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UNIVERSITY OF SAN DIEGO  
Hahn School of Nursing and Health Science  
DOCTOR OF PHILOSOPHY IN NURSING

*Justifying Coercion:*

Nurses' Experiences Medicating Involuntary Psychiatric Patients

by

Paula K. Vuckovich, RN

A dissertation presented to the

FACULTY OF THE HAHN SCHOOL OF NURSING AND HEALTH SCIENCE

UNIVERSITY OF SAN DIEGO

In partial fulfillment of the requirements for the degree

DOCTOR OF PHILOSOPHY IN NURSING

March 2003

Dissertation Committee

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Paula K. Vuckovich

## Abstract

This grounded theory study delineates the process inpatient psychiatric nurses use to respond to the challenging nursing problem of medicating resistant involuntary patients. Since approximately one third of all admissions to psychiatric units in the United States are involuntary (Durham, 1996), caring for involuntary patients is a significant part of psychiatric nursing. Medication administration is a major treatment modality that is expected in caring effectively for psychiatric patients (American Psychiatric Association (APA), 1994; APA, 1997; Patel & Hardy, 2001). The process of getting the involuntary patient to accept medication is a major nursing function in a psychiatric unit that treats involuntary patients (Gutheil & Appelbaum, 2000; Susman, 1998). If the nurse is able to convince a patient to accept medication voluntarily, involuntary medication treatment can be avoided. If not, legal procedures will be initiated that may lead to the nurse administering medication without the consent of and/or over the protests of the mentally ill individual being treated. The need for psychiatric nurses to participate in forced involuntary medication constitutes a recurrent ethical problem in settings that accept involuntary patients.

This study used grounded theory methodology to uncover the process of Justifying Coercion that participating California psychiatric nurses use to resolve this problem. The process consists of three stages: (a) Assessment of Need, (b) Interpersonal Negotiation, and if the negotiation reaches an impasse, (c) Justifying and Taking Coercive Action. There are two distinct “critical junctures”, Decision to Engage and Impasse, which define the transitions from one stage to the next. The process continues after each instance of forced medication with the goal of replacing coercion with



voluntary acceptance of medication for subsequent doses. The nurses believe patient improvement will be the eventual outcome of the coercive action. This belief motivates their intensive efforts at negotiation and is one of the primary explanations for Justifying Coercion.

## Preface

This study grew out of a career-long interest in the care of the severely and persistently mentally ill (SPMI) and the effects of involuntary treatment on the course of mental illness. From the time I received my Master's degree I have been employed in acute care psychiatric facilities and have participated in involuntary treatment. I have participated in adapting facility policy to changing mental health regulations in three states.

In all of my practice settings recidivism has been a major concern. I have a special interest in compliance issues in bipolar disorder and schizophrenia. The current study is the first in a projected program of research investigating how inpatient psychiatric nurses can make a contribution to treatment adherence by the SPMI. I hope eventually to be able to identify best practices in the inpatient psychiatric nursing care of this population.

## Acknowledgements

It was very important to me to have staff nurses as participants in this project. I owe debts of gratitude to Pat Flanigan who assisted me in recruiting participants in northern California and Manny Alvano who facilitated my recruitment efforts in the Los Angeles area.

This study would not have been possible without the active support and assistance of my committee. They have accommodated my difficult schedule needs, encouraged me, and supported me for two years. The chairperson, Dr. Mary Ann Thurkettle has

shepherded me through the process from forming the committee through writing the proposal to writing the final document. Her review of multiple drafts has clarified my thinking and strengthened my analysis as well as improving my writing. Dr. Barbara Artinian has served as my grounded theory methodologist and mentor. She has reviewed my coding, helped me conceptualize, and assisted me to clarify the process. She has guided me through multiple attempts at conceptual models from the first diagram with over thirty separate steps to the current model of the process. Dr. Mary-Rose Mueller assisted me in the literature review. With her help I succeeded in writing an article from that review. She has provided timely support when I was discouraged and helped me keep on going.

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Finally, I need to acknowledge my husband, Steve, who has supported me throughout my doctoral studies. He has taken on my usual chores, put off his own work to help me get the computer back up, driven me to San Diego when I was too tired to make the 120 mile trip alone, and delayed making a career change so that I could complete my research without hindrance. I couldn't wish for a better husband.

## Table of Contents

Preface .....	ii
List of Tables.....	vii
List of Figures.....	vii
List of Appendices.....	viii
CHAPTER ONE.....	1
The problem.....	1
Context of the Problem.....	3
Purpose.....	5
Limitations of existing theory.....	6
Ontological and Epistemological Assumptions.....	9
Influences on Researcher.....	9
Symbolic Interactionism.....	10
Nursing Models.....	11
Rationale for Methodology.....	13
Grounded Theory.....	13
Limiting the Focus.....	14
CHAPTER TWO: Literature Review.....	16
Medication treatment of mental illness.....	18
Compliance/Noncompliance.....	19
Therapeutic Alliance.....	22
Qualitative research.....	24
Outcome studies.....	25
Coercion: Ethical Considerations.....	26
Involuntary Treatment.....	28
Involuntary hospitalization.....	30
Involuntary medication.....	33
Critique.....	35
CHAPTER THREE: Methodology.....	38
Research design.....	38
Data Collection.....	39
Data management.....	39
Participants.....	40
Data Analysis.....	41
Ensuring Theoretical Rigor.....	44
Human Subjects Protection.....	45

CHAPTER FOUR: Findings.....	47
Context.....	50
Initiating a Relationship.....	52
Establishing Rapport.....	54
Explaining.....	54
Assessment of Need.....	57
Meeting Criteria/Really Sick.....	57
Finding out why.....	60
“Medications Will Help” and “Action Necessary”.....	63
The Decision to Engage.....	64
Interpersonal Negotiation.....	66
Generally Helpful Interventions.....	68
Verbal Interventions: Talking To.....	70
Verbal Interventions: Talking With.....	72
Nonverbal Interventions.....	76
Persistently Trying.....	78
Impasse.....	80
“The Last Resort”: “Justifying and Taking Coercive Action”.....	82
Justifying Coercive Action.....	83
Taking Coercive Action.....	86
Summary of the Process.....	88
 CHAPTER FIVE: Discussion And Conclusions.....	 91
Ethical and Legal Considerations.....	93
The Ethical Conflict.....	93
The Decision to Use Coercion.....	100
Justifying Seclusion and Restraints.....	103
Justifying Involuntary Medication Administration.....	106
The Basis for Justification.....	107
The Therapeutic Relationship as Context and Strategy.....	108
Establishing Rapport.....	110
Negotiating Values.....	112
Being a Good Psychiatric Nurse.....	114
Maintaining Self Image.....	116
Maintaining the Relationship.....	116
Efficacy.....	116
Nursing Strategies Across The Stages.....	121
Assessment of Need.....	121
Decision to Engage.....	123
Interpersonal Negotiation.....	125
Impasse: Reaching the Last Resort.....	131

Justifying and Taking Coercive Action.....	132
Generalizability of Justifying Coercion.....	133
CHAPTER SIX: Conclusions and Implications.....	137
Implications.....	139
Recommendations for Further Research.....	141
Summary.....	144
Reference.....	146
Appendices.....	164

## List of Tables

Table 1: Assessment of Need.....	58
Table 2: Interpersonal Negotiation Techniques.....	69
Table 3: Justifying and Taking Coercive Action.....	83

## List of Figures

Figure 1: Justifying Coercion.....	48
Figure 2: Justifying Coercion in Involuntary Administration of Medication.....	56
Figure 3: The Context.....	109
Figure 4: Justifying Coercion in War.....	134

## List of Appendices

Appendix A: Involuntary Procedures In California.....	164
Appendix B: Interview Guide.....	174
Appendix C: Demographic Data.....	175
Appendix D: Participant Demographic.....	176
Appendix E: Committee on the Protection of Human Subjects Proposal Approval.....	177
Appendix F: Consent to Participate in Research.....	179
Appendix G: Information About the Research.....	180
Appendix H: Sample of Memos.....	181



## CHAPTER ONE

### Introduction

This grounded theory study delineates the process inpatient psychiatric nurses use to respond to the challenging nursing problem of medicating resistant involuntary patients. While psychiatric nurses certainly have other roles in caring for involuntary patients, medication administration, medication education, and monitoring the effects of medication are a significant part of a nurse's role. California nurses from a variety of psychiatric facilities in several different parts of the state were interviewed about the ways they responded to the challenge of treating resistant involuntary patients who were refusing medication. Their responses revealed a process of Justifying Coercion.

### The Problem

Involuntary procedures pose an ethical dilemma for psychiatric nurses. The problem is how to give appropriate nursing care to involuntary psychiatric patients who are resistant to accepting a diagnosis of mental illness and are refusing medications. Do the nurses support autonomy and self-determination by accepting the refusal or support treatment even to the point of engaging in coercion? Psychiatric nurses are the mental health professionals who are most involved with implementing involuntary procedures. Their assessments of behavior often form the basis of decisions to institute involuntary

restraint procedures (Davis, Aroskar, Liashenko, & Drought, 1997). Nurses carry out involuntary admission procedures, administer involuntary medication, deny rights, seclude and In psychiatric nursing texts (Frisch & Frisch, 1998; Stuart & Laraia, 2001; Varcarolis, 2002), involuntary procedures are addressed only as ethical dilemmas. As a result psychiatric nurses are routinely responsible for implementing involuntary procedures (Frisch, 1998) for which there is legal justification but no supporting theory or research.

In acute psychiatric inpatient settings there is a high proportion of involuntary patients.

Each year in the United States well over one million persons are civilly committed to hospitals for psychiatric treatment . . . Approximately two-thirds of these admissions are officially identified as voluntary commitments; the remaining one-third as involuntary actions.” (Durham, 1996, p. 17)

Every state has a different mix of voluntary versus involuntary admissions depending on a variety of factors (Monahan et al., 1999). In 1997 California had 106,314 admissions (approximately half the recorded psychiatric admissions) under 72-hour holds (Rand Corporation, 2001). California law specifies 72-hour holds as a form of emergency involuntary admission to a psychiatric facility for initial evaluation and treatment. (Appendix A details California law regarding involuntary mental health treatment.) With so many involuntary admissions, involuntary procedures are too significant a part of psychiatric nursing practice not to be addressed.

### *Context of the Problem*

In the care of the severely and persistently mentally ill (SPMI), involuntary hospitalization is used in an attempt to reduce the symptoms that arise because of noncompliance. Noncompliance, defined as failure or refusal to accept recommended treatment, has enormous consequences for SPMI. Noncompliance is estimated to account for about 40% of the \$100 billion mental illness costs the US economy each year (Flynn, 1994; Goldberg, 1997; Weiden & Olfson, 1995). Weiden and Olfson report that re-hospitalization rates for schizophrenics who stop taking their medications can be as high as 11.0% per month in contrast to rates as low as 3.5 % for those who are treatment adherent. Treatment refusal also has been cited as a contributing factor to murders committed by certain mentally ill individuals, stimulating legislative efforts to provide for outpatient involuntary commitment (Gutheil & Appelbaum, 2000). Treatment refusal has significant consequences; adequate treatment consistently has been proven beneficial (Lehman & Steinwachs, 1998).

Substantial evidence exists that early, appropriate and continuous treatment leads to improved outcomes in terms of mortality, morbidity and quality of life (Fenton, Blyler, & Heinssen, 1997; National Alliance for the Mentally Ill (NAMI), 1999). The guidelines for appropriate treatment of serious mental illness (APA, 1994; APA, 1997; Lehman, Carpenter, Goldman, & Steinwachs, 1995; Lehman & Steinwachs, 1998) are well established. There is, however, no universal “right to treatment” which guarantees that the mentally ill receive appropriate treatment. Only involuntarily committed mental patients must be provided with some form of treatment (Gutheil & Appelbaum, 2000). Families of the mentally ill represented by the National Alliance for the Mentally Ill

(NAMI) are outraged by the emotional and financial toll of trying to obtain appropriate treatment for the severely and persistently mentally ill (SMPI). Consequently, the Treatment Advocacy Center, an organization created by NAMI and concerned legislators are engaged in an effort to modify the laws governing involuntary treatment of the mentally ill to make it less difficult to force the mentally ill to accept treatment. This effort is controversial even within the ranks of NAMI (Mental Health Weekly, 1998) but is being vigorously pursued.

California's 1969 Lanterman-Petris Short (LPS) Act was the model for more restrictive laws across the nation (Davis, et al., 1997). California law restricts involuntary treatment to individuals whose mental illness constitutes a danger to self or others or renders them incapable of maintaining food, clothing, and shelter (Appendix A). In the last five years however, legislation has been repeatedly introduced to make the California's rules governing involuntary treatment less restrictive and to add involuntary outpatient commitment (IOC) to the involuntary procedures possible. The primary impetus has been to assure that resistant SPMI remain on their medications and participate in treatment. Assembly member Thomson, a psychiatric nurse, spearheaded the legislative initiative. In 2000, a bill (AB1800), which would have achieved both those objectives, passed the Assembly but failed to get to the Senate floor for a vote. Instead the California Senate commissioned the Rand Corporation to do a study on outcomes of involuntary outpatient commitment. That report (Rand corporation, 2001) did not support a definite benefit for IOC. The American Nurses Association-California (ANA-C) support of AB1800 (Hellinghausen, 2000) was not generally known, with nothing published or on the World Wide Web that outlined nursing's position. Four psychiatric

nurses interviewed about the proposed legislation were not aware of the bill's existence (Vuckovich, 2000). Two bills: AB1424 which required history to be taken into account in commitment proceedings, and AB1421 which allowed involuntary outpatient commitment if counties had services available, were introduced in 2001 and (AB1421 stripped of any funding to implement it) had become law by the end of 2002. The ANA-C web site ([www.anacalifornia.org](http://www.anacalifornia.org)) did not list the 2001 bills nor did the California chapter of APNA take a position (Personal communication, Lyn Marshall, Chapter President May 24, 2001). Psychiatric nurses were not visible in the debate, in spite of one of their own number introducing the legislation and a mandate from the American Nurses Association (ANA) *Code of Ethics* (2001) and the *Scope and Standards of Psychiatric Nursing Practice* (ANA, 2000) to participate in development of public policy.

Without research that establishes a clear long-term benefit of involuntary treatment and with an ethical mandate against coercion, organized nursing has difficulty agreeing on a position. The APNA established a task force in 1999 to investigate the evidence on IOC and to recommend a position. By fall of 2000 they had been unable to reach a consensus. Although the task force reported having reached a compromise position at the 2001 convention, the position statement was unpublished by the end of 2002. Such difficulty arriving at an evidence-based and ethical position highlights the need for nursing research on involuntary treatment, particularly the issue of forced compliance to medication.

#### *Purpose*

The purpose of this study was to develop a theory of the processes of implementing involuntary procedures. The specific aim was to discover the underlying

process a psychiatric nurse uses when he or she cares for a patient and subjects that patient to some form of involuntary treatment. Involuntary treatment is the global descriptor for a variety of specific acts, such as medicating a patient against his will, that constitute “involuntary procedures”. Each specific act is a human interaction in the context of the nurse-patient relationship. The goal was “to generate a theory that accounts for all aspects of a pattern of behavior that is relevant and problematic for those involved” (Glaser, 1978, p. 93): the nursing care of a patient before, during and after implementation of involuntary procedures.

#### *Limitations of Existing Theory*

Psychiatric nursing practice is historically based in Peplau’s (1952/1991; 1997) theory of the nurse-patient relationship. Regardless of what other theories psychiatric nurses use in their practice, therapeutic use of self is a foundation principle for most psychiatric nurses (Forchuk & Brown, 1989). Other theories and models have been developed that expand the understanding of the nurse-patient alliance (Hummelvoll, 1996) and the ways that the SPMI recover from psychosis (Erickson, Tomlin, & Swain, 1983; Murphy & Moller, 1998). These theories do not address coercion and do not mention involuntary procedures. Noureddine (2001) indicates that nursing theories have not addressed ethical issues explicitly and that there is little guidance in nursing theory for ethical decision-making.

