

## **Moral evaluation of coercion in mental health care – A qualitative study of patients’ perspectives**

### **Abstract**

*Background: Coercion in mental health care has led to much ethical debate on its nature and use. Few studies have explicitly explored patients’ moral evaluations of coercion.*

*Aim: The purpose of this study is to increase the knowledge of patients’ moral views and considerations regarding coercion.*

*Research design: Semi-structured focus groups and individual interviews were conducted and data were analysed through a thematic content analysis.*

*Participants and research context: 24 participants with various mental health problems and experiences with coercion. Data were collected in 2012–2013 in three regions of Norway.*

*Ethical considerations: Ethical approval and permissions were obtained according to required procedures. Informed consent and confidentiality were secured.*

*Findings: The moral deliberation of coercion included six main considerations: the need for alternative perspectives and solutions, the existence of a danger to oneself or others, the problem of discrimination and stigma, the need for proportionality, the content of and consequences of coercion, and the way that coercion is carried out in practice.*

*Discussion: The participants' considerations reflect normative arguments commonly encountered in ethical and legal debates, but emphasise the need for alternative treatment opportunities.*

*Conclusions: Broader perspectives on coercion are required to comprehend its ethical challenges and derive possible solutions to these from a patient perspective.*

## **Keywords**

Mental health care, coercion, nursing ethics, user involvement, patient acceptance of health care

## Background

Coercion is a common practice in mental health care. The serious effects of coercion on individual autonomy and liberty make coercion an inherently value-laden practice.

Consequently, there has been much debate on the ethical justifications for and the best practices of coercive interventions, including mental health nursing.<sup>1-3</sup>

Persons with experiences of ill mental health and coercion have, until recent years, seldom participated in ethical debates and research regarding coercion.<sup>4</sup> However, prevailing research displays variations in patients' moral views on coercion, for example, those who find involuntary hospitalisation to be right or wrong or are ambivalent.<sup>3</sup> Important values for patients are having freedom of choice, autonomy and the feeling of being safe during hospital stays, together with being listened to and receiving non-paternalistic behaviour from staff.<sup>5, 6</sup> Patient participation in the decision-making process during involuntary admission is important for justifying coercion.<sup>7</sup> Other influential factors for patients are their perceptions that others hold beneficial motives, act fairly and have the necessary qualifications;<sup>8</sup> and that the expected outcomes will be positive, such as having therapeutic value or contributing to the recovery process.<sup>3, 6, 9</sup> These go together with patient views on the necessity of coercion during illness and whether they feel that voluntary alternatives or less restrictive measures should be used instead.<sup>3</sup> Several studies also reveal the moral significance of the way coercion is carried out, such as patients being acknowledged, treated with

respect and as a human being, and treated with trust and warmth, together with the existence of a therapeutic relationship and receipt of sufficient information.<sup>5, 10-12</sup>

Correspondently, perceptions of staffs' abusive behaviour and violations, failure to listen or to include, and deceit or restriction of freedom due to labelling attitudes and stigma contribute to patients' view of coercion as morally unjustified.<sup>5, 8</sup>

### **Research aims**

Previous research provides valuable information on patients' views of coercion.

However, there is still limited empirical research explicitly exploring patients' moral views and considerations regarding coercion.<sup>3, 5, 13</sup> Increased understanding of patients' values and considerations might point to aspects of ethical theory and legal regulations that need to be revised or refined, or to quality improvements for coercive interventions in mental health practice. Further, it could improve management of ethical conflicts in clinical practice or stimulate dialogue about ethical challenges between stakeholders.<sup>5, 13</sup>

This study aims to contribute knowledge to this subject through a qualitative study of people with coercive experiences in Norway. Most of their considerations regarding coercion are retrospective, although a few experienced coercion during the interview period. Finally, the findings are compared to prevailing research and current ethical

debates on coercion. Implications for ethics, as well as mental health practice, will be discussed.

## **Methods**

### **Study context and design**

Mental health care in Norway is publicly funded and organised as ‘specialised health services’ – i.e., hospital trusts (hospitals and outpatient clinics) – and as ‘community health services’ (general practitioners and local emergency and home care). Formal coercion is mainly performed within specialised health services, while community health services may request involuntary hospitalisation.

