How do health care workers in psychiatric wards justify the use of coercion as a treatment tool?

In what ways does the use of coercion in psychiatric units affect patient outcome?

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Abstract

Health care providers need to be cognisant of how patients perceive their actions (Norvoll, Hem, & Pedersen, 2017). Assuming the ultimate goal of psychiatric treatment is to restore patients to a level of mental "self preservation," the concept of force is somewhat contradictory. If a patient perceives that they are being coerced or involuntarily forced to participate in their treatment, or a certain aspect of it, this may affect the usefulness of treatment (i.e. their "self preservation"). The research question is as follows: How do health care workers in psychiatric wards justify the use of coercion as a treatment tool? In what ways does the use of coercion in psychiatric units affect patient outcome? I hypothesise that health care providers justify their use of coercion through weighing pros versus cons in each individual situation. Furthermore, I hypothesise that perceived coercion by patients will lower their trust and, therefore, cooperation during treatment. Subsequently, I hypothesise that when high levels of perceived coercion are present in treatment, patients end with a worse off outcome than patients that are more active and willing participants in their own treatment. The aim of this study is to provide insight into the relationship between the ethical acceptability versus the practical usefulness of using different types of force in psychiatric treatment.

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1. Introduction

Laws on the use of force or coercion in psychiatric units varies among first-world nations. There is much debate regarding ethical dilemmas of using coercion on mentally-ill patients (Aasland, Husum, Førde, & Pedersen, 2018; Jacob, & Holmes, 2018). Two main cornerstones of this debate are 1) the lack of a mentally-ill patient's ability to consent, and 2) whether or not the use of coercion ultimately has a positive or negative effect on a patient's outcome. The phrase "it's for their own good" enters the conversation often, however research indicates that is is unclear whether or not this statement is true (Johnston, & Kilty, 2016). Due, Connellan, & Riggs (2012) argue that "in contemporary mental health care surveillance is used primarily as a form of risk management, rather than also as a way of facilitating healing relationships between staff and patients." To some psychiatrists, the use of force belittles their professionalism. However, others may consider it necessary under the assumption that "irrational," or mentally unstable, people may be opposed to treatment in the first place. The idea of irrationalism in psychiatric patients is greatened by literature of some psychiatrists who doubt the true existence of mental illness (Szasz, 1974; Laing, 1990).

> "There is an ongoing ethical and professional debate regarding patients' autonomy and coercion in psychiatric care . . . On the one hand, this debate is concerned with principle issues relating to whether coercion should be allowed or not . . . On the other hand, there is a more clinical and practical discussion relating to in which clinical situations coercion should be considered acceptable and which particular types of coercion that may be safe, effective and most appropriate in various clinical situations" (Wynn, Kvalvik, & Hynnekleiv, 2010).

The true extent of mental illness prevalence worldwide is unknown. What is certain, however, is that mental health conditions are on the rise. The World Health Organization (WHO) reports that between 2007 and 2017, there was an unprecedented 13% rise in mental health conditions and substance abuse disorders globally (WHO). Increasing cases of mental illness necessitates increased knowledge on how to treat them. Whether or not force or coercion should be applied in treatment is among this knowledge that is necessary for health care providers to know in order for patients to recover properly, and rejoin society healthy.

1.1 Research question

Health care providers need to be cognisant of how patients perceive their actions (Norvoll, Hem, & Pedersen, 2017). Assuming the ultimate goal of psychiatric treatment is to restore patients to a level of mental "self preservation," the concept of coercion is somewhat contradictory. If a patient perceives that they are being coerced or involuntarily forced to participate in their treatment, or a certain aspect of it, this may affect the usefulness of treatment (i.e. their "self preservation"). My proposed research is, thus, as follows: How do health care workers in psychiatric wards justify the use of coercion as a treatment tool? In what ways does the use of coercion in psychiatric units affect patient outcome?

The aim of my study is to provide insight into the potential usefulness or potential damage of using force in psychiatric wards to psychiatric patients outcomes. Additionally, this study can provide knowledge to health care providers on the when it may be and when it is not ethically correct to use coercion on psychiatric patients. The overall goal of the study would be for psychiatric care providers to be capable of providing a higher level of service, thus improving patients' results.

1.1.1 Hypothesis

I hypothesise that health care providers justify their use of coercion through weighing pros versus cons in each individual situation. For example, a health care provider may weigh a patient's physical safety as more important than the violation of the patient's personal space. Furthermore, I hypothesise that perceived coercion by patients will lower their trust and, therefore, cooperation during treatment. Subsequently, I hypothesise that when high levels of perceived coercion are present in treatment, patients end with a worse off outcome than patients that are more active and willing participants in their own treatment.

1.1.2 Concepts

I will focus on a number of main themes, or concepts. Amongst these are coercion, consent, cooperation, mental illness, and the principal/agent problem. While seemingly obvious concepts, difficulty arises when attempting to precisely define each.

Following the concept of coercion as defined by Wertheimer (1993), coercion is a form of power. While related, coercion is distinct from persuasion, inducement, and authority; coercion almost instinctively includes aspects of all three. Coercion may involve persuading someone to want to do something, however persuasion leads to consent of the action. Meanwhile, coercion does not necessarily lead to consent. More times than not deception is

used in coercion, where as deception is not utilised in persuasion. Similarly, inducement does not utilise deception. Inducement on an elementary level can simply be viewed as bait. Imagine a parent says to their child "if you clean your room, you can go to your friend's house." This is hardly coercion because the exact necessary action for achieving the defined reward is clearly known to each party. How this scenario could become coercion is if, after the child cleans their room, the parent says "you cannot actually go to your friend's house;" they only used this as deception so the child would clean their room. Authority is often present in coercion. For example, the parent in the previous anecdote has authority over their child. However, it is possible for someone in an inferior authoritative position to coerce someone in a superior authoritative position. Imagine in the anecdote above the child responses "Okay, but I need help cleaning fast enough! John said I have to come in 30 minutes or it's too late!" So the parent inevitably assists their child cleaning and allows him to run off to his friend's home in 30 minutes. However, the friend John never said that 30 minutes was the limit. The child simply wanted to do less work and get to their friend's house as soon as possible. Now the coercion has shifted from the parent, the authority figure, to the child. Formally, I will define coercion as *the practice of manipulating someone to do something by using force, threats, and/or deception*. A difficulty with coercion in medical treatment is health care workers' inability to form such an exact definition; "clinical staff appears more sensitive to perceiving ethical uncertainty or conflict than being prepared to articulate a focus of ethical concern i*n precise terminology* [emphasis added], especially regarding coercion" (Montaguti, Schürmann, Wetterauer, Picozzi, & Reiter-Theil, 2019).

Consent is a less difficult concept than coercion. Consent directly involves an action being voluntary or involuntary. Any action that is involuntary is *ipso facto* nonconsensual. For an action to be consensual, it must be voluntary. However, an action being voluntary is necessary but not sufficient for it to also be consensual. Voluntary is willingness to do or have an action be done to oneself, while consensual is the knowledge and acceptance of said action. Often the line between voluntary and consensual is the law. Consent is specifically important in psychiatric treatment when it comes to minors or patients deemed "dependent." In these cases, the need for content shifts from the patient to a legal guardian, who may or may not have the patient's needs in mind. Formally, consent is the conscious and knowing permission or agreement to do something or to allow something to be done to oneself, or to someone one is

responsible for. Cooperation is related to consent; cooperation is defined as the process of two or more people working together to achieve the same end. For cooperation to occur, consent from all parties must be present. Furthermore, persuasion can come prior to consent; as stated above, persuasion leads to consent of an action. This can be related to a pressure to please or to conform to a norm.

Directly related to all the above concepts is the principal/agent problem. A principal/agent problem occurs when when one person or entity, is able to make decisions and/or take actions on behalf of, or that impact, another person or entity. Once a patient is officially admitted to psychiatric treatment, a principal/agent problem immediately is created. This theory will be expanded on in detail in a later chapter.

As previously stated, a mental health condition can be described as any condition that affects your mood, thinking, and behaviour. I will define mental illness itself as to lack a state of well-being in which the individual realises his or her own abilities, cannot cope with the normal stresses of life, cannot work productively and fruitfully, and is unable to make a contribution to his or her community, or a various combination of these.

2. Background

The World Health Organization (WHO) reports that between 2007 and 2017, there was an unprecedented 13% rise in mental health conditions and substance abuse disorders globally and estimates that 20% of adolescents worldwide suffer from a mental health condition. "Failure to invest in mental health as a matter of urgency will have health, social and economic costs on a scale that we have rarely seen before" (WHO). This begs the question of how to properly "invest" in mental health. Standard mental health treatment varies country by country, city by city, even individual psychiatrist by individual psychiatrist. Nonetheless, one common topic in mental health treatment is universal: force. Is the use of force in treatment beneficial? Is it for their own good?

