The Experience of Coercion and Violence: Service User, Professional and Informal Caregiver Perspectives

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1 Introduction

This chapter is a revision of the fourth chapter ‘Users’ Perceptions and Views on Violence and Coercion in Mental Health’ published in the first edition of this book. We thank the authors of the first edition, Christoph Abderhalden (1954–2013) and Gian Maria Galeazzi, for their profound work, which is the basis of this revised chapter.

Professional workers in medicine and psychiatry are usually considered clinical experts and thus are entitled to deal with service users. However, in most countries, social, attitudinal and legal changes in medical treatment now underline the right of opinion and self-determination of each service user. Service users—encouraged and empowered by the recovery movement—ask to be involved in the decision-making process of their therapy and the choice of the pathway to recovery (Slade et al., 2012; von Peter, 2017). These changes have led to the development of cooperation-based medical and social services (World Health Organization (WHO), 2021; Gooding, 2023). Furthermore, informal caregivers (relatives, friends or neighbours) want to be heard and involved. They would like their opinion and experience to be taken into account and ask to be involved in the treatment process and caring system.

On the other hand, shifts in the attitudes of professionals towards violence and coercion occur slowly. Coercion and restraint are still considered useful clinical

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responses in acute emergency situations to protect society, service users and staff and to guarantee the safety of the persons involved.

The paternalistic model (in which decision-making authority is reserved for the professionals, because they know what is best for the patient) may be considered useful by some professionals as it side-steps the complex task of informing, explaining, negotiating and reaching an agreement with the service user, who might even dissent from the recommended treatment. Moreover, the paternalistic model of interaction generally reinforces the mental health professional's position.

The main argument in favour of a paternalistic approach is that psychiatric patients lack insight into their illness and sometimes have to be (or are) treated against their will. Therefore, from the viewpoint of the paternalistic approach, measures such as involuntary admission and forced medication are considered unavoidable. Today, the view that some service users lack insight into their illness is complemented by the view that some service users lack capacity to consent. This has led to some services being based on voluntary informed consent and the assessment of the service user's capacity to consent. This in turn has led to the development of tools to systematically assess service users' capacity to consent. It has also led to coercion not being seen as coercion in the absence of capacity and objectifiable service user resistance, for example in psychogeriatric care where service users are fixed to their chairs by tables and do not appear to resist this fixation (Hofmann & Hahn, 2013).

In most European countries, this intricate situation is regulated by a law that allows psychiatrists to hospitalise service users against their will when assessed as dangerous to themselves and others (Wasserman et al., 2020; Dressing & Salize, 2004). Sociological studies have drawn researchers' attention to the link between the description of mental illness in the media (that often emphasises the risk of violence) and its impact on subsequent social and recovery policies that support coercive practices (Rose, 1998; Philo, 1996). Public concern for the perceived risk of violence caused by the presence of psychiatric patients in the community has led some countries to expand the setting of involuntary treatment from the hospital to community services (Rugkåsa, 2016). Research has examined the relationship between media information and hospitalisation rates. These studies suggest that political decisions and media information on crimes committed by psychiatric patients in the community increase the rate of involuntary admissions to inpatient forensic psychiatric services (Brophy & McDermott, 2003; Cutcliffe & Hannigan, 2001). As a result, psychiatrists are increasingly responsible for risk assessment, despite the lack of standardised and clinically feasible instruments (Whiting et al., 2021). Consequently, this development does not encourage a flexible approach towards service users but reinforces the paternalistic model of care (Gowda et al., 2019b) and the opinion that some service users represent a danger to themselves and others. Hence, mental health services have the responsibility of protecting service users from themselves and others, e.g. in circumstances such as suicidality, self-harm, acute psychosis or dementia. In other words, service users who show signs of serious behavioural disorganisation, confusion and extreme agitation.

These developments in mental health services can promote violence and coercion, but they can also empower service users and informal caregivers. Likewise, reflective professionals are increasingly questioning current practices and the negative impact they can have on service users' feelings of dignity and therapeutic relationships (Gowda et al., 2019b). This chapter reviews the current literature on service users', informal caregivers' and professionals' views towards aggression, violence and coercive practices and examines their impact on mental health practices and future research.

1.1 Public Response to Violence and Coercion

The civil and service user rights movements have, for decades, condemned the use of force and coercion in psychiatry, questioned the legitimacy of paternalism and authoritarianism in mental health care (Szasz & Alexander, 1968) and, consequently, generated a shift in psychiatric perspectives. Thus, laying the foundation for a novel ethical approach, i.e. respect for the individual as a person, and not simply as a patient, with his/her subjective experiences, choices, values and rights. This change empowers service users by placing them at the centre of therapy, scientific research and care (Funk et al., 2022). The public, however, is on the whole not that critical towards the use of coercion in mental health care. Current research has shown that coercive measures are accepted when the public recognises potential benefits from their use (Steiger et al., 2022a, 2022b). Nevertheless, stigmata do reinforce the social perception of the danger caused by mentally ill people (Schomerus et al., 2023).