According to the accepted standards of care (ANA, 2000) psychiatric nurses are expected to care for patients in the context of a therapeutic relationship and with respect for a patient’s dignity and autonomy. The ANA *Code for Nurses* (2001) and the newly revised standards of psychiatric nursing care (ANA, 2000) explicate that coercion is to be

avoided. Nursing's ethical positions regarding autonomy, adherence, behavioral change and therapeutic alliance, however are based on an underlying assumption of rational thought processes (ANA, 2000; 2001; Hummelvoll, 1996). Hummelvoll acknowledges that some mentally ill patients need others to make decisions for them and cannot fully engage in a nurse patient alliance and recommends *genuine paternalism* in such cases. Paternalism is defined as "unilateral decision-making by health care providers that implies they know what is best, regardless of the patient's wishes" (Aiken, 1994. p. 285). Ethics texts for nurses (Aiken; Davis et al, 1997; Husted & Husted, 1995) indicate that paternalism is unethical and recommend not using it as a basis for ethical decisions. The psychiatric nursing standards (ANA, 2000) acknowledge the need to set aside patient choices for safety's sake, but instruct the nurse to protect the rights of the patient as much as possible while restricting choice only as necessary. None of these recommendations assist the nurse to determine at what point a protesting individual should be forced to accept unwanted treatment.

Involuntary treatment beyond an initial evaluation period is generally reserved for those with serious mental illness. The relationship between a psychiatric nurse and an involuntary patient is complicated by four factors. The first two factors are related to the nature of mental illness and the other two factors are related to the involuntary nature of the relationship.

The two complicating factors caused by serious mental illness are: (a) behavior that is hard to interpret and (b) failure to interpret other's behaviors. Interpersonal process depends on the mutual identification of the meanings of interaction behavior (Charon, 1998). A therapeutic nurse-patient relationship is based on the nurse's ability to

understand the patient's behavior and make the nurse's behavior understandable to the patient. Psychosis can render a person both unable to consistently behave within culturally agreed upon patterns of interaction and unable to recognize and interpret others' behaviors (Moller & Murphy, 1998).

Major depression presents a different challenge to mutual interaction. The symptoms of depression include lack of attention, loss of emotional responses, and loss of will or interest in interpreting other's behavior (Varcarolis, 2002). These symptoms can cause a person's behavior to vary from easily recognizable patterns and reduce willingness and ability to recognize and respond to the nurse's behavior. Severity of psychiatric symptoms is linked with both the probability of involuntary treatment and the difficulty of establishing a therapeutic relationship (Frank & Gunderson, 1990; Inderbitzin, 1990).

The other two complicating factors are related to the power functions in involuntary treatment. The first factor is the marked power imbalance that results from involuntary treatment. The second is an ethical prohibition against using coercion.

In any inpatient nurse-patient relationship the nurse has significantly more power than a patient, being able to dictate many things about the patient's daily activities, the time and duration of interactions, and how much advocacy the nurse will do for the patient (Hewison, 1995). In involuntary relationships, the nurse has coercive power that is established by law, in addition to the power already inherent in the nurse's role, to force the patients to do things against their wills. The patient is involved in the relationship against his or her will and, thus, has no initial motivation to engage in relationship building. In fact the only power left to the patient is the power to resist.



At the same time, use of coercive power overtly violates the nurse's understanding of the proper nurse-patient relationship. Nursing is a profession based on the premise that the nurse provides care at the patient's instigation not that the nurse forces care on an unwilling recipient (ANA, 2000; 2001; Orem, 1985). Nursing care is provided as a response to a genuine patient need (Artinian & Conger, 1997). The lack of insight that is often a basis for treatment refusal involves explicit rejection of belief in any need for care. When the nurse perceives the need and the patient does not there is no basis for the therapeutic alliance or nurse-patient partnership that is the ideal (Arnold & Boggs, 2003; Artinian & Conger, 1997; Breeze & Repper, 1998; Hewison, 1995; Hummelvoll, 1996; Wilson & Hobbs, 1995). The nurse is confronted with a power imbalance that may increase patient resistance to relationship building, and with an ethical directive to refrain from using coercive power. The nurse is expected to provide nursing care that respects the patient's autonomy while simultaneously providing treatment that the patient is refusing.

#### Ontological and Epistemological Assumptions

The investigator is a psychiatric nurse with extensive experience in implementing involuntary procedures. She strives to maintain and teach evidence-based practice. As a nursing educator for many years, she is frustrated by a lack of material on involuntary treatment to assist in preparing her students for the challenges of acute care psychiatric nursing. She began the research with the aim of discovering the most effective interventions for the nursing care of involuntary patients.

#### *Influences on the Researcher*

As a nurse who was taught and now teaches basic nursing process, the investigator is deeply influenced by positivist, objectivist beliefs (Charmaz, 2000; Lincoln & Guba, 2000) about the nature of reality. This leads to an assumption that there are “real” chemical and structural changes in the brain that coexist with and may be the cause of the symptoms of mental illness. The basic problem solving or nursing process approach that is foundational in her understanding of nursing also informs her approach to research.

In addition, the investigator’s understanding of human nature and psychiatric nursing was shaped by the existential writings of Carl Rogers (1961), Gordon Allport (1955) and Sidney Jourard (1964) and the interpersonal theories of Peplau (1952/1991) and Sullivan (1953). The cognitive therapists Beck (1976) and Ellis (1973) and the transtheoretical writing of Prochaska and Norcross (1994) have also influenced her thinking about the nature of psychiatric illness and therapeutic relationships.

This combination of influences creates a perspective that an individual’s mental illness has biological roots but his or her experience of health and illness is grounded in history, culture, beliefs, and perceptions. That experience is ever changing and evolving influenced by internal construction of meaning and external social realities. This is a postpositivist, interactionist (Lincoln & Guba, 2000) view of the world that is congruent with Symbolic Interactionism.

### *Symbolic Interactionism*

Symbolic Interactionism holds that social processes derive from the interaction of individuals with the meanings they construct and the definitions they derive from their observations of the situation at hand. “Perspective” is the basic framework of symbolic Interactionism. The perspective of Symbolic Interactionism is that individuals act in

response to the symbols that they use to role take, communicate, think, and interpret another's acts. Persons' identities in social situations arise from labeling and attribution by themselves and others. (Charon, 1998)

"Mentally ill" is a symbolic identity that has meaning to a psychiatric nurse. The labeling of behaviors and symptoms that leads him or her to attribute such an identity to another person influences the nurse's actions in interaction with patients. "Mentally ill" is also a stigmatized, "spoiled" identity that a patient is reluctant to assume (Goffman, 1963). To understand the social processes that result in the implementation of involuntary behaviors requires discovery of the definitions of self and others and the choices of direction that are involved in the situations in which involuntary procedures are possible.

#### *Nursing Models*

The investigator practices a holistic, nurse-patient relationship model of psychiatric nursing. She believes that intimate involvement in a process with other human beings impacts all the participants and their relationships. Although influenced by other theories, particularly Orem's (1985) Self-Care Deficit Theory, the Murphy-Moller Wellness Model (1998) and The Intersystem Model (Artinian & Conger, 1997), her basic assumptions about psychiatric nursing are essentially grounded in Peplau's (1952/1991; 1997) work on the nurse-patient relationship. Since none of those models addresses the nature of involuntary care she perceives a gap in psychiatric nursing's theoretical base.

Committed to the understanding that nurses as health care providers have an obligation to raise their voices in national and local debates about health care policy, the investigator subscribes to a "Therapeutic Jurisprudence" philosophy (Winick, 1997) about mental health legislation. Therapeutic jurisprudence seeks to examine the law's impact on the mental health of the people it affects. It holds that all other things being equal, therapeutic effects are the proper aim of law and anti-therapeutic effects are undesirable and should be avoided. She believes that mental health law should work to the therapeutic benefit of the individuals it affects and is not supportive of extending the

governments' police power to control individuals without considerable proof that there is some benefit in doing so. She knows from experience that simply changing a law or rule will not necessarily change practice. She concurs with Applebaum (1994) that unless those who implement the laws are in agreement, changing commitment laws is not an effective way to transform practices around involuntary treatment. She is strongly committed to psychiatric nurses having a voice in mental health policy and legislation and sees that as an integral part of nursing practice.

The researcher is biased towards a belief in the efficacy of biological treatments in combination with relationship therapy as providing the best outcomes. She was in psychiatric nursing practice before there were multiple antipsychotic medications available and is convinced that the nurse-patient relationship has healing power separate from, and not reliant on, biological treatments. She has also witnessed the effectiveness of antipsychotic and mood-stabilizing medications and the multiple devastating exacerbations that can occur without medication. She strongly believes that for most SPMI medication is required on a routine basis for a lifetime. The impetus for this research was a desire to learn how nurses used the nurse-patient relationship to promote long-term medication adherence in patients who are initially resistant. She was concerned about the effects of the coercion involved in involuntary treatment on the long-term outcomes for involuntary SPMI patients.

She believes the only way to provide more effective psychiatric nursing for patients subject to involuntary procedures is for nurses to understand what nurses do that makes a positive difference. Nurses are known to be the primary contributors to inpatients accepting medication even though involuntary (Gutheil & Appelbaum, 2000; Susman, 1998). The technique used by nursing has been labeled bargaining or negotiating (Susman, 1994) but not clearly described in the literature. Nurses evidently learn how to manage difficult involuntary situations on the job (Fisher, 1989). The researcher (as an educator) finds that an inadequate basis for practice. She wants to be able to teach from a

base of theory and research. In the absence of established formal theory she looks to the experiences of practicing nurses for data with which to inductively derive substantive theory to guide clinical practice. She hoped to develop a substantive grounded theory upon which to base further clinical research.

#### *Rationale for Methodology*

There were no conceptual descriptions of the nursing interventions involved in implementing involuntary procedures that could be used to define variables for a quantitative study. The current context for implementing involuntary procedures in the United States is different from that in other countries and from that of this country even a decade ago (Segal, Akutsu, & Watson, 1998) so that most of the research which has been done is not or is no longer applicable to current psychiatric nursing practice. In the absence of clear descriptors of either context or process, a qualitative methodology was seen as appropriate (Morse, 1994).

Qualitative research enables us to make sense of reality, to describe and explain the social world, and to develop explanatory models and theories. It is the primary means by which the theoretical foundations of a social science may be constructed or reexamined. (Morse & Field, 1995, p. 1)

#### *Grounded Theory*

One research method that is appropriate to develop knowledge in the absence of existing theory is grounded theory (Chenitz & Swanson, 1986; Glaser, 1978; 1998; 2002; Hutchinson, 1993; Strauss, 1987). Stern says that the purpose of grounded theory “is to identify problems and discover what the actors themselves see as solutions” (1985, p. 153). Grounded Theory is based on the philosophy of Symbolic Interactionism (Milliken & Schreiber, 2001; Morse, 2001). To understand a social process such as the initiation and implementation of involuntary procedures, one must understand the perspectives of the participants in the process (Charon, 1998).

Grounded theory is a methodology designed to discover and conceptualize basic

social psychological processes (Hutchinson, 1993). It is specifically appropriate for capturing complex reality (Strauss, 1987). Implementing involuntary procedures is clearly a complex social process with multiple influencing factors and a variety of contexts. While initially the researcher anticipated that all involuntary procedures would be problematic for those involved, the method called for entering the field with an open mind and letting the problem emerge from the data (Glaser, 1998). The problem that emerged was that of medicating the involuntary patient.

### *Limiting the Focus*

As the current study progressed it became apparent that although other involuntary procedures are problematic at times, the ongoing daily concern of nurses working with involuntary patients is getting them to take their medication. Involuntary hospitalization was generally not a problem. In a setting that cares for involuntary patients the psychiatric nurses that remain for any length of time have come to an ethical position that involuntary treatment is “necessary” for some individuals. As one participant said, “if we didn’t have the involuntary status then we wouldn’t be able to help the people.”

In California the criteria for involuntary admission are clearly spelled out (Appendix A) and the nurses interviewed had a clear and consistent understanding of what to do if the criteria were not met. If they were in a position with power to approve or disapprove involuntary admission, they withheld approval. If the patient had been admitted and only the psychiatrist could release the patient, they would immediately advocate for the patient by “talking to the doctor”. If the facility or the psychiatric staff were consistently unresponsive to the nurse’s advocacy, the nurse would leave.

Another involuntary procedure that can be problematic is seclusion and restraint. During the implementation of new procedures to comply with the 1999 HCFA regulations and the changes in JCAHO standards (2000), however, the nurses in the study had all participated in education about seclusion and restraint. They were aware of the

profession's position on trying to obtain a restraint free environment (ANA, 1999, APNA, 2000) and knew their own agencies' policies and procedures. These nurses had examined and defined their personal beliefs about seclusion and restraint during the recent changes. Many of them expressed strong opinions on the subject, but they all knew what actions they would take if a situation arose that might result in seclusion and or restraint. Since such episodes were relatively infrequent occurrences on their units and they knew what to do, seclusion and restraint was not a daily concern.

What was a daily concern was how to help a person being held involuntarily become a person receiving effective treatment. In current psychiatric practice, medication is the treatment of choice for acute psychiatric illness (APA, 1997). Actual administration of medication is sometimes delegated to a Licensed Psychiatric Technician (LPT) or a Licensed Vocational Nurse (LVN), but the RN is responsible for all of the activities on the unit that are involved in getting an involuntary patient to take the prescribed medication. The process involved in medicating involuntary patients seemed to be the same as that used in other involuntary procedures but medicating involuntary patients is more prevalent, more ethically troubling, and potentially more important to long-term outcomes. Thus the study became focused on the experiences of psychiatric nurses in medicating involuntary patients and the purpose became to discover a theory of getting patients to accept unwanted medication.

## CHAPTER 2

### Literature Review

This study evolved from an interest in whether involuntary treatment promotes or hinders long-term adherence while guaranteeing short-term compliance among the SPMI. A literature search for peer reviewed journal articles in English from 1983 through July of 2002 was done using the databases available through Medline, CINAHL, ERIC, Dissertation Abstracts and OVID using key words compliance, adherence, psychotropic medicine, involuntary hospitalization, involuntary treatment, medication refusal, nursing ethics, psychiatric nursing, coercion, and consent separately and in combination. Additional searches were done for articles related to SPMI using the terms Schizophrenia, Bipolar Affective Disorder, psychosis, therapeutic relationships, and therapeutic communication. Online material was searched through links from professional nursing organizations' web sites. Searches for additional literature (books) were done through the catalogues of material available through the University of San Diego and the California State University library systems as well as the reference lists and bibliographies in the literature of interest.



North American nursing literature contains relatively little discussion of involuntary procedures. Much of the nursing literature on this topic comes from the United Kingdom, the Nordic countries, and Australia where psychiatric nursing practices and laws governing mental health care are different from those in the United States. The five Nordic Countries (Denmark, Finland, Iceland, Sweden and Finland) are cooperating in a multinational –multidisciplinary research project on involuntary psychiatric hospitalization (Hoyer, et al, 2002) that is reflected in the recent psychiatric nursing literature from there. Five articles in English (Hoyer, et al., 2002; Hummelvoll, 1996; Hummelvoll, & Severinsson, 2002; Olofsson, Gilge, Jacobsson, & Norberg, 1998; Olofsson, & Norberg, 2001) from the collaborating nations were included in this review. Playle and Keeley (1998) attribute the rise in interest in the topic in the United Kingdom to the 1995 Patients in the Community Act that authorizes nurses to return noncompliant psychiatric patients to the hospital. The nursing literature from all sources reflects little research on involuntary procedures. Most reported studies are qualitative.

When nursing participation in involuntary procedures is discussed in the literature from the United States, the procedure involved is most likely to be seclusion and restraint. Changes in the legal responsibilities of nurses brought about by changes in the law (HCFA, 1999) have resulted in increased writing related to seclusion and restraint without corresponding increases in literature related to other involuntary care. The APNA (2000) statement on seclusion and restraint is supported by an extensive bibliography, 89% of the citations from nursing literature. In contrast the ANA Center for Ethics and Human Rights (2000) bibliography on psychopharmacology, which is intended to address nurses' ethical questions about administering psychiatric medications, has only one 1981

nursing reference. There is very little in the nursing literature about administering medication involuntarily.