2.1 Background from a social perspective

With global prevalence of mental health conditions on the rise, proper treatment and rehabilitation of psychiatric disorders has come to the forefront as an issue in the medical sector — especially in the first world. One, of many, topics vital to positive patient outcomes is that of coercion both at admission to treatment and throughout the treatment process.

The discussion of human rights as a whole has become vitally important in the 21st century. More and more, marginalised groups of people have been beating down antiquated norms to gain personal rights. Here are some examples of this trend in various aspects of society. Firstly, the #metoo movement has seen women from all backgrounds stand up against sexual assault and condemn the social structures that exacerbate inappropriate behaviour toward women. The Black Lives Matter (BLM) movement stands up for its namesake. BLM particularly denounces and actively fights against police brutality in the United States. Supporters of BLM are not limited to black people nor to the United States, but are a worldwide system of justice fighters. Gay rights activists came long before the 21st century, however the LGBTQIA+ (which stands for lesbian, gay, bisexual, transgender, queer and/or questioning, intersex, asexual and/or agender) movement has gained huge momentum in recent years with activists all around the world protesting for equal rights to marriage, adoption, and even existence. The progress these, and similar, movements have accomplished is impeccable. However, progress is never synonymous to completion.

One group of marginalised people that has been relatively overlooked, at least by the general public, during these years of human rights' reform is psychiatric patients. Nonetheless,

they are now starting to enter the conversation — especially in the medical field. Though it is impossible to say, one could partly contribute the increased discussion of psychiatric patients' rights to the increased prevalence of movements by other marginalised groups; while it will not be covered in this study, there could be an argument for prevalence coming to equate acceptability.

Central to the rights of patients with mental conditions is the use of coercion to get them into treatment, to get them to comply with treatment, or to keep them in treatment. It is important here to consider what rights psychiatric patients have versus what rights they voluntarily or involuntarily surrender when admitted, what can they knowingly *and* legally consent to, and what laws surround treatment methods.

"If you don't watch it people will force you one way or the other, into doing what they think you should do, or into just being mule-stubborn and doing the opposite out of spite" (Kesey, 1962).

2.2 Mental illness

"Mental health conditions contribute to poor health outcomes, premature death, human rights violations, and global and national economic loss" (WHO). A mental health condition can be described as any condition that affects your mood, thinking, and behaviour.

2.2.1 Types

Mental health disorders include behavioural disorders, such as depression, anxiety, and bipolar disorder, delusional disorders (i.e. psychoses), such as schizophrenia and multiple-personality disorder, eating disorders, such as anorexia, bulimia, and pica, and addictive behaviours, such as obsessive-compulsive disorder (OCD) and substance abuse. Given the wide range of types of mental health condition, symptoms, impact on life, and treatment vary greatly by type of disorder. To further exacerbate the complication of treatment is that lines between mental health conditions are not clean-cut. An individual patient may experience multiple mental health conditions at once and experience their disorder(s) differently than other patients.

Briefly defined, depression is feelings of sadness and a loss of interest in activities one previously enjoyed. Symptoms can include withdrawal and self-harm. Anxiety is a constant or fleeting feeling of unease or uncertainty, and is often associated with worry and nervousness. A common symptom is insomnia — difficulty sleeping well. Depression and anxiety are

sometimes experience simultaneously by the same patent. Patients with anxiety or depression or both are relatively likely to seek out care based on the negative side effects of their symptoms. Bipolar disorder consists of depressive episodes and manic episodes, often separated by "normal" phases in between. Patients with bipolar disorder may or may not seek out treatment on their own based on their individual situation and symptoms.

A delusional disorder is considered a serious mental illness; a person is unable to discern what is real from what is imaginary. Severe delusional disorders, such as schizophrenia, are often associated with hallucinations and patients distribute characteristics of being out of touch with reality. Patients with delusional disorders often do not seek out treatment because they are living a separate reality; they often do not even realise they have mental health disorder. For example, a patient with paranoia disorder may genuinely believe that a psychiatrist is *out to get them* and, thus, avoid treatment at all costs.

There are many types of eating disorders; all eating disorders involve abnormal or disturbed eating patterns or habits. Anorexia is an emotional disorder defined by an obsession to lose weight by refusal to eat. Similarly, bulimia is an emotional disorder defined by an obsession to lose weight, however patients with bulimia experience binges, or eating extreme amounts of food all at once, followed by purges, or self-induced vomiting. Purging may also include other forms of burning calories, such as high levels of exercise, submitting oneself to cold temperatures, or excessive use of laxatives. Pica is the craving for or desire to eat things that are not food. While pica is somewhat common in children (i.e. tasting sand at the beach), pica can be extremely dangerous as an addiction in adulthood. Patients with eating disorders vary in the extent to which they seek out treatment, and vary in their reasons for either seeking or not seeking treatment. In most cases, anorexic patients avoid treatment because of their desire to remain their current, albeit unhealthy, body weight. Bulimia patients may seek out treatment in hopes of recovering a normal eating schedule, but may also avoid it as binges can create feelings of euphoria. Additionally, bulimia patients may avoid treatment due to feelings of shame or embarrassment surrounding their condition. Shame or embarrassment additionally may contribute to pica patients' avoidance of treatment.

Addictive disorders are tricky to define as a whole. The reason for this is that many other mental health conditions have addictive or obsessive components. For example, anorexics and bulimics are obsessed with losing weight. Pica patients are addicted to whichever

non-food the particular patient is associated with. Many schizophrenics become obsessed with alternate realities. On the other hand, certain mental health conditions revolve primarily around addiction. Symptoms of OCD include continuously repeating a behaviour, or compulsion, because of a recurring thought, or obsession. OCD can manifest in many different ways. Two examples are a "cleaning" type may constantly wash their hands even if they are already clean, meanwhile a "hoarding" type may be unable to dispose of already used things. Substance abuse is another primarily addictive disorder. Substance abuse involves the excessive consumption of prescription drugs, alcohol, cigarettes, illegal substances, or any other drugs in a way in which they were not meant to be used. Addiction can manifest in many other ways, such as problem gambling, sexual addiction, kleptomania — the addiction to stealing or inability to resist urges to steal even items that are not needed or have little worth to the individual — and many more. Patients with addictive disorders may or may not seek out treatment; this varies widely by condition. Patients with substance abuse often do not seek out treatment until reaching a breaking point in their health and financial position such as they can no longer finance their addiction; even in this case, a patient may not want treatment because their addiction is too strong, their can be stigma behind addiction, and recovery can be both mentally and physically painful. For example, severe alcohol withdrawal — from which the actual substance withdrawal is ethanol — can result in delirium tremens (DTs), a condition which causes a confused reality, hyperactivity or seizures, and, in the worst cases, cardiovascular collapse and death. While DTs are treatable, they are obviously incredibly unpleasant, so much so that an alcohol addict may prefer to just keep drinking. In other addictions, such as kleptomania, treatment may not be wanted by the patient but may be sanctioned by a court of law in a case that said patient is arrested for their stealing.

From these brief descriptions, it is obvious that mental illness is difficult to define and treat due to large amounts of overlap. Many bulimics and schizophrenics exhibit anxiety. Many anorexics and addicts exhibit depression. Overlap is unfortunately common and complicated. Depression can lead to addiction. Anxiety can lead to paranoia. Additionally, it is clear how coercion is related in a unique way to mental health in contrast to other medical fields, based on mental health patients may not actively seek treatment in the same way an individual with a physical issue would immediately call for an ambulance. The above is a brief, non-exhaustive introductory list of various mental health disorders.

2.2.2 Prevalence

The true extent of mental health prevalence worldwide is unknown. WHO estimates that one in five children and adolescents suffer from a mental health condition globally. Additionally, WHO reports that nearly 20% of all people in post-conflict zones struggle with a mental health condition.

Among the most common mental health disorders are anxiety and depression. Nearly 5% of all adults battle with depression. Depression, importantly, is often a contributing factor to suicide; suicide is the second leading cause of death among 15- to 29-year-olds worldwide. Related to depression, bipolar disorder is estimated to affect 45 million people globally. The global prevalence of anxiety is difficult to discern as many adults struggling with anxiety do not seek treatment.

Around 20 million people are affected by schizophrenia. Due to the nature of the disease, schizophrenia patients, and other psychoses patients, are susceptible to human rights violations; "stigma and discrimination can result in a lack of access to health and social services . . . people with psychosis are at high risk of exposure to human rights violations, such as long-term confinement in institutions" (WHO).

The true number of people living with an eating disorder or addictive disorder is unknown as, often times, the individual is the only one aware of their mental health condition. Not all eating disorders, addictions, or any mental health disorders are obvious to outsiders, including psychiatrists themselves. In some cases, seeking treatment is the only way a mental health condition is officially noted.