1.2 Research on the Views of Service Users and Informal Caregivers

Historically, service users' perceptions of mental health care were ignored. Some decades ago, thanks to the quality assurance approach—first developed in the industrial field and next in the health sector—brought forth an increasing interest in service users' perceptions of the healthcare sector and also of mental health services. This approach underlined that the 'user satisfaction criterion' could be an outcome measure for assessing the quality of a treatment plan (Ruggeri et al., 2004). It also highlighted the need to explore the subjective determinants of a patient's satisfaction, focusing on the entire care process (including informal caregivers) and not only on the psychopathological outcomes. This shift in perspective emphasises the importance of involving psychiatric service users in their care. It is also useful to include service users and/or informal caregivers as experts in all the stages of service planning.

Moreover, there is a current ongoing discussion on the meaningful involvement of service users and informal caregivers as active collaborators in research projects, and on the advantages of such partnerships in all stages of a scientific project.

Efforts are needed to develop recruitment and training strategies to support this type of active participation of service users (Hahn & Wolfensberger, 2022; Trivedi & Wykes, 2002; Bird et al., 2020). Incorporating the perceptions and personal experiences of service users and informal caregivers into research opens new avenues for studying violent incidents, prevention, and the reduction of violence and restraint. Although an increasing number of studies examine service users' perspectives and include them in studies on aggression, violence and coercion in health care, the perspective of informal caregivers is still rarely analysed (Hotzy et al., 2019).

2 Instruments to Measure the Experience and Perception of Aggression, Violence and Coercion

2.1 Instruments to Measure the Experience of Aggression and Violence

According to a systematic review of studies on the perception of aggression and violence prevention in mental health care, there are no instruments available to measure the perceptions of violence and foster prevention in a psychometrically sound manner (Hallett et al., 2014). The only scale—the Perception of Aggression Scale (POAS) (Jansen et al., 1997)—that is supposed to do so, is in reality an instrument that measures attitudes, rather than experiences and perceptions.

2.2 Instruments to Measure the Perception of Coercion

However, there are several instruments available that measure the perception of coercion from the different stakeholders' perspectives. The most frequently used scale for service users is the MacArthur Perceived Coercion Scale (MPCS). It is a five-item scale that measures perceived coercion on hospital admission (Gardner et al., 1993). It was built on the MacArthur Admission Experience Interview (AEI), a semi-structured interview, and the MacArthur Admission Experience Survey (AES), a 15-item instrument (Gardner et al., 1993). Each item of the MPCS comprises a different aspect of perceived coercion. The items are 'influence' ('What had more influence on your being admitted: what you wanted, or what other people wanted?'), 'control' ('How much control did you have?'), 'choice' ('You chose' or 'Somebody made you choose'), 'freedom' ('How free did you feel to do what you wanted?'), and finally 'idea' or 'perceived initiative' ('Whose idea was it to come to hospital?'). The MPCS has demonstrated several psychometric qualities, leading to its adoption by numerous research teams—initially in North America, where it was developed, and subsequently in Europe and New Zealand.

The AEI and the AES also measure other relevant dimensions of coercion in psychiatric treatment, i.e., 'coercion related behavior' (experienced by users during hospital admission) and 'procedural justice'. 'Coercion related behavior' is categorised by the MacArthur Collaboration in three clusters: 'positive pressure' (persuasion, inducements and asking for preferences), ‘negative pressure’ (threats, giving orders, deception and exhibition of force), and ‘force’ (legal and physical forces that impede the patient to refuse what is imposed by staff) (Lidz, 1998). As for ‘procedural justice’, research highlights that the degree of procedural justice (or process inclusion) perceived by the service user is linked to their likelihood to be heard, have their opinions been taken into account and also to their perception of fairness in the decision-making process, in other words, up to what point they feel treated with respect and dignity by the decision-maker (Poythress et al., 2002).

The MacArthur Experience Survey has recently been adapted to assess antipsychotic medication related to involuntary treatment (Horvath et al., 2018). Further instruments have been developed to measure coercion experiences such as informal coercion, including the Experienced Coercion Scale (ECS) (Nyttingnes et al., 2017) and the Coercion Experience Scale (CES) (Bergk et al., 2010). Additionally, the Staff Attitude to Coercion Scale (SACS) has been developed to study staff attitudes towards coercion (Husum et al., 2022).

