staff participants, there were divided opinions as to whether the increased demands on patients narrow the patient population who attend the ward. Some noted that it is important to recognize the level of need for patients while simultaneously expecting patients to learn and develop. Such expectations were viewed as therapeutic interventions in themselves, which could help motivate patients, promote their agency, and aid recovery:

> …the only thing we can promise them is hard work. (…) Over time, and that it is tough, and it will be hard work. And then you see a spark is lit. When you understand the treatment program (…) Then you want to try. (…) And they become motivated. (Fanny, staff)

Conversely, some staff participants noted that patients must be functioning rather well to be in the unit. Given the increased patient preparations around expectations, staff suspected that the patients eventually admitted to the unit represented a self-selected group of patients motivated to undertake the hard work:

> …I think they are very prepared, when, ehm, when they come that it is hard work. (…) It is no rest home to be here for eight weeks. (…) There is much to take in, much to go through and much to cope with. (…) and we understand that, but they

want to. (…) So, I believe those who choose to come here, they are motivated for it. (Heidi, staff)

Staff participants mentioned patients who had stated they were too depressed to be in the medication-free unit and others who wanted to come back and try again when they were feeling better. Given the changed role of the staff, there was some uncertainty about which patients the treatment would be suitable for and how to handle the more fragile patients within the new treatment approach.

The status of shared decision-making compared with traditional services is complex overall, but patients have more freedom to reduce or not use medication

As mentioned previously, patients and staff participants experienced that medication-free treatment provided patients with a greater influence regarding reduction of medication. However, staff participants also felt patients had less influence regarding the opportunity to receive controlled substances. These changes were understood to form part of the medication-free mandate. Both patient and staff participants described that the focus on individual goals in IMR as well as a treatment program fostering more patient activity contributed to increased patient ownership of the process. Some patients described that spending more time in treatment increased their influence overall. Staff reported that they now collected patients' views and feedback more systematically to adjust the treatment program. There were mixed reports of the experience of coercion in patient interviews; some patient participants reported feeling safer, but others still feared being coerced.

Some patients seemed to feel empowered by the high expectations for treatment activities and taking on responsibilities. Despite the higher expectations for participation, they expressed a feeling of autonomy about this and internalized the sense of responsibility for participation in ways they had not before:

> There is more going on. One works more and decides more for oneself. Or, one decides there as well, but one sort of has to… how shall I explain? One has to choose to participate in what is going on. (…) you sort of have to "yes, now I am going to IMR," you can't just sit and not take part in what happens when you are here… at least I think! (…) you have the responsibility to participate, in a way. You have responsibility for your treatment. And I think that is very good (…) if I sleep long then no one comes and like… or they come eventually, but they give you some time. While at [another ward] it was more like "now it is this, now we have to go," "now you shall participate on this," "now you shall do that". While here it is like "Well, you have slept. That's it, then you missed it". (…) I find it wonderful [laughing] (…) For example I was not on IMR today because I felt queasy, and I just said I was not up to it. And then that was understandable (…) they don't give in right away. It is like "but why not?" "but you could try and maybe it gets better" (…)» (…) it is okay that they ask as long as it does not cross that line. (Bella, patient)

As indicated above, other patient participants experienced the expectation as pressure and expressed a need for greater support in asserting their own needs:

> …but I didn't manage to say so much… I kept a lot to myself. (…) Yes, there is a lot of shame. Ugh, it is shame. I have it still. But I am working on it. (…) They should have asked me… I wish they had asked me how much I can manage. (..) Because when they say that it is.. [thinking], yes when they say that it is mandatory. Then one feels one has to. (…) but at the same time, I was not conscious when I sat there. I heard nothing and I said nothing. (Anita, patient).

Integration and integrative statements regarding characteristics of medication-free treatment

The mixed matrix for the integration of results is shown in Table 9. The integrated findings are summarized in integrative statements in the table.

Table 9 Joint display for the integration of results

Overall issues[a]	Quantitative outcome Medication-free treatment compared with TAU	Qualitative outcome	Relationship	Integrative statement
Medication	- Fewer patients treated with medication. - Larger dose reduction during treatment. - Patients felt more respected for their wish not to use medication. Otherwise, the help they received with medication was similar to that for TAU.	- Medications play a less central role as a means of recovery - More room for patients to reduce or not use medication - More restrictive regarding controlled substances - More belief in medication-free alternatives among staff	Convergence and complementarity	Medication-free treatment involved less focus on medications in the process of recovery and more support in reducing or not wanting medication. There were greater restrictions on using controlled substances and staff reports of a stronger belief in medication-free possibilities. However, the withdrawal of medications was complex and not straightforward.
Psychosocial treatment	- About twice as long treatment stays - Higher mean intensity of psychosocial treatment elements	A wider range of psychosocial treatment activities - more treatments - improved treatments - increased openness and group cohesion	Convergence and complementarity	Medication-free treatment involved more psychosocial treatment in terms of intensity and duration. This was understood as inherent in the mandate for medication-free units. The treatment was experienced as richer.
Assessment	Equal	Not mentioned regarding experience of treatment	No comparison	The extent of formal assessment seemed not substantially different to that of standard treatment (TAU).

Higher demands	- Higher mean intensity of psychosocial treatment elements.	Higher demands - intense programme - expectations to participate and work hard - increased focus on individual responsibility. - Staff stand back to foster patient independence. Patients are expected to ask for help when needed. - Emphasis that improvement requires work.	Convergence and complementarity	More was expected of patients in terms of both activity and responsibility. For patients, this could be connected to a stronger sense of purpose and experienced as helpful but could also be experienced as pressure and lack of understanding.
Patient influence	Patient ratings: - Overall shared decision-making, support for personal recovery and alliance equal to standard treatment - More respect for the wish not to use medication	A complex picture - Medication: More patient influence regarding reduction, less on increasing controlled substances - Several changes contribute to increased patient influence - Higher demands and more mandatory activity can lead to both increased and reduced sense of empowerment	Convergence and complementarity	The comparison of patient influence between medication-free care and TAU was nuanced. Overall measures related to patient influence were not substantially different. There was more freedom to taper, quit or not use medication. Other differences moved in varied directions.
Patient satisfaction	- Greater satisfaction with treatment	Changes regarded as positive by patients: - A wider range of psychosocial treatment activities - A less central role of medication as a means of recovery - More room for patients to reduce or not use medication - Focus on individual goals - Fostering more patient activity (somewhat mixed) - More time - Participation in treatment meetings	Convergence and complementarity	Patients in medication-free treatment reported greater satisfaction with treatment, which may be linked to a richer psychosocial treatment that focuses on patient participation and freedom from pressure to use medication.