2.2.3 Relation to coercion

It is necessary to mention here that this study will not focus on any particular mental illness. It will, instead, look at psychiatric treatment broadly with a spotlight on not only psychiatric patients, but also the health care workers within these units.

It could be noted that coercion may be more relevant to certain psychiatric disorders or diagnoses than others. For example, a patient with anxiety may be more "willingly" coerced into complying with medication schedules because their anxiety causes the patient themselves discomfort. On the other hand, a patient recovering from drug addiction may see coercion as a significantly more agonising part of their treatment if it means going through uncomfortable and physically painful withdrawals. Unfortunately, like all medical treatment, psychiatric

treatment is not perfect; the diagnosis may vary from the actual disorder. From a health care providers perspective, the diagnosis rather than the actual disorder may superficially or immensely alter treatment, including the extent coercion is utilised (Lassemo & Mykelbust, 2021). Based on diagnosis, a patient may be deemed more dangerous or more of a threat and, therefore, more conscious physical coercion, such as isolation, may be implemented from the beginning of treatment. This issue of a diagnosis as "labelling" can create situations in which coercion is justified by health care providers based on their previous experiences with a similar diagnosis, or a medically accepted "understanding" of certain diagnoses.

Nonetheless, any official statistics on the rate, types, and extent of coercion used in psychiatric treatment centres is difficult, if not impossible, to find. This is not only due to issues of patient privacy within medical treatment, but also due to factors of ignorance on behalf of either the patient, the provider, or both; a patient may not always perceive coercion that is being used, and a provider may not even be cognisant that their actions are coercive.

2.3 Mental health treatment

Treatment for mental health conditions vary widely not only by disorders, but by location. Certain treatments may be considered acceptable by some psychiatrists in certain countries or practices, however the same treatments may be deemed useless or adverse by other practices.

2.3.1 Typical treatment styles

The two most common treatment styles for mental health conditions are in-patient and out-patient treatment. Usually treatment style is chosen based on the severity of the condition — with more severe cases being treated in-patient.

The way treatment looks varies by condition and by individual patient. I will briefly outline potential treatment paths for three example patients: an adult with schizophrenia, a minor with an eating disorder, and an adult with substance abuse. Please note that these are examples, and may vary from treatment recommended to patients with similar diagnoses; I wish to outline how broadly treatment may vary.

Firstly, an adult with schizophrenia may be involuntarily admitted, based on being deemed "irrational." Patients with delusional disorders may be unable to cope independently outside of a clinical setting and, thus, must be kept in-patient against their will. Their treatment regimen would likely include some form of medication, psychotherapy such as cognitive

behavioural therapy, and possibly some other form of therapy, such as electroshock therapy. Deemed "irrational," this patient may or may not be able to consent to their treatment regimen. Furthermore, it can be difficult to determine success rates of treatment as some patients are unable to accurately report their own symptoms. Medications administered to schizophrenia patients can range from anti-depressants and anti-anxiety to antipsychotics.

Secondly, a minor with an eating disorder could be involuntarily admitted by their legal guardians. In this case, it is the consent of the guardians, and not the patient, that is required. Eating disorder patients are typically treated in-patient for a certain amount of time, and then switched to out-patient when they are in less severe states of health. Eating disorder treatment regimens often include general practitioners to check their overall health from disordered eating, a nutritionist to create a food plan for them, a psychiatrist to administer medication, and a psychotherapist to talk about their thoughts with. Additionally, a minor with an eating disorder may have a family therapist for either group sessions, or sessions without the patient themselves so the family can learn to help the patient in the best ways possible. Specialists or additional medication may also be included in treatment if any other health problems arise. For example, anorexia patients often develop bradycardia from lack of nutrients, in which case a cardiologist may become key to recovery. Depression or anxiety is widespread among eating disorder patients, which may prompt use of medication. Female eating disorder patients can experience amenorrhea — the unnatural loss of one's menstruation, which may require a gynecologist.

Thirdly, an adult with substance abuse may voluntarily admit themselves with a desire to recover. However, this is not always the case. Substance abuse treatment varies widely by the substance in question. Often times withdrawal can be emotionally and physically painful. It is not uncommon for treatment to involve "weening off," rather than "cold turkey." Treatment may include psychotherapy, medication, group therapy and activities, and treatment for other health problems cause by addiction, such as liver damage, heart problems, rash, and more. Some substances may create more physical health problems than others, but in most cases, substance abuse has various physical side effects that are damaging to the body.

All in all, it is clear that treatment is not clearcut; there is no "one size fits all" for treating mental health conditions. While certain forms of care could be entirely viable and helpful in

some cases, they may be harmful to a patient's recovery in a different case. It is of the upmost importance that treatment is individually catered to unique patient situations.

2.3.2 Use of coercion

From the three examples above, it is clear that coercion can be central to mental health treatment. "Medical coercive measures include mainly: measures restricting liberty, compulsory treatment, and involuntary committal/ detention of persons admitted voluntarily. The right to self- determination and the right to liberty are affected by coercive measures" (Montaguti et al, 2019).

Nonetheless, it is important to note that coercion is not evenly distributed in all psychiatric units. "Rates of involuntary hospital admissions vary considerably between countries . . . [and] rates of different types of coercion also vary within countries and even between comparable hospitals" (Lassemo & Myklebust, 2021). Not only can there be variations between countries, but Lassemo & Mykelbust (2021) also note that "staff's attitudes to coercion and how the law is interpreted may also vary within and between national institutions, and between different groups of staff."

In the first example, involuntary admission could be considered coercion. "Involuntary" could qualify as "missed opportunities to forewarn and prepare patients timely" (Montaguti et al, 2019). Additionally, one could argue that any testament given to psychotic patients is coerced, based one their inability to consent; any medication or therapy could be seen as forced upon the patient against their will. Coercion can be noted in many ways in the second as well. In this case, the patient is also involuntarily admitted, and consent for treatment is given by a third party — parent or legal guardian — rather than the patient themselves. Eating disorder patients are considered "partially rational," the irrational part being their relationship with food. With this in mind, one can imagine that a food plan is a coerced aspect of eating disorder treatment. However, an eating disorder patient may be willing to accept therapy or medication without any persuasion. This is, of course, dependent on the individual patient; how much coercion is used in treatment is variable. In the third example, voluntary admission assumes that no coercion was used for treatment to begin. However, this does not necessarily eliminate coercion throughout the entire treatment. Importantly, it is often difficult for psychiatric patients to choose end treatment, even if they were voluntarily admitted. When admitted,

whether by choice or by force, certain rights of the patient are signed over to the treatment team.

Overall, coercion is evident in many ways in psychiatric treatment. As noted by Montaguti et al (2019), "patients may show complex conditions connected with psychiatric symptoms, especially loss of capacity, sometimes in connection with lacking insight and adherence contributing to deterioration of physical health." These conditions vary by diagnoses and, thus, the severity and extent of coercion varies by condition, by practice, and by individual patient.

2.3.2.1 Laws

Coercion is unique in a medical context as it removes from patients some of their fundamental human rights, such as the liberty of movement and the liberty of one's own decision-making. Laws on the use of coercion on psychiatric patients varies by country. Some developing countries have not yet established any laws regarding this specific issue; due to this, this study will focus on developed nations. In developed nations, "coercive measures in patient care have come under criticism leading to implement guidelines dedicated to the reduction of coercion" (Montaguti et al, 2019).

In many nations, such as Germany, Norway, and the Netherlands, experimenting with various coercive measures has led to more and more policy implementation. Certain policy measures and experimentation has included, but is not limited to, "efforts . . . [in support of] different interventions and projects, [such as] policy statements to the systematic measurement of various types of coercion, various educational programmes, campaigns focusing on attitudes, and the revision of clinical procedures involving coercion" (Lassemo & Myklebust, 2021).

Additionally, many developed nations require that any coercion used against persons to be legally justifiable. In Switzerland, this is titled ethical justification. "Medicine and health care workers are, therefore, obliged to consistently justify any limitation of their patient's personal freedom within reason, specifically to prevent harm to the patient or others" (Montaguti et al, 2019). Often times, however, ethical justification is difficult to prove. For this reason, in Swiss law, "restriction of privacy or freedom of communication, detention of persons admitted voluntarily, or physical coercion (holding)" are permissible under particular circumstances without the need for ethical justification (Montaguti et al, 2019).

> "From a legal perspective, only 'formal' coercion is considered a serious matter and is precisely regulated. That said, "informal" coercion also occurs in medical contexts; it is described as more insidious, often hidden, and more common than one might think; sometimes, caregivers do not realise that they make use of it" (Chieze, Clavien, Kaiser, & Hurst, 2021).