2.3 Instruments to Measure Involuntary Admission

Only one instrument, as far as we know, measures the perception of involuntary admissions (Gabriel, 2017). This 21-item instrument was developed by people who have experienced involuntary admission and by clinical experts in Canada. However, this instrument should be adapted to the different influencing factors due to differences in legislation and practical implementation in different countries.

3 View on Violent Incidents from Service User, Staff and Informal Caregivers

3.1 Service Users’ Views on Violent Incidents

Some studies examine participants’ perceptions of violent incidents in a broad sense, revealing thus the multiple and complex components of aggression. Benson et al. (2003), for example, emphasise that one of the central concerns of service users is the discourse of the mutual attribution of blame about reasons for violent incidences. Kumar et al. (2001), using the grounded theory approach, revealed from the viewpoint of experienced service users that the power imbalance observed in the mental health system fosters institutional violence against service users.

When service users are interviewed on the causes of aggressive behaviour, they mention various aspects of the hospital environment (Johnson et al., 1997; Love & Hunter, 1999), institutional, interpersonal or procedural factors, lack of communication, unmet needs, interpersonal conflicts and personal factors (Välimäki et al., 2022b). However, further research underlines that service users often describe staff behaviour as provocative and disrespectful, and therefore the main trigger for violence (Duxbury, 2002; Duxbury & Whittington, 2005; Fagan-Pryor et al., 2003;

Ilkiw-Lavalle & Grenyer, 2003; Fletcher et al., 2021). For example, Omérov et al. (2004), studying 41 violent incidents, found that service users considered staff behaviour provocative in 75% of the episodes analysed. The findings are confirmed by a systematic review of qualitative studies and examine the service users' opinion about the reason for patients' violent behaviour (Gudde et al., 2015). Another systematic review has also linked these impressions of service users' about staffs' provocative behaviour to the occurrence of coercive treatment practices in the mental health care system (Tingleff et al., 2017).

3.2 Staff Views on Violent Incidents

Current research underlines the fundamental differences in perspective on aggression and violence between staff and service users. While service users consider staff behaviour as a potential trigger for violence, staff often highlight organisational policies, staffing levels and/or patients' personalities and diagnoses (Fletcher et al., 2021). A survey revealed clear differences in the attitudes of nurses ($n = 782$), service users ($n = 886$) and informal caregivers ($n = 765$) towards aggression in psychiatric hospitals (Välimäki et al., 2022a). Nurses had a significantly lower tolerance and more negative perceptions towards violent behaviour than service users and informal caregivers. Nurses were significantly more likely to perceive violence as unpleasant, repulsive, unnecessary and unacceptable behaviour that causes mental or physical harm than the other participants.

3.3 Informal Caregivers' Views on Violent Incidents

There is little research on informal caregivers' perspectives on aggression and violence. Informal caregivers agreed with staff and service user view that illness itself can be a reason for violent patient behaviour. Also, problems with communication and relationships on the ward can lead to social conflicts as a reason for violence. Informal caregivers identified sudden change in treatment without a clear explanation as trigger for service user violence. Staff and relatives sometimes also see no reason for violent behaviour (Välimäki et al., 2022b) As an intervention, informal caregivers described comforting service users after an event (Välimäki et al., 2022a, 2022b; Duxbury et al., 2013). In dementia care, Duxbury et al. (2013) found that both informal caregivers of individuals with dementia and nurses attribute aggressive behaviours observed in these individuals to the condition of dementia itself.and they support the person-centred approach of nurses in the prevention and non-coercive approaches in dealing with aggression.

4 View on Coercion from Service User, Staff and Informal Caregivers

4.1 Service Users' Views on Coercion

Service users tend to have a negative view of the coercive measures they have experienced (Tingleff et al., 2017). Systematic reviews have highlighted that the majority of service users, subjected to coercive measures, do not consider them positive (Chieze et al., 2019; Aguilera-Serrano et al., 2018; Akther et al., 2019) chiefly because their rights are not respected (Allison & Flemming, 2019; Hawsawi et al., 2020). The most common emotions triggered by coercive incidents are anger, discontentment, feeling powerless or overwhelmed, depression, fear, anxiety, humiliation, desperation and a feeling of dependency. Most service users are convinced of not being heard, nor taken seriously (Krieger et al., 2018; Armgart et al., 2013; Thøgersen et al., 2010; Hawsawi et al., 2020; Fugger et al., 2016; Ling et al., 2015).