Involuntary procedures have been subject to debate in the psychiatric and legal literature in the United States since the 1860s. A number of reviews trace changes in practice over time. Gutheil and Appelbaum (2000) describe the alterations in societal perspectives. Durham (1996), Hiday (1992), and Kapp (1996) outline legal changes and the research designed to measure changes in treatment brought about by the changes in the law. This chapter reviews literature elucidating what is known about involuntary procedures in psychiatric care, focusing on medication administration. Particular attention is paid to nursing literature where it exists. Topics include (a) medication treatment of mental illness, (b) compliance /noncompliance, (c) therapeutic alliance, (d) coercion as an ethical dilemma in psychiatric nursing care, and (e) involuntary treatment, both hospitalization and medication.

#### *Medication treatment of mental illness*

Hospitalization without treatment is at the best custodial care and at its worst is essentially incarceration. For voluntary patients informed consent is required for treatment. For involuntary patients and criminals sentenced to psychiatric forensic units the law has essentially maintained that treatment must be made available but the patient cannot be forced to accept it without a determination of lack of capacity to consent (Appelbaum & Hogue, 1986; Gutheil & Appelbaum, 2000; Kapp, 1996; Winick, 1997). There is good evidence that over long episodes of care psychosocial treatment is effective but the primary expected treatment for an acute episode of mental illness is medication (APA, 1994; 1997). Lehman, Carpenter, Goldman, and Steinwachs (1995) summarized

the research on schizophrenia and concluded that adequate medication management plus appropriate psychosocial modalities lead to the best outcomes. Baldessarini, and Tondo (1998) reviewed a number of studies indicating that maintaining medication is essential for bipolar patients. Reviews of the empirical research literature conclude that early, appropriate and continuous treatment with psychotropic medication leads to improved outcomes in terms of mortality, morbidity and quality of life (Fenton, Blyler, & Heinsen, 1997; National Alliance for the Mentally Ill (NAMI), 1999). Patel and Hardy (2001) summarize the best practices position: medication improves the outcomes for SPMI patients and those with a first psychotic episode. They state that if consent is not forthcoming involuntary measures should be initiated.

The consequences of not taking medication are equally clear. 75% of those that discontinue their medication will ultimately relapse (Jarboe, 2002). Weiden and Olfson (1995) report that re-hospitalization rates for schizophrenics who stop taking their medications can be as high as 11.0% per month in contrast to rates as low as 3.5 % for those who are treatment adherent. Since medications make so much difference, gaining compliance is crucial.

#### *Compliance/Noncompliance*

The primary reason for involuntary treatment is noncompliance with recommended treatment. Noncompliance is defined as failure or refusal to accept recommended treatment. It has enormous consequences in severe and persistent mental illness (SPMI). Noncompliance is estimated to account for about 40% of the 100 billion dollars mental illness costs the US economy each year (Flynn, 1994; Goldberg, 1997; Weiden & Olfson, 1995).

A review of the empirical studies on compliance in schizophrenia (Fenton, Blyler, & Heinssen, 1997) indicated that the noncompliant patient has a 3.7 times greater risk of relapse. Baldessarini and Tondo (1998) report that discontinuation of lithium in bipolar patients leads to greatly and rapidly increased risk of reoccurrence of symptoms coupled with a 20-fold increase in life-threatening suicidal acts. Jarboe (2002) reviewed the research literature on psychiatric medications and estimated that 75% (Range 53-100%) of patients prescribed the older antipsychotics discontinued medication within two years. Fenton et al. and Jarboe make the point that rates of nonadherence to prescribed medication in psychotic illnesses are comparable to the rates of nonadherence in depression and physical illnesses. Psychiatric patients are not significantly less adherent than other patients.. The difference is that if a mentally ill patient refuses medication there are legal measures that can be used to force the patient to comply.

Some characteristics of SPMI patients who refuse or stop taking medications have been identified. There is agreement across the reviews of the compliance research (Dunbar-Jacob, Schlenk, Burke, & Matthews, 1998; Fenton et al., 1997; Haynes, McKibbon, & Kanani, 1996) that virtually no demographic data except age and degree of psychiatric symptoms predict adherence or noncompliance and that decisions about health behaviors are multi-faceted. Previous behavior is the best predictor of future behavior. Comorbid substance abuse is clearly a factor contributing to increased noncompliance in psychiatric patients (Fawcett, 1995; Fenton et al. 1997; Pages et al, 1998). Medication refusers in psychiatric facilities are sicker (higher scores on the Brief Psychiatric Rating Scale {BPRS}), younger, less socially supported, more likely to be male and more grandiose (Marder, et al., 1983; Zito, Routt, Mitchell, & Roerig, 1985).

Zito et al. found that early refusers were more likely to be bipolar or schizoaffective while persistent refusers were more likely to be schizophrenic. Studies that measure insight as a variable find that poor insight is statistically associated with noncompliance but a sizable subgroup adheres to medication in spite of poor insight. (Amador, et al., 1993; Baier & Murray, 1999; Buchanan, 1992; Fenton et al, 1997, Van Dongen, 1997). Dysphoric reactions to medication side effects are also related to noncompliance, particularly akathisia (a persistent motor restlessness with subjective distress) from neuroleptic medication and cognitive impairment and weight gain from lithium (Baldessarini & Tondo, 1998; Bowden, 1998). Buchanan (1992) found significant differences in compliance between voluntary and involuntary patients after discharge with involuntary patients less likely to comply.

In Illinois a state hospital embarked in a campaign to get the psychiatrists to file petitions as soon as patients refused medications for more than a week rather than waiting and found that there were improvements in the quality of care (Patel & Hardy, 2001). Their belief is: although involuntary medications may be perceived by patients as a negative event, there are clear indications that untreated patients fare worse than those that are involuntarily medicated.

In most instances if the patient can be persuaded to comply it will result from nursing interventions within the first week of hospitalization (Gutheil & Appelbaum, 2000). It would be desirable that those nursing interventions be evidence-based and replicable. However, in spite of over 14, 000 English-language articles on compliance (or adherence) through the year 1994 little insight has been gained into the key factors (Jarboe, 2002).

The consensus of the literature is that mentally ill individuals benefit from adherence promoting interventions in the context of a therapeutic alliance. No single intervention has showed a clear advantage compared with another and it is apparent that comprehensive interventions combining multiple components are more effective than single approaches (Dunbar-Jacob, Schlenk, Burke, & Matthews, 1998; Jarboe, 2002). There are indications that the newer medications may be associated with better compliance (Jarboe, 2002). Individuals with therapeutic alliances with multidisciplinary staff of comprehensive programs integrated across all treatment settings combining accurate diagnosis and prescription, case management, patient and family psychoeducation, long-term ongoing patient and family support services, and occupational and vocational rehabilitation services are more likely to adhere to treatment and have better outcomes (Faloon, 1999; Miklowitz & Goldstein, 1997; Pinikahana, Happell, Taylor, & Keks, 2000). In short, the more efforts the treatment team makes and the better the patient's therapeutic alliance with treating staff, the better the chances are for compliance. There is no single intervention that has been found better than the others.

### *Therapeutic Alliance*

Therapeutic alliance is the preferred term for an effective helping relationship. Therapeutic alliance is defined as a collaborative relationship between client and health provider in which the client believes that the health provider is genuinely interested in and knows the client and has the client's best interests at heart. Collaboration is defined as mutual decision making by patient and health care provider. Collaboration requires that the client's concerns be "voiced" and addressed and that the client has at least some say in the final decision (Hornung, Klingberg, Feldmann, Schonauer, & Schulze

Monking, 1998). Voice is defined as the opportunity and ability to present one's thoughts and feelings on the choices to be made (Susman, 1998).

Inderbitzin (1990) in defining therapeutic alliance with acutely psychotic patients discusses the importance of the client perceiving that the therapist's main interest is being helpful. He says making emotional contact is the first task of treatment and is clear that this must be done even in the face of decisions about involuntary treatment. Further he assumes that honesty, concern, empathy, respect, and acceptance of the patient on his or her own terms are integral to the therapeutic attitude that is necessary for the therapist to promote an alliance. He is willing to delay administration of medication in order to establish an alliance.

In outpatient practice with the SPMI population, nurses are advocating for a partnership model and empowerment of patients (Hobbs, Wilson, & Archie, 1999; Hummelvoll, 1996; Wilson & Hobbs, 1995) but Thorne and Patterson (1998) warn that in advocating for partnership models of management of chronic illness we must not ignore those who require expert professional control of their disease management. In the acute psychiatric hospital setting and at times when the psychotic patient's illness is manifest in significant impairment of reality testing, partnership models may be inappropriate.

Therapeutic alliance is a collaborative model in which the client's and family's voices are heard and their concerns addressed but the involvement of patient and family is not a reflection of equal power nor does it prevent the clinician from making appropriate although disputed decisions based on superior knowledge and clinical expertise (Hummelvoll, 1996; Treisman, 1997). Particularly in the first episode of psychosis when denial is to be expected and in periods where client noncompliance has

created a dangerous situation, the therapeutic nurse-patient relationship is more about caring and listening than about shared decision-making. Hummelvoll (1996) acknowledges that her nurse-client alliance model is not appropriate for involuntary patients and suggests that the emancipatory action approach and the partnership model are also inadequate for acute episodes. A therapeutic nurse-patient relationship is expected, however, even if illness and system constraints impede a genuine therapeutic alliance. The mid-range theories that support psychiatric nursing practice (Erickson et al., 1983; Hummelvoll, 1996; Murphy & Moller, 1998; Peplau, 1952/1991; 1997) are all based on a therapeutic nurse-patient relationship.

#### *Qualitative research*

Older studies such as Wilson's (1983/1986[data collected in the 1970s]) and Fisher's (1989) grounded theory studies of nursing practice in psychiatric settings described treatment decisions regarding involuntary procedures in their study settings being negotiated among members of the staff without including the patient in the process. In fact Wilson says,

Sorting decisions with fateful consequences for patients are based on the noncredibility assumption. The fact that the patient has gotten himself into the hospital is used as evidence that the patient is not managing. The likelihood that his or her story will be received as credible is very slim . . . (p.187)

Recent qualitative studies of patient experiences of involuntary treatment in the United States (George & Howell, 1996; Joseph-Kinzelman et al., 1994; Susman, 1998) concluded that nursing approaches that provide opportunities for patients to understand and have a voice in their treatment prior to implementation of involuntary procedures



favor development of a therapeutic alliance. Therapeutic alliance between caregivers and the SPMI patient were reported to promote adherence to treatment and positive outcomes (Forchuk & Brown, 1989; Wilson & Hobbs, 1995). Olofsson and Norberg's (2001) participants said that a good relationship between the nurse and a patient made coercion less likely and less restrictive but that use of coercion did not break an established relationship. Participants in that study believed a therapeutic alliance to be possible in involuntary treatment but there is a mention of "many years of work" (¶ 30).

Olofsson and Norberg (2001) found in their interviews with nurses, physicians and patients that nurses believed that if they had a "good relationship" with the patient they felt that they had done the right thing in using coercion. The participants in that study said that even in a legally coercive situation, building a therapeutic relationship remains possible although it may not always happen.

#### *Outcome studies*

In studies measuring how therapeutic alliance correlates with outcomes (Frank & Gunderson, 1990; Marder, et al., 1983; Mohl, Martinez, Ticknor, Huange, & Cordell, 1991; Tehrani, Krussel, Borg, & Munk-Jorgensen, 1996) alliance was measured by items reflecting positive affect, sense of being understood, working within the relationship, and belief that the treatment and the treatment provider are working in the best interests of the patient. In these studies the strength of the alliance was positively correlated with improvement in outcome.

Susman (1998) studied the procedures leading up to involuntary medication administration. Nurses took the patients' statements into account, while psychiatrists did not. This was credited for the patients' preference for the nurses' approach. Evidently in

his study setting nurses communicated that patients had a role in decision-making. He concluded that the nurses' listening, tact, and willingness to negotiate reduce the likelihood of violence. Allowing the patient a "voice" may not be considered a full therapeutic alliance, but a patient's perception that he has been treated fairly is a step towards the trust required for an alliance.

Swensson and Hansson (1999) found that strength of therapeutic alliance was directly correlated with specific curative factors in each stage of therapy. In the discharge phase therapeutic alliance was correlated with the patient's problem solving capability, an important predictor of readiness for discharge. Frank and Gunderson's (1990) study reported that six months (a mean of 3.9 months inpatient) of psychotherapy were necessary to establish a therapeutic alliance with schizophrenics

#### *Coercion: Ethical Considerations*

There is no question that involuntary care involves coercion. Since the days of Goffman's 1961 book *Asylums*, there have been reports in the psychiatric, legal, and social science literature about coercion in psychiatric care. Although there is good evidence that "soft coercion" or "extra legal" coercion exists even in voluntary admissions to the hospital (Hoge, et al., 1998; Prescosolido, Gardener, & Lubell, 1998) and the experiences of voluntary patients after admission (Nicholson, et al., 1997), Nicholson et al. found that there were significantly higher amounts of perceived coercion experienced by involuntary patients. In their study, although 93.9 % of those participating indicated that the treatment helped them in spite of the coercion experienced, 2/5 of their original sample did not participate and those who did not were more likely to be

involuntary. There is no question that coercion exists in involuntary care and it is apparent that coerced care benefits many of those subject to it.

Davis et al. say, “The single most important factor in the intelligent use of such techniques is an ethically grounded clinician, who for moral reasons hesitates in order to think through the clinical and ethical implications of his or her actions” (p. 205).

Leung (2002) says that the traditional balance of beneficence versus autonomy is too simplistic and inadequate. The Davis et al. book *Ethical Dilemmas and Nursing Practice* (1997) has an entire chapter on “behavior control” and never gets beyond defining it as a dilemma. They say that the basic ethical problem is how to maintain personal liberty when suppression can be rationalized by both the common welfare and the person’s happiness. They identify the possibility that involuntary treatment might be used to control deviant behavior rather than to act in the best interests of the patient. They point out that psychiatric nurses are the primary source for information that determines whether or not patients are subject to coercive measures. They warn against not taking the patient seriously and point out the value of autonomy. They see the question that must be resolved as whether a person has a right to personal integrity: being himself or herself even if deviant or dangerous. The basic position they take is that only society’s obligation to protect its members justifies coercion and that only dangerousness creates a need for society’s protection. They point out dangerousness is hard to predict and give no guidance on determining when coercion may be used.

Liaschenko (1995) says that “acting for” the patient can be ethical as long as the nurse is acting to preserve the “integrity of the self” but then adds, “How does a nurse

know what actions are in keeping with the integrity of the self” (§ 40). She says the most significant question is the worthiness of the ends acting for is intended to accomplish.

Psychiatric nursing texts (Boyd, 2002; Frisch & Frisch, 1998; Stuart & Laraia, 2001; Varcarolis, 2002) identify the dilemma but make no suggestions as to how to reach a solution. Stuart says, “Obviously, there are no simple or perhaps even equitable solutions to such clinical dilemmas, yet they are real and ever present. All mental health professionals must focus on prevention.” (p.181) Boyd alternates between saying,

In certain instances people with mental disorders are unable to make sound decisions regarding their treatment and care. Fortunately, certain laws protect them from their own poor decision-making abilities. (p. 43)

And

There are strong arguments against forced treatment under these circumstances. Forced treatment denigrates individuals and according to self-determination theory, individuals are not as likely to experience treatment success if it is externally imposed. (p. 45)

Clearly, at this point psychiatric nurses have no guidance other than state laws and their own consciences regarding when coercive practices are permitted. Oriol and Oriol made this point in 1986 when federal case law started to support the right to refuse treatment and Smith reiterated it when discussing the new laws regarding IOC in 1995. Both articles refer to the nurse as the individual in the best position to protect patient rights. The nurse is expected to protect the patient from unnecessary coercion and apply coercion when required. The legal requirement for least restrictive choices makes coercion a last resort but lack of viable alternatives is a constant limitation on preventing

coercion.