Note.
[a]Overall issues addressed (with quantitative measures) or identified (qualitatively) in the data.

Medication

The quantitative findings show less medication use on the medication-free ward and that patients feel more respected for not wanting medication than what was the case on the comparison wards. The qualitative findings elaborate upon how both patients and staff experience that medications play a less central role and complements by showing that there is an increased belief in medication-free alternatives among some staff and that they are also more restrictive regarding controlled substances the patients may want. Hence, both quantitative and qualitative results point to medication playing a less central role in medication-free treatment, providing more support for alternative paths.

Psychosocial treatment

The quantitative findings document that the extent of psychosocial treatment differs from comparison wards. The qualitative findings document that this is experienced by both patients and staff, and that they also experience a richer treatment program characterized by increased openness and group cohesion. Hence, more extensive psychosocial treatment is reflected in both qualitative and quantitative findings.

Assessment

The extent of formal assessment seems equal to standard treatment in the quantitative findings, and is not mentioned in the qualitative findings regarding experience of treatment. It is mentioned regarding expectations for treatment, which is elaborated in Standal, Solbakken, Rugkåsa, Martinsen, Halvorsen, Abbass and Heiervang [3]. Patterns on ward level indicate there may be spillover effects masking differences. hence, we cannot conclude strongly that this is similar.

Higher demands

The finding regarding higher demands in medication-free treatment is most explicitly found in the qualitative material but may also be reflected in the higher intensity of psychosocial treatment elements in the quantitative data. The qualitative data elaborate the form it takes and how this is experienced differently by different patients.

Patient influence

The quantitative findings indicate no substantial differences in overall patient influence except regarding being respected for the wish not to use medication, which is greater on the medication-free ward. The qualitative findings corroborate, complement and nuances this by showing that while there was increased support for using less medication, there were more restrictions on using controlled substances. While several changes were experienced to increase patient influence (goal focus in IMR, fostering patient activity, more time, collecting feedback more systematically), higher demands and more mandatory activity could lead to both increased and reduced senses of empowerment.

Patient satisfaction

The quantitative findings indicate greater patient satisfaction on the medication-free ward. The qualitative findings complement this by showing changes that are regarded as positive by patients. Hence, greater satisfaction may be linked to a richer psychosocial treatment that focuses on patient participation and freedom from pressure to use medication.

Discussion

The core features of medication-free treatment were understood and experienced by both patient and staff participants as involving less use of medication and more focus on other forms of treatment, as well as patients having more room for reducing or not using medication. Staff also understood the mandate to encompass a more restrictive use

of controlled substances that are traditionally regarded as addictive. Our findings suggest that staff participants have developed a greater belief in the potential for medication-free treatment but that the withdrawal of medications is complex and not straightforward. Another feature that distinguished medication-free treatment from traditional treatment was higher expectations of patients regarding their activity and responsibility. This may also be indirectly related to the medication-free mandate. Patients in medication-free treatment reported greater satisfaction with treatment, which may be linked to a richer psychosocial treatment that focuses on patient participation and freedom from pressure to use medication.

Our findings are similar to those of other investigations of medication-free services in terms of the less intense focus on medication as a means to recovery, more extensive psychosocial treatment, a greater focus on individual responsibility and staff experience of the challenges in balancing different issues [24-27]. There also seems to be a common focus on patient influence [24,25,27]. However, in our study, this seems to play out in nuanced ways, and the general measures of shared decision-making support for personal recovery, and alliance were not substantially different between medication-free treatment and TAU.

Overall, the ward seems to fulfil the main purpose of medication-free units, which is to contribute to the increased freedom of choice regarding medications. The ward is perceived as providing more alternatives to medication and as free from pressure to use medication. Patient satisfaction is greater in medication-free treatment than in TAU. However, the withdrawal of medication in patients with a serious disorder is not simple and straightforward, and staff are aware of the need to balance different issues. Nevertheless, they seem to provide a treatment environment in which patients feel more supported in choosing a medication-free path.

Although patients in medication-free treatment reported feeling significantly more respected for not wanting medication with a large effect size, few patient participants reported not being respected overall in the included wards (*n* = 5 or 7% of the patient respondents). There may be spillover effects in the hospital at large, or the units that participated in this study may have a greater awareness of this issue due to their participation in this study. Patients reported experiences before admission indicate that this is more prevalent elsewhere in mental health care (*n* = 24 or 25.8% of those for whom the question was applicable). Taken together with our other report of small differences in outcomes [2], our findings suggest that it is possible to create a treatment environment that is more supportive of alternatives to medication without compromising patient health.

Changes toward a culture that values openness and expression of feelings may follow from the specific elements implemented, such as in the IMR program, which encourages patients to find support persons among their fellow patients [23]. These changes may also follow from a greater focus on the psychosocial aspects of treatment in general, although there is no strict contradiction to the use of medication. If patients do not manage their feelings through medication, they must deal with them in other ways, which typically involves talking and sharing. Staff participants referred to former policies that prohibited patients from talking about their treatment with each other. Such policies aim to protect patients, but they also stifle openness. When the focus is on the psychosocial aspects, it may be less feasible, or even desirable, to protect patients in this way. Challenges occurring during interactions may be viewed as opportunities to learn, as well as necessary costs when working psychotherapeutically.

Participants noted the greater demands on the patients in the medication-free unit. Within this was a focus on individual responsibility, which seems to be a shared feature of several medication-free units [25,27]. In our material, this was not explicitly linked to the

medication-free mandate but sometimes to the recovery approach. However, both the recovery approach and medication-free mandate share an inherent critique of the traditional approaches in mental health care that minimize the patient's influence regarding medication [22]. The recovery tradition also positions itself as an alternative to the traditional approach by shifting emphasis from professional accountability and control, which rewards passivity and compliance, to personal responsibility and self-management [46]. Therein lies a probable link between the medication-free mandate, recovery approach, focus on individual responsibility, and focus on more active ways of coping.

There is a tension within the recovery tradition regarding individualism in the sense of highlighting individual responsibility [47]. This focus has been criticized for neglecting structural, environmental and societal conditions, and challenges [47-49]. The user organization Recovery in the bin distinguishes between the initial grassroots recovery movement and a newer co-opted recovery version that is consistent with neoliberalism [49]. Price-Robertson, Obradovic and Morgan [47] have promoted the notion of relational recovery, which highlights the idea of humans as interdependent relational beings. This aligns with the more radical conceptualization of empowerment as a collective and political struggle for the rights of underprivileged groups , which includes raising awareness about connections between a person's life and outer societal conditions, as well as the possibility that others in the same circumstances may experience the same struggles [50]. With the focus on individual responsibility, several medication-free units, including this one, seem to be on the more individualistic path [25,27]. Our results suggest that this can lead to feeling both more and less empowered.

