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The problem of coercion

FRA REDAKTØREN

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The recent amendments to the Norwegian Mental Health Care Act give patients a greater say with respect to the health care they receive. We welcome new restrictions on the use of coercion, but can foresee some challenges.

Photo: Journal of the Norwegian Medical Association

In the minds of doctors and other healthcare personnel, the use of coercion is inextricably linked to caring for people with serious mental health disorders. An alleged over-reliance on hospitalisation and coercive intervention has to some extent been met with considerable criticism. The health policy mantra about reducing the use of coercion in psychiatry is applauded by the general public as well as practitioners in the field (1). The Mental Health Care Act amendments that came into force on 1 September this year were introduced with the intention of reversing this situation (2).

The amendments are generally based on a greater emphasis on autonomy, non-discrimination and the patients' right to make decisions that have a bearing on their own health (1–3). This fits in with the scenario referred to as 'the patient's health service' by the Minister of Health and Care Services. The most important changes involve the right of patients with capacity to consent to decline any offer of coerced observation, examination and treatment. The criterion for treatment – that a potential positive effect of the treatment may be lost – does not apply unless patients give their consent. If coercion is applied to a patient who has no capacity to consent, this decision must be reviewed if the patient recovers capacity (2, 3).

In the opinion of Aslak B. Syse, a law professor and medical doctor, there lies a challenge in assessing a patient's capacity to consent, as this may vary from day to day, or indeed from hour to hour (4). Elisabeth Swensen, MD describes the amendments to the legislation as a disclaimer of responsibility which has been rebranded as striking a blow for freedom and

human worth (5). Furthermore, she points out that people with serious mental health issues generally have a low-status background and shorter life expectancy. They are particularly adversely affected by the scaling down of psychiatric inpatient services – including the necessary use of coercion. There are clearly fewer people who speak up for them in the public debate (5).

Whatever the objections, the mental health service is in need of change. A recent PhD thesis concluded that the human rights of patients are being systematically violated, yet without the patients, hospitals and Control Commission being aware of it (6). The study demonstrates discrepancies between the legislation and the clinical procedures in seven out of eight specific areas. For instance, the distinction between coercion and seclusion is anything but clear, which may suggest that the patient's legal protection is seriously at risk (6). The amendments to the Act should dispense with all such vagueness.

In 2012, the Norwegian Knowledge Centre for the Health Services published a systematic review of methods used to reduce the use of coercion in psychiatry (7). The report concludes that it is difficult to compare the use of coercion in Norway with the situation in other countries, primarily due to differences in legislation, the organisation of services and the reporting procedures involved. In general, limited research has been conducted on these matters and the quality of existing research is either low or very low. The potential for future research, with a view to reducing the use of coercion, lies in comparative studies conducted in areas such as crisis planning, assertive outreach teams, acute mental health teams and the drawing up of so-called treatment contracts (7).

Most Norwegian health trusts have set up a clinical ethics committee. In 2016, Oslo University's Centre for Medical Ethics published a review of 256 annual reports issued by these clinical ethics committees in the period from 2003 to 2012 (8). Most cases concern coercion, confidentiality, information and patient autonomy. The authors made no clear recommendations for the establishment of dedicated ethics committees for psychiatric health care, but wished instead to strengthen the existing committees' ethical expertise with respect to mental health (8). Considering the fact that the amendments to the Act may cause an increase in the number of reported cases, this proposal deserves support.

In another study emanating from the same group of researchers, 379 employees at seven psychiatric units were asked to answer questions about attitudes to the use of coercion (9). The main findings were that respondents were uncertain whether the use of coercion was degrading to patients, and that they found coercion to be indispensable for the sake of providing care and safety. However, they were doubtful as to whether coercion could be considered treatment. According to the authors, these moral dilemmas should be discussed in greater depth based on specific case histories (9). The amendments to the legislation increase the need for greater awareness among professional staff with respect to the use of coercion.

Coercion in psychiatry can in many ways be compared to the use of screening tests, where there is unease and challenges associated with the 'false positive' – often unlawful – choices being made. The new legislation will hopefully lead to the development of more alternatives to coercion. The law can also be interpreted to suggest that all training and care provided by the health service must be evidence-based. Both results would be welcome. Considering the Knowledge Centre's disheartening summary, it is certainly appropriate to ask what has happened to the report's recommendations in the five years that have elapsed since its publication (7). The answer can only come from the practitioners in the field.

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