### *Involuntary Treatment*

Although Faloon (2001) and Lehman et al. (1995) advocate for comprehensive treatment including appropriate medications, the schizophrenia PORT study (Lehman & Steinwachs, 1998) indicated that for schizophrenia the best practices were not being widely implemented. It was this clear conviction that the best practices are well known but not actively implemented that sparked NAMI's (1999) *PACT across America*. One of the platforms that NAMI (2001) espouses is the need for increased accessibility of both inpatient and outpatient involuntary treatment. The strong belief that it is necessary to get SPMI patients to take their medications is the impetus for their efforts to change mental health laws and increase legislative appropriations to ensure the availability of involuntary treatment. However another organization that focuses on mental illness: the National Mental Health Association (NMHA) is opposed to use of involuntary procedures except as a last resort when there is imminent risk of danger or a person is substantially incapable of self-care (NMHA, n.d.) and is opposed to IOC and any expansion of the ability to treat people involuntarily. NMHA's position is that coerced treatment is ineffective compared to voluntary treatment and that legislative focus should be on increased funding for voluntary treatment and psychiatric advance directives that allow patient choice even when lacking capacity.

In the United States the nursing literature currently addressing involuntary treatment is primarily focused on seclusion and/or restraint. The ANA, the International Society of Psychiatric-Mental Health Nurses (ISPN) and APNA have developed positions. The ANA in its testimony to JCAHO stated its position as "Only when no other viable option is available should restraint be employed"(1999b, p. 9). The APNA, citing 35 contemporary (within the last 10 years) articles regarding seclusion and restraint including both qualitative and quantitative nursing research, published a "Position

Statement on the Use of Seclusion and Restraint” in May of 2000. The organization’s position is one of commitment to the reduction of seclusion and restraint and advocacy for research to support evidenced based practice for prevention of behavioral emergencies. APNA said, “Seclusion or restraint must be used for the minimal amount of time necessary and only to ensure the physical safety of the individual, other patients or staff members and when less restrictive measures have been proven ineffective”(p.19). The ISPN’s position (ISPN, 2000) is virtually identical although it warns against blanket adoption of a “zero tolerance policy”.

*Involuntary hospitalization.*

Views on involuntary hospitalization range from Szasz’s (1997) indictment of all coercion because mental illness is a construct by which society attempts to deal with deviance rather than a true illness to the biological perspective of schizophrenia as a neurodegenerative disorder with cognitive deficits that it is unethical not to treat. The premise upon which involuntary hospitalization is based is that forcing compliance in the immediate situation will result in therapeutic outcomes among which will be future treatment adherence (Winick, 1997).

Quantitative outcome research is limited. Hiday (1996) in her review of the research on coercion in civil commitment says that post discharge attitudes of those involuntarily hospitalized have been found to be predominantly positive particularly in those who have experienced significant reduction in symptoms. However, her review of the studies cites findings that a substantial minority (in Kane, Quitkin, and Rifkin [1983] 42.9%) felt that involuntary hospitalization, the physician, and their medication were not helpful. She concludes that there is insufficient empirical evidence to support the efficacy of involuntary hospitalization. Nicolson et al (1997) found no evidence that outcomes for “coerced” patients were worse than those not “coerced” and that 94% rated their treatment as helpful. They found coercion (defined as requiring involuntary treatment) correlated to higher functioning at discharge and speculated that perhaps individuals who

protested treatment had retained more ego strength than those who complied.

Four major reviews of the empirical research of the outcomes of involuntary treatment (Appelbaum & Hoge, 1986; Durham, 1996; Maloy, 1996; Rand Corporation, 2001) each found that there were few quality studies. All four reviews concluded that the existing literature provides no empirical evidence that involuntary treatment solves compliance problems or improves long-term outcomes. Research on outcomes of involuntary hospitalization shows little difference within an episode of treatment between those admitted and agreeing to medication voluntarily and those who are involuntarily treated (Hiday, 1992; Nicholson, Ekenstam, & Norwood, 1997). A recent Israeli study (Fenning, Rabinowitz, & Fennig, 1999) showed that those initially hospitalized involuntarily are likely to be hospitalized involuntarily again on subsequent admissions while those initially voluntary are likely to remain so no matter how often hospitalized. Otherwise voluntary and involuntary courses were not significantly different. In the United States, where treatment is not equally available to all (NAMI, 1999), the long term courses for those refusing treatment and not treated involuntarily, those treated involuntarily in the public sector, and those treated in the private sector either voluntarily or involuntarily have not been directly compared.

In 2000, Lidz, Coonz, and Mulvey found that psychiatric emergency room decisions about involuntary hospitalization were almost always contextual, rather than clinical. In the setting studied, a nurse-clinician did the initial screening, and then a psychiatrist reviewed the nurse's findings, interviewed the patient and made a disposition. The researchers did qualitative text analysis on 100 observer-recorded interviews to determine salient variables and then used logistic regressions to analyze the data. They found what they called a "pass-through" model of assessment where the most salient predictor of disposition in their hierarchic regression analysis was who brought the patient in: self, family, or police. Police referred patients were most likely to be admitted. Chronic patients requesting admission were often not admitted despite their request.

Anderson and Eppard's (1995) psychophenomenological study of clinical decision making for involuntary hospitalization described a process for involuntary commitments.

The process of clinical decision making for involuntary psychiatric admission is systematic, cautious, and individualized. It is important to connect with the client and use intuitive reasoning. State-mandated criteria must be met, and treatment alternatives must be considered. All contingencies cannot be controlled. The decision to involuntarily admit a patient is never made alone. (p. 727)

Engleman, Jobes, Berman and Langbein, (1998) found that when patients meet legal criteria, clinician attitudes about commitment, knowledge that there were available beds, and mobile response location of the assessment were significant indicators of the likelihood of patient involuntary detention. Clinician attitudes for or against commitment operated in the direction the attitude predicted. Knowledge that beds were available and mobile assessments increased the probability of commitment.

Holly Skodol Wilson (1983/1986) did a nursing grounded theory study of a California acute inpatient service in the 1970s that showed a very similar pattern of post admission decision-making and disposition for involuntary patients. She called it "dispatching". Wilson describes the process of "usual hospital treatment in the 1970's" as "processing patients through a clearinghouse" (p. 184). Stages of dispatching include "piecing a story together," "the holding pattern," "sorting and stamping with a label," and "distributing." As Wilson describes routine hospital care in the community mental health system at that point in time, she describes a process of interacting with patients that is focused primarily on figuring out where the patient belongs once discharged from the hospital. Little time or attention is paid to active nursing interventions. Wilson concluded that the pressure to move the patients rapidly out of the inpatient setting coupled with insufficient and highly selective outpatient alternatives created a system in which



nursing's primary responsibility was deciding on and justifying the decisions about involuntary status and discharge placement that would enable the facility to move the patient elsewhere. She says, "There is not even any pretense at keeping up the "individualized" rhetoric." (p. 186). She suggests research into "the processes and patterns of interaction that limit self-care and self-determination wherever they occur." (p. 188) The context of care has changed since this study in the 1970's but there remains pressure to discharge rapidly (Segal, Akutsu, & Watson, 1998). No recent research was found from the United States regarding inpatient psychiatric nurses' perceptions of involuntary hospitalization.

Two nursing studies focused on patient experience of involuntary hospitalization: Joseph-Kinzelman, Taynor, Rubin, Ossa, and Risner's 1994 exploratory descriptive study and George and Howell's 1996 phenomenological study. Joseph-Kinzelman et al. found clients experienced fear, anxiety, and confusion during the admissions process. They wanted information and support, but were often too anxious to participate actively in the admission procedures. Patients experienced the court hearings negatively and felt anger, sadness and a trapped feeling rather than a sense of due process or being heard.

George and Howell (1996) identify themes of frustration at lack of collaboration and loss of control that accompanied involuntary hospitalization in their interviews with five schizophrenic clients and their caregivers. They also identified themes of relief, hope and an opportunity for medication restabilization. The clients in their study experienced the coercion as a trade off for safety. The researchers conclude their report with recommendations for interventions to give the client and family more voice in the treatment plan.

### *Involuntary medication*

Nursing research on involuntary medication is scarce. Nurses' roles in involuntary procedures have been discovered mostly as aspects of a study of something else. Gutheil and Appelbaum (2000) refer to a neglected finding that nurses are a critical factor in

resolving medication refusals but did not cite the study. Susman (1998) studied patients undergoing hearings to determine if they should be involuntarily medicated. He found that most resolution of medication disputes depended on the nurses' negotiation style.

A recent grounded theory study from Australia (Watters, 2000) uncovered a theory of a social control process in the nursing care of psychiatric patients. He labeled the basic social process they discovered "regulating". The phases of regulating included "inducting," "labeling," "negotiating," "taking charge," and "disengaging." At its most coercive regulating includes involuntary practices they called "constraining."

"Constraining refers to the use of force sufficient to produce the desired result" (p. 424) and involves administering medication to patients against their will. It is one of sub-processes of taking charge. The other sub process is "Threatening." This research, coming from Australia, is reflective of a completely different context than that generally found in American settings where, except in emergencies, due process is required before giving medications by force.

Schwartz, Vingiano, and Perez (1988) discovered that 70.8% of 24 individuals who were medicated against their will later believed the decision was correct. Hiday's 1992 review of outcome studies cited similar results. There is no reported research on United States nurses' perceptions of the experience of involuntarily medicating patients. Swedish nurses were troubled by using coercion to administer injections (Olofsson, Gilje, Jacobson, & Norberg, 1998). They found that the nurses did not question the need for coercion but were disturbed by having to participate and focused on mitigating the coercion by using the gentlest techniques possible.

Research from other countries (Hummelvoll & Severinsson, 2002; Olofsson, et al., 1998; Olofsson & Norberg, 2001; Roe, Weishut, Jaglom, & Rabinowitz, 2002; Watters, 2000) indicates that nurses in the settings studied are generally unquestioning of the need for coercion and buy into an ethic of control. They are bothered by the need to exert coercion but feel they have no other choice. Hummelvoll and Severinsson say that

the nurses in their study of caring for manic patients displayed “genuine paternalism”. Genuine paternalism is acting on the basis of hypothetical consent, assuming that the patients would consent if they were well enough to understand what was genuinely in their interest. They reframed their coercive actions as “caring deprivation of liberty”. This allowed them to perceive the coercive actions as being consistent with a therapeutic relationship.

### *Critique*

Rand Corporation (2001) critiqued the research on outcomes of involuntary treatment as being equivocal. There were insufficient quality studies to determine whether involuntary treatment had any long-term benefit. Sample sizes, lack of true comparison groups and questions about the representativeness of the samples were all noted. Unfortunately, involuntary patients and sicker patients were more likely to refuse to participate in the studies. This means that it not possible to rely on their data as evidence that the “sickest” involuntary patients actually had similar outcomes to voluntary patients or found their treatment helpful.

It is critical to note that all but the most recent studies of the impact of involuntary treatment have been conducted with subjects who had significantly longer stays than is current practice. Studies initiated prior to 1990 were likely to report stays substantially more than 30 days; one 1985 study gave median length of stays of 117 and 211 days (Zito, Routt, Mitchell, & Roerig). Segal, Akutsu, and Watson’s (1998) study of involuntary recidivism had an average length of inpatient stay of six days and Pages et al. (1998) reported a mean 11.37 day stay ( $s = 8.86$ ) for regular discharges and a mean of 6.41 days ( $s = 6.01$ ) for those who left AMA. Rand corporation (2001) reported a median hospital stay of six days for their 1997-1998 California sample of involuntary patients hospitalized more than once. There needs to be a good deal more empirical research before the efficacy of current forms of involuntary treatment can be established.

As far as nursing research is concerned, the qualitative studies of patient

experiences (Baier & Murray, 1999; Breeze & Repper, 1998; Chafetz, 1996; George & Howell, 1996; Hobbs, Wilson, & Archie, 1999; Hutchinson, 1993; Joseph-Kinzelman, Taynor, Rubin, Ossa & Risner, 1994; Olofsson & Norberg, 2001; Van Dongen, 1997; Vellenga, & Christenson, 1994) are beginning to form a pattern of client perspectives on involuntary treatment. Across studies there are themes of anxiety, fear and humiliation during involuntary admission, lack of insight into the illness but willingness to be helped, resentment at being controlled but “giving in” to the system, and finally appreciation for nurses who care, who listen, who are respectful and who allow as much choice as possible. Much more needs to be done, but the published studies seem credible.

There are very few studies of nursing experiences and nursing interventions in involuntary care of adults other than those of seclusion and restraint. Those that there are (Hummelvoll & Severinsson, 2002; Olofsson et. al. 1998; Olofsson & Norberg, 2001; Watters, 2001) are not from the United States. There is a gap in psychiatric nursing understanding of the care of involuntary patients. Except for Davis et al. (1997), the subject has rarely been addressed in the United States nursing literature outside of psychiatric nursing texts. The research to support best clinical practices has not been done since new medications and managed care have changed the environment. Research based theories such as *A Wellness Approach* (Moller & Murphy, 1998) do not address involuntary treatment. There is no consensus on the ethical issues and no research that has described the ethical problem solving that psychiatric nurses use to resolve the conflict between avoiding coercion and participating in involuntary medication administration. There is not even an attitude survey that reveals what American psychiatric nurses think about involuntary care and how often they participate in coercive practices. There is a great need for research on nursing involuntary patients.

Throughout the nursing ethics literature there are themes of advocacy, self-determination and empowering patients. Coercion is deplored and only to be used as a last resort. Compliance is to be secured through therapeutic alliance (Evangelista, 1999).

Alternatives to coercion are to be actively sought. Playle and Keeley (1998) express the general consensus that nurses should aim for negotiation rather than coercion and avoid exercising their power to control patients or enforce compliance. There is little literature to examine the situations in which coercion is ethically justified. Nurses who work in environments in which coercion is an inevitable consequence of involuntary treatment need research and theory that illuminate the situations they face.

Involuntary care and particularly involuntary medication administration presents an ethical conflict. Research shows that SPMI patients benefit from antipsychotic and mood stabilizing medication. Other studies demonstrate that a least a portion of individuals with schizophrenia and bipolar disorders have cognitive deficits that reduce their capacity for autonomous decision-making. Believing that a therapeutic alliance is essential in obtaining patient adherence and with an ethical mandate to preserve patient self-determination, psychiatric nurses must deal with the challenge of providing involuntary care to between a third and a half of all inpatients and many outpatients. How they deal with this challenge is a question that needs to be studied.

## CHAPTER THREE

### Methodology

The study was designed as qualitative research using grounded theory methodology. Grounded theory methodology was chosen because of the lack of existing theory related to the psychiatric nursing problem of caring for resistant involuntary patients. “If little is known about a topic and few adequate theories exist to explain or predict a group’s behavior, the grounded theory method is particularly useful” (Hutchinson, 1993, p. 182). This chapter will provide an overview of the research design, describe the data collection and analysis techniques used, and outline the procedures used to ensure theoretical rigor and human subjects protection.

### *Research Design*

The study used Glaser’s (1978; 1992, 1998) grounded theory methodology to concurrently collect and analyze data regarding nurses’ experiences implementing involuntary procedures. This process is called constant comparison. Data were collected primarily by interview. However observations, discussions with peers both in a grounded theory work group and as experts reviewing the findings for creditability, and literature review contributed to the data. All data were entered into a QSR NVivo® 1.3 (2001) qualitative software program, and coded. Coding was done at three levels and continued until a core category emerged. Once the core category was confirmed by constant comparison of categories and theoretical sampling, selective coding of the data continued until all categories were accounted for as properties of the core category and saturation of

the category was achieved. Memos were written throughout data collection and analysis to capture the process of the analysis. Memos and codes were sorted and combined until all the data could be explained as a basic social process labeled Justifying Coercion that accounted for all the variation in the data (Glaser, 1978). A methodologist and a grounded theory research group reviewed each step of the research process to ensure that grounded theory methods were appropriately applied and the theory resulting was actually grounded in the data.