This study is part of a large-scale project in Norway called ‘Mental health care, ethics and coercion’ (PET), which started in 2011. This project was inspired by discourse ethics<sup>14</sup> and aims to explore ethical challenges regarding coercion from all stakeholder perspectives. The study used a qualitative design with individual and group interviews across various service user and patient settings. Focus-group interviews were chosen as the primary method for gathering empirical data because group interactions can stimulate moral deliberation and open, democratic discussions about coercion.<sup>15</sup> This is particularly important because coercive experiences are easily individualised,

stigmatised and silenced.<sup>13, 16</sup> Individual inpatient interviews were used as a supplemental source of data.

### **Interviews and sample**

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

The sample consisted of 24 adults – ten women and fourteen men between 22 and 60 years of age – who had various mental health problems and coercion experiences. Participants' marital and employment status varied, and many were receiving disability pensions. Participants shared their mental health problems, such as psychosis, bipolar disorder, prenatal psychosis, schizophrenia, depression or/and substance abuse. They had experienced involuntary commitment, forced medication, seclusion, restraint and coercive treatment in community health services. Experiences varied from one recent episode, to episodes years' earlier, to multiple and extensive use of coercive measures over several years. Many participants were still using mental health services, and at

least two participants were receiving coercive treatment in the community at the time of their interviews.

### **Recruitment and data collection**

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

The focus-group interviews occurred in a meeting room in a user-organisation’s office, a county house and a hotel. Interviews were three hours in length and included lunch and short breaks. Individual interviews occurred in the hospital’s visiting room or the researcher’s office and lasted from 25 to 60 minutes. An interview guide was finalised by the two authors after it was reviewed by the PET research group and users collaborating in the recruitment process. The individual interviews were conducted by

one researcher (the first author), and the focus-group interviews by two researchers. One researcher (the first author) was the moderator and ensured that all voices were heard. The researchers supplemented each other in monitoring alertness to the group dynamic, participants' well-being and follow-up questions. The interview guide included the following main questions: (1) What is coercion?; (2) is coercion right or wrong, and why?; (3) are there alternatives to coercion?; (4) and what are your views on participating in care? Questions 2–4 are the main focus of this article. Participants were encouraged to illustrate their views with concrete examples and experiences.

In all focus-group interviews, the atmosphere and discussions were positive. All participants actively participated. Most participants found the interviews to be meaningful and perceived the sharing their experiences as a form of social support, though some participants found the process tiring. Given the potential burden of recollecting difficult experiences, we were careful to create a safe and accepting atmosphere, guided by advice from experienced users and the NCKE. Additionally, the user organisations acted as a social security net by offering peer support. Afterwards, the researchers contacted all participants in case they needed further support.

## Data analysis

Interviews were audio recorded and transcribed verbatim in Norwegian. Data were analysed using qualitative thematic content analysis according to Malterud's (2012) system. This is an inductive, phenomenologically inspired method that offers structured ways of doing thematic analyses of qualitative data, but has many similarities to general strategies for analysing qualitative data.

The analyses explored participants' evaluations of coercion in general rather than specific coercive measures. Both authors read through the transcripts to obtain an overarching impression of participants' views and experiences. We described important themes on the basis of our first impressions. Afterwards, one researcher (the first author) conducted more systematic and detailed analyses. First, answers and discussions were sorted by the first author into 15 categories in NVivo Version 10, 2012. To grasp participants' perspectives, we conducted an initial analysis of their understanding of the concept of coercion. This showed that participants had wide-ranging accounts of coercion, including formal and informal coercion across health and welfare services.<sup>17</sup> Core descriptions of coercion included deprivation of freedom, power relations (in terms of powerlessness and 'counter-power') and existential and social life events.

We then carried out more in-depth analyses of participants' moral views and considerations of coercion. Data from the categories concerning their moral views were

coded as meaning-units and condensed into short statements expressing the essence of their meaning. We looked for *explicit* statements about coercion as right and wrong, and *implicit* statements touching on values (e.g., ‘respect’) and normative evaluations (e.g., ‘should’, ‘ought’, ‘must’). These meaning-units were arranged in data matrixes for comparative analyses of the participants’ views across interviews and in relation to the interviews as a whole. Finally, both authors synthesised the meaning-units and sorted them into broader descriptive themes displaying the main concerns and considerations of the participants’ moral evaluations of coercion. These themes are presented in the findings section together with selected illustrative quotations. The two authors met regularly throughout the analytic process to ensure intercoder reliability.<sup>18</sup> Ethical theory and empirical research were referred to throughout the analyses.