In situations of restraint and/or seclusion, service users often feel bored and/or unsettled by the absence of stimuli (Kontio et al., 2012). Even if restraint might appear necessary from the viewpoint of service users, this psychiatric practice remains a distressing and dehumanising experience for the patient (Wilson et al., 2017; Wong et al., 2020). During seclusion, some service users feel neglected, powerless, fearful, anxious or even punished (El-Badri & Mellsop, 2008), while others feel safe, protected, more at ease and in control (Van Der Merwe et al., 2013).

Service users' level of perceived coercion is influenced by experienced coercive incidents, from personal attitudes towards prescribed medication or from their capacity to reflect and gain insight into their own mental state (Hirsch et al., 2021; Horvath et al., 2018). The perception of coercive incidents can also derive from the type of hospital admission: voluntary or involuntary. Service users who have experienced involuntary hospitalisation tolerate less coercive measures (Reisch et al., 2018).

Informal coercion (positive motivational influence, imposing threats of negative penalties) is also associated with a broader sense of coercion but is perceived by service users as unfair treatment. However, the treatment fidelity of service users who have experienced this form of coercion does not seem to differ from those who have not (Jaeger & Rossler, 2010).

The personal experience of coercion will, however, influence the choice of coercive treatment (Georgieva et al., 2012). For example, physical and/or mechanical restraint may be perceived as more violent than forced medication or seclusion (Mielau et al., 2016; Guzmán-Parra et al., 2019; Vishnivetsky et al., 2013).

It is not surprising that these negative experiences of coercive practices—which should not be overlooked—can generate feelings of rejection and a loss of trust between service users and health professionals (Ling et al., 2015; Sheehan & Burns, 2011). Negative experiences impact both the patient's quality of life and level of satisfaction with the therapeutic setting (Lee & Seo, 2021). Furthermore, it is probable that a recurring experience of coercive measures increases a service user's resistance towards coercion and lowers his or her confidence in the benefits of such a practice (Brady et al., 2017). Coercive measures are considered unproductive when other less drastic measures could solve the problem and they can also be interpreted as a violation of the service user's freedom of choice and autonomy (Norvoll & Pedersen, 2018).

In brief, service users are more critical of hospitalisation if they have already suffered coercive measures (Guzmán-Parra et al., 2019; Stanhope et al., 2009). The more psychologically stable the service user is, the more negatively she or he will regard coercive treatment. However, now and again, some service users understand why such coercive clinical measures are taken (Armgart et al., 2013). However, service users usually prefer other treatment options to coercion. To bear in mind service users' opinions could result in a qualitative improvement in the mental health care system (Norvoll & Pedersen, 2018).

4.2 Staff Views on Coercion

Staff views on coercive incidents derive from the wish to feel safe at work. Coercion is thus considered necessary to ensure a safe working environment and to contain the fear of losing control when a patient becomes violent or suicidal (Doedens et al., 2020; Gowda et al., 2019a; Gerace & Muir-Cochrane, 2019) or when the personnel has to deal with violent or suicidal behaviours. Therefore, staff view the use of coercion as safeguard against violence and as protection of the service user, rather than a therapeutic measure (Wilson et al., 2017; Molewijk et al., 2017; Morandi et al., 2021; Doedens et al., 2020). However, coercion can also be seen from staff's view as a therapeutical intervention rather than violence and suicide prevention, e.g. seclusion can be viewed as a treatment and a benefit for the service users—the seclusion room or restraint can calm the service user down and allow them to regain control of their behaviour through less irritation from the environment (Larsen & Terkelsen, 2014; Van Der Merwe et al., 2013; Kinner et al., 2017). Therefore, some staff tend to believe that institutions could not function effectively without seclusion (Van Der Merwe et al., 2013).

In brief, professionals view the following indicators as reasons to consider seclusion or restraint: violence and physical aggression, self-harm, sexualised behaviour, vandalism, drug abuse, intoxication, as well as a history of coercion and uncooperative behaviour (Gerace & Muir-Cochrane, 2019; Happell & Koehn, 2011; Muir-Cochrane et al., 2015; Vedana et al., 2018).

The work environment and conditions also influence staff decision-making regarding the use of coercive measures. Clinical professionals at times feel compelled to use coercion, feeling as though they have no other option. Several factors influence decisions such as low staff-to-patient ratio, employee restrictions for an intervention, low job satisfaction, stressful work conditions, the gender composition of the team, the absence of planning options, a lack of consensus when deciding on coercion, and finally, insufficient opportunities for professional training (Hawsawi et al., 2020; Krieger et al., 2021; Muir-Cochrane et al., 2015; Happell & Koehn, 2011; Raveesh et al., 2016b).