Central to coercion policies in medicine is the contradiction faced by health care workers: the obligation to protect versus the obligation to respect. "Any presupposition depreciating coercion in general as 'unethical' would be simplistic, neglecting the needs for ethical and practical orientation originating in situations of urgency and emergency where competing values have to be weighed" (Montaguti et al, 2019). Put simply, proper use of coercion requires legal ethical justification.

3. Principal/agent theory

The relationship between a patient and their health care worker or treatment team inherently contains a power imbalance in which, often times, the power is not in the hands of the patient. However, it is known that health care workers intend to act in their patients' best interests to the best of their ability. To reword in a theory initially rooted in economics, the patient is the principal and the health care worker is the agent.

At its core, principal/agent theory occurs when when one person or entity, is able to make decisions and/or take actions on behalf of, or that impact, another person or entity. The relationship that principal/agent theory deals with is that of delegation, "in which two actors are involved in an exchange of resources" (Braun & Guston, 2003). In this way, there is a "principal," who is in possession of certain resources, but ""not those of the appropriate kind to realise the interests (for example, has money but not the appropriate skills)" (Coleman, 1990). The principal then requires an "agent," who accepts these resources and the responsibility to act on the principal's behalf with the *principal's*, and not their own, interests in mind. It is important to ask "Does an agent have their own agenda? If so, in whose favour?" This distinguishes principal/agent *theory* from the principal/agent *problem*. A principal/agent problems occurs when the agenda of the agent does not match, for whatever reason, the agenda of the principal. In economics, of course, the agent may act in favour of their own financial gain, rather than that of the principal.

Inherent to the principal/agent theory is asymmetric information. While already stated, the agent has some skillset or knowledge that the principal does not possess; this skillset or knowledge automatically creates a situation of asymmetric information because the principal may not even understand the realm in which the agent is operating on their behalf. The agent has the ability to benefit off of the ignorance of the principal, if the the agent choses to, and it is possible that this could happen without the principal even noticing. Let's take a very basic example: Two men are in Las Vegas. One man, we'll call him Man A, does not know how to play blackjack, but has $100. The other man, Man B, knows how to play blackjack very well, but has no money. Man A gives Man B a $20 payment and $80 to gamble, saying that he will give him another $20 for every $100 he wins but Man B must repay Man A the $80 should he lose everything. Man A then leaves, and Man B gambles without supervision. Let's say Man B wins $500 total. In this case, his total payment from Man A would be $120 (the initial $20 plus $20

per each $100 earned). However, there is incentive for Man B to pocket $420, and only return the promised $80 back to Man A. In a later section, I will describe how the principal/agent problem can arise in mental health treatment due to similar asymmetric information that creates a power imbalance.

Below, it will be seen that contracts are the most common solutions to such monetary principal/agent problems.

3.1 In economics

The above quote from Coleman (1990) is a perfect example of the principal/agent problem in economics — one party has the money and one party has the means. The reason why in economics this "theory" is deemed a "problem" is because the agent may have motivation to act in a way that does not align, or is even entirely contrary, to the best interests of the principal. One obvious example of the principal/agent problem in economics is that of a stockbroker — essentially a stockbroker is a financial professional who is in control of and executes orders on the stock market on behalf of their clients.

In economics, the principal/agent theory is defined as a separation of *ownership* and *control*. Separation of control begins when a principal hires an agent. The principal authorizes a degree of control over decisions to the agent. However, the principal retains ownership of the assets and the liability for any losses. Thus, any mistake made by the agent falls back onto the principal. Additionally, any agent neglect or deception can fall back on the principal.

In order to avoid shirk, poor decisions, or self-interest on behalf of the agent, principals will pay agency costs. Agency costs are more or less incentives for an agent to always act in the best interest of their principal. Principals are willing to undergo these extra costs so long as the expected increase of the return on the investment from hiring the agent is greater than the overall total cost of hiring the agent.

Economic solutions to the principal/agent theory are mostly contractual. Often times a principal will write an agent contract in a manner that aligns the goals and interests of the principal. Principals can also require regular reports or tracking to keep tabs on the successes or failures of agents. A common contractual solution in a principal/agent relationship is a clause that directly ties agent compensation with performance measurements. Such clauses shift some of the risk of mistakes, poor decisions, or ineptitude from the principal to the agent — in other words, any mistake made by the agent will not fall back just onto the principal, but partly

onto the agent as well. The last straw for solving the principal/agent problem is terminating the relationship entirely.

3.1.1 In other situations

While the principal/agent theory is originally rooted in economics, it is present in many other aspects of life. I shall give some quick examples. Firstly, the relationship between a teacher and a student represents a principal/agent problem in which the teach is the agent and the student is the principal. In a teacher/student relationship, there is an obvious power imbalance, in which the teacher holds a superior position to the student. The student is more or less at the teacher's mercy to learn what the teacher choses to teach them. While this is not necessarily (i.e. private school) a monetary-based example, it still emphasises that asymmetric information and unequal resources are the basis for any principal/agent problem. Similarly, a parent/child relationship could be viewed as a principal/agent problem, with the child unknowingly or unwillingly adopting habits and beliefs of the parent. An important aspect of this example is that this power imbalance is not monetary, but based on primarily on age — minors are the legal responsibility of their guardians, such that the power is legally awarded to parents, and often cannot be challenged by the child.

Both a teacher/student relationship and a parent/child relationship represent a principal/agent *problem* because there could be incentive for the agents in these relationships (teachers or parents) to act in their interest rather than the principals (students or children). For example, a teacher or parent may have beliefs against the mainstream that they wish to impart upon a student or child that may or not may be within the principal's best interests to also adhere to.

Other situations which could be seen as a principal/agent *theory* are that of a travel agent and their client, a hairstylist and their client, a consultant and their client, a tattoo artist and their client, etc. In other words, it is most likely a principal/agent situation if one party is referred to as the "client." However, contrary to the economical version, these situations reflect the "theory," but not the "problem." In other words, in these situations, there is not much, if any, incentive for the agent to act in a way contrary to the agent's best interests.

3.2 In this study

This study takes the view that the agent has the principal's best interests in mind, at least hypothetically, rather than potentially having an alternative agenda. It is generally

assumed that health care workers conduct their actions for the betterment of their patient. This is evident in medical fields such as pathology, in which medical professional attempts to detect any oddities, perhaps using a biopsy sample, through study and then diagnoses. The doctor will then use the diagnosis or diagnoses to prescribe treatment to heal the patient as best they can back to full health. In such cases, the agent (the doctor) acts entirely on what is best for the principal (the patient).

Unfortunately, in psychiatric treatment, it is not always clear what is in the patients' best interests. Consider an example of a substance abuse patient who has an addiction to heroin. Heroin withdrawal is known to be extremely emotionally and physically painful. Often "weening," rather than "cold turkey," is used in treatment for patients struggling with heroin abuse. This then leaves the power of access to heroin in the hands of the agent — however, the agent may not know what the best rate of weening is, when to be slightly more lenient, or when to get stricter. A situation of asymmetric information arises quickly; whenever there is asymmetric information, there is *ipso facto* a power imbalance. In this case, the power imbalance goes both ways; the agent has control over the heroin, and the principal can potential deceive the agent into how much he "needs." Perhaps a sympathetic agent will become more lenient to requests, while a stricter agent will reduce access because "it's for their own good." The phrase "it's for their own good" is often brought up in discussions on the use of coercion is psychiatric treatment, however research indicates that whether or not this statement is true remains unknown (Johnston, & Kilty, 2016).

Asymmetric information in which the information that is being withheld is known to the patient but not to the provider is, for the most part, exclusive and unique to psychiatric care within the medical field. "Never before did I realise that *mental illness could have the aspect of power* [emphasis added], power. Think of it: perhaps the more insane a man is, the more powerful he could become" (Kesey, 1962). A pregnant woman experiencing abdominal pain is unlikely to withhold any information about her symptoms to her health care provider; a teenager with a broken leg probably won't fake that he is just fine and able to walk perfectly; parents of a toddler who fell while learning to bicycle would be negligent to say "oh, she doesn't need stitches!" Even traditionally more controversial situations are now being recognised as situations in which one should still be entirely honest with medical staff, such as cases in which the patient ended up in medical care through illegal actions. For example, in the United

Kingdom, festival-goers are encouraged to upfront with medical staff about any substances consumed, be them legal or illegal, such that proper treatment can be administered without creating any adverse effects (Royal Society for Public Health, 2017). The overall message the Royal Society for Public Health (2017) is intending to give is that one should never lie to a medical professional; even the legality of the actions that led to treatment are a moot point, let alone any "embarrassing" moment or mistake.