## **Research ethics**

In accordance with Norwegian law, the study was formally evaluated by the Regional Committee for Medical and Health Research Ethics, which deemed the study to fall outside of its responsibility because it was considered to be ‘health services research’ (REK South-East, September 13, 2012, project number 1329). Therefore, the study was assessed and approved by the National Data Protection Official for Research (Approval

September 18, 2012, project number 31302) and the local research committee at the participating hospital.

Written and oral information and consent and confidentiality in line with the Helsinki Declaration are secured, including about their right to withdraw at any stage. We encouraged sufficient breaks and self-regulation of privacy.

## **Findings**

The participants' broad perspectives on coercion as described above influenced their moral views on and evaluation of coercion. The analyses revealed six main considerations, often reflecting current legal criteria and ethical debates on coercion, as elaborated below.

### **A need for alternative perspectives and solutions**

In their moral evaluation of coercion, many participants highlighted the need to include alternative perspectives of and solutions to mental health problems. These alternatives should address changes in the underlying understanding of people with mental health problems and the nature of mental illness (specifically psychosis), along with changes in treatment philosophies and available alternatives. For example, instead of using

coercion, treatment should focus on increasing patients' capacity to overcome and express their problems in constructive ways, as well as the content, quality and availability of voluntary services.

Several participants stated that the use of coercion was not always related to a patient's lack of insight or refusal of help. Many had actually sought help from the health services, but had been rejected until they became so ill that coercion was considered necessary. Others wanted help but were refused voluntary treatment, such as activities and counselling, which they found more helpful than seclusion and medication. Ethical discussions on coercion should therefore address the lack of voluntary opportunities or use of alternative solutions at home or in the community. Some participants related wrongful use of coercion to a systemic shaping of mental health care toward the use of coercion instead of voluntary treatment as a first choice. For example, one patient said: *'Wrongful use of coercion is connected to the system's wrongful modelling of treatment.'* As a consequence, they found that too much money is spent on ineffective and even damaging treatment, especially forced medication, without adequate scientific evidence. Coercion could, in this way, be an inexpedient solution to mental health problems.

## **Dangerousness**

Another important ethical consideration that arose during group discussions concerned the need to balance the legal criterion of ‘being a danger to oneself or others’ (sometimes also discussed as ‘harm’) with the potential harm from coercion. The discussions revealed a broad understanding of danger and harm, including patients’ ability to act in their own best interests or take care of themselves.

## **Danger to others: Violence and aggression**

Most participants found coercion to be morally justified if a person were violent. Their ethical considerations regarding aggression had greater moral complexity. Several considered a moral justification for coercion to be dependent on the subjective reasoning behind the aggression, the interactional processes leading up to the aggression or acting-out (for example, violating behaviour from staff) and the availability of alternative solutions. Moreover, they distinguished between anxiety, frustration, anger and violent aggression due to substance abuse. Some participants also stated that both living under the constant threat of coercion or actual experiences of coercion could even lead to aggressive and violent behaviour in patients who were neither under more normal circumstances. Hence, staff coercion or expectations of patient dangerousness could lead to a vicious circle or self-fulfilling prophecy of acting- out or violence.

## **Danger or harm to self**

Several participants considered involuntary hospitalisation morally justified (even if it caused temporary anger) in situations where people were not able to take care of themselves, such when people lacked understanding of the seriousness or acuteness of their mental health problems or when they were confused, psychotic or emotionally driven by fear or rage. A person wandering around in a confused state could, for example, end up being run over by a car. As Johanna explained:

*Well I think, regarding deprivation of liberty, that it is OK to put someone behind thick walls (and that might actually feel like safety after awhile) when a person is wandering around without being able to ask for this kind of safety himself. Then, maybe someone has to do something: to take this person who is wandering around and put him behind locked doors, even if that may create a lot of despair and anger for a period of time, and you need to reassure them and so forth. But I always put my foot down when it comes to medication. Because I find it incomprehensible; it's so hard for me to accept that someone would put chemicals into me to regulate my behaviour. They might just have to stand me raging a bit.*

However, as shown by the quotations, several participants considered that coercion required serious psychosis to be morally justified and should be a last resort after trying voluntary options. Also, more participants found forced medication to be less morally justified than involuntary hospitalisation. This was due to the serious side effects of medication and involuntary medication's intrusive effects on personality.

The participants expressed uncertain and divergent moral views on coercion when a person was suicidal or conducting self-harm. A few participants mentioned the right to commit suicide. However, several participants considered the use of coercion to be morally right and, to some extent, a moral duty when a person was obviously suicidal.