#### *Data Collection*

The investigator began data collection by interviewing psychiatric nurses selected because they were engaged in inpatient psychiatric nursing within the State of California. The sample of those interviewed was limited to nurses from a single state because state law governs involuntary procedures and the law differs from state to state. (The pertinent statutory procedures for California can be found in Appendix A.) An interview guide was used to prompt the investigator to enquire about issues that had emerged from the literature and earlier interviews. The interview guide evolved as the study progressed but eventually took a stable form (Appendix B).

*Data Management.* Interviews were audio-recorded. Although Glaser is opposed to taping, preferring to rely on his memory of the interview and immediate recording of field notes (1998), the methodological consultant and other nurses who are grounded theorists (Morse, 2001, Schreiber, 2001) find taping to be appropriate. The investigator was not willing to rely on unaided memory to accurately reflect the content of each interview. The investigator recorded in memo form observations made during the interview immediately following each interview. The investigator transcribed the initial four interviews, which comprised the pilot study. For efficiency, subsequent tapes were sent to a transcriptionist familiar with grounded theory interviews for transcribing. Before a tape was forwarded to the transcriptionist, the investigator listened to the tape to get a general impression of the interview without the distraction of the interview process and

added notes to the observational memo if additional ideas came to mind.

Glaser (1998) says that all information derived from a substantive area of investigation is data. In this study data included transcribed audiotapes, demographic data forms (Appendix D), and the interviewer's observational notes of unstructured interviews with psychiatric nurses who care for involuntary patients. Additional data were derived from informal conversations with psychiatric nurses that were recorded in notes and memos by the researcher and from literature related to the concepts emerging from the interviews. Peer discussions in a grounded theory research group and two experts review of the early findings also contributed to the data.

As the research progressed, all conversations about the research were either tape recorded and/or recorded in memos. Memos and pertinent articles were added to the database as if they were transcripts and coded as data. Data collection continued until there were no new codes emerging and the over 200 initial codes had been consolidated into 16 major concepts that were properties of the core category Justifying Coercion..

*Participants.* In grounded theory sampling refers to selecting particular pieces of data or particular sources of information for constant comparison (Glaser, 1978). Consequently the sample consists of data rather than participants. In this study transcripts of interviews with 17 participants were the primary source of data.

Participants were all Registered Nurses currently practicing in California psychiatric facilities that evaluate or treat involuntary patients. Participants were recruited through approaches to the nursing departments of private psychiatric facilities that contain locked psychiatric units and admit both voluntary and involuntary patients and through announcements to inpatient psychiatric nurses through the investigator's professional networks. One participant responded directly to an announcement on the list serve of the California chapter of APNA. Six participants were recruited through a psychiatric nursing conference.

Each participant was asked to provide simple demographic data (Appendix C)



such as age, sex, ethnicity, length of experience with mental illness, and amount of experience with involuntary procedures. Nurses were asked to provide general data about their current position(s) in nursing. Four interviews from a pilot study were included in the sample as it was impossible for the researcher not to be informed by the transcription coding and analysis that had already taken place.

Seventeen registered nurses (Appendix D) were interviewed. All were currently or recently employed in an inpatient psychiatric facility accepting involuntary patients. They practiced in seven different California counties in both northern and southern areas of the state and one was a traveling nurse who was licensed in several states. There were 5 men and 12 women. Eleven were Caucasian. The remaining six were equally split between Asians, Latinos, and Blacks.. The average age was 45 (Range 26-63). All were psychiatric nurses, but they varied in education and experience. The initial nursing preparation of most participants was an associate degree in nursing. One started in nursing as a military corpsman and another as a Licensed Vocational Nurse (LVN). At the time of interview seven had advanced education, but six had no additional education beyond their original degree. The average number of years of psychiatric experience was 13.3 years. One nurse had only 18 months of experience and two had over 30 years in psychiatric nursing. The facilities they worked in varied from a private for profit freestanding hospital to a county jail. There were two nurse educators. Several nurses had more than one position. All participants were self selected as individuals willing to participate in research and interested in sharing their experiences with the researcher as they did so on their own time and without compensation.

#### *Data Analysis*

All transcripts, memos, and other data were entered into a QSR NVivo® 1.3 (2001) software program. The analysis began with open coding as soon as a transcript or other form of data was entered into the program. “Coding is the general term for conceptualizing data. . . . a code is the term for any product of this analysis”(Strauss,

1987, pp. 21-22). Thus, codes are words that serve as labels for various ideas, actions, situations and results of actions described by participants. Initial coding was line-by-line and concept-by-concept. As concepts emerged from the data the concepts were constantly compared to one another and the incidents from which the concepts were derived were reviewed iteratively looking for similarities, differences, and relationships between concepts. Analysis was done concurrent with data collection. Theoretical memos (narrative notes that describe the emerging theory) were written describing the researcher's thoughts, feelings, hypotheses, questions and speculations (Hutchinson, 1993; Stern, 1985; Strauss, 1987). Memoing was a constant form of analysis. Memos were written to capture the thinking and discoveries at each instance of comparison. Other memos were written to document and audit the progress of the research and verify the research process that was used. A sample of memos can be found in Appendix G.

As coding progressed, codes were developed at more abstract levels, linked, combined, condensed and discarded to develop categories or Level II codes and then theoretical constructs or Level III codes (Hutchinson, 1993) Each code was defined, categorized in terms of its theoretical family and sorted for relationship to other codes. Models were developed of possible patterns. The initial models were extremely complex and had little explanatory power but served as a starting point for discovering a process.

As each new transcript became available it was compared with all the previous data for patterns, recurrences and variation. Observational memos, theoretical memos and proxy documents for literature containing relevant data were also entered into NVivo for coding and comparisons. Each code was identified by a set of attributes and codes with identical attributes merged and redefined until only those concepts that could not be subsumed into another remained as categories.

In grounded theory saturation is defined as the point at which no new variables or relationships among variables are discovered and all new data are repetitious of that already analyzed. As more and more data are analyzed core processes are identified that

explain and define what is happening. Each core process is then explicated until all its properties are identified and a narrative can be constructed using the core processes to describe in an understandable manner the essence of the social process that is being investigated. This explanatory description becomes the theory of the process (Glaser, 1978).

Glaser stated, “The generation of theory occurs around a core category” (1978, p.93). The core category can be any kind of theoretical code that accounts for most of the variation in a pattern of behavior and resolves the problematic nature of the pattern. Criteria for determining a core category include: (a) the category is central, (b) reoccurs frequently, (c) relates easily and meaningfully with other categories, (d) has implications for formal theory, and (e) is completely variable. In this study the core category turned out to be the basic social process (BSP) of Justifying Coercion. All the data were reviewed to determine if Justifying Coercion was apparent in all 17 interviews, related to all other categories, and reflected in all other data to determine that saturation had been achieved.

“A process is something which occurs over time and involves change over time” (Glaser, 1978, p. 97). A basic social process is a core category with at least two clear emergent stages “that differentiate and account for variations in a problematic pattern of behavior” (p. 97). “The transition from one stage to another is ordinarily contingent upon one or more things happening. This contingency may be in the form of a critical juncture - a period of time between stages when the occurrence or non-occurrence of a particular critical event will determine whether a new stage is entered or the previous stage maintained”(p.99). With three stages and two critical junctures Justifying Coercion meets the criteria for a BSP. Of the possible core categories that might be discovered, basic social processes are the core categories most likely to transcend the substantive unit and have potential for development of formal theory.

### *Ensuring Theoretical Rigor*

Criteria have been defined for ensuring the validity of qualitative research findings. Rigor is judged by the accuracy of the representation of the participants experience and can be described in terms of credibility, dependability, confirmability and transferability (Lincoln & Guba, 1985; Streubert & Carpenter, 1995. Sandelowski (1993) says rigor is about fidelity to the spirit of qualitative work.

Grounded theory is judged by the extent to which it meets its central criteria: fit, relevance, work, and modifiability (Glaser, 1992). “ Fit is another word for validity which means does the concept represent the pattern of data it purports to denote “ (Glaser, 1998, p. 236). Relevance means the theory answers a question of importance in the substantive area where the data were collected, and has impact because it describes a resolution of a complex and continuing problem (Glaser, 1998). Work indicates that the theory explains how something is resolved in a way that is useable because it organizes and makes meaningful multiple incidents (Glaser, 2002). Modifiability is the property of being able to incorporate changes in context and substantive area. It is abstract from time, place, and people and thus has enduring power to explain. It has “grab” (Glaser 1998; 2002).

To ensure that the theoretical sampling, data collection and data analysis were creditable and dependable, an experienced grounded theorist agreed to review and audit the processes. Everything that was done or decided during the course of this study was documented in memos and audit files from the evolution of the question to the definitions of each and every code. She reviewed every step of the research concurrently from the initial formulation of the interview guide through line-by-line coding and abstracting of concepts to the final definition of the process. The investigator also conducted a group validation of the analysis process through a research support group of peers also engaged in grounded theory research. The group reviews interview data, coding, concept formation and process definition for each of the group members as their individual

research progresses. The group discussions about this study were taped and memos were written reflecting on ideas emerging or clarified during the research group.

After the central category emerged, the findings were reviewed by some of the participants and other nurses who work in the same context for relevance and fit. This review also provided confirmability. Confirmability means affirmation of what the researcher has discovered by those knowledgeable in the substantive area. Checking with participants in the research is one method of doing this (Leininger, 1994). The findings were also submitted to two expert psychiatric nurses, who practice and teach in settings caring for involuntary patients. They examined the concepts for credibility.

Once the theory of Justifying Coercion had been developed from data related to involuntary administration of medication, theoretical sampling of data about other involuntary procedures, literature from other countries with different conditions and different laws about involuntary procedures, and material from other substantive areas was done. Data from these areas were compared to the theory to verify that it was generalizable to a wider context. Basic social processes do not meet the criteria of modifiability unless they are generalizable.

#### *Human Subjects Protection*

The research proposal was submitted to the University of San Diego Committee for the Protection of Human Subjects (CPHS) for approval prior to any data being collected (Appendix E). Consent and information forms used during the study were those approved by the committee. In those instances where participants were recruited through psychiatric facilities, the proposal was submitted to the appropriate institutional review committees through the nurse in charge. The investigator then complied with any additional requirements that the institution requested. At one facility she appeared before the committee in person. When participants were recruited through the professional network, the procedures approved by the CPHS were strictly followed.

Nurses who consented to participate in this study were asked to sign an informed

consent (Appendix F). Prior to consent, the focus of the interview being requested was discussed as well as the general content covered on the information sheet (Appendix G). Prospective participants were offered the opportunity to ask questions. Participants were informed of the risks, benefits, confidentiality, and their right to withdraw at any time without penalty.

The only benefit participants derived from their role in the research was the satisfaction inherent in contributing to the expansion of nursing knowledge. In this study, the risks to consenting experienced psychiatric nurses voluntarily participating in interviews were minimal. One possible adverse consequences identified was that the interview content might in some way arouse anxiety, embarrassment or other uncomfortable emotions. Another possible risk was that somehow responses to the questions might reveal something about a participant that would necessitate action on the part of the investigator. Participants were advised in the consent form (Appendix F) that information shared with the investigator that revealed patient abuse was reportable. To eliminate any possibility that the responses might put a participant at professional risk, nurses in subordinate positions to the investigator at any facility where the investigator has supervisory responsibilities were excluded. All identifying data were omitted from the transcripts. The tapes and discs were labeled only with a coded research number and were accessible only to the investigator and the transcriptionist. Consent forms were kept in a separate locked file unconnected to the cabinet containing the data. There were no instances of emotional response or recounting of situations involving patient abuse.

## CHAPTER FOUR

### Findings

The findings of this study resulted in a substantive grounded theory of “Justifying Coercion” which psychiatric nurses use to resolve the ethical and clinical-legal conflicts involved in providing involuntary care. Justifying is defined as: proving or showing to be just, or conformable to law, right, justice, propriety or duty (Thatcher, 1971, p. 468); or to provide a good reason in law for something (Encarta®, 2003). Coercion is defined as the use of force or threats to make people do things against their will (Encarta®, 2003). “Justifying Coercion” meets Glaser’s (1978) criteria for a basic social process (BSP). A BSP has two or more stages that “differentiate and account for variations in a problematic behavior” (p.97).

Justifying Coercion occurs when a more powerful entity, in this case a psychiatric nurse, has determined that a less powerful entity, in this case a patient, is required to do something that the less powerful entity is unwilling to do. Coercion requires power over another. In some relationships the power balance changes from time to time, depending on the situation, but at the time coercion occurs the balance of power favors the coercer. In order to administer medication involuntarily, a nurse may call upon other staff to provide sufficient physical power to carry out the action. Although the more powerful

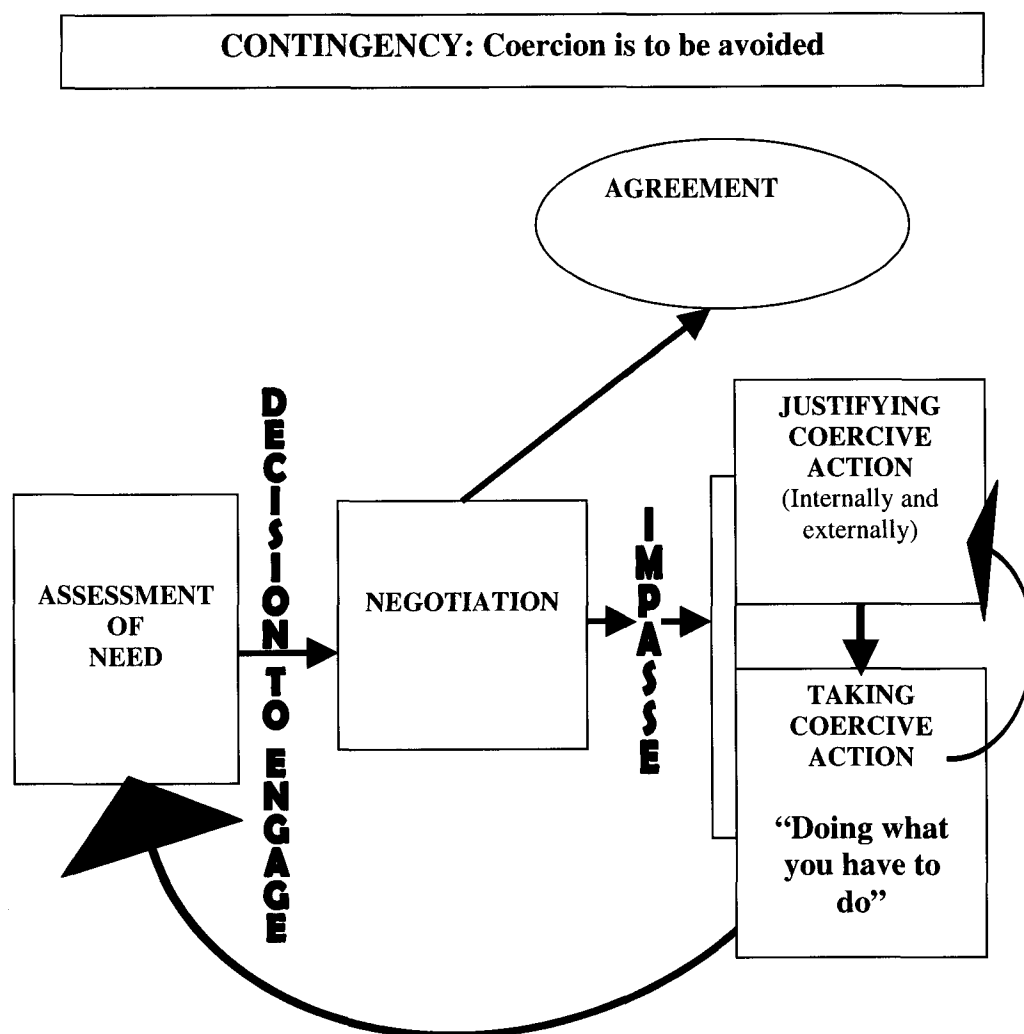


Figure 1: **Justifying Coercion**



entity has the capacity to force its will on the other, it is constrained by a prohibition against using force. Legal or ethical rules or both require that all possible alternatives be attempted before resorting to force.