This, then, begs the question of why psychiatric patients are often not truthful with health care personnel. The answer to such a question could vary endlessly by patient. Some falsities may be considered "harmless" white lies by the patient, such as a patient with depression answering "I'm doing fine" to "how are you doing lately?" when, in reality, they are still struggling. Nonetheless, no matter how "harmless" the patient may consider this response, they are still creating a situation of asymmetric information that can cause the providers subsequent actions to be suboptimal in comparison to the actions they would've taken should the patient been truthful about their wellbeing. Meanwhile, other falsities may be deliberately misleading. For example, an out-patient in addiction recovery could be secretly using while claiming to be "clean." What a patient does or does not disclose can create an authoritative situation in which the power is actually in the hands of the patient, and not in the hands of the provider. Frequently, it is difficult to discern when a psychiatric patient is outright lying versus when they are simply withholding the truth. This begs further questions: Do psychiatric patients intend to give incorrect information? If so, do they do so with moralistic or malicious intentions? Does the asymmetric information caused by such incorrect information affect health care providers ability to adequately diagnose and, thus, adequately treat patients? Consequently, do psychiatric health care providers deem the use of coercion necessary in order to mitigate a situation in which the providers themselves can be manipulated by their own patients?

In addition to a focus on this asymmetric information, this study focuses on the concept of coercion in psychiatric units, and recognises that, in this situation, not only can the agent make decisions on behalf of the principal, but also has the potential to force these decisions upon the principal without their consent. Here arises the prior discussed issues of consensual versus voluntary; how and in what ways do persuasion, inducement, authority, and deception come into play, and how are they ethically and/or lawfully justified?

3.3 Separation of ownership and control in regards to medical treatment

Not always, but often times, one gives up control of their own body when undergoing medical treatment. Principal/agent theory is rooted in the separation of ownership and control. In traditional principal/agent theory, the principal gives permission for the agent to make decisions on their behalf using resources that they own; in other words, the principal gives up control of their own body. Presumably, this is because they wholeheartedly trust their health care provider to provide the highest quality service possible. This, then, begs the question: does one own their own body in they same sense one owns monetary or material objects? When hugely in debt, most governments in the modern world can repossess your car, your home, or other of your material belongings, but they cannot repossess *you*. With this in mind, why and how can health care providers consciously choose to admit and treat certain patients involuntarily? Put differently, what justifies the control of another human being's physical body in psychiatric treatment when such control is not socially, morally, or ethically acceptable in most other circumstances?

Separation of ownership and control in medical settings where admission is voluntary and treatment is desired (e.g. a child with a sprained ankle) is not controversial. However, ethical issues arise when the patient does not wish to relinquish the control of their body, when ownership and control are separated involuntarily, unknowingly, unwillingly, forcibly, *coercively*. "Ethical reasoning about [these] competing options is crucial for an unprejudiced decision complying with the normative framework and for building a robust consensus" (Montaguti et al, 2019).

4. Methods

My research design will be a hybrid of literature review, comparison, and finally interpretation. After determining which studies may positively contribute to my research and which are moot, I will compare the findings of those determined helpful, accounting for location of study, size of study, patient type (diagnoses, age, gender, history), and any other factors that arise that may be of concern. Finally, I will try to garner a combined interpretation of these studies for a general consensus on the use of coercion in psychiatric units, the ultimate goal being to uncover the ethical acceptability and practical usefulness of coercion as a treatment tool in psychiatric units.

4.1 Literature Review

I will first conduct a literature review of theoretical concepts of the brain — or as Eagleman (2011) call it "the three-pound organ in your skull," — psychiatry, and coercion. Secondly, I will do an empirical literature review of former studies that stress the volume of coercion used and the impact of this on patients.

The data to be used will consist mainly of previously conducted surveys, interviews, observations, and field work. I will analyze the data primarily through literature review, with document/content analysis where applicable. I selected articles based their relevance to the use of coercion within psychiatric care; relevance was determined by examination of their titles and abstracts.

4.2 Research methodology

I began my literature review by using Google Scholar. My initial criteria for articles included key words [(coercion) OR (force)] AND [(psychiatry) OR (psychiatric) OR (mental health) OR (treatment) OR (mental illness)] AND [(ethical) OR (moral) OR (justification)]. Additionally, I checked the references of each chosen article to identify other articles relevant to my research. While Google Scholar was a useful tool to begin my search, articles referenced in the first articles I discovered tended to contain more useful data.

After this initial search, I found many articles of potential helpfulness. I narrowed my selection process to focus specifically on the key words [(coercion)] AND [(mental health)] AND [(treatment)]. My overall empirical focus being the use of coercion in mental health treatment.

I selected the following six articles after analysing my options to be used in my research: "Coercive measures in psychiatry: A review of ethical arguments." (Chieze, M., Clavien, C.,

Kaiser, S., & Hurst, S., 2021), “The Role of Ethics in Reducing and Improving the Quality of Coercion in Mental Health Care.” (Norvoll, R., Hem, M.H. & Pedersen, R., 2017), “Changes in patterns of coercion during a nine-year period in a Norwegian Psychiatric Service Area.” (Lassemo, E., & Myklebust, L. H., 2021), “Reflecting on the Reasons Pros and Cons Coercive Measures for Patients in Psychiatric and Somatic Care: The Role of Clinical Ethics Consultation.” (Montaguti, E., Schürmann, J., Wetterauer, C., Picozzi, M. & Reiter-Theil, S., 2019), “Perceived coercion among patients admitted to acute wards in Norway.” (Iversen, K. I., Høyer, G., Sexton, H., & Grønli, O. K., 2002), and "Attitudes to coercion at two Norwegian psychiatric units.” (Wynn, R., Kvalvik, A.-M., & Hynnekleiv, T., 2010).

As previously mentioned, I wished to keep my research within the realm of psychiatric care in first-world nations. Of these studies, two were conducted in Switzerland and four were conducted in Norway. Other sources used occasionally but to a lesser extent in this study were conducted in Australia and Canada. However, the large majority of my research is based in the Norwegian and Swiss context. While desiring to keep my research up to date and relevant in current treatment, the oldest article analysed was published in 2002; the two newest were both published in 2021.

My chosen studies vary in their methodology. Chieze et al (2021) conducted a narrative literature review focused on “coercive/compulsory measures/care/treatment, coercion, seclusion, restraint, mental health, psychiatry, involuntary/compulsory hospitalisation/ admission, ethics, legitimacy.” Norvoll et al (2017) conducted semi-structured telephone interviews with key informants; “combination of purposive and snowball sampling was used to find mental health facilities and stakeholders.” Lassemo & Myklebust (2021) analyzed data obtained from the Norwegian Patient Register (NPR). They "identified all patients having received specialized psychiatric treatment in the areas of Vesterålen and Lofoten, in the County of Nordland, Northern Norway” (Lassemo & Myklebust, 2021). They then statically analysed the identified patients for episodes of coercion for a nine year period from 2003 to 2012. Montaguti et al (2019) screened and categorised ethics consultations (ECs) from two Basel hospitals for the topic of coercive measures. Iversen et al (2002) conducted interviews with “patients aged 18 – 60 admitted to four acute wards at two Norwegian psychiatric hospitals from October 1998 through November 1999.” Of the initial 382 patients approached, 223 were actually interviewed; 89 were discharged prior to the interview and 68 refused to participate.

Wynn et al (2010) distributed a questionnaire to clinical staff at two Norwegian psychiatric wards. The questionnaire described two fictional cases, and asked respondents how they would act in these situations. They then "performed a stepwise multiple regression analysis with backward elimination . . . Degree of restrictiveness was the outcome variable. The characteristics of the respondents were the independent variables: age, gender, profession, duration of employment, unit and type of ward" (Wynn et al, 2010).

4.3 Explanation of analyses

The analytical framework I will be using is a stylised version of the principal/agent theory, in which providers are "the agent" and patients are "the principal." I say "stylised version" because my research will not involve economics or monetary transactions, as in the original theory. Moreover, my research will be stylised to the concept of coercion in psychiatric units, where not only can the agent make decisions on behalf of the principal, but also has the potential to force these decisions upon the principal without their consent. This causes ethical issues to arise. I will define coercion following the concept of Wertheimer (1993).

Dranove & White (1987) echo the concern of agency in health care; "the problem with using agents is that they may not always do what they are supposed to." In psychiatric settings, this does not necessarily mean that providers intentionally do not do what they are supposed to, but rather that they do not know what is best for the patient. However, this problem is exacerbated even more in psychiatry because the patient themselves also likely does not know what is best for themselves. "As long as informational problems continue, agency problems will continue as well" (Dranove & White, 1987).

The conceptual base for my research question — How do health care workers in psychiatric wards justify the use of coercion as a treatment tool? In what ways does the use of coercion in psychiatric units affect patient outcome? — is that the principal/agent problem in psychiatric units can lead to or even encourage provider coercion and, thus, a negative of patient outcome. In other words, the structure itself of psychiatric units may propagate the use of coercion, and justification of it.