The underlying question of the place for individual responsibility is fraught with philosophical and political issues, and difficult to pinpoint empirically. However, it is important to undertake continuous reflections on how different positions affect and shape

interactions with different patients, including their opportunities for shared decision-making. Our findings indicate that patient needs and wishes may be difficult to express when they conflict with expectations in the treatment culture, whether related to adherence to medication or assuming responsibility and working hard. Hence, reflexivity is crucial for avoiding pitfalls in either direction.

Strengths and limitations

Mixed-methods designs give the opportunity for a more in-depth investigation of the influences at play in this context. This can facilitate theoretical generalization as well as the triangulation of results obtained using different methods.

The disadvantage of the local nature of the study is that data from different contexts were not available. The results may be colored by the unique characteristics of the local medication-free unit compared with the available alternatives and how these are presented to the patients via referrers, the media, the medication-free unit, or other sources. The unit under study, like most MFT units in Norway, is at an intermediate level of care and excludes the most acute conditions. Hence, MFT might appear different in other populations.

The patients were not randomized to medication-free treatment but rather prepared in advance to enable them to make a choice whether this was the right treatment regimen for them. Hence, we may have missed including participants who may have been more critical of the focus in this particular ward.

The response rate for the questionnaires on the medication-free ward was high (73.8%), and lower in the TAU unit (41.5%). However, as we show elsewhere [2], our research sample was fairly representative of the population admitted to the wards during the inclusion period. There may have been bias in the selection for interviews because about half of the patients declined to participate in the interview, and the resulting sample

was small. From what is known about the reasons for declining such participation, we may have missed including the most distressed patients.

According to posthoc sensitivity calculations there may be below medium sized differences that could have been significant in a larger sample.

Because interview participants were sampled before the questionnaire participants and questionnaire recruitment stretched over years, changes in the ward over time may have affected the data sources differently.

Conclusions

The core features of medication-free treatment involve less use of medication, a greater focus on psychosocial aspects in the process of recovery, and more room for patients to reduce or not use medication. In the medication-free ward, patients reported feeling more supported in choosing a medication-free path even as medication was withdrawn carefully, and staff participants were aware of the risks and complexity. The psychosocial treatment in the medication-free unit is more extensive and entails a culture of openness and room for patients to express their feelings, and a greater focus on individual responsibility and intensive work. Our findings of more extensive psychosocial treatment, less reliance on medications, a greater focus on individual responsibility, and staff struggles with conflicts are similar to those reported by other investigations of medication-free services [24-27].

This study illustrates how a medication-free treatment service works and that it can provide a viable alternative for people not comfortable with the current focus of medication in mental health care. Alluding to debates within and around the recovery tradition, mental health professionals should be conscious of the dimensions of individualism–relationalism in such treatment services.

Future directions

Shared decision-making is complex, and we need greater clarity about how to create a healthcare system that is flexible enough to accommodate individual patients' needs in the best possible manner. To improve shared decision-making in mental healthcare at large, one could examine the attitudes of mental health professionals toward medication-free treatment, identify potential barriers to its implementation and develop strategies to address these barriers and promote the integration of medication-free options into standard care. Factors that contribute to patient satisfaction in medication-free treatment could be investigated in more detail and across units to identify specific aspects of psychosocial treatment that are most valued by patients. We need more knowledge about long -term outcomes and cost effectiveness of different treatment strategies and in different populations.

Abbreviations

MFT = Medication-free treatment

TAU = Treatment as usual

C = Clinician

P = Patient

CTO = Community treatment order

WHO = World Health Organization

CRPD = United Nations Convention on the Rights of Persons with Disabilities

DDD = Defined daily dose according to the WHO

OQ = Outcome Questionnaire

AII = Affect Integration Inventory

GAF-F/S = Global Assessment of Functioning, function scale and symptom scale

SSRIs = Selective serotonin reuptake inhibitors

SNRIs = Serotonin and noradrenalin reuptake inhibitors

IMR = Illness Management and Recovery

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Supplemental analyses

Investigation of patterns between wards on treatment characteristics

Table S 1 Statistics per ward, continuous variables

Continuous variables	Source	MFT *n* valid	MFT M (SD)	NTAU *n* valid	NTAU M (SD)	DTAU *n* valid	DTAU M (SD)	NTAU more similar to MFT or DTAU	Anova ward level F(B,W)	Anova ward level *p* value	Anova ward level η^2 Point estimate (95% CI)
Treatment duration, weeks		59	8.9 (2.2)	66	4.0 (1.9)	57	5.4 (2.3)	DTAU	84.6 (2, 179)	.000	0.49 (0.38; 0.56)
Mean intensity, psychosocial treatment elements	C	56	2.5 (0.2)	52	2.2 (0.4)	19	2.3 (0.4)	DTAU	12.6[a,b] (2, 44)	**.000**[b]	0.16 (0.05; 0.26)
Number of psychosocial treatment elements received		56	9.8 (1.4)	52	8.1 (2.1)	19	9.9 (2.0)	MFT	13.9 (2, 124)	<.001	0.18 (0.07; 0.29)
	P	49	10.5 (2.6)	42	9.7 (3.2)	42	9.2 (3.0)	DTAU	2.6 (2, 130)	.081	0.04 (0.00; 0.11)
Dose[c] change, all psychotropics	C	59	–0.4 (1.2)	66	0.0 (1.3)	57	0.0 (1.1)	DTAU	2.1 (2, 179)	.123	0.02 (0.00; 0.08)
Satisfaction (CSQ-8)		48	28.5 (3.5)	43	26.4 (4.3)	43	26.5 (4.3)	DTAU	4.0 (2, 131)	**.021**	0.06 (0.00;0.14)
Support for personal recovery (Inspire support)		48	72.4 (14.7)	43	66.1 (13.2)	43	70.8 (18.0)	DTAU	2.0 (2, 131)	.140	0.03 (0.00; 0.10)
Shared decision-making (CollaboRATE)	P	47	7.5 (1.3)	42	7.2 (1.5)	39	7.1 (1.8)	DTAU	0.9 (2, 125)	.391	0.01 (0.00; 0.07)
Alliance (WAI-SP)		51	5.6 (1.0)	43	5.5 (1.1)	43	5.5 (0.9)	DTAU	0.5 (2, 134)	.586	0.01 (0.00; 0.05)
Being respected for not wanting medication (M7)	All	37	4.8 (0.5)	17	3.9 (1.2)	17	3.8 (1.2)	DTAU	6.9[a,b] (2, 36)	**.003**[b]	0.22 (0.06; 0.36)
	Not CTO	36	4.8 (0.5)	16	4.1 (0.9)	14	3.8 (1.3)		6,7[a,b] (2, 27)	**.004**[b]	0,25 (0,07; 0.39)