Attitudes, behaviour and personal traits can also influence the way coercion is implemented. Optimistic or more experienced staff members may use seclusion less frequently, adopting a more pragmatic and critical approach towards coercive measures (Happell & Koehn, 2011; Krieger et al., 2021). Furthermore, male staff tend to use more coercion than female staff, and also more often with male patients (Al-Maraira & Hayajneh, 2020; Bregar et al., 2018). Other factors such as low self-esteem or doubts about their professional skills, lack of professional models in the team, little or no supervision, and poor clinical management all increase the use of coercive practices (Gandhi et al., 2018; Gerace & Muir-Cochrane, 2019). Furthermore, the more often coercive practices are used, the less staff perceive the negative aspects of coercion (Doedens et al., 2020).

It is not clear which coercive measures clinical staff are more willing to use. Some professionals consider seclusion the most useful restraint procedure, some prefer physical or mechanical restraint (Gerace & Muir-Cochrane, 2019), and others consider restraint and seclusion too restrictive and would prefer using less ruthless measures (Doedens et al., 2020). Chemical restraint is usually depicted as the least harmful practice (Kinner et al., 2017).

In short, staff consider coercion the last resort after having tried out all other interventions that either did not work or were unsatisfactory. Clinical professionals underline that many different interventions can be put into practice before using coercion. Moreover, the decision to use coercive measures is not an easy decision to take (Gerace & Muir-Cochrane, 2019; Morandi et al., 2021; Moran et al., 2009), as problems usually arise when coercion is used (Muir-Cochrane et al., 2015; Vedana et al., 2018).

Staff have difficulty justifying the use of coercive practice as safety measures, because care is seen as engaging, compassionate, calming, comfortable and free from coercion. Staff can also consider coercion potentially risky for patients and team members (Hawsawi et al., 2020; Vedana et al., 2018). The impact of coercive episodes can be traumatic for both service users and staff (Bigwood & Crowe, 2008; Hawsawi et al., 2020; Krieger et al., 2021). Staff are also aware that coercion can harm the service user's feeling of integrity and influence negatively the therapeutic relationship (Raveesh et al., 2016b).

In a nutshell, staff are aware of the harm coercive measures can cause to the relationship between service users and staff, for instance, producing a lack of regard for the service user's opinion (Gerace & Muir-Cochrane, 2019; Gowda et al., 2019b). Seclusion and restraint are deemed stressful, for they generate anxiety and feelings of guilt (Moran et al., 2009). Staff hence try to cope by suppressing emotions, without always being successful. This unsuccessful suppression of emotions can provoke an emotional distance between staff and service users that can disrupt communication between them and hamper their relationship (Morandi et al., 2021). Staff can also consider coercive measures an offence against service users' rights (Morandi et al., 2021) and feel ethically in the wrong when using them. Staff, as a rule, endeavour to keep the patient situation under control, and can occasionally understand the service user's resistance against coercive practices (Hawsawi et al., 2020; Larsen & Terkelsen, 2014; Happell & Harrow, 2010; Bigwood & Crowe, 2008; Gerace & Muir-Cochrane, 2019; Haugom et al., 2019). This can also lead to resistance to coercion if staff do not see the need for restriction. They raise their voices against coercive interventions and against a superior ordering this measure (Gandhi et al., 2018). Also, staff agree that it is necessary to be transparent with the service user about the use of coercive interventions and the reasons behind it, and meeting with patients after the incident is seen as important, but it does not always happen (Krieger et al., 2021).

4.3 Informal Caregivers' Views on Coercion

Informal caregivers, mainly in acute and emergency situations, consider it necessary that the staff use coercion (Gowda et al., 2019a), even if they criticise this type of treatment (Reisch et al., 2018). Compared to other coercive measures, chemical restraint is the most accepted in these acute situations (Gowda et al., 2019a). Coercion is seen as a way to help service users with the difficulties they experience as a result of their mental health problems. Coercion can also reduce stress for informal caregivers, for example by relieving them of the 24-h care they have been providing. Other positive effects of coercion can be seen as building structure and control in a challenging situation within the family, which can lead to a better quality of life for the family members involved (Norvoll et al., 2018). Sometimes informal caregivers use coercion (such as threats or forced persuasion) to convince the service user to be hospitalised (Gowda et al., 2019a).