As Susie argued:

*Thinking about being a danger to yourself, I find this to be a huge dilemma. Because when you are in such a state, you might have lost your whole perspective. And I would appreciate being saved if I were so close [to committing suicide]. After all, I want to live.*

She said that a person ought to be saved when his or her actual preference is to live.

Participants often indicated that the risk of self-harm or health impairment due to mental health problems should be balanced against the risk of harm from the use of coercion.

For example, Kenneth argued:

*I believe that coercion may, and I underline may, be right when the patient is psychotic and a great danger to himself or others. On the other side, (...) coercion may or will result in traumas that may have negative consequences for self-esteem and zest for life later on, along with all the problems following involuntary commitment or compulsory treatment. So I agree that it's important to consider what can be done ahead of hospitalisation to avoid a coercive experience.*

Considerations of possible risks from coercion included physical, psychological and social harm, as well as the possibility that a coercive episode could have a negative impact on the course of peoples' lives or deprive them of valuable time: *'You're stealing peoples' time. You're stealing valuable years, months or minutes in involuntary hospitalisation'*. Other examples provided were experiences of torture, trauma and humiliation, along with psychological brokenness, shame and social anxiety. Moreover, the side effects of medication could be severe, including physical injuries; suicidal thoughts; inability to take care of oneself; sleeping too much; and loss of free thinking, creativity and sexuality.<sup>17</sup>

## Paternalism and harm

Several participants discussed coercion in connection with paternalism and freedom of choice. Few related the need for care and protection to the argument for paternalism. Rather, the overly paternalistic culture of mental health care was criticised. Such paternalism was considered wrong because it reduced genuine voluntariness or freedom of choice, and indicated a lack of attention to patients' views on and experiences with their own problems. This could lead to unfortunate situations, such as continued use of inappropriate medication or underestimating the treatment value of other types of interventions. Martin said:

*And then, I didn't want to begin using medication at all. I believed that milieu therapy and such things could help me out of my depression, or whatever I had. But my therapist said, 'No, it's going to be medication'. And I felt that I had no choice, really. And I was not even involuntarily committed; I was there voluntarily. But she said, 'No, it's going to be medication'. (...) I didn't think it was right then, nor do I today. [Interviewer asks why.] Because I had found it helpful to go outside and meet people, I felt I really got a boost out of it and that it was more of that that would help me out of the situation. And it was really bad medication she put me on, as well. I think it was the first or second generation of antipsychotics. And I had a lot of side effects. And retrospectively, I find it totally irresponsible to make that decision, to put me on that medication.*

Several participants also argued that paternalism or claims of ‘lack of insight’ could be used in an oppressive way to discredit patients’ opinions. For example, one participant said: *‘If I have objections towards something, I either lack insight into my illness or lack the ability to cooperate, and this is written in my medical record’*. Further, although some found that a lack of insight could be a problem during illness, health personnel often underestimated patients’ ability to make reasonable judgements or informed choices on their own behalves if given enough information and time to process it. Insight should, therefore, be understood in a more nuanced and process-oriented way, because patients often gain insights into their illnesses over time.

### **The content of and consequences of coercion**

Another concern of importance for the moral evaluation of coercion was the content of and consequences (or outcomes) of coercion. As Willy explained:

*But, I think, what we are talking about now and might agree on – and I know that many patients talk about it as well – is that it is not necessarily coercion in itself that is always wrong, but the content of it.*

This was also reflected in Susie’s considerations:

*On the other hand, it's a question of what you are forced into as well. (...) It's precisely that. It has to be something that saves you.*

In line with this, participants with more approving views found that coercion had led to many positive outcomes, such as being well. For example, June stated, *'Coercion can sound negative, but it results in many positive things'*. Martin also considered his involuntary hospitalisation due to depression to have been morally justified because it had put him on a different track and made him more receptive to help.

Similarly, many participants related wrongful use of coercion to the lack of positive content of the coercive measures being used (e.g., the content of seclusion or involuntary stays in the hospital) or to worse outcomes than voluntary solutions could have achieved. For example, Emma described situations in which coercion would be morally wrong in her eyes:

*But what I don't respect is being taken by force to a more or less empty, vacuous, vapid treatment, and chemicals. In a way, I can respect and accept coercion if it leads me to a place where I want to be. That is to say, when coercion results in something constructive. (...) Sometimes I don't understand what's best for me; I'm not bothered. I lack motivation, and then I might need someone to give me a kick up the backside, to make me do what is good for me. Then, coercion is constructive. And as long as coercion is constructive, I am not against it either.*