Note. *N* = 183 (MFT, *n* = 59; Neighboring TAU, *n* = 66; Distant TAU, *n* = 58), MFT = medication-free treatment, NTAU = Neighboring comparison ward, DTAU = Distant comparison ward, C = clinician, P = patient, Yellow = neighboring TAU more similar to MFT than distant TAU

[a]Asymptotically F distributed

[b]Brown-Forsythe test for scewed variables violating Levene's test of homogeneity of variance

[c]Dose = Defined daily dose (DDD) according to the WHO

Table S 2 Anova Multiple comparisons at ward level for contiuous variables using the Tukey HSD test

Dependent Variable		Wards I	Wards J	Mean Difference (I-J)	SD	p	95% CI		Comment
Satisfaction (CSQ-8)		MFT	NTAU	**2.1**	0.8	0.042	0.1	4.1	MFT higher than both comparisons
			DTAU	**2.0**	0.8	0.048	0.0	4.0	
		NTAU	MFT	**-2.1**	0.8	0.042	-4.1	-0.1	
			DTAU	0.0	0.9	0.998	-2.1	2.0	
		DTAU	MFT	**-2.0**	0.8	0.048	-4.0	0.0	
			NTAU	0.0	0.9	0.998	-2.0	2.1	
Support for personal recovery (Inspire support)		MFT	NTAU	6.3	3.2	0.132	-1.4	13.9	No significant differences Insufficient power to detect eventual below medium effects.
			DTAU	1.6	3.2	0.877	-6.1	9.2	
		NTAU	MFT	-6.3	3.2	0.132	-13.9	1.4	
			DTAU	-4.7	3.3	0.337	-12.6	3.2	
		DTAU	MFT	-1.6	3.2	0.877	-9.2	6.1	
			NTAU	4.7	3.3	0.337	-3.2	12.6	
Shared decision making (CollaboRATE)		MFT	NTAU	0.4	0.3	0.524	-0.4	1.1	
			DTAU	0.4	0.3	0.425	-0.4	1.2	
		NTAU	MFT	-0.4	0.3	0.524	-1.1	0.4	
			DTAU	0.1	0.3	0.982	-0.8	0.9	
		DTAU	MFT	-0.4	0.3	0.425	-1.2	0.4	
			NTAU	-0.1	0.3	0.982	-0.9	0.8	
Alliance (WAI-SP)		MFT	NTAU	0.2	0.2	0.631	-0.3	0.7	
			DTAU	0.2	0.2	0.674	-0.3	0.7	
		NTAU	MFT	-0.2	0.2	0.631	-0.7	0.3	
			DTAU	0.0	0.2	0.998	-0.5	0.5	
		DTAU	MFT	-0.2	0.2	0.674	-0.7	0.3	
			NTAU	0.0	0.2	0.998	-0.5	0.5	
Being respected for not wanting medication (M7)	All	MFT	NTAU	**0.9**	0.3	0.003	0.3	1.5	MFT higher than both comparisons
			DTAU	**1.0**	0.3	0.001	0.3	1.6	
		NTAU	MFT	**-0.9**	0.3	0.003	-1.5	-0.3	
			DTAU	0.1	0.3	0.980	-0.7	0.8	
		DTAU	MFT	**-1.0**	0.3	0.001	-1.6	-0.3	
			NTAU	-0.1	0.3	0.980	-0.8	0.7	
	Not CTO	MFT	NTAU	**0,8**	0,2	1,5	**0,8**	0,2	
			DTAU	**1,0**	0,4	1,6	**1,0**	0,4	
		NTAU	MFT	**-0,8**	-1,5	-0,2	**-0,8**	-1,5	
			DTAU	1,4	-0,6	0,9	1,4	-0,6	
		DTAU	MFT	**-1,0**	-1,6	-0,4	**-1,0**	-1,6	
			NTAU	-0,1	-0,9	0,6	-0,1	-0,9	
Dose change, all psychotropics		MFT	NTAU	-0.4	0.2	0.173	-0.9	0.1	Differences only significant at regimen level. MFT had 0.4 standard doses larger dose
			DTAU	-0.4	0.2	0.179	-0.9	0.1	
		NTAU	MFT	0.4	0.2	0.173	-0.1	0.9	
			DTAU	0.0	0.2	0.999	-0.5	0.5	
		DTAU	MFT	0.4	0.2	0.179	-0.1	0.9	

		NTAU	0.0	0.2	0.999	-0.5	0.5	reduction than both comparison wards.
Number of psychosocial treatment elements received (c)	MFT	NTAU	**1.7**	0.4	<.001	0.9	2.5	MFT higher than neighboring TAU Distant TAU higher than Neighboring TAU
		DTAU	-0.1	0.5	0.973	-1.3	1.0	
	NTAU	MFT	**-1.7**	0.4	<.001	-2.5	-0.9	
		DTAU	**-1.8**	0.5	<.001	-3.0	-0.7	
	DTAU	MFT	0.1	0.5	0.973	-1.0	1.3	
		NTAU	**1.8**	0.5	<.001	0.7	3.0	
Number of psychosocial treatment elements received (p)	MFT	NTAU	0.9	0.6	0.341	-0.6	2.3	Number was highest on medication-free ward, but this only reached statistical significance in regimen level analyses.
		DTAU	1.4	0.6	0.072	-0.1	2.8	
	NTAU	MFT	-0.9	0.6	0.341	-2.3	0.6	
		DTAU	0.5	0.6	0.713	-1.0	2.0	
	DTAU	MFT	-1.4	0.6	0.072	-2.8	0.1	
		NTAU	-0.5	0.6	0.713	-2.0	1.0	
Psychosocial treatment, mean intensity 1→5a	MFT	NTAU	**0.3**	0.1	0.000	0.2	0.5	MFT higher than neighboring TAU
		DTAU	0.1	0.1	0.221	-0.1	0.4	
	NTAU	MFT	**-0.3**	0.1	0.000	-0.5	-0.2	
		DTAU	-0.2	0.1	0.178	-0.4	0.1	
	DTAU	MFT	-0.1	0.1	0.221	-0.4	0.1	
		NTAU	0.2	0.1	0.178	-0.1	0.4	
Treatment duration weeks	MFT	NTAU	**4.9**	0.4	0.000	4.0	5.8	All wards different MFT>DTAU>NTAU
		DTAU	**3.5**	0.4	0.000	2.6	4.4	
	NTAU	MFT	**-4.9**	0.4	0.000	-5.8	-4.0	
		DTAU	**-1.4**	0.4	0.001	-2.3	-0.5	
	DTAU	MFT	**-3.5**	0.4	0.000	-4.4	-2.6	
		NTAU	**1.4**	0.4	0.001	0.5	2.3	