However, informal caregivers also perceive coercive measures as inconsiderate when they feel excluded by the healthcare team and are uncertain about the measures' beneficial outcomes (Norvoll et al., 2018). In coercive situations, informal caregivers often feel responsible and anxious, even if the professionals carry responsibility for the treatment (Førde et al., 2016). Informal carers may have little social support, and feel lonely and uneasy when disclosing their negative experiences (Førde et al., 2016). Therefore, coercive incidents often put informal caregivers in an uneasy situation (Norvoll et al., 2018). So, it is not surprising that informal caregivers often disapprove of coercive measures, even if they object slightly less than service users. They clearly don't have the same opinion as staff on this topic (Reisch et al., 2018; Raveesh et al., 2016a). Norvoll et al. (2018) used qualitative interviews with 36 family members of adult and adolescent people with mental health problems and experiences of coercion and describe that informal caregivers have a different level and type of responsibility (Norvoll et al., 2018). Parents of hospitalised teenagers, for instance, worry mostly about the harm coercion could do to their children now or in the future (Norvoll et al., 2018). They fear the negative impact of coercive interventions on their family member (Norvoll et al., 2018). Hence, it is crucial to reassure a family that the patient will be well looked after and receive good care. After coercive incidents, informal caregivers usually feel more positive having been helped thanks to the compulsory admission of their family member. However, after some time, they usually feel guilty and disheartened by the course of events. They notice that coercive incidents can harm their relationship with the service user. Coercion, threats of coercion, or not disclosing health-related information can foster mistrust, damage relations and trigger conflicts in a family system (Norvoll et al., 2018).

According to informal caregivers, low quality of care, lack of alternatives or concrete interventions, staff shortages and negative attitudes are all factors that foster the use of coercion (Norvoll et al., 2018). Informal caregivers do agree with the idea of eliminating coercion (Kinner et al., 2017; Brophy et al., 2016) and believe that coercion would be less needed if health workers could spend more time with the patients (Raveesh et al., 2016a). Finally, they have little knowledge of the risks and consequences of coercive measures (Shrestha, 2018).

4.4 Summary

There are many areas in which the views of service users, staff and informal carers on coercion in mental health care do not coincide. These sometimes divergent views highlight the challenges that all parties face in preventing, using and following up coercive interventions in mental health care. In all mental health care settings, service users disapprove of coercive practices that, in their opinion, violate the patient's rights and trigger past traumas. Informal coercion is perceived as unfair and interferes with relationships with professionals, leading to feelings of rejection. In contrast, staff and informal caregivers consider coercion necessary to react to aggressive behaviour of service users to ensure a safe environment. However, staff usually consider coercion a last resort as it fosters ethical dilemmas and preferences for types of coercion vary according to the ward's style of work, working conditions and staff attitudes. Informal caregivers often maintain a critical attitude towards coercive measures. They consider coercion as an extreme practice that generates among informal caregivers feelings of exclusion and insecurity. Service user, staff and informal caregiver view the impact of coercion on the service user as distressing and as having the potential to disrupt the therapeutic relationship. The importance of being explicit with the service user when coercion is needed is supported by staff and informal caregivers. Informal caregivers do understand the complexities of coercive measures but advocate for its elimination, requesting more staff to allow more personal contact between personnel and patient.

5 Service User, Staff and Informal Caregivers Perspectives on Coercion in the Community

Involuntary admission and Community Treatment Orders (CTO) are commonly used coercive practices in the community. Service users' perceptions of coercion, involuntary hospitalisation and treatment have received attention on a global scale, at least in part due to the United Nations Convention on the Rights of Persons with Disabilities (UN-CRPD) (United Nations, 2006). The convention has been signed by 182 states. The UN-CRPD emphasises 'respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons; non-discrimination; full and effective participation and inclusion in society; respect for differences and acceptance of persons with disabilities as part of human diversity and humanity; equality of opportunity; accessibility […]' (United Nations, 2006, Article 3). Article 15, in particular, addresses the use of coercion and its ties with torture: 'No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment'. By international legal standards and UN bodies, compulsory treatment is considered a form of torture (UN General Assembly, 2013). Even so, countries are still not reducing hospitalisations, nor do they propose to ban involuntary hospitalisation. Quite the opposite, a trend of increasing rates of coercive admissions is becoming a serious cause of concern (Sheridan Rains et al., 2019; de Stefano & Ducci, 2008; Dressing & Salize, 2004). This is happening even though research provides evidence that shared decision-making interventions (including advance directives, crisis cards and patient-held information strategies), CTOs, adherence-enhancement interventions and integrated care interventions can reduce involuntary hospitalisation (Barbui et al., 2021).

In brief, forced admission to hospital with deprivation of autonomy is an extreme, but commonly used, practice in psychiatry. The widespread opinion, that persons suffering from psychiatric disorders represent a danger to themselves and the community, legitimises the policy of involuntary hospitalisation, often used as a preventive measure against social disturbances (Georgieva et al., 2019). Laws on this issue vary from country to country, but usually also prescribe the provision of impartial information and a legal procedure to appeal against compulsory measures (Wasserman et al., 2020).