*But the coercion I have experienced wasn't constructive. It didn't have anything constructive in it. At least, I am not able to see it in my case. Then it is totally objectionable. It is such a terrible waste of resources.*

Coercion was also considered morally wrong when it obstructed patients' own work on their recovery (e.g., by reducing their capacity to cope with difficult emotions) or when it worsened problems by increasing anger, fear, stress and psychosis (e.g., through forced passivity and social isolation during seclusion or through stimulating a vicious cycle of coercion). As Ruth told us:

*Well, my experience is that I only get worse and worse and worse from the compulsory treatment that I have been exposed to. And that is not only my own subjective judgement; my children have said the same. (...) I just get hostile and start acting out in any way to demonstrate my opposition towards the system. And then you get punished for that, of course, and then it just gets worse.*

Some participants also reported that such negative experiences contributed to loss of trust in the health services and avoidance of seeking help. Consequently, they found that a justified use of coercion requires good care, and a continuous and integrated care planning in the community, to support patients and prevent further use of coercion.

## Discrimination

Several participants related their moral evaluation of coercion to societal discrimination against people who are viewed as different or who have mental health problems.

Some participants argued that coercion was morally wrong according to the United Nations Convention on the Rights of Persons with Disabilities and when coercion was used solely to secure normalisation and conformity. For example, Liam thought he had been forcibly medicated due to social disapproval of his ‘unusual’ life views:

*Then you also have this thing of forcing attitudes on me that I can't answer for, and that my perception of reality – it's not approved of, so it has to be medicated away. I mean, you can see how people are fighting for their religion (...). But my life views are pathologised. And that is in fact rather offending. (...) I mean, it's not approved of and then you're crazy. That is a quite provoking statement that is pathogenic in itself.*

Further, coercion was evaluated as morally wrong when people with mental illness were considered more dangerous than they actually are due to stigmatisation, resulting in overuse of police force during admissions or an excessive focus on security in hospital wards (such as alarms and the scanning of visitors), creating unnecessary anxiety of the patient.

Several participants considered it morally problematic that the legal criteria for coercion were not followed in practice and that the use of coercion was based on biased or superficial assessments by therapists. Another problem was what participants saw as insufficient and ineffective legal protections. This was especially true in situations in which committed patients were prevented from communicating what they experienced as staff abuse to the outside world. Another problem described was ineffective control by health authorities due to carelessness or lack of independent evaluation and assessments. This made it futile for patients to raise legal complaints about what they regarded as unnecessary coercion or dehumanising care.

Several participants considered a lack of information, especially regarding medication, to be morally problematic. Some told us that they had not been given information about their medication or had been refused the opportunity to seek information or a second opinion during hospitalisation. This had resulted in their taking medication for years without knowing about potentially serious side effects or being unprepared for frightening side effects. For example, John said that the staff told him that his side effect of tiptoeing (called ‘tripping’ in Norwegian) from antipsychotics was not real but was due to his mental illness:

*And then I was better. But a few years later, when I was walking down the street, I suddenly saw a book about the chemical power of psychiatry. And then I turn it over, and it said that Trilafon is nicknamed ‘Trippafone’. And that what they*

*[the staff] said was just my imagination, actually was real. And I bought the book and found out that I had been tricked and lied to.*

Such episodes where faulty information was provided or side effects were trivialised were seen as deceitful and particularly unjustified.

### **Proportionality**

Another important ethical consideration was the proper relationship between the kinds and scope of coercive measures used (and their effects) and the seriousness of patients' mental health problems or actual danger of harm.

Participants felt that coercion was morally justified in situations where they had been 'really ill' and were not able to take care of themselves. Conversely, unjustified coercion was characterised by disproportionate use of coercive measures (e.g., restraints), hard-handed physical force towards non-dangerous patients (e.g., being held down by five big, male staff members) or 'overly heavy medications' (often antipsychotics). Coercion was seen as especially wrong if used in situations characterised by less-disturbing behaviour, lack of compliance towards rigid house rules or prescribed medication, or unfounded staff anxiety.

Disproportionate use of coercion was considered wrong because it was unfair and did not fulfil the legal requirement of being necessary or the last available option. It was also wrong because it amplified the experience of coercion being a violation or punishment. Sophie explained:

*Some of the episodes with mechanical restraints that I experienced almost felt like an act of kindness or care. Because I was totally disintegrated, not able to take care of myself, and maybe I would have killed myself. (...) But, most of the situations were different, and felt more like a kind of violation, especially because punishment was a significant element. I found that, 'If you don't behave, or if you act out in this way, then we have to punish you'. And the punishment was not proportionate to the situation at hand.*

### **The way coercion is carried out**

Most participants agreed that the way coercion is carried out is important in determining whether it is morally justified. Some described coercion as a social situation with great potential for humiliation and offence, yet in which some humiliation could be easily avoided by improving communication and care. The punitive aspect of coercion, as described by Sophie above, was an important marker for whether it was morally right or wrong.