Note. *N* = 183 (MFT, *n* = 59; Neighboring TAU, *n* = 66; Distant TAU, *n* = 58), **Bold** = The mean difference is significant at the 0.05 level, MFT = Medication-free treatment, NTAU = Neighboring TAU, DTAU = Distant TAU, p =patient reported, c = clinician reported

Table S 3 Categorical variables on treatment characteristcs, descriptive statistics on ward level

Categorical variables	Source	MFT		NTAU		DTAU		NTAU more similar to MFT or DTAU
		n valid	Received *n* (valid %)	*n* valid	Received *n* (valid %)	*n* valid	Received *n* (valid %)	
Medication treatment received	Clinician	56	43 (76.8)	51	49 (96.1)	18	17 (94.4)	DTAU
	Patient	46	25 (54.3)	42	35 (83.3)	40	40 (100)	DTAU
Assessment received	Clinician	55	32 (58.2)	51	32 (62.7)	19	16 (84.2)	MFT
	Patient	48	31 (64.6)	41	30 (73.2)	41	34 (82.9)	

Note. *N* = 183 (MFT, *n* = 59; Neighboring TAU, *n* = 66; Distant TAU, *n* = 58), MFT = medication-free treatment, NTAU = Neighboring comparison ward, DTAU = Distant comparison ward, C = clinician, P = patient, Yellow = neighboring TAU more similar to MFT than distant TAU

Table S 4 Categorical variables, analyses of differences on ward level

Variable	Source	Comparisons	χ^2	0.3	Phi/ Cramer's V	df	Comment
Medication treatment received	Clinician	All wards	assumptions violated				Wards that can be compared differ Too few clinican reports from DTAU to run all comparisons
		Regimen	9.9	**.002**	0.3	1	
		TAU wards	assumptions violated				
		Neighboring wards	8.2	**0.004**	0.3	1	
		MFT/DTAU	assumptions violated				
	Patient	All wards	27.1	**<.001**	0.5	2	
		Regimen	23.8	**<.001**	0.4	1	
		TAU wards	8.5	**0.004**	0.3	1	
		Neighboring wards	8.5	**0.004**	0.3	1	
		MFT/DTAU	24.2	**<.001**	0.5	1	
Assessment received	Clinician	All wards	4.2	0.122	0.2	2	Insufficient power to detect eventual below medium effects
		Regimen	1.0	0.311	0.1	1	
		TAU wards	2.0	0.152	0.2	1	
		Neighboring wards	0.1	0.779	0.0	1	
		MFT/DTAU	3.1	0.077	0.2	1	
	Patient	All wards	3.8	0.151	0.2	2	
		Regimen	2.1	0.143	0.1	1	
		TAU wards	0.6	0.423	0.1	1	
		Neighboring wards	0.4	0.522	0.1	1	
		MFT/DTAU	2.9	0.088	0.2	1	

Note. *N* = 183 (MFT, *n* = 59; Neighboring TAU, *n* = 66; Distant TAU, *n* = 58), MFT = Medication-free treatment, DTAU = Distant TAU, **Bold** = Statistically significant

Reliability, multi-item scales

Table S 5 Reliability of multi-item scales in our sample

	Cronbach's alpha
Satisfaction (CSQ-8)	.920
Support for personal recovery (Inspire support)	.932
Shared decision-making (CollaboRATE)	.901
Alliance (WAI-SP)	.933

Characteristics of the sample compared with those from other sources

Comparison of our research sample with all registered users included in hospital statistics during the recruitment period, where available.

Table S 6 *Gender, age, and treatment duration, compared with hospital statistics*

Regimen	Variable	Category	Statistic	**Research sample**	**All registered***	**Difference (All – research sample)**
MFT	Gender	Female	*n* (%)	42 (71.2)	60 (68.2)	18 (–3.0)
		Male	*n* (%)	17 (28.8)	28 (31.8)	11 (3.0)
	Age		M (SD)	38.6 (13.1)	40.7 (13.3)	2.1 (0.2)
			Valid *n*	59	88	29
	Treatment duration (weeks)		M (SD)	8.9 (2.2)	7.6 (3.2)	–1,3 (1.0)
			Valid *n*	59	88	29
TAU	Gender	Female	*n* (%)	72 (58.1)	273 (62.5)	201 (4.4)
		Male	*n* (%)	52 (41.9)	164 (37.5)	112 (–4.4)
	Age		M (SD)	43,7 (12.9)	43.8 (13.4)	0.1 (0.5)
			Valid *n*	124	437	313
	Treatment duration (weeks)		M (SD)	4.7 (2.2)	3.1 (2.9)	–1.6 (0.7)
			Valid *n*	123	437	314

Note. *n* research sample = 183 (*n* MFT = 59, *n* TAU = 124), *n* all registered = 525 (*n* MFT = 88, *n* TAU = 437), MFT = Medication-free treatment, TAU = Treatment as usual.
[a] Hospital statistics including stays at the units during the recruitment period, excluding emergency admissions and readmissions within 30 days. Because the number of self-referral admissions stays come from a different source, the sample size in the flow chart and Online Resource differ slightly, the flow chart being closest to our inclusion criteria.