The BSP “Justifying Coercion” (Figure 1) has three distinct stages: (a) “Assessment of Need”, (b) “Negotiation”, and (c) “Justifying and Taking Coercive Action”. There are two distinct “critical junctures”, “Decision to Engage” and “Impasse”, which define the transitions from one stage to the next. In the context of involuntary administration of medication there may be multiple coercive actions, each requiring its own justification, so the process begins again each time that medication is administered. When the coercive action is obtaining legal permission to medicate involuntarily the process evolves over three to ten days. When the action is to give a shot rather than wait for the patient to accept a pill the entire process may be accomplished in minutes rather than days. The process becomes truncated after repeated episodes of coercion. This chapter will describe the data grounding this theory and the subsequent interpretation of the data that led to the discovery of “Justifying Coercion” as the BSP that psychiatric nurses use to resolve the difficult problem of involuntary administration of medication.

The overall context of the process of Justifying Coercion within the study will be described. The properties of the process will be identified. Then each of the stages and critical junctures will be described in detail. The techniques and strategies the nurse uses within the stage and the descriptors of justification that are properties of the stage will be described and supported by the data that grounds each concept. Where it is possible, the nurses’ own language will be used as labels rather than more formal terminology.

## Context

As is often true when using grounded theory methodology, the process that emerged from the data is not a direct answer to the question the investigator began the study with (Glaser, 1978). The investigator's aim was to discover the process that psychiatric nurses used to minimize coercion and maximize adherence during the involuntary procedures required for involuntary patients in acute psychiatric settings. Consequently, she interviewed nurses employed in psychiatric facilities that treated both voluntary and involuntary patients about their experiences caring for involuntary patients. After multiple attempts to discover in the data a process of implementing involuntary procedures, and subsequently a process of medicating involuntary patients, it became clear that neither could account for the preponderance of data. When the researcher asked the question suggested by Glaser "What is this data a study of?" (1978, p. 57). The answer was: "This is a study of 'Justifying Coercion'".

The nurses, who participated in the study, did not have a problem with the procedures that needed to be done, nor with establishing and sustaining a therapeutic nurse-patient relationship even with a very difficult patient. The problem they confronted daily was the conflict between the required procedures and the ethical demands of the profession. There was also conflict between meeting the clinical needs of the patient and satisfying the legal requirements for treating an unwilling patient. The process used to resolve the conflicts was "Justifying Coercion". If the nurse could justify the coercive behavior on the basis of safety or need, then the emotional distress related to violating a patient's right to self-determination diminished. There was an added benefit in being prepared for administrative and regulatory agency scrutiny of their actions.

The process that participants described has three stages, (a) “Assessment of Need”, (b) “Interpersonal Negotiation”, and if Interpersonal Negotiation does not result in an agreement but ends in an Impasse, (c) “Justifying and Taking Coercive Action”. In the case of medication administration the agreement desired is for the patient to willingly accept all prescribed psychotropic medication on an ongoing basis. Coercive actions that must be justified in medication administration include: (a) threats of longer hospitalization if medication refusal persists, (b) initiating a petition for a hearing on the patient’s capacity to consent for psychotropic medication (Riese hearing), (c) involuntary administration of oral medication based on a finding of incapacity during the Riese hearing, and (d) forcible intramuscular (IM) administration of antipsychotic medications when refusal persists after the finding of incapacity. Once a Decision to Engage is made, the one to one nature of the nurse-patient relationship makes the Negotiation stage an Interpersonal Negotiation.

In the context of psychiatric nursing the stages of Justifying Coercion are embedded in the stages of the overall nursing process. Techniques and strategies for working with involuntary patients are not unlike those for working with voluntary patients. The nurses’ practice is founded on a reliance on the nurse-patient relationship and the belief that the patient will “improve with medication”. Throughout their relationships with patients, a persistent effort is made to avoid coercion and maintain the patient’s dignity to the extent possible. The participants felt that coercion of involuntary patients who were refusing medications was sometimes “necessary”, but was inevitably humiliating and traumatic. It was important to them to establish a therapeutic relationship

and maintain their connection to the patient throughout the process of Justifying Coercion to mitigate the negative effects of coercion.

For the participants in this study, the ability of the patient and nurse to form and maintain a relationship was critical to the nurses' actions and decisions at each stage of the process. A patient's inability to relate to any of the nursing staff is one of the criteria that nurses use to determine need for intervention and the existence of Impasse. The existence of a relationship and the beginnings of trust influence the nurses' Decision to Engage. Interpersonal Negotiation strategies are based on the relationship. The nurse's ability to understand the patient's responses and gauge what is most likely to persuade the patient to agreement with the treatment plan is dependent on the level of connection between nurse and patient. These factors are not unique to caring for involuntary patients but form the basic condition under which Justifying Coercion occurs in the context of "Involuntary Treatment in a Psychiatric Facility".

#### *Initiating a Relationship*

In order to provide nursing care the nurse must initiate a relationship. An accurate assessment requires a connection with the patient. One of the nurses says,

I find that the nurse-patient relationship is probably one of the most important relationships. You have to develop their trust, just like it says in the textbooks.

Several other nurses also specify that the primary tool they use is the nurse-patient relationship and all of the nurses involved in the study made references to the nurse-patient relationship.

Nursing care depends on the ability of the nurse to make contact with the patient and induce the patient to enter a nurse-patient relationship. When this relationship serves the purpose of moving the patient towards health psychiatric nurses refer to the nurse-

patient relationship as a therapeutic relationship. All of the strategies a nurse uses to determine what the patient needs and what actions are necessary are embedded in the nurse-patient relationship.

The nurse who does the required admission assessment has a structured interview to do and therefore is compelled to engage in a more or less formal interaction to collect the required data at the beginning of the relationship. A nurse with the responsibility of passing medications also has a formal requirement for interaction within a specified time frame. All other nurses who interact with the patient choose how and when they will approach the patient. Even within the constraints of formal roles such as “admitting nurse” or “medication nurse” each nurse has a unique style. One nurse says,

You really don't want to get so focused on the goal to make them take their medication. You don't want them to hear that like first thing that you talk to them, right away. It's more important that you just back off a little bit. You don't want to get overly anxious about OK this is a 9:00 med and the patient may refuse it.

Another nurse says about giving medications,

I try to get mine out early cause I'm into time management. So I do try to get mine out right away. You know. And I probably am pushy some times. I think I am sometimes, and the patients will tell me.

Both of these nurses talk about really listening to the patients and making sure that you attend to their concerns but when it comes to timing an initial attempt to give medications their approaches are different.

Within the context of individual style, however, there are two basic types of behavior involved in initiating and maintaining the nurse-patient relationship. One is showing that the nurse cares and the other is helping the patient to understand the nature of his or her situation. Nurses describe their caring behaviors in a variety of ways such as “making the patient comfortable”, “reaching out”, “making myself available” and “letting

them know that they are safe”. Several use the term “Establishing Rapport” which seems to be the overall aim of these initial caring moves. The ways that nurses go about helping the patient understand the nature of their situation is most often labeled “Explaining”. In general these two types of behavior happen simultaneously but if the nurses specify an order establishing rapport begins first.

### *Establishing Rapport*

To establish rapport nurses do a variety of things to meet a patient’s immediate needs and take the focus off issues of control. One nurse says,

“ I just cater to him for a little bit . . . talk about things he likes to talk about . . . ordered him two meals”.

Another nurse says,

“I just start by making them feel comfortable”.

Still another says

“You don’t go directly to medicine, have them take a bath, listen to music. . . The only thing that matters is what they think and want.”

If these actions communicate that the nurse is there for the patient, then the possibility exists that the patient will begin to trust the nurse.

“You have to develop trust.”

Once the nurse establishes credibility as a helping person, the explanations the nurse makes about the situation are more easily accepted.

### *Explaining*

The nurse has a substantial amount of information to impart to the patient. Since an involuntary admission is usually a psychiatric crisis the patient is often unable to comprehend information given to him at admission. The patient may be both confused

and angry at finding himself in a psychiatric unit and reject information that is unwelcome. Determining a patient's ability to comprehend and respond appropriately to information forms an important component of the assessment. Each nurse that interacts with the patient is expected to explain what has happened to the patient and what is expected. Once again each nurse approaches this task differently depending on individual style. Some take a very factual approach:

I am pretty blunt and frank . . . I explain," look, you're on a 72-hour hold as of right now. Whoever initiated the hold, you obviously displayed some behaviors to them that warranted them to place you on the hold.

Basically I explain to them that they're on this hold and that there is nothing I can do about changing that legal status and that the things that will get them out of the hospital are to take their medications and be part of the program.

Others take an exploratory approach:

"I give them a chance to tell their story";

"I let them know who I am . . . sit down and talk about the problems they have".

After they have listened to the patient they gently "point out" reality.

"Somehow things weren't working out on the outside".

"You are going to be here three days. What do you want to get out of this?"

Whichever way they approach the explanations, they make it a point to spend time with the patient and keep going back.

"Talk to them a lot; frequent interventions show you care".

In describing the process of Justifying Coercion in involuntary administration of medication, the nurses use the language of nursing process and psychiatric nurse-patient relationships to describe the techniques they use in each stage to care for resistant involuntary patients. However, when they justify their actions, they describe the

properties of the stages of Justifying Coercion by using concepts that describe the severity of the patient's illness, the imperative of acting, the conviction that they have reached an impasse, and the necessity of using coercion as the "last resort" (Figure 2).

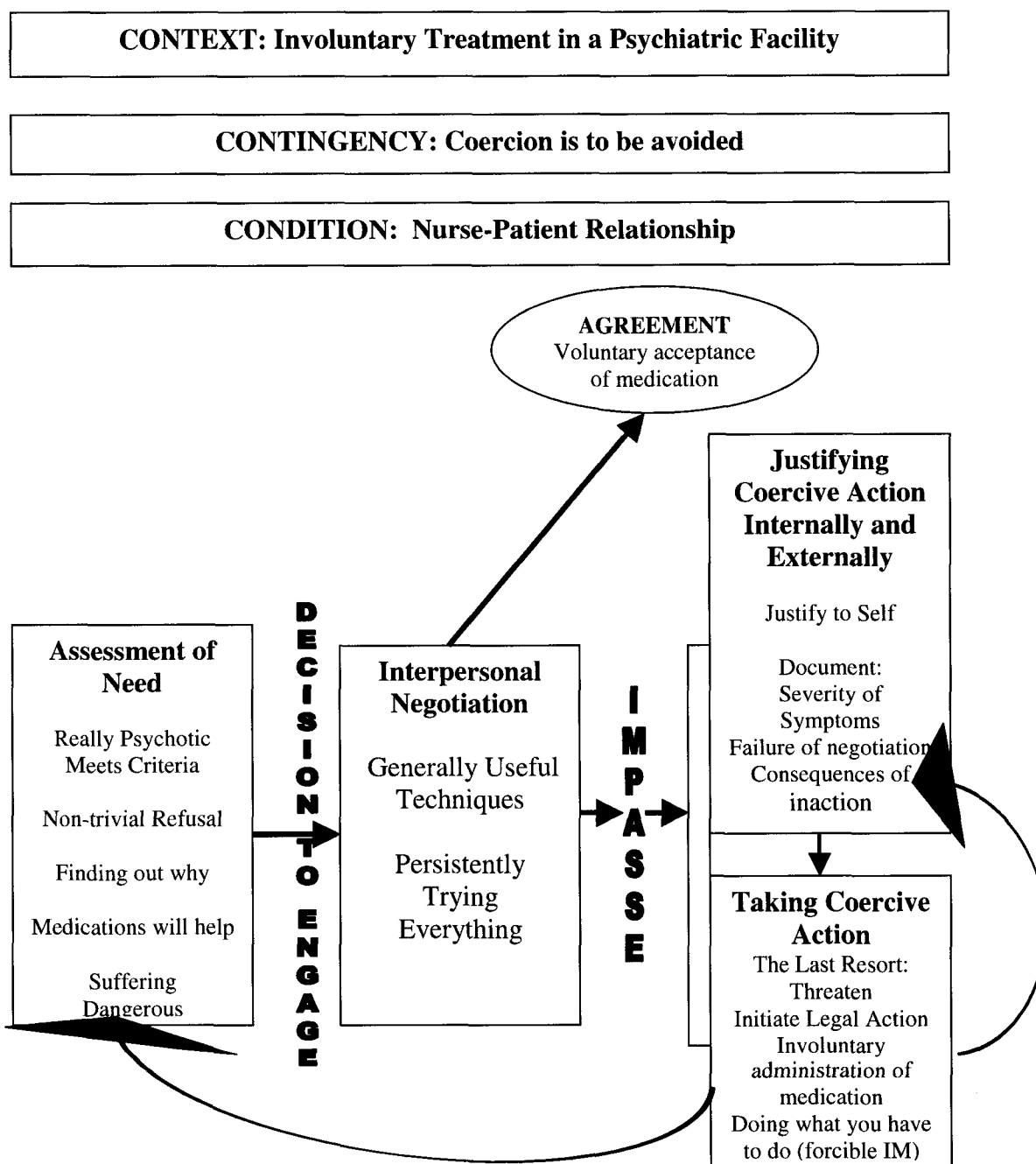


Figure 2: Justifying Coercion in Involuntary Administration of Medication



The initial stage of the nursing process is assessment and the initial strategies a psychiatric nurse uses for assessment are behaviors designed to make a connection and attempt to establish rapport. Each nurse has an individual style and habitual sequence of behaviors for connecting with a patient. The initial goal of this stage is to determine the need the patient has for nursing services. The ultimate goal is to establish a plan of care for the patient mutually agreed upon by patient and nurse. A crucial part of the assessment for an involuntary patient is “finding out why” the patient is not agreeing to hospitalization and treatment and determining whether agreement on treatment can be reached. In order to get such information the nurse must find a way to get the patient to tell him or her what is going on. The nurse hopes that listening to the patient’s concerns will assure the patient who the nurse cares, and that acting on those concerns within the nurse’s power to influence will begin the process of developing trust.

#### Assessment of Need

The first stage of Justifying Coercion is the Assessment of Need upon which all justification is based. The properties of Assessment of Need include determination of need, the condition of resistance or refusal, the belief that action is beneficent, and a decision that action is necessary (Table 1). The properties will be discussed in the sequence most frequently appearing in the data.

#### *Meeting Criteria/Really Sick*

Early in the initial interaction with the patient the nurse makes a decision about the patient’s involuntary status. The first concern is if the patient meets involuntary criteria. The nurses know what the definitions are of “danger to self”, “danger to others”

Table 1

**Assessment of Need**

<b>Property of Stage</b>	<b>Definition</b>	<b>Codes Illustrating Property</b>
Action Needed (Treatment is indicated)	A condition in which the specified action is an appropriate remedy to an undesirable state	“Really Sick” “Really Psychotic” “Meets Criteria” “Self-degradation”
Resistance to required action (Non-trivial refusal)	A situation in which the less powerful entity is unwilling or unable to agree to the action	“Refusing Medication” “Just can’t turn it around” “Doesn’t think he needs it”
Beneficence (Belief in efficacy)	The ultimate outcome of the action will be good.	“Medications will help” “They do improve”
Action Necessary (Must Treat)	A condition in which it is unsafe or damaging to refrain from action	“Suffering” “Dangerous” “Desperate”

and “gravely disabled”. From time to time police or other individuals write holds that don’t match the definitions:

“We got a lot of involuntaries that don’t need to be involuntaries”.

The nurses then talk to the doctor about releasing the patient who doesn’t meet criteria.

I don't see anywhere here where the patient is threatening anybody, not even themselves, they have a place to live, they have money; why are they on a hold, you know? And most of the time, Dr. A is wonderful about coming in and looking at the holds, saying, "this is a bogus hold, I'm discharging the patient."