The participants characterised the best ways of carrying out coercion in practice: It should be as short term and gentle as possible, the patient should be thoroughly informed and prepared, there should be dialogue and possible alternatives to coercion should be thoroughly assessed. Further, it was important that participants be valued, respected and treated like human beings and that staff acknowledge and be attentive towards their problems and views. For example, Sophie reflected on her coercive experiences:

*I've thought a lot about what characterised those coercive situations that became very dramatic and harsh. What was it that distinguished them from other situations that weren't like that? And then I remembered individuals who showed me respect, who were nice fellow humans, who didn't speak to me as if I were an ape from a foreign planet or something like that. But [they] merely took me seriously, listened to me, and then things were solved in totally different ways.*

Overall, coercion was more acceptable if staff was flexible, trusting, friendly and oriented towards collaboration on equal terms instead of towards distant hierarchical relationships. In contrast, coercion was evaluated as morally wrong when done in a punitive, rigid, cold or uncaring way, leading to disempowerment, humiliation and offence. Lack of information about the use or timing of coercion (e.g., forced medication) was also seen as wrong because it increased feelings of powerlessness and fear; some participants described such episodes as 'torture'.

## Discussion

The strength of the study is that we have explicitly sought ethical perspectives of coercion from people who have experienced coercion. However, our findings are based on a small sample and thus the findings might reflect our recruitment strategy, group dynamics and policy discourses in user settings. Yet, we recruited participants from several outpatient and inpatient settings, and the lengthy and active group interviews provided rich and varied data on individuals' views and experiences, hence stimulating insight into their moral perspectives. Recruiting participants from mental health organisations outside the health services may also have contributed to them more freely expressing their critical views.<sup>13</sup>

The study shows that participants hold balanced views on coercion, reflecting the situational and moral complexity of coercion.<sup>7</sup> The findings are in many ways consistent with previous research exploring such moral views more implicitly, as described in the introduction. Moral justifications of coercion, for example, are related to exploring and using alternatives to coercion to the highest possible extent, ensuring beneficial treatment, averting further harm and providing an opportunity to recover in a safe place when regarded as necessary due to patients' lack of recognition that they need help when they are acutely unwell. To the contrary, coercion is considered to be wrong or partly wrong when patients' problems could have been managed through less coercive

interventions or when it is perceived as an unjust infringement of patients' autonomy posing a permanent threat to their independence.<sup>3</sup>

The study shows that the participants' deliberations were influenced by current legal or ethical discourses on coercion and draw on arguments from the perspectives of both human rights and medical ethics. However, they also highlighted the problem of injustice and discrimination and had more critical views than those of medical and nursing ethics towards the beneficial outcome of forced medication and paternalism.<sup>19</sup>

<sup>20</sup> Their threshold for legitimate use of coercion also seemed to be higher. Similar to users internationally, they emphasised the potential harm from coercion and underlined the need for more nuanced perspectives on insight and competence, and on aggression and violence.<sup>13, 16</sup>

Their emphasis on positive outcomes and proportionality confirm the moral and legal significance of the 'outcome' and 'necessity' of coercive measures, although the treatment value of coercion as seen from the patient's perspective has greater weight than it does in much professional ethics. They also confirmed the importance of the way coercion is carried out as described in previous studies. However, relational qualities are not always sufficient to transcend the intrusive and burdensome character of coercion caused by the loss of individual liberty and autonomy.<sup>13, 16, 17</sup>

## **Conclusion**

The study shows that people with mental health problems are well able to participate in ethical discussions about coercion and should be included in such discussions.

Participants' considerations reflected the normative arguments found in prevailing legal and ethical debates on coercion. However, they also stressed the need for qualitative improvement of the mental health care system; a critical assessment of benefit versus harm; increased patient involvement; and the development of alternative perspectives, treatment methods and solutions in mental health care and nursing. Hence, the study confirms the need to view coercion within a broader context in order to understand what is important from patients' perspectives.<sup>13</sup>

## **Acknowledgements**

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## **Conflict of interests**

The authors declare that they have no conflicts of interest.

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