Table S 7 *Main diagnoses at end of treatment compared with hospital statistics*

Regimen	Diagnosis groups	Research sample		All registered[a]		Difference	
		n	Valid %	*n*	Valid %	*n*	Valid %
MFT	Personality disorders F60–F61	12	20.3	14	16.1	2	–4.2
	Psychosis F20–F29	9	15.3	13	14.9	4	–0.3
	Bipolar disorder F30–F31	8	13.6	13	14.9	5	1.4
	Affective disorder. nonbipolar F32–F39	11	18.6	12	13.8	1	–4.9
	Trauma/stress F43	6	10.2	10	11.5	4	1.3
	Anxiety F40–F41	5	8.5	8	9.2	3	0.7
	Dissociation F44 + F48.1	2	3.4	4	4.6	2	1.2
	Hyperkinetic disorder F90	4	6.8	4	4.6	0	–2.2
	Obsessive compulsive disorder F42	0	0	3	3.4	3	3.4
	Drug-related disorders F10–F19	0	0	2	2.3	2	2.3
	Pervasive developmental disorders F84	1	1.7	2	2.3	1	0.6
	Somatoform disorders F45	1	1.7	1	1.1	0	–0.5
	Eating disorders F50	0	0	1	1.1	1	1.1
	Valid	59		87		28	
TAU	Affective disorder, nonbipolar F32–F39	37	30.3	92	22.5	55	–7.8
	Psychosis F20–F29	12	9.8	82	20.0	70	10.2
	Personality disorders F60–F61	12	9.8	78	19.1	66	9.2
	Bipolar disorder F30–F31	20	16.4	53	13.0	33	–3.4
	Trauma/stress F43	20	16.4	46	11.2	26	–5.1
	Anxiety F40-41	9	7.4	17	4.2	8	–3.2
	Pervasive developmental disorders F84	1	0.8	10	2.4	9	1.6
	Eating disorders F50	1	0.8	8	2.0	7	1.1
	Dissociation F44 + F48.1	0	0	7	1.7	7	1.7
	Drug-related disorders F10–F19	5	4.1	6	1.5	1	–2.6
	Organic mental disorders F00–F09	1	0.8	2	0.5	1	–0.3
	Obsessive compulsive disorder F42	1	0.8	2	0.5	1	–0.3
	Somatoform disorders F45	0	0	1	0.2	1	0.2
	Other neurotic disorders F48 excluding F48.1	0	0	1	0.2	1	0.2
	Enduring personality change F62	1	0.8	1	0.2	0	–0.6
	Mental retardation F70–79	1	0.8	1	0.2	0	–0.6
	Hyperkinetic disorders F90	0	0	1	0.2	1	0.2
	Mixed disorders of conduct and emotions F92	0	0	1	0.2	1	0.2
	Other/unspecified developmental disorder	1[b]	0.8	0	0	–1	–0.8
	Valid	122[c]		40		287	

Note. *n* research sample = 183 (*n* MFT = 59, *n* TAU = 124), *n* all registered= 525 (*n* MFT = 88, *n* TAU = 437), MFT = Medication-free treatment, TAU = Treatment as usual.
[a]Hospital statistics including stays at the units during the recruitment period, excluding emergency admissions and readmissions within 30 days. . Because the number of self-referral admissions stays come from a different source, the sample size in the flow chart and Online Resource differ slightly, the flow chart being closest to our inclusion criteria.
[b] Our research sample and hospital statistics were drawn from different sources (questionnaires and electronic journals). There may be errors or differences in registration, which may explain some inclusions in our research sample that were not included in the overall statistics.

[c] One unknown: one patient received no F diagnosis.

Table S 8 *Main diagnoses at end of treatment, total research sample*

	n	Valid %
Affectiv disorder, non-bipolar F32-F39	48	26,5
Bipolar disorder F30-F31	28	15,5
Trauma/stress F43	26	14,4
Personality disorders F60-61	24	13,3
Psychosis F20-F29	21	11,6
Anxiety F40-41	14	7,7
Drug related disorders F10-F19	5	2,8
Hyperkinetic disorder F90	4	2,2
Dissosiation F44+ F48.1	2	1,1
Pervasive developmental disorders F84	2	1,1
Organic mental disorders F00-F09	1	0,6
Obsessive compulsive disorder F42	1	0,6
Somatoform disorders F45	1	0,6
Eating disorders F50	1	0,6
Enduring personality change F62	1	0,6
Mental retardation F70-79	1	0,6
Other/unspecified developmental disorder F88-F89	1	0,6
Valid	181[a]	100,0

Note. *n* research sample = 183.
[a] One unknown: one patient received no F diagnosis.

Sensitivity analyses of nonsignifcant results

Table S 9 Sample characteristcs, sensitivity analyses of nonsignificant results

Variable		*n* *(each group)*	Obtained ES (95% CI) (interpretation)	ES able to detect (interpretation)
Gender	Female Male	183 (59 + 124)	-0.127[p] (s)	0.207[w] (below m)
CTO		163 (58 + 105)	-0.077[p] (s)	0.219[w] (below m)
Diagnoses	Psychosis	182 (59 + 123)	-0.081[p] (s)	0.207[w] (below m)
	Bipolar	182 (59 + 123)	0.035[p] (s)	0.207[w] (below m)
Mental health at baseline	OQ-45-2	175 (57 + 118)	0.144[d] (-0.2; 0.5) (s)	0.454[d] (below m)
	GAF-S	177 (58 + 119)	0.184[d] (-0.1; 0.5) (s)	0.451[d] (below m)
	GAF-F	177 (58 + 119)	-0.158[d] (-0.5; 0.2) (s)	0.451[d] (below m)

Note. MFT = medication-free treatment, TAU = treatment as usual, OQ = Outcome Questionnaire, GAF-F/S = Global Assessment of Functioning, function scale and symptom scale, ES = Effect size, [p] = Phi, [w] = w, [d] = Cohen's d, s = small, m = medium, l = large

Table S 10 Assessment received, sensitivity analyses of nonsignificant results

Source		N valid	ES obtained (interpretation) regimen Phi	ES obtained (interpretation) ward Cramer's V	ES able to detect (interpretation) regimen W	ES able to detect (interpretation) ward W
Received assessment	Clinician	125	0.107 (s)	0.184 (s-m)	0.251 (below m)	0.278 (below m)
	Patient	130	0.147 (s)	0.171 (between s and m)	0.246 (below m)	0.272 (below m)

Note. MFT = medication-free treatment, TAU = treatment as usual, ES = Effect size, s = small, m = medium, l = large, *Not enough reports from distant TAU ward to compare.

Table S 11 Patient-rated experiences of admission, sensitivity analyses of nonsignificant results

	N valid	ES obtained η^2 Point estimate (95% CI) (interpretation) regimen	ES obtained η^2 Point estimate (95% CI) (interpretation) ward	ES able to detect Cohen's f (interpretation) regimen	ES able to detect Cohen's f (interpretation) ward
Support for personal recovery (Inspire support)	134	0.02 (0.00; 0.08) (below m)	0.03 (0.00; 0.10) (m)	0.244 (m)	0.271 (just above m)
Shared decision making (CollaboRATE)	128	0.02 (0.00; 0.08) (below m)	0.01 (0.00; 0.07) (s)	0.250 (m)	0.278 (just above m)
Alliance (WAI-SP)	137	0.01 (0.00; 0.06) (s)	0.01 (0.00; 0.05) (s)	0.241 (m)	0.268 (just above m)

Note. MFT = medication-free treatment, TAU = treatment as usual, ES = Effect size, s = small, m = medium, l = large

Questions from questionnaires used in this study that are not from standardized instruments, translated from Norwegian

Figure S 1 Question about CTO, patient form, baseline

Is under a community treatment order (CTO)?