There is pride in advocating for these patients and preventing unnecessary involuntary treatment. When voluntary patients are placed with the very ill involuntary patients and are thinking about leaving against medical advice, a situation that will trigger an evaluation for an involuntary hold, this same nurse says,

"We've got people who are really sick. . . . And well, when we get the higher functioning ones I try as fast as I can get them to the other (less acute) unit".

Being "really sick" is an important component justifying the nurse's commitment to engage in the process of getting the patient to accept medication. Part of the nurse's initial assessment is gauging the degree of distress that the mental illness is causing. They say things like the patient "desperately" needed help, was "suffering terribly" and was "dirty and malodorous" and experiencing "self degradation". They cite all the symptoms of severe mental illness prefaced by the superlatives "really", "truly" and "totally". For these nurses involuntary care is only justified if the person "really needs treatment" and part of their assessment is looking at behavior that indicates that the patient is unable to meet basic standards of self-care like eating and maintaining hygiene.

The inability of patients to control themselves to the extent that they jeopardize others also factors into the nurse's Decision to Engage in the process of getting the patient to accept medication. They are clear about their obligation to maintain patient and staff safety. If the patients can control their behavior, they will give them time to adapt and adjust. If safety is imperiled, they will use all the alternatives they can think of before

coercing the patient, but will not allow a great deal of time for the alternatives to be successful. Perception of danger will change the assessment from “need” to “necessary”.

*“Finding Out Why”*

Once the nurse assesses the patient as “really needing medication” the next imperative is discovering the reasons for medication refusal.

“The first thing is to sit down and find out why”.

They try to enter into the patient’s perspective:

I try to put myself in that spot. If I really believe, if I’m sitting in the hospital and I’m delusional, I believe whatever it is that is going on in my head. And so if I really believe that I’m not delusional, and I can’t convince these people out there, in this hospital, that I’m not delusional, and they’re going to give me medication, like Haldol I would be really like angry and upset.

And I think that the role of the nurse in trying to help the patient is to help that patient figure out what they want out of that hospitalization. Or the patient who’s having severe anxiety how they think that the problem can be helped. And then as the nurse we try and kind of fit what we need to do into what that patient wants, so that they’re satisfied with the outcome. If we intervene in ways that we think are appropriate, they probably might not think that our ideas are right for them, and then they’re not going to be compliant with them.

The nurses have an understanding of some of the problems with medication that contribute to medication refusal. They check for history of side effects and allergic reactions. They look to see if the refusal can be reversed with simple adjustments that will overcome objections based on bad experiences.

With medication, I try to find out why they don’t want to take their medication; is there a side effect you’ve had? The experience? What is it about taking medication? Do you not take your medication at home; have you taken anything before? And that kind of thing. Try to find out what their history is with the medication.

And in lots of cases it’s either the side effects or it could be that the dosage is too high, or just even the time of day of dosing makes a big difference. If they have a

heavy dose in the morning, and they feel that all day long they don't want to take it. I point out to them that you know, that there are adjustments that can be made as to the time and even the amount, maybe if it's a large dose that it can be divided. Or if they don't they really don't want to take the medicine, then maybe it doesn't need to be in divided doses. It can be taken at bedtime, so that they can wake up in the morning and they don't have to worry about it.

They can't intervene without knowledge.

One time it was simply a patient said, "I don't like your drinking water here. And the medications give me dry mouth." And so, you know, we now have bottled water that patients can have. But finding out why is really, really critical, because if we don't know why we can't really move towards resolution and compliance.

The nurses are also aware that medication refusal may be based in lack of insight into the illness, in concern about the stigma of needing psychiatric medications, or in fear. They investigate for other reasons, reasons based in the attitude towards the illness or in the emotional response to what has happened. If they can find a simple solution they implement it, if not they have a basis for the Interpersonal Negotiation that they will use to try to persuade the patient to change his mind.

Usually what it takes is talking to the patient to find out what it is that's making them reluctant to take medication. And then exploring that with them to see if they have any kinds of misconceptions about the medication, what they think is going to happen to them if they take it. Some patients don't want to take it because they don't want to feel better. So, those are usually the kinds of things that come out when you talk to patients who don't want to take medicine.

Sometimes it's a power struggle type issue. And so if I can handle the power struggle and make it not a power struggle, um, a lot of times they'll comply.

But his, his thing is I like being the way I am; I don't want therapy, I don't want to talk to the doctors, I don't want to be medicated. I don't want to go to group. Just leave me alone and let me live my life.

He was scared and also because of his cultural background, they don't believe in taking medications. Once I did tell him you know, let's just start counting you know. And then on the count of 10 just take your medication, because I know that

your illness is probably preventing you from taking it, cause you're scared and you're a little paranoid, but I know that at the same time you want to get well. And, so maybe if you can just not think about it and take it, then it will help you. And he did that and it seemed to help.

When the patient gives realistic and understandable reasons for refusal, such as side effects from or reactions to the medication that the patient perceives as intolerable, the nurse perceives the patient both as less psychotic and less likely to benefit from coerced medications. No matter how symptomatic the patient is otherwise, the nurse will try to problem solve with the patient and the physician to arrive at an acceptable medication that the patient will not stop taking immediately after discharge. Since the goal is a mutually agreed upon treatment plan, disregarding the patient's concerns defeats the purpose. Believing the patient and working with the patient is much more likely to produce benefit than coercion.

If the assessment yields interventions that quickly resolve the patient's medication refusal with the patient's voluntarily taking prescribed medications, the nursing process takes a conventional form and neither Interpersonal Negotiation nor Justifying and Taking Coercive Action occurs. The nursing process takes this form:

Assessment: Needs treatment

Goal: Remission of symptoms that are creating danger

Mutually agreed upon plan: Administer medication

Interventions: Explaining/ establishing relationship/ education/administrating medication/ monitoring/ reinforcing

Evaluation: Improvement with medications

If the assessment does not reveal a quick way to resolve the patient's refusal a Non-trivial Refusal exists, and coercion may be indicated. In general the time frame for establishing a Non-trivial Refusal is about 48 hours. The participants say,

That's the point where they've been in there for several days. . . they haven't stabilized at all, they're getting worse.

I'd say after you know, two days of not taking meds, you need to start thinking about filing a Riese.

#### “Medications Will Help” and “Action Necessary”

If the patient responds to the nurses questions about medication with grossly delusional answers and is unable to recognize the implications of his or her behavior, the nurse has more evidence the patient is “really sick”. The nurse will try to obtain evidence from the treating psychiatrist, the family, and old records if available about previous responses to medication to assist them in their determination of whether the patient will benefit or not. If no information about previous failure to respond is forthcoming, the nurse's basic belief that medication is beneficial provides the justification for efforts to persuade the patient to accept medication. (Sometimes if several emergency doses of antipsychotics are given as chemical restraints the patient's symptoms will improve and provide evidence of benefit.)

At the end of the assessment of a patient who continues to refuse medications, the nurse expects to understand the basis for the patient's refusal, as well as the likelihood that the patient will respond to nursing interventions to reverse that decision. The nurse has developed a plan of care that includes repeated attempts to offer medication and documentation of the response to those attempts. Although patient participation in and agreement to this plan has not been achieved, the patient's perspective has been heard

and taken into account. Patients' positive responses to certain interventions will result in continuing those particular nursing interventions. Documentation of patient refusals will serve as the basis for a petition for a capacity hearing should one be required.

The nurses' perspective on the urgency and necessity of getting the patient medicated is based on two parameters. The first is safety. A patient who is requiring seclusion and restraints or chemical restraints in the form emergency doses of medication will be perceived as requiring action in the form of regular doses of medication. The second parameter is suffering. If the patient is "deteriorating", "extremely frightened", "tormented by hallucinations" or perceived as possibly doing something to destroy their future because of psychosis the nurse feels action is necessary.

It's not that I want to force medications on people. It's just that the difference is so dramatic when you take medications. It ends the suffering. I mean, the suffering. That's the bottom line, the suffering. It's inhumane not to give treatments to people when there's a high likelihood that one of these medications is going to at least help them get out of this acute state.

#### The Decision to Engage

Once the assessment has been made that the patient needs medication but is demonstrating a non-trivial refusal a critical juncture has been reached. The nurse has a choice to make about whether to actively engage with the patient in Interpersonal Negotiation. Some negotiation must be demonstrated to document that an attempt has been made to secure the patient's agreement since involuntary administration of medication requires evidence of the patient's incapacity to provide informed consent. Who negotiates and how much time and energy are devoted to negotiation however is not specified.



When a patient refuses medication, nursing staff must continue to offer medication and provide medication information in hopes that the patient will change his or her mind. Each offer and each refusal must be documented. The nurse is obliged to keep the patient safely in the environment, to carry out the assigned procedures, and to document results. When there is no safety issue that compels nursing action the amount of attention a particular patient gets is a nursing choice. Establishing a therapeutic nurse-patient relationship, persuading the patient to accept treatment, and assisting the patient to effectively participate in care planning represents a considerable investment in time and emotional energy. Attempting to establish sufficient communication is a job expectation. Making an emotional investment, persisting in the face of resistance, and expansion of techniques beyond the habitual repertoire to establish a therapeutic nurse patient relationship is not required. The job demands of the registered nurse's role do not allow a nurse to devote a great deal of time to every patient. A decision to spend the time and energy necessary to engage actively in Interpersonal Negotiation with a particular patient is determined by the nurse's belief that such an effort is necessary and has a possibility of success. Sometimes that decision is not made. If the Assessment of Need determines that it is necessary that the patient be medicated in spite of his or her refusal, unit staff is obliged to make at least a perfunctory attempt at negotiation. Who takes on that responsibility is not predetermined. Whether an individual nurse decides to engage determines that nurse's participation in Interpersonal Negotiation.

One nurse speaks of a patient who is very labile and has "a narrow window of opportunity" during which she can be reached. She says that when the patient is withdrawn and not causing problems she becomes low priority and the staff tend to "just

let her be” and “say, ‘don’t worry she’ll be up on PMs’”. She adds “But I don’t feel that good about it.” She says, “I know I need to keep working with her and keep trying . . . “ Another nurse admits, “I guess I tend to spend more time with people who are not resistant.” And in speaking of the most resistant patients, “You know, sometimes I just avoid them, you know. I know I shouldn’t, but . . . “ The choice of how much time and energy to spend belongs to each individual nurse. “You really have to work with them and it takes a lot of patience and energy and effort.”

Interestingly, those nurses who worked primarily with children did not feel much of a need to justify giving them medications unless the parents refused. They did not engage in negotiation with the children about whether or not they would take medications. They felt that their adult status was sufficient justification to expect that the children take medications when medications were indicated. The child and adolescent nurses seemed to be very invested in their relationships with the children and were more concerned with helping the child to understand than getting the child to agree. They did, however, give very detailed descriptions of debriefing children after taking coercive action such as giving IM medication. Engagement in Interpersonal Negotiation to prevent repetition of coercive actions was clearly evident. Often the Decision to Engage in Interpersonal Negotiation for the child and adolescent nurses was about engaging in negotiation with the family around medication consent.

#### Interpersonal Negotiation

When simple interventions do not bring the patient to a quick decision to accept the prescribed medication, and the team is faced with a non-trivial refusal, Interpersonal Negotiation by the nurses sometimes resolves the patient’s resistance. Patient agreement

to take medication is obtained before involuntary administration of medication is necessary. Although one nurse may be assigned as the primary nurse for a particular patient, with continued refusal over a number of days a number of nurses may be involved in the effort to persuade the patient to accept medication. In addition, the psychiatrist and family or friends who see medication as necessary will also be attempting to influence the patient. The entire team will be responsible for persuading the patient to go along with the treatment plan.

For an individual nurse, Interpersonal Negotiation consists of committing to the effort of convincing the patient to accept medication. Strategies include (a) trying those interventions that are generally helpful such as medication education, encouraging participation in the unit program, and talking with the patient; and (b) persistently trying any intervention in the nurse's repertoire anticipated to produce a favorable response. Throughout the negotiation the nurse continues to demonstrate caring behaviors and respecting patient dignity. The primary intervention continues to be use of the nurse-patient relationship. If all efforts at negotiation of medication acceptance fail then coercion is seen as justified. Generally the nurse will use some informal coercive interventions, such as telling the patient what will happen if they don't agree, prior to the formal legal procedures that make it possible for involuntary administration of medication. Even after formal, legal coercive measures are initiated, Interpersonal Negotiation will continue. Nurses avoid forcible administration of intramuscular medication until there is no other choice. They do all they can to avoid this most coercive measure

So that they don't have to go through the trauma of an IM and having to go through all these people standing around and everything, which I hate. I hate it for the patient." "It's a very traumatic thing to go through.

They describe continuing Interpersonal Negotiation right to the very last minute.

Well, say somebody has just had their Riese hearing upheld. I will go over everything with them again. You know, that the decision has been made, by the courts that you are not competent to make the decision right now to about your own meds, so we can give it, we are going to give it to you; you have the option of pill or injection. And usually we will have the pills there, with an injection back up. We don't show them the syringe yet, but just you know, "you can take it this way or if you don't, we will have to give you an injection." And if they say, "No you're not going to, I don't believe that" then I just reiterate, "We, we will hold you down if we need to, to give you the medication to be injected, but you have the option of taking it by mouth first." Some people go one way; some people go the other. I like to give them at least some choice. The decision has been taken away, about whether they take their medicine, so I like to give them a choice about how this can be done.

After the initial involuntary dose, nurses continue Interpersonal Negotiation hoping that as the medication takes effect the patient will begin to take the medication voluntarily and coercion will no longer be necessary.

#### *Generally Helpful Interventions*

Participants in this study each had a repertoire of generally helpful therapeutic interventions (Table 2) designed to build a therapeutic relationship and convince the patient who the treatment being proposed would "help". Although the researcher hoped to discover a particular technique or group of techniques that were successful in avoiding coercion, what the data revealed was that Interpersonal Negotiation was a relationship process unique to each nurse-patient dyad.

The participants started by treating the resistant patient in the same manner that they treated any patient. Each nurse had preferred ways of initiating a relationship and doing medication education that they believed were generally successful. They modified

their approaches depending on the response. If a nurse-patient relationship seemed to be developing in a therapeutic direction, or if the nurse was motivated by the suffering he or she observed to try harder, intensify the effort and persistently try the same or additional techniques hoping to reach an agreement to the plan of care.

Table 2

### **Interpersonal Negotiation Techniques**

#### VERBAL INTERVENTIONS:

“Talking To”

Explaining

Educating

Medication Education

Pointing Out

Limit Setting

“Talking With”

Listening

Persuading

Offering Options

Offering Inducements

#### NONVERBAL INTERVENTIONS

Giving time and space

Spending time

Coming back repeatedly

Staying with

**Initial generally helpful interventions consist of verbal communication techniques, i.e. talking to and talking with, and nonverbal actions such as sitting with the patient, spending time, doing things for the patient, checking on the patient, and leaving the patient alone in the process of giving him time and space. The nurse determines which interventions will be used by the stage of the nurse-patient relationship and the willingness and ability of the patient to engage in particular activities and forms of interaction. Timing of particular interventions is influenced by the structure of activities on the unit as well as the patient's response.**

*Verbal Interventions: "Talking to"*

Within the category of verbal interventions there is a set of essentially one-way communications or "talking to" from nurse to patient. These include explaining, educating, pointing out, and limit setting. Participants describe explaining illness, how medications work, and situations to patients. They refer to educating patients and specifically they refer to doing medication education, but they also refer to other specific types of education such as stress or anger management, giving information on a diagnosis, discharge instructions, and orientation to the unit. They discuss pointing out benefits, situations, behaviors and reality to patients. They speak of setting limits and boundaries.

*"Explaining"*. Explaining is very directive but informal, it is used to give information currently needed to make a decision or change a behavior. The information given is assumed to be new or not currently understood by the patient. Explaining is a critical part of initiating a nurse-patient relationship but does not stop when the Assessment of Need is completed. It is an ongoing intervention throughout negotiating and justifying. It is crucial when interpersonal negotiating recommences after an involuntary administration of medication.