5.1 Service Users' Views on Involuntary Hospitalisation and Community Treatment Orders

Service users of mental health services have conflicting opinions on involuntary hospitalisation. Opponents of coercive treatment argue that these laws violate basic human rights—i.e. autonomy and freedom of movement—and should simply be withdrawn (Sugiura et al., 2020). Other service users agree that involuntary hospitalisation may be helpful in extreme situations of crisis (i.e. as a last resort if serious hazards are feared), provided that other options in less restrictive environments have been attempted first and legal or advocacy support have been guaranteed. Service users recognise that involuntary treatment can have some positive aspects, as they appreciate that they could have experienced more problems if they had not been hospitalised (Allison & Flemming, 2019). Involuntary hospitalisation can generate positive feelings, including emotional states of comfort and safety (Krieger et al., 2018).

In brief, service users' views on compulsory hospitalisation vary. For some, hospitalisation can be considered necessary. Moreover, a service user can change opinions and feelings towards coercion (Sibitz et al., 2011; Larsen & Terkelsen, 2014; Verbeke et al., 2019). Finally, a service user who has suffered involuntary admission tends to report higher levels of coercion than a patient admitted voluntarily to hospital (Hirsch et al., 2021). This is probably related to higher acceptance of the illness model and the entire mental health care system.

Most service users view the Community Treatment Order (CTO), recently introduced in several countries, as an alarming increase in social control. Recommended for emergency situations or to address simple everyday events, CTOs risk severely limiting people's rights and freedoms. The UN-CRPD recommends that member states ensure that people with mental disabilities enjoy the same rights and bear the same duties as the rest of the population. Therefore, disabled persons have the right to set their priorities and choose what treatments to receive (United Nations, 2006). This convention has strengthened the rights of service users and has restricted the possibilities for clinical care services to use compulsory commitment. Now and again however some clinicians are concerned that they will no longer be able to protect service users (Scholten & Gather, 2017) or follow service user's preferences (Dawson, 2015).

Service users on the whole consider CTO coercion less aggressive than other coercive measures, and on occasion, even consider it helpful and supportive, i.e. when it offers access to local mental health care services (Pridham et al., 2016). Nonetheless, service users still have mixed feelings about CTOs. They acknowledge that CTOs can consider personal needs, yet they emphasise that it remains a stressful experience due to the loss of the right to decide (Riley et al., 2014). The absence of a shared decision-making process during CTOs represents a substantial problem. In brief, even if service users are not physically coerced, they still feel coerced as they are not free to live how they want to (Riley et al., 2014).

5.2 Staff Views on Involuntary Hospitalisation and Community Treatment Orders

Health professionals consider involuntary hospitalisation necessary when they feel threatened or misunderstood by a patient and in need of help from their colleagues. They have a desire for better communication and coordination among team members (Sugiura et al., 2020). CTOs are primarily viewed as medication-oriented by psychiatrists who have been interviewed about this (Canvin et al., 2014). However, the establishment of a therapeutic relationship with the patient under CTO seems to be challenging for staff, but of paramount importance (Jansson & Fridlund, 2016).

5.3 Informal Caregivers' View on Involuntary Hospitalisation and Community Treatment Orders

Informal caregivers often struggle with the issue of involuntary admission of family members. Involuntary hospitalisation can however also produce distressing feelings, for instance when informal caregivers worry that their family member may suffer coercive practices (Norvoll et al., 2018). They may feel responsible for the hospitalisation of their family member and fear the disruption of their relationship (Sugiura et al., 2020). Often, professional help and support are sought prior to involuntary hospitalisation, but at times informal caregivers do not receive, or do not know how to get the help they need (Jankovic et al., 2011). Also, from the informal caregivers' perspective, alarming changes in the patient's behaviour reinforce the decision to ask for involuntary hospitalisation (Gowda et al., 2019a). When a service user is admitted involuntarily, informal caregivers often feel anxious and guilty, but also relieved (Jankovic et al., 2011).

Informal caregivers have mixed feelings towards CTOs context (Canvin et al., 2014). They feel responsible for having asked for the treatment but do not consider themselves a member of the health team. The CTO gives them a feeling of security: the patient is looked after in a steady context. However, in some cases, family members feel excluded and that their personal experience is not taken into consideration.

Coercion is accepted by informal caregivers, when they believe that the patient is suffering and the available medical help does not solve the informal caregivers' problems in dealing with the entire situation (Stensrud et al., 2015). In the caregiver's opinion, CTOs should have a more integrated approach and should be more specific when responding to the patient's needs. Hence, informal caregivers can have conflicting ideas, either they want to help the service user to make personal decisions, or they choose to assist the professional in medical treatment. Yet, informal caregivers usually do not consider CTOs hazardous.