4.4 Validity and reliability

A literature review is appropriate for my research due to the vast quantity of previous research on this topic, especially within the last 20 years, considering varying laws by country and varying types of coercion based on different diagnoses. In other words, the scope of my

research question is beyond generating new data from a single study because it can be answered using data generated from the six studies I focus on.

Additionally, the six studies I focus on include empirical research through interviews of both patients and clinical staff, analytical research from systematically studying both past medical documents and administrative consultations, and a literature review itself. This broad spectrum of research methods, while not exhaustive, still allowed me to explore, consider, and evaluate many points of view during the investigation of my research question — How do health care workers in psychiatric wards justify the use of coercion as a treatment tool? In what ways does the use of coercion in psychiatric units affect patient outcome? This question would be difficult, if not impossible, to research and answer without analysing multiple opinions, including psychiatrists, nurses, and other clinical staff, as well as a variety of patients, including both involuntarily and voluntarily admitted patients.

Nonetheless, literature review is always based on previous research, of which may or may not have been conducted in proper manners. With that said, my chosen article were thoroughly analysed for academically correct practices. Furthermore, literature review inherently consists a second-hand data; I did not experience first-hand interviews, questionnaires, or panels; my research is not empirically based on observation or experience. While, my methodology is not without limitations, it is within the scope in order to properly and academically answer my research question.

5. Results

I will first briefly summarise the findings of each article I analysed for my research. I will then explore common themes and empirical implications of these findings.

5.1 Findings from articles

Chieze et al (2021) studied 99 articles after a selection and elimination process that began with 1,614 articles; the articles included English, French, and German studies. Their results found that very few studies recommended a complete ban on the use of coercion in medical practice; for the most part, their results suggested that coercion could be an acceptable measure in treatment, however only in relevant circumstances. They found that there are situations in which the use of coercion could be argued against; "the most obvious reasons to reject coercive measures lie in the fact that they tend to infringe upon fundamental rights such as freedom, autonomy, dignity, and integrity" (Chieze et al, 2021). In their research, they discovered that caregivers need to be careful in their application of coercion, and that caregivers who overstep their bounds by applying the "it's for their own good" mindset can appear to patients as domineering and peremptory. All in all, they find that "the authors [of the articles they studied] elaborate on the fair application of coercion, which requires one to take the time to balance the reasons for and against its use. Such an evaluation needs to be undertaken anew in each situation" (Chieze et al, 2021).

Lassemo & Myklebust (2021) found a general decrease in the number of patients coerced in Norwegian psychiatric care from 2003 to 2012; "the rate of patients that were coerced fell from nearly 350/100,000 in the population ages 18–66 in 2003 to approximately 100/ 100,000 in the population ages 18–66 in 2012." However, this overall generalisation did not hide other patterns they uncovered in their research. While the overall number of patients coerced and rate at which patients were coerced decreased, the amount of times a coerced patient experienced coercion increased. This was noted in both inpatient and outpatient treatment. "The use of coercion seem to be reduced overall, although the increase in treatment-episodes per patient may indicate a complex pattern in use and registration of coercion" (Lassemo & Myklebust, 2021).

Iversen et al (2002) studied perceived coercion in acute wards in Norway, during both treatment and the admission process and for both involuntarily and voluntarily admitted patients. They found that perceived coercion is often associated with feelings of force and

threats, as well as feeling excluded from their own treatment; specifically, patients felt coercion when they felt they point of view or opinions were being disregarded or ignored.

> "Almost one-half of the legally voluntary group reported that someone else believed they needed to be admitted. One-third of the legally voluntary group believed they were mentally ill . . . Sixteen per cent of the voluntarily admitted answered that they *had felt offended during the admission process* [emphasis added] and as many as one-fifth wanted to be discharged. In the legally involuntary group, 26% reported they were mentally ill . . . More than one-third of the involuntary group said they would prefer other alternatives than hospitalisation and 44% wanted to be discharged" (Iversen et al, 2002).

Montaguti et al (2019) studied 100 fully documented ECs, conducted between 2013 and 2016, with the main goal of screening for coercive measures. All the patents discussed in the ECs were adults aged 20 to 70, with the median age being 47.

> "Twenty-four out of 100 EC cases addressed coercion in relation to a clinically relevant question, such as compulsory treatment (70.8%), involuntary committal (50%), or restricting liberty (16.6%) . . . In slightly more than one third of all 24 ECs, the participants of the EC (including the ethics consultant) agreed on *applying* one or more coercive measures for the patient in question as the best course of action (37.5%). Coercive measures most often agreed upon were involuntary committal (25.0%), followed by compulsory treatment (20.8%)" (Montaguti et al, 2019).

They found that approximately one-fourth of all ECs discussed coercion in a manner relevant to clinical treatment, and that in one-third of these cases coercion was a recommended treatment tool for the given patient. Furthermore, they found that it was clear the participants in the ECs were aware of coercion as a treatment tactic, having discussed different types of coercive measures that could be utilised, including "compulsory treatment . . . such as compulsory pharmacological treatment, artificial nutrition, sedation, or diagnostics; involuntary committal . . . and measures restricting liberty such as mechanical restraints or isolation" (Montaguti et al, 2019).

Norvoll et al (2017) conducted telephone interviews in Norway from May to June of 2012 in order to "explore how the morality of coercion unfolds in everyday life in mental health care." This included health professionals' reflection on ethical challenges surrounding coercion,

strategies used to accomplish the goal of restricting coercive measures to ethically and clinically justified situations, and to determine the best practices for using coercion as a treatment tool. A key finding of their research surrounds the morality of using coercion in mental health care; they found that health care providers could develop "feelings of moral unease or distress in their daily work due to observing low-quality treatment or violations against coerced patients . . . [and] moral unease could unfold on both an individual and a collective level" (Norvoll et al, 2017). They then determine that the facilitation of a space to engage in a critical and reflective moral thinking process is important; "there is a need to address the institutional processes that shape and constrain moral concerns, ethical dialogue and practice" (Norvoll et al, 2017).

Wynn et al (2010) studied the attitudes of clinical staff towards the use of coercion at two Norwegian psychiatric wards. Their main finding was that staff tended to be careful in their deliberation when deciding whether or not to utilise coercion as a treatment tool; "staff appeared to be careful in their use of the maximum restrictive interventions and that they preferred using the less restrictive interventions when possible" (Wynn et al, 2010).

> "The statistical analysis suggested that, for the case where the patient was violent . . ., gender accounted for some, albeit a small degree of the variance in the choice of interventions, and the male respondents were somewhat more restrictive than the female respondents. In the case where the patient was self-harming, profession explained some of the variance in staff's choice of interventions, and the unskilled staff were the most restrictive and the doctors the least" (Wynn et al, 2010).

However, despite these differences in respondents decisions to use more restrictive forms of coercion, the overall study found restraint and seclusion were not used indiscriminately, and were often used only last resort. Staff most often resorted to the use of coercion in psychiatric care when a patient was aggressive, violent, or self-harming.

5.2 Common themes in findings

Summarised well by Norvoll et al (2017), "a key theme [is] the importance of moral values, ethical principles and informal moral deliberation in creating an explicit 'normative basis' for development projects and ensuring morally justified coercion in individual cases." Among all the research, it is agreed upon by the authors that coercion should only by used in circumstances that cannot be solved through other treatment tools. It is conclusive that

deliberation should be carefully taken before resorting to the use of coercion. "Our results are comparable with prior studies suggesting that staff are most likely to accept highly restrictive interventions, such as restraint and seclusion, when patients are physically violent" (Wynn et al, 2010).

Furthermore, a common theme exists revolving around patient perception of coercion and treatment. Patients can, albeit subliminally, feel threatened into treatment or to remain in treatment. While providers may not necessarily recognise their tactics as coercion, the patients may perceive them as such. In particular, patients may experience process exclusion and/or negative pressures; "feeling coerced in the admission process means perceiving that one does not have influence, control, freedom or choice, or does not make the decision to enter the hospital" (Iversen et al, 2002). This relates about to the basic human rights that all humans, including psychiatric patients. have. Providers must be careful to facilitate an environment in which patients do not feel that their freedom, autonomy, dignity, and integrity are violated or impeded.

Another often touched upon topic from my research is the idea that coercion itself is controversial as a psychiatric tool; after all, why would all this research on it exist otherwise? Related to this is clinical ethics versus legality; there is a tightrope to walk between the state saying it's legal and the actual impact it has on the patient. While "legal requirements provide a framework for answering questions arising in the area of conflict between respect for autonomy, beneficence, and non-maleficence," it is ultimately individual providers who make the call to use or not to use coercion (Montaguti et al, 2019). "Psychiatrists or clinical specialized psychologists are responsible for making the final decisions" (Lassemo & Myklebust, 2021). Thus, as mentioned earlier, providers must use mechanisms to determine whether or not coercion as a treatment tool is justifiable or not; their choice should be both legal *and* ethical. In other words, the choice must actually be "for their own good," not just for the ease of the clinical staff themselves or other patients. "Acceptability [varies] and depend[s] on the moral values prioritized . . . on the content of local laws, and on official recommendations" (Chieze et al, 2021).