☐ 1 Yes ☐ 2 No

Figure S 2 Benefit of interventions, patient form, end of treatment

Benefit of interventions

Insert only one cross on each line

What benefit do you think you have had from the treatment forms mentioned below?	**If you have received such treatment**				**If you have not received such treatment**	
	1 No benefit	2 Little benefit	3 Large benefit	4 Very large benefit	0 Have not wanted it	5 Would have wanted it
1. Assessment						
2. Treatment with medication						
3. Individual conversations						
4. Network meetings based on open dialogue						
5. Other conversations with family, couple or network						
6. Illness management and recovery (IMR)						
7. Evaluation meeting						
8 Life value group						
9. Affect consciousness group						
10. Cognitive group						
11. Physical activity (e.g. exercise, hiking, strength training)						
12. Creative group (picture therapy, music therapy/listening group …)						
13. Relaxation group						
14. Body consciousness group						
15. Education (e.g. sleep hygiene, patient education etc.)						
16. Treatment meeting with patient						
17. Other ward meetings (e.g. morning meeting, evening meeting, tv meeting)						
18: Other:						

Figure S 3 Use of medication, clinician form, start and end of treatment

Use of medication for mental disorders (indication)*

☐ **The patient uses no medication**
☐ **The patient uses medication (complete the form about all current medications)**

Currently prescribed medications, daily dose and scoring of the side effects and adherence

Medication (write clearly in capital letters)	Medication group: 1 Antidepressants 2 Antipsychotics 3 Tranquilizers/sleep aids 4 Mood stabilizers 5 Stimulants 6 Other 7 Don't know	**Daily dose (mg)**	Weeks with this medication in last 6 months	Used since month/year	**Side effects** 1 None 2 Light 3 Moderate 4 Serious 5 Unknown	**Adherence** 1 Totally/mainly as prescribed 2 Mostly as prescribed 3 Partly as prescribed 4 Mainly not as prescribed 5 Unknown

Note. Information in light grey is not used in the current article.
*At the end of treatment, the heading is **Use of medication by mental disorders (indication) *during admission***

Figure S 4 Treatment duration, clinician form, end of treatment

Duration of admission	**Number of weeks**

Figure S 5 Diagnosis, clinician form, end of treatment

Current diagnosis

Main diagnosis ICD-10

Diagnosis	Set year/month	How*
F .		

Other psychiatric diagnoses ICD-10 (also drug-related diagnoses)

Diagnosis	Set year/month	How*
F .		
F .		
F .		
F .		
F .		

*) Coding of "How" in tables above

1 MINI/MINI-PLUSS
2 SCID-I
3 SCID-II
4 Other diagnostic tool:_____
5 Clinical consensus by two or more clinicians
6 Clinical evaluation by one clinician
7 Don't know

Note. Information in light grey is not used in the current article

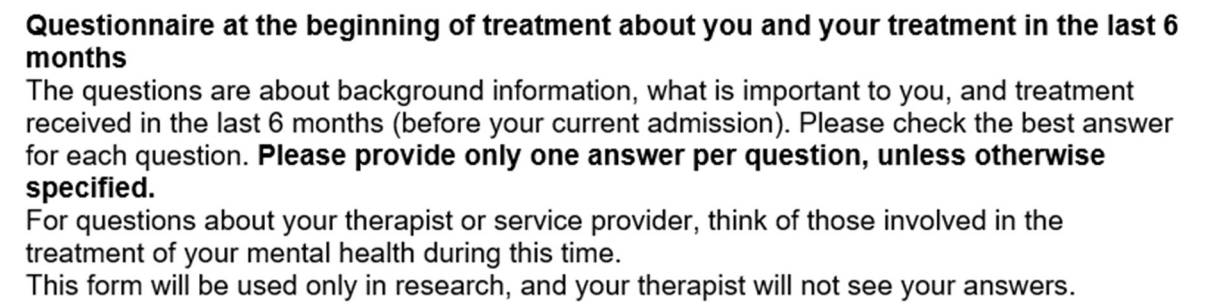
Figure S 6 Treatment received, clinician form, end of treatment

Treatment and interventions given during the treatment stay

Place one cross on each line

	1 None	2 Less than once weekly	3 1–2 times weekly	4 3–4 times weekly	5 >4 times weekly
1. Assessment					
2. Treatment with medication					
3. Individual conversations					
4. Network meetings based on open dialogue					
5. Conversations with other family, couple or network					
6. Illness management and recovery (IMR)					
7. Evaluation meeting					
8 Life value group					
9. Affect consciousness group					
10. Cognitive group					
11. Physical activity (e.g. exercise, hiking, strength training)					
12. Creative group (e.g. picture therapy, music therapy/listening group)					
13. Relaxation group					
14. Body consciousness group					
15. Education (e.g. sleep hygiene, patient education etc.)					
16. Treatment meeting with patient					
17. Other ward meetings (e.g. morning meeting, evening meeting, tv meeting)					
18: Other:					

Figure S 7 General introduction, patient form, baseline



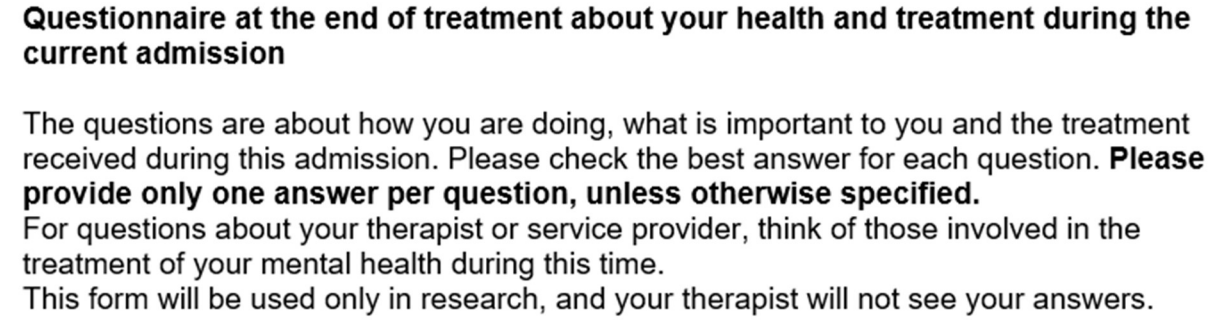
Questionnaire at the beginning of treatment about you and your treatment in the last 6 months

The questions are about background information, what is important to you, and treatment received in the last 6 months (before your current admission). Please check the best answer for each question. **Please provide only one answer per question, unless otherwise specified.**

For questions about your therapist or service provider, think of those involved in the treatment of your mental health during this time.