I try to explain to them that they, you know, received a medication ... and they are going to feel sedated and that's okay because we like some of that. You know, we don't want you to be agitated, you know. Very often, I let them know that some of these side effects that they're experiencing are a temporary kind of

thing. And that their bodies are going to adjust to taking medication and they're not going to always be feeling so drowsy.

*“Educating”*. Educating is giving specific information on a particular topic, or teaching specific skills. The information and skills may be new, repeated, modified, or familiar to the patient but consist of material considered to be professionally sound and generalizable to a large number of patients. Almost every participant referred to educating the patient.

*Medication education*. A major part of the negotiating process involves medication education. The nurses think that if they can only get the patient to understand the benefits of the medication the patient will accept it voluntarily. This often proves to be the case. The nurses use informal teaching and formal classes. They give out pamphlets and information sheets, usually printed materials developed by the drug manufacturer, or pharmacist specifically for patient education. They recommend books by authors who have had the same illness. They take the patient to self-help meetings or send the patient to talk to peers on the unit who found medication helpful. They tell stories about patients who have gotten better. They enlist family members to remind the patient of how they have behaved while not taking the medication. They explain, answer questions, and provide advice on managing side effects. They encourage the patient to test the information by giving the medication a trial.

*“Pointing out”*. Pointing out is closer to explaining than to educating. It is informal and applies specifically to the particular patient and situation. It is the presentation to the patient of information or observations that are presumed to be already

known or easily accessible to the patient but not currently being used by the patient to make decisions. For instance,

“The grounds for your hold are danger to others; if you threaten the doctor, the doctor is not likely to release you from the hold.”

“*Setting limits*”. Setting limits is a very specific form of information giving, which establishes rules and consequences for breaking the rules. It is particularly mentioned as an intervention for manic patients, adolescents, and patients with personality disorders. Establishing boundaries is an essential part of setting limits. Setting limits is one of the interventions that participants identify as being used to maintain safety and prevent a situation from escalating to the point that coercive interventions are required. If a patient is able to maintain behavior within the limits, the time available for Interpersonal Negotiations is extended, if not an impasse is determined more quickly. Need to maintain safety is the most impelling reason for Justifying Coercion, and creates pressure for quick action.

*Verbal Interventions: “Talking with”*

“Talking with” is a two way communication process that has a variety of purposes including: (a) establishing and maintaining rapport, (b) assessing the patient, (c) finding out the patient’s perspective, reasons for behavior and understanding of the situation and the illness, (d) encouraging the patient either in general or to a specific course of action, and (e) empowering the patient to participate in decisions about care.

“Talking with” does not consist of merely two parties engaging in verbal communication. Although technically an admission assessment interview could be considered talking with a patient it was never referred to in those words. “Talking with” is more informal than a structured interview. It follows the patient’s leads rather than a specified format, but is



not less purposeful. “Talking with” is a significant element, along with nonverbal forms of communication, in establishing the nurse as someone who can be trusted and developing a therapeutic relationship. Nurses refer to this type of verbal communication in terms of what they do to assist the patient and promote the relationship. They explain that, “I find out why” or “I investigate the reasons” to discover the patient’s perspective. They characterize their communications as being honest and maintaining the patient’s dignity. They talk of making the patient comfortable and establishing rapport. They use words for connecting and caring and for respecting and valuing their patients.

“*Listening*”. There is also a clear concept of listening to and hearing the patient who is integral to the process of talking with.

Basically I feel the best way for me to do that is to get them to talk. If they can talk about what is making them mad, and I can listen to that, and maybe come up with some kind of compromise, then you know a lot of times it’s just the fact that I sat down with them and listened to them talk about what they’re worried about that seems to help.

I think one of the things is being willing to, for instance, hear the patient out. Because they’ve got anger, they’ve got resentment, there are issues about trust, and I think it is very critical that the patient is allowed to express all those feelings. Because for me, part of why of it is happening anyway, is that they probably have not had a history where they were allowed to talk about those difficult feelings with a parent, or a family member, or their partner. Allowing them to do that is critical. Because then they know I’m able to be with their positive behaviors, and able to be with behaviors that are difficult to manage. And also the feelings that are difficult to share. And I don’t think I’ve ever had a conversation like that that went poorly. If it ever did go poorly, I didn’t listen enough to begin with. And that’s my problem.

Another nurse describes a patient telling the nurse what finally brought the patient to acceptance, “Somebody listened to my pleas.” I asked, “Do you think the issue was that the patient felt listened to?” and she replied, “In her case it was.”

Nurses allow the patient to explain their perception of what happened and accept the patient's perception as a genuine reflection of the patient's beliefs. They don't argue about what really happened, but may confront the patient with the discrepancies between what they say and what has been documented. They acknowledge that the stories don't match and withhold judgment. They gently point out that they are obligated to take into account the "official" version as well as the patient's version of events, but do not deny that the patient's version may be true.

*"Persuading"* The nurses try to use logic and problem solving to get the patient to accept that taking medication is the best decision. They say,

"When it comes to medications, I really like to get to talk about the benefits."

We certainly do a lot of encouraging people to take meds. You know, you're looking, you are looking really agitated, and you're looking really angry, there are things that we can do to help with that.

I got a good rapport with him, and then I started in on how he should take the medication 'cause he is really super anxious and not thinking clearly.

The nurses really do their best to convince the patient to see things their way. Fisher and Brown (1988) say there is a distinction between coercion, which operates against the will, and persuasion, which convinces the mind. Although psychosis at times makes reasoning impossible, if the patient seems at all open to persuasion, the nurse will try. He or she will spell out all the rational reasons for taking medication and counter the patient's arguments against medication one by one hoping to persuade the patient to give medication a try.

*Offering options.* The nurses refer often to "giving the patient options" or "choices". One of the strategies that participants see as caring and empowering is the offering of options. Patients are presented with choices and the ramifications of each

choice are carefully outlined. Some of the choices involve negative consequences either created by the impact of the symptoms on the patient's life or imposed by the institution. The patient is encouraged to choose options with fewer negative consequences. Offering options is seen as a persuasive strategy. What options the staff gives the patient depend on patient behavior and response to intervention.

Some options are related to method of medication administration. The nurses tell the patients they can take the medication voluntarily or the psychiatrist can ask the court to order them to do so; they can take the medication orally or have it given to them in an injection; they can offer their arm for the needle or be held down and have the medication injected. Sometimes these choices appear to be threats.

The participants in the current study sometimes fail to recognize the threats implicit in "presenting options". However at times the preferred option is presented without the alternative option and the participants simply wait to see if the patient will "make a good choice". Early in the patient's stay, before a decision has been made to petition for a hearing, the nurses will often offer a medication, accept the patient's refusal and go on to give medication to someone else, then return to talk to the patient about the medication and offer it again later. Sometimes, even after a hearing officer has ruled that the patient cannot refuse medication, the nurse will use persuasion and wait for the patient to accept a pill rather than resorting immediately to force.

*Offering inducements* The nurses also offer inducements such as being able to spend more time on the smoking patio or eating in the cafeteria where there are food choices instead of having a tray on the unit. Sometimes actual bargains are made such as changing the patient's room or reducing the frequency of checks or allowing them to

listen to music instead of going to group if they take their medications. The most potent consequences and inducements involve being retained longer or discharged sooner. By giving information in the form of illness and medication education, pointing out reality, advising of consequences and offering inducements, the nurses hope to persuade the patient to accept the medication.

### *Nonverbal Interventions*

The nurses also refer to a kind of patterning in their interactions with the patient who responds to the patient's availability and readiness to interact or make a decision. They call it "giving time and giving space". It is an important way of empowering the patient in coming to accept medication rather than coercing compliance. One nurse describes it this way,

There's been a woman on the unit. She's very agitated and I was just giving her the time and the space and not saying anything...and it was rewarding, because she initially didn't want to take her medication, but she really needed it. And somehow I think for her . . . she really needed that. And she was able, I think, was able to feel in control if she made the decision to take it, which really was rewarding. I could see people around me getting kind of restless and they were wondering what's going on here, because I was giving her that time, and it was slow.

Another nurse says.

"I give them a little space and time - to pick a better moment later on to process, to help them process and understand."

and still another nurse says

"I give patients space. I always kind of just say I'll come back and talk to you a little bit later. I don't push people."

"*Spending Time*". Equally important to giving time and space without too much presence is being with the patient. Spending time is a critical intervention. One nurse says,

“ I just sit with somebody and establish trust. I mean you don’t have to communicate to give them time.”

Another tells the interviewer,

I say what was the thing that I did that helped you the most or that I can do better, so I could have helped you, you know. And I think that the one thing that I always get is the fact that I took time to talk to them, to explain to them. And that seems to be the thing that helps. Or, they say the thing that could of helped more, if I had spent more time with them.

Spending Time is especially important after the nurse has administered involuntary medication and is trying to reenter Interpersonal Negotiation. A nurse describes

So, just processing basically, sticking it out with them. Having the patience to sit there while they call them names. You know. So long as they are not violent or overtly acting out or putting anyone in danger. I don’t have a problem with them yelling, whatever.

And another says,

“It’s a very traumatic thing to go through. Especially if once they’re Rised they won’t take the p.o. meds and it ends up being an injection. Just, doing it, then get a chair, be with them.”

“*Staying With*”. Staying With a patient after an episode of involuntary medication administration is seen as very important. The nurse does not want to abandon the patient. One purpose of staying with the patient at this time is to maintain the understanding that the nurse-patient relationship is not about getting the patient to take medications but about helping the patient. The nurses hope that this will establish the next round of negotiation on a basis of trust.

### *Persistently Trying*

If the generally helpful techniques initially don’t work, the nurses have two basic approaches: (a) continue doing the same thing, and (b) trying everything they can think of. The critical element in Interpersonal Negotiation is getting the patient’s trust. Despite

intervening in ways the patient does not like, if the nurse has managed to establish themselves as a helping person there is a chance that eventually the patient will work with them.

You know, we got to get through that wall somehow. You know. You just got to keep going at them. You just keep coming back; they may be hallucinating, they may be yelling at you and calling you the Devil themselves, but just keep coming back. Because they know, some part of their brain is knowing that somebody is coming and talking to them. So somebody cares. And that's the whole thing. You got to get that part of the brain to connect with the rest of the brain and let them know this is not a person that's going to hurt me. This is somebody who wants to help me.

Participants talk about going back three to eight times a shift. One says,

“I know that I need to keep working with her and keep trying”.

Another doesn't just speak about her own trying but about persistent efforts to get the patient to try,

I just keep on the same theme of: give it a try; at least give it a try. Try to go to group, take this medication, and if you have horrible side effects you know, we'll talk to the doctor, you don't have to take it again. Let's at least try.

The essence of this Interpersonal Negotiation is bargaining with the patient to concede to taking a single dose. The nurses use all the knowledge they have accumulated about the patient. They work from a focus on the patient's strengths, they discover the patient's wants and needs, they ask what the patient believes will help them and try to provide that. Over and over again they go back.

They don't give up. If nothing that they have been doing works they will ask a colleague to try. If they think something might work, they chance it. A nurse with whom the researcher discussed the developing process said,

“Oh yeah, you should hear some of the hokey things I come up with as reasons why they should take their meds.”

They direct patients to other patients for whom medications have worked.

I don't think confrontation works very well so I try to avoid that. Education about medication is something I do. . . and getting them to talk to other patients who have similar problems, . . . often I'll say "why don't you go to someone you feel comfortable with" and "talk to so and so" and suggest someone.

They use tangible rewards; one describes literally paying a developmentally disabled patient to take medication. They use privileges as a leverage and discharge as a goal.

"It will help you leave more quickly if you show the doctor you can make good decisions by taking your medication."

One nurse says,

"You use logic and skills, its really kind of tricky."

Another nurse tells of an unsuccessful effort to avoid involuntary medication,

We had a patient who was bi-polar and an adolescent. And we were debating whether to give him a shot. Well, he needed medicine. That was clear. We had been through everything; we had tried sitting him by himself, giving him books to read, letting him listen to music, sitting by the door, which was a problem, but we let him do it anyway. We tried probably 20 different interventions to try and get him to calm down. . . . We got an order for some medication. The LVN drew up an injection for him, but we had had an order for a PO PRN. . . . By this time he was in open seclusion. And we didn't want to put him in locked seclusion. So we went in with the medicine and she has a shot, and I said where is the PO stuff. And she said well, we're not going to give it to him PO we're just going to give it by injection. So I said, well, well, why? I mean if at least he sees both of those in your hand then we can present him with the option. She said I've already presented him with PO medication twice and he hasn't accepted it. I said, well, when we present it to him, that he is going to get medication, and the option he has is how he is going to get it, then maybe he'll take the PO. And so it ended up that he wouldn't take the PO, but I still even on that last try, went in taking both. So that even when it comes down to the fact that he's not going to have a choice about getting the medicine, for the form in which he gets a medication, he still has a choice. So it gives them some kind of dignity in the fact that they still have an option.

The underlying message is that the patient is expected to eventually make the "right choice". The nurses are willing to wait for the patient to come to agreement as long

as the patient's and other people's safety is not compromised and the patient does not appear to be getting sicker. However, in the psychiatric units employing the participants there is a definite pressure for patient progress and early discharge. There is an expectation that initiation of medication will take place as soon as possible. Given the realities of reimbursement for hospital care, unless there is clear evidence of patient response to Interpersonal Negotiation within the initial 72-hour hold, in some facilities the need to initiate a 14-day hold signals the existence of an impasse. One of the nurses presents this explanation of the time pressure,

Because at the end of that time, you know, there is no (benefit). We're not doing them a favor by not giving them their meds. They're suffering terribly from psychosis.

#### *Impasse*

Impasse is determined by the perception that sufficient time has been spent and that everything possible has been tried so that further efforts will be futile. The nurses have exhausted their repertoire of interventions and coercion is the only remaining choice. More experienced nurses had greater repertoires and persistently tried longer than those newer to psychiatric nursing. Nurses with three years of experience or less were more ready to see the negotiation at an impasse than the nurses with more than ten years in psychiatric nursing.

How soon a nurse perceives an impasse also depends on the patient's behavior.

One nurse says,

If the patient has been able to control himself, been able to not to hurt himself, you know, maintain the safety of him and others and all that, I would - probably would give it a good maybe two shifts.

Another says,



“If they’re very threatening and they’re probably a danger to other people or themselves it’s sooner rather than later.”

Safety and control are important issues and will justify moving to involuntary measures more rapidly with less time and fewer interventions included in interpersonal negotiating.

“We can get some very violent patients in here. And if we have to wait until they either do something, or are imminently about to do something, I think that’s too long”.

Risk to safety leads to urgency. However, a gravely disabled person may be allowed to go for a week without showering if she is not “filthy and malodorous”.

For “frequent flyers”, history either justifies jumping quickly to asking for a capacity hearing or giving up.

Sometimes we have a patient who I’m familiar with because they have been through here before, and they’re traditionally noncompliant with their medication and I suggest to the physician that they Riese them immediately.

For the individual nurse, “impasse” is a subjective determination that there is no benefit in further efforts to negotiate. It is time for “the last resort”. At that point, the nurse is ready to ask the psychiatrist about petitioning for a hearing or call for other staff to assist in administering medication if a hearing ruled that involuntary medication was allowed.

Formal coercive action, however, depends on a consensus that an impasse has been reached. The psychiatrist must agree to petition, documentation must include notes from more than one nurse indicating that the patient has refused medication after a credible effort at persuasion, and the hearing officer must rule that it has been demonstrated that the patient lacks capacity to consent. During the Riese hearing a patient

advocate (or, if the patient requests one, an attorney) will assist the patient (LADMH, 1998) to defend his or her position that refusing medication is an informed choice made by a person capable of rationally weighing the information given. An individual nurse having reached impasse will not be sufficient to obtain court permission for involuntary medication.

*“The Last Resort”: “Justifying and Taking Coercive Action”*