Finally, there is a common pattern of intent to decrease, limit, or eliminate the use of coercion as a treatment tool in psychiatric care. This includes "different interventions and projects, ranging from policy statements to the systematic measurement of various types of

coercion, various educational programmes, campaigns focusing on attitudes, and the revision of clinical procedures involving coercion" (Lassemo & Myklebust, 2021). There is an overwhelming attention given to reductions efforts in the Norwegian and Swiss contexts regarding coercion of patients. While it is generally accepted that coercion is unavoidable in certain situations, it should only be used to prevent harm, be it to the patient or others. In other words, if coercion creates more harm than good, a different treatment path should take precedent.

6. Discussion

Based on the results, the overall consensus uncovered in my research is that coercion is only permissible in exceptional situations. In other words, coercion can be justified when the violation of a patient's basic human rights is the sole solution to a larger issue. For example, a patient prone to violence may be coerced by involuntary admission, however for the more important purpose of protecting their family or the public in general. Thus, "coercion may be an adequate measure, but only in certain circumstances" (Chieze et al, 2021).

Additionally, perceived coercion can have negative effects on patient outcomes. While voluntary treatment is typically perceived in better light, both voluntarily and involuntarily admitted patients can experience coercion. "Caregivers who assume that they know better than patients what is good for them tend to be considered authoritative and paternalistic" (Chieze et al, 2021).

Before discussing the ways in which health care workers justify the use of coercion in psychiatric settings, it is first worth nothing that my research uncovers little to no evidence in favour of an absolute ban on the use of medical coercion. Nonetheless, Chieze et al (2021) point out that there are some medical professionals that "are not convinced that infringement of . . . fundamental rights and principles can be legitimately overridden in a psychiatric context, regardless of the reasons provided."

6*.1 Evidence in support of the use of coercion in psychiatric treatment*

Some health care workers argue in favour of the use of coercion based on their belief that such use is not necessarily a violation of patient rights, such as autonomy, dignity, and integrity. On the contrary, the use of coercion is rationalised as a way to actually protect patients' fundamental human rights. For example, in order to preserve the dignity of a delusional patient, physical coercion or force must be used to restrain this patient from self-harm or harm to others. In this scenario, the coercive measure is used for the purpose of safeguarding the patient's long-term values and hopes. Although physically restraining the patient may violate the patient's personal autonomy and bodily integrity, but it upholds the patient's overall dignity. In this cases, "autonomy corresponds to respect for a person's free choice and self-determination, dignity corresponds to respect for the whole person, and integrity is primarily understood as respect for bodily integrity" (Swiss Academy of Medical Sciences, 2018).

Chieze et al (2021) outline various moral values in which the use of coercion can be morally justified in the eyes of medical professionals. Amongst these are beneficence, or the advocacy of well-being, non-maleficence, or the avoidance of harm to oneself or to others, and equity, or the fair distribution of care amongst patients according their particular needs. Related to non-maleficence is also safety; while non-maleficence is the avoidance of harm, safety is the promotion of a caring, secure, and inclusive environment.

As mentioned above, coercion may be justified in the name of safety. Creating a safe, liveable environment often demands more than just securing physical safety.; psychiatric need not only feel safe, but to also feel comfortable in order to properly rehabilitate. Communal peace is important is psychiatric recovery. On occasion, the conservation of a calm communal environment may be used as justification for the use of coercion on an individual patient. For example, in Switzerland, "the serious disruption of communal life (particularly in hospital units) is a criterion […] for instituting a coercive measure" (Chieze et al, 2021). However, it is of vast importance here for health care workers to distinguish between what is legal and what is ethical. The Swiss Academy of Medical Sciences (2018) states that legality is not equivalent to morality or ethics.

> "'The guidelines [in Switzerland] are designed to promote and maintain awareness of the fact that coercive measures of any kind — even if they comply with all the relevant procedural requirements — represent a serious infringement of fundamental personal rights and thus require ethical justification in each case. [. . .] In all cases, careful ethical reflection is just as indispensable as rigorous compliance with legal provisions and applicable guidelines'" (Montaguti et al, 2019).

This is emphasised in cases when a patient's rights are restricted for the primary reason of reserving or ensuring the contentment of other patients or the staff through limiting disturbances, rather that for maintaining the well-being of the patient in question. In this sense, psychiatric medical workers, whether they are aware of it or not, walk on a three-way tightrope between at care and comfort, safety and security, and control and legality. As mentioned previously, there is a legal distinction between formal coercion and informal coercion. Thus, it is of vital importance that health care workers do their best to be cognisant of and act on not only what is legal, but what is ethical. "Using coercive actions to prevent a potential and/or indirect

risk to others is, in any case, not the same as punishing a person who has already attacked someone else, a role clearly outside the scope of psychiatry" (Chieze et al, 2021).

A final justification given in defence for the use of coercion in psychiatric care is that of the therapeutic relationship between the health care worker and the patient. Here the concept of perceived coercion comes into play. For example, a patient who is an active participant in their own treatment may be aware that coercion is being used but be willing to accept it as the best way to avert a potential crisis. On the other hand, a patient may regard their entire treatment as involuntary and forced; thus, they may actively oppose particular or all forms of therapy because they perceive them as coercion. Whether or not a positive relationship is established between the physician and the patient depends on whether or not the patient is amendable to treatment, and *aware* of it. "Patient decisional capacity proved to be a key component of ethical reasoning, especially in relation to the duty to prevent harm. Alone, [however] it is not a sufficient reason to justify coercion" (Montaguti et al, 2019). A patient who is amenable to treatment will be more consenting to a physician's authority, while a patient who is not amendable to treatment will protest a physicians authority. In the latter case, coercion is not equally justifiable because the patient may earnestly sense a violation of their autonomy.

6.*2 Evidence against the use of coercion in psychiatric treatment*

"Patient's best interests are increasingly taken as critical elements for deciding upon or justifying coercive measures" (Chieze et al, 2021). However, as previously mentioned, health care workers may not necessarily know what treatments or treatment paths are within their patients' best interests. In other words, caregivers can overstep their role as the agent for the patient and, in turn, be perceived as controlling, authoritative, and paternalistic. "As far as the professional *judgment* [emphasis added] of capacity is made in a less than systematic way, the rationality or even ethicality of decision making on coercion may be impaired" (Montaguti et al, 2019). For this reason, my research uncovered various arguments against using coercion or force in psychiatric treatment.

As mentioned multiple times previously, the key argument opposing the use of coercion in psychiatric care is that coercion infringes upon basic human rights, "such as freedom, autonomy, dignity, and integrity. In some cases, coercion [also] violates beneficence, non-maleficence, or safety" (Chieze et al, 2021). Safety in this reference implies not only to communal safety, but to the physical safety of the patient in question. Certain forms of coercion

can cause physical harm, in addition to rights' violations. For example, an act of coercion that causes a patient to be physically restrained violates freedom, autonomy, dignity, and integrity; however, this same act could cause bodily pain the the patient. Chieze et al (2021) indicate multiple additional "significant [potential] side effects of coercion," including but not limited to post-traumatic stress disorder (PTSD), increased or agitated symptoms, thrombosis, strangulation, and death. Quite clearly, if the overall goal of psychiatric treatment is to alleviate the symptoms and habits of a patient that are inhibiting them, such that they are capable of rejoining society in a healthy manner, these potential side effects are detrimental to recovery.

> "It is critical to be aware of the risks of abuse of power [. . .] Some authors attribute the use of unjustified coercion in psychiatry to an inadequate assumption of authority-with-the-right-to-impose. Such an erroneous view of caregiver's authority over the patient is also described as having negative effects on the patient-caregiver relationship and as denoting a lack of competence on the part of caregivers" (Chieze et al, 2021).

Thus, health care providers need to be cognisant of how patients perceive their actions (Norvoll, Hem, & Pedersen, 2017). The ultimate goal of psychiatric treatment is to restore patients to a level of mental self preservation. If a patient perceives that they are being coerced or involuntarily forced into treatment, to participate their treatment or a certain aspect of it, or for other comfort of punitive reasons, this may affect the usefulness of treatment. A patient's negative feelings or reactions to perceiving coercion utilized in their treatment could be detrimental to the patient's mental health, physical health, and relationships.

> "The use of coercion in psychiatric care is an important topic clinically, ethically and legally. It is of concern to patients and staff in their everyday activities and it is important to those who make decisions concerning the function and structure of the psychiatric health services. There seems to be a consensus regarding the need to limit the use of coercion. However, there are different opinions as to what constitutes an appropriate level of coercion and how coercion can be reduced" (Wynn et al, 2010).

