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Minimizing the use of coercive practices in mental health: the perfect storm [Editorial]

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Editorial

Welcome to this special edition of JPMHN focusing on the challenges associated with individuals with mental health problems who display aggressive behavior and implications for coercive practice. In this edition we are seeking to explore contributory factors, which are commonly multimodal. For some time now I have suggested that the causes of such behavior can be seen as part of an inter-related triad of factors broadly seen to be of an internal, external or situational origin. In other words a person may be aggressive because of personal influences such as substance abuse, individual personality traits or illness related factors, as a result of aspects of the environment whether that be physical or atmospheric; and/or as the result of interpersonal relationships and encounters. Each of these aspects are particularly heightened when an individual is unwell or in an alien environment such as the clinical setting. This can then result in reactive practices and an over reliance upon coercion by practitioners particularly if contributory factors are not recognised or indeed addressed as part of a preventative strategy.

In light of the new NICE guidelines to be released in 2015 on the prevention and management of imminent violence and the DH's Positive and Proactive Guidelines published earlier this year, there is a real need to oversee the successful implementation of preventative and minimization strategies to counter against the development of aggressive behavior in mental health settings and related encounters. Further, the overuse of coercive practices to tackle aggression, perceived and real has become a significant problem.

We are facing a real opportunity given the drive nationally and internationally to 'turn the spotlight on' the use of coercive practices and their place in modern day mental health care. This is a time for us to be introspective and consider whether any approaches might be outdated and/or inappropriate, particularly when poorly evidenced one-way or the other. This is not a new dilemma for mental health practitioners and one which has no easy solution given the difficulties of balancing paternalistic with participatory approaches with regards to practice, education and policy.

Obrien and Goulding (2003) in a JPMHN paper over a decade ago suggested that coercive practices are relatively common in mental healthcare, and that coercion is ethically problematic because it involves acting against an individual's autonomy. They argued that the failure to make a conceptual distinction between what counts as coercive practice and what justifies coercive practice results in instances of unjustified use of coercion. They argued that the presupposition that mental illness involves limited autonomy cannot be taken to justify use of coercion. In taking this stance they defined coercive practice as the use of authority to restrain another's autonomy, and paternalism as the ethical justification, made on the basis of an appeal to beneficence, for a coercive action.

In this special edition, we are proposing that the moment is now with regards to tackling overly coercive cultures in mental health with a real opportunity to rediscover our original focus to foster human-centred approaches in mental health philosophy and practice. This relies fundamentally on a belief that compassion and person centredness are intrinsic to the needs of human beings regardless of and in spite of their situations and the attitudes of those who care for them whether nurses, police offices, or carers. This is in contrast to rising concerns that we may be retraumatusing and alienating those we care for. Such a fundamental approach has become compromised with complicated and contrasting pulls and agendas including, autonomy versus paternalism, restriction versus freedom, participation versus control, and proactivity versus reactivity.

Historically, while treatment in mental health settings has had a coercive thread since the inception of institutional care, often compounded by a societal view that fears mental illness, the need to be person centred and compassionate has always followed a parallel stream. This has reflected the care versus control dichotomy and the empassioned works of Aschult, Pepalu and to some extent Stockwell. Modern day activists have continued to address this paradigm including Bowers, Repper, Norman and indeed myself to name but a few.

So, in this special edition, we are focusing not only upon the incidence, associated causes and underlying beliefs about aggression across a range of professional settings and encounters that can be both contributory and consequential but also the resultant practices and the significance of these. With this in mind, we have included in this edition papers on professional attitudes, matters relating to social psychiatry and biomedicine, legal and ethical issues that can impinge upon positive risk taking and person centred care and their application to the causation and management of aggressive behavior.

From a biomedical causative perspective Stewart and Bowers highlight how practitioners can easily be drawn into believing that internal factors such as substance abuse are significantly contributory. Whilst some research has suggested that this may be the case in the general population, there is emerging evidence that in fact in the clinical setting, the causes of aggression are less likely to be associated with substance abuse. These authors concluded that beliefs that substance-using patients are likely to be violent where not supported in their study and can be damaging and that as a result further studies are needed to examine how staff intervene with and interact with intoxicated patients.

The social climate of psychiatric units (external) in contrast is seen to be important by McCann and Muir-Cochrane who argue that there is a direct relationship between social climate and levels of aggression. As a result the promotion of a favorable social climate with a least restrictive atmosphere can be of significant value particularly with although not excluded to vulnerable patients in old age psychiatry inpatient units.

As outlined by Stewart and Bowers, the attitudes of staff are clearly an important feature of the care experience and can influence the quality of care that patients receive. This however is not just attributed to clinical relationships but can be a feature of encounters outside of the therapeutic role. Martin & Thomas remind us for example, that allied professionals such as the police, are increasingly expected to deal with individuals with mental health problems. Commonly seen as unpopular, those with personality disorders may be ostracized in society and indeed by healthcare professionals who find them a difficult patient population to understand and relate to. Officers in Martin's study reported that emergency departments were reluctant to assess people with personality disorders leaving the police frustrated and unprepared when having to manage patents who have been excluded.

I examine common 'defenses' for the use of practices such as restraint and remind us that in the absence of a strong evidence base, the dangers physically and psychologically of such practices for services users prevail and cannot be ignored. This is further highlighted in a study by McCann who argues that despite the harmful effects of both seclusion and restraint reported in the literature, and in his qualitative study, their use continues. Having explored nurses' views of these approaches in older people settings, a neglected area of investigation, he highlight the impact of unfavorable contextual factors including 'an adverse interpersonal

environment, an unfavorable physical environment and a practice environment influencing the adoption of restraint and seclusion'. Here we see contributory factors that lead to coercion not so dissimilar to those that lead to aggression in the first place.

What is common to all of the papers is this edition is the focus upon the assessment of need and causation and the inter-related beliefs of professionals, which may positively or negatively influence the care patients, receive. This may then contribute unintentionally to professions such as nursing being an unpopular choice as proposed by Jansen & Venter who reported personal factors and the working environment as the most important reasons for not choosing psychiatric nursing as a career by university students. Perceptions therefore can clearly be influential at a number of levels and not just with regards to the relational care of patients.

The prediction of violence has been argued to be essential for some time leading to a plethora of actuarial tools in recent years. Debates continue as to whether actuarial or clinical risk assessment is most beneficial and in some regards the jury is still out. However, having compared three well known tools to assess the risk of violence in clinical areas, Jaber & Mahmoud argue that they have their place if one balances the benefits and limitations of each and targets their use accordingly. Interestingly they argue that the tools they have reviewed are low in personal bias. This may however conflict with the more qualitative research of authors in this edition suggesting that attitudes can influence care of which assessment and clinical judgment is clearly a part.

Personally I am clear in my view that staff can be drawn into a false view of the world in the absence of strong evidence when making decisions about approaches used to manage aggressive behavior such as the use of restraint. Having outlined and challenged three common and somewhat anecdotal defences for the use of such hazardous approaches, there remains work to be done in this area. The legal and ethical debates prevail and Paterson in response warns us ……

So, in this edition of the JPMHN, we are sharing in a period underpinned by a 'perfect storm', whereby clinical and public concerns, are both driving and reflecting policy and calls for new evidence. From this we are hoping that future editions will carry more reports of anti coercion and minimization approaches in the care of mental health patients, together with a commitment to reflect upon personal and professional perspectives, and more participatory approaches in practice, education and research in order to improve the experiences of patients and those who care for them.

Refs

DH (2014)
NICE
O'Brien & Goulding (2003)