This form will be used only in research, and your therapist will not see your answers.

Figure S 8 General intruduction, patient form, end of treatment



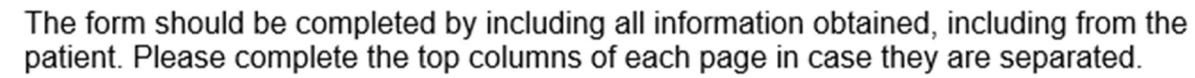
Questionnaire at the end of treatment about your health and treatment during the current admission

The questions are about how you are doing, what is important to you and the treatment received during this admission. Please check the best answer for each question. **Please provide only one answer per question, unless otherwise specified.**

For questions about your therapist or service provider, think of those involved in the treatment of your mental health during this time.

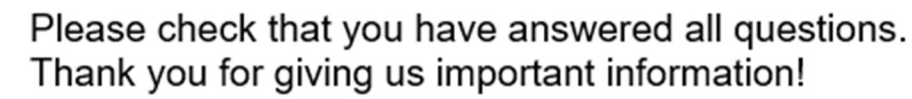
This form will be used only in research, and your therapist will not see your answers.

Figure S 9 General introduction, clinician form, baseline and treatment end



The form should be completed by including all information obtained, including from the patient. Please complete the top columns of each page in case they are separated.

Figure S 10 General ending, patient form, baseline and treatment end



Please check that you have answered all questions.
Thank you for giving us important information!

Interview guides
Translated from Norwegian

Interview with patients
Part one: Reasons for medication-free treatment

1. This ward is called a 'medication-free inpatient ward'. What does this term mean to you?
2. When did you first hear about this phenomenon?
3. Before you came, how did you picture you would notice the difference between a medication-free ward and an ordinary ward?
4. How did you first hear about this ward?
5 What was important to you when being referred for this admission?
Was it important for you to come to a medication-free ward?

If yes	If no
6. Why was this important to you? 7. Do you have any experiences that contribute to this being important for you? Would you like to share some of these? 8. How long have you wanted such a service?	6. What do you think about the ward being medication free? 7. If you could choose freely between a medication-free and an ordinary ward, all else being equal (treatment offer, duration, waiting time, persons, own reasons, etc.) which would you have chosen? a. Why?

Part two: Experience of medication-free treatment

9. All in all, what do you think about your stay here on the medication-free ward?
- What have you been most satisfied with during the stay?
- What have you been least satisfied with during the stay?
- If you had met another man or woman who was in need of mental health care, would you recommend this ward?

10. If you have been admitted to another inpatient ward earlier (including this ward before it became a medication-free ward), what would you say is the biggest difference between those wards and this one?
11. During your stay, if you have chosen to not use medication or to reduce medication, what has this been like?
- Do you think you have received help in working with your problems in other ways (than taking medications)?
- Have you been offered alternatives/help you have not received elsewhere?
- Do you feel supported in tackling your challenges without medication?

12. During your stay, did you feel you had an influence on your treatment? (decide, affect, participate, be heard)
- Do you feel you had enough influence, or would you have preferred more?
- *If much influence:* Do you think this opportunity to decide would be as good on a ward that was not medication free?

14. If you wish to give advice to us working here to improve the treatment, what would it be?
15. If you could choose exactly the treatment you wanted, what would you choose?

If time is left:
1. Do you feel your thoughts about choices and needs regarding treatment were taken into consideration by therapists (therapists in general, not just those you have met)?
2. What kind of experiences do you have from conversations about treatment choices? Some say they do not dare to tell all about how they feel, because they are afraid they will not get to choose the treatment they want but may be forced to take medicines, or even admitted involuntarily. Do you have such thoughts?

Interview with staff

Theme 1: What is medication-free treatment at [ward name]?
- Can you remember the first time you heard about 'medication-free treatment'? Tell me about that. What did you think? How is it now?
- How do you understand the term 'medication-free treatment'? What does it entail?

Theme 2: What characterizes the patients in the medication-free ward?
- Can you tell me what kind of people come here? Are they different from patients admitted here earlier?

Theme 3: What characterizes the workday in a medication-free ward?
- Can you describe your most important tasks in the medication-free treatment programme? Are they different from before?
- Can you describe situations that are typical when working in a medication-free ward? Both positive and challenging aspects.
- Can you remember a situation where you experienced conflicts between the concept of medication-free treatment and other concerns?
- Have you experienced conflict between your clinical opinions and the medication-free mandate?

Theme 4: What does medication-free treatment entail for the patients?
- What kind of experiences or benefits do you think patients receive in the medication-free ward? Are these different from earlier?
- Alternatively, in what way do patients benefit from medication-free treatment? Do you think this treatment is better than the treatment they received earlier?

Theme 5: What does medication-free treatment entail for the staff?
- What do you think about the implementation of medication-free treatment at [ward name]? (What do you think the others think? What do you think now?)
- Alternatively, what kind of experiences do you think other employees have working with medication-free treatment at [ward name]?
- Have you changed views in any areas because of working in a medication-free ward? If so, what has changed?

Ending:
- The theme of this interview has been your experiences with medication-free treatment. Is there anything important I have not asked you about?
- Is there anything else you would like to say before finishing? Clarifications, elaborations.

Erratataliste

Navn kandidat: Kari Standal
Avhandlingstittel: Medication-Free Treatment in Mental Health Care: Characteristics, Justification, and Clinical Outcomes

Forkortelser for type rettelser:
Cor – korrektur
Celtf – endring av sidelayout eller tekstformat

Side	Linje	Fotnote	Originaltekst	Type rettelse	Korrigert tekst
10	161		Classification of problems presented by patients present is seen as essential….	Cor	Classification of problems patients present is seen as essential…..
10	164		Therefore, diagnoses are at the center of the clinical decision-making hub.	Cor	Therefore, diagnoses are at the center of the clinical decision-making.
12	197		This approach has been characterized using the CHIME (Slade et al., 2012)	Cor	This approach has been characterized using the acronym CHIME (Slade et al., 2012)
35	Table 4		Row with column headings was missing	Cor	New row at the top of the table, columns from left: 2: Baseline 3: Weekly during treatment 3: End of treatment