6.3 Implications for psychiatric care

It is imperative heath care providers be cognisant of their actions and how these actions are perceived by their patients. "Coercion may concern treatment, diagnostic measures, patient location, accommodation, and social environment. It may also *affect the therapeutic alliance*

between patient and therapist [emphasis added] and, thus, cause problems for the involved healthcare professional" (Montaguti et al, 2019). In other words, it may affect the relationship between the agent and the principal. A primary concern is that the patient as the principal may lose their trust in the providers as the agent.

> "Providers [are] more likely to perceive the hospital as being a potentially unsafe environment. Such perceptions by providers have important implications for patient-centered care, as hospital staff may feel more comfortable with practices aimed at containing risk (e.g. seclusion, restraint) rather than engaging and collaborating with patients" (Livingston, Nijdam-Jones, & Brink, 2012).

If trust between the principal and agent is lost, the principal, or patient, may become more and more inclined to terminate treatment, even if their mental health is not yet stable. This could have clear implications for the patient. Prematurely terminated treatment can inhibit patients from reentering society in a physically and emotionally manner. For example, an eating disorder patient could still be experiencing side-effects of malnutrition, or a schizophrenic may still be living in an "alternate reality," or could revert back to some kind of "alternate reality" without adhering to a prescribed medication regimen.

While my research points to coercion as a positive treatment tool for protecting the physical safety of clinical staff and other patients, there is no evidence that points to coercion as a positive treatment tool for the mental health of already mentally ill patients. This, then, begs the question if coercion is even a treatment *tool* or just a clinical strategy to keep the environment of the care unit stable, peaceful, and calm. In which case, the agent would no longer be acting in the best interest of the principal, as they are supposed to, but rather have developed an alternative agenda that benefits others. Of course, this is a difficult position for clinical staff to be in because they are not solely the agent for a single patient, but all patients within their care.

> "Thinking of coercive measures *not only as safety and risk reduction methods, but also as part of a process aiming to rebuild identity and autonomy* [emphasis added] in the medium term, could result in coercion processes that are more acceptable to patients and caregivers" (Chieze et al, 2021).

To summarise, psychiatric care providers could benefit from being aware of their patients' perceptions of their actions. That Lassemo & Myklebust (2019) noted that coercion in

treatment-episodes per patient increased could imply that particular patients are more prone to interpreting providers' actions. Like in all medical care, the ultimate goal is recovery and the best path for the patient should be taken in every case; this path should be deliberated and reassessed throughout treatment to guarantee the best possible care.

6.4 Implications for patients

As I have stressed throughout my opening chapters, each and every mental health patient have illnesses that manifest in unique and individualistic symptoms. Thus, the use of coercion as a treatment tool will have different effects on each individual patient. To illustrate this, I will revisit the three examples I used in chapter 2 — an adult with schizophrenia, a minor with an eating disorder, and an adult with a substance abuse problem.

Firstly, an adult with schizophrenia may or may not even recognise coercion is taking place. If gone unrecognised, the coercion may assist the patient in their recovery by encouraging timely and proper medication prescribing and therapy sessions. However, if a schizophrenia patient sense coercion, they may feel tricked. A common side-effect of schizophrenia is paranoia. A schizophrenic patient may feel that the clinical staff is, in fact, not their "agent" at all, but rather someone working against their best interests. In such a case, a patient may become even more uncooperative, be it if they had or had not been cooperative to begin with. With this, a cycle may start in which a patient senses coercion, becomes untrusting and uncooperative because of this, such that more coercion is necessary to implement treatment, thus the patient may become even more resistant to treatment. In a case like this, *perception* is key. Schizophrenic patients are often difficult to treat because they live in "alternate realities." Thus, clinical staff must be extra cautious with considering how their actions may be interpreted by their patient.

Secondly, in most cases, minors with eating disorders are involuntarily committed. Thus, they may view their entire treatment as nonconsensual and forced. In such a case, the patient may adamantly refuse medication, therapy, or other treatment tools. In the beginning of such cases, the patients' physical well-being and health should be first priority. Eating disorder patients can be malnourished, experience fatigue, heart problems, brittle skin, hair loss, and more. Solving these issues for the sake of the principals' lives will come before anything more, as the agent is acting in their best interest. However, this is not to say that the principal will not experience coercion. To solve malnutrition for an anorexia patient, will require to coerce them

to eat. To regulate a bulimic patient's heart rate, will require to administer a balanced and regular diet. However, even life-saving treatment tools for physical health could be perceived by the patient as forced. An anorexic patient may not want to eat; a bulimic patient may want to continue to binge and purge. Unfortunately, there is no handbook to handle cases like this for clinical staff. Patients may be compliant solely for the sake of getting released in order to continue their old habits; they may feel resentment, spite, and anger toward the clinical staff. The clinical staff, as the agent trying to do their best for the principal, may do more harm than good by coercing minors in treatment by creating deep-rooted distrust in medical institutions.

Thirdly, an adult with substance abuse may or may not recognise they have a mental health condition. However, considering an adult that does recognise this problem and, thus, voluntarily admits themselves may actually *expect* coercion to take place. Such coercion, obviously, includes eliminating and strictly limiting any substance use encouraging continued treatment if the patient desires to leave and a certain medication regimen to regulate the patients' internal physical health. As previously mentioned, withdrawal can be emotionally and physically painful and, thus, to voluntarily subject oneself to it comes with certain expectations for restricted consumption, and perhaps even social seclusion. Obviously, it is the care providers as the agents to determine what level of restriction is best for their patients, or principals. Sadly, however, even the smallest misstep could cause overdose.

Overall, in all mental illness cases, it is important to view the care providers and the patient as a team, in which rehabilitation is the ultimate goal. Each individual case is unique and each individual patient deserves for their best interests to be the priority of their treatment. It becomes very clear when elaborating on specific examples that principal/agent theory *and* principal/agent problem is extremely relevant to mental illness treatment. The principal, as the patient, may or may not be irrational, nonconsensual, and involuntarily admitted. Meanwhile, the agent may or may not understand their principal, their best interests, and the overall best treatment path for them.

7. Limitations

As previously mentioned, my main limitation of this study is using literature review as the primary study method. Literature review is inherently based on previous research, which may have potentially been conducted inaccurately or unethically. However, all my sources were thoroughly analysed for academically correct practices. Additionally, a literature review inherently consists a second-hand data; I did not experience first-hand interviews, questionnaires, or panels. In other words, my research is not empirically based on observation or experience.

My literature review was non-exhaustive, meaning that there is more research on this topic that is not covered in my research. However, all of my sources contain several cross-references, implying that, while it is not exhaustive, it does cover a broad spectrum of the data available on this topic.

A further limitation is that, as previously mentioned, laws on coercion in psychiatric care vary and, thus, what is and is not considered ethical may vary by study based on what country, region, or individual practice that particular study was conducted in. However, I based my research primarily in Norway and Switzerland, which have fairly similar laws regarding the use of coercion in psychiatric care. Additionally, different language choices, such as coercion versus force, may vary across academic groups, such as philosophy versus medicine versus economics.

8. Conclusion

Once again, my research question was as follows: How do health care workers in psychiatric wards justify the use of coercion as a treatment tool? In what ways does the use of coercion in psychiatric units affect patient outcome? I hypothesised that health care providers justify their use of coercion through weighing pros versus cons in each individual situation, that perceived coercion by patients will lower their trust and, therefore, cooperation during treatment, and that when high levels of perceived coercion are present in treatment, patients end with a worse off outcome than patients that are more active and willing participants in their own treatment.

In conclusion, to reiterate, the cumulative justification for the use of coercion in psychiatric care uncovered in my research is that coercion is only permissible in extraordinary or exceptional situations. My findings stress the importance of not only legality, but also of ethics. Such exceptional or extraordinary situations include when patients are aggressive, violent, self-harming, or a combination of the three. I found perceived coercion to be important to patients cooperation during treatment, as patients who perceive coercion consider their caregivers authoritative and domineering. Finally, I found that patients who experience coercion have more negative attitudes toward treatment and have a higher likelihood to desire to end treatment, in contrast to patients who do not feel insulted during admission or treatment, and actively engage in treatment rather than having treatment passively happen to them.

All in all, coercion is justified on the basis of saving the lives or creating better lives for patients. "The application of coercion may, in the individual case, save life rather than accept premature dying, terminate reversible suffering rather than tolerate severe symptoms, and help to rebuild patient autonomy" (Montaguti et al, 2019). The aim of this study was to provide insight into the relationship between the ethical acceptability versus the practical usefulness of using different types of force in psychiatric treatment. My research suggests that careful deliberation into the use of coercion as a treatment tool in psychiatric care; each individual situation should be approached uniquely as health providers decide whether or not to use coercion and, if so, which forms of coercion are ethically acceptable and clinically useful for each patient.

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