5.4 Summary

Many service users support the proposed ban of coercive measures as expressed in the UN-CRPD. Even if the principles of dignity, autonomy and inclusion are underlined, many countries still struggle to reduce involuntary hospitalisation. Research suggests interventions such as shared decision-making, CTOs and integrated care can reduce involuntary admissions. However, challenges are still on the agenda as national health policies and professional associations often do not support the proposed abolition of coercion.

Service users have varied perspectives on involuntary hospitalisation and CTOs. Some people disagree with involuntary hospitalisation, others consider it useful in situations of extreme crises, if less restrictive options have been tried, and legal advocacy and support have been given.

Health professionals consider involuntary hospitalisation as necessary when a service user, from a professional perspective, becomes a risk to others or to himself or herself. Under these circumstances, there is an increasing demand for improved coordination among staff and services.

For informal caregivers, involuntary hospitalisation remains a challenge even when it represents a last effort in developments that often result in difficult family tensions. Informal caregivers can express concern and internal conflicts feeling responsible for the hospitalisation. While seeking professional assistance is common, informal caregivers frequently encounter difficulties in accessing appropriate support. The changes in the patient's mental state and the alleged danger provide a rationale for the request for involuntary admission. The informal caregiver initially feels anxious, but afterwards relief. Informal caregivers have mixed feelings about CTOs. They appreciate the feeling of safety and its stabilising effect, and welcome the return of a sense of security, but also feel excluded and psychologically unsettled by the medical intervention. They live in a contradictory way as they are upholding the service user's autonomy, but at the same time also assisting with medical treatment. However, they are convinced that the CTO does not deal with everyday problems. In brief, informal caregivers generally do not consider CTOs to be problematic.

6 Conclusion

The original chapter, published in the first edition, concluded that service users' perspectives should be taken into consideration in the research and the present state of research has indeed advanced in this direction. Service users' views of coercion and violence have not however led to significant changes in legal and clinical practices, which are still underpinned by formal and informal coercion. While service users' views have been included in research recently, informal carers' perspectives have not. Furthermore, few studies have been led, or co-led by service users. Nevertheless, research on this topic has become much clearer and, in some ways, more stable.

Service users, staff and informal caregivers often have differing views about violence and coercion. Although no stakeholder group agrees with today's clinical practices, staff and informal caregivers still see the root cause of violence in the service user's mental disorder and behaviour. This fundamental belief explains why coercion is seen as necessary more by staff and informal caregivers than by patients. Service users, however, often do not attribute the reasons for problems and conflicts to a mental illness.

A key conclusion is to challenge the conventional view on aggression and coercion that prioritised the service providers' perspective. Clinical practice will not advance in the direction of minimisation or abolition of violence and coercion as long as service users are not involved as active participants in research, teaching and service provision. While shared decision-making in mental health care has been promoted by official bodies such as the US Substance Abuse and Mental Health Services Administration for some years (SAMHSA, 2010), research has highlighted that shared decision-making usually does not work even in non-risk situations in everyday practice (Gurtner et al., 2022; Huang et al., 2020). In many situations, service users' views are not taken into account, let alone followed. This is particularly true in the case of conflicts between patients and staff and when there is a risk of self-harm or harm to others from a staff perspective.

6.1 Next Steps

As the UN-CRPD has explicitly stated, the issue of decision-making is central to the use of coercion in mental health care. Clinicians should be aware of the political and legal discussions around decision-making in mental health care, that currently go beyond shared decision-making, in order to promote supported decision-making (ENNHRI/MHE, 2020; Gooding, 2013). Supported decision-making leaves the final decision on health matters to the service user exclusively, while the service provider's role is to support the client with information, but not to instruct on the best ways of being treated. The legal and political discussions mentioned above increasingly support the transformation to supported decision-making.

As shared decision-making has not yet been fully implemented in clinical routine, there is still a long way to go to achieve supported decision-making. Based on our knowledge and experience and to advance the next steps into this direction, the involvement of stakeholders' perspectives on violence and coercion prevention could be organised practically as follows:

- Involving service users in mental health care management, providing training and service provisions.
- Involving informal caregivers in advisory boards of service providers.
- Training mental health professionals to interpret aggressive incidents in care settings not solely from a pathological viewpoint, but additionally sensitising them to be aware of their own role in escalating aggression.
- Take into consideration and explore, if possible, the service user's perspective after an aggressive and/or coercive incident in order to learn from it.
- Explore possible traumatic or fear-inducing consequences after service users have experienced a coercive incident directly or indirectly.
- Prevent aggressive and/or coercive incidents by utilising advance directives.
- Utilise shared decision-making or even supported decision-making, in risk-prone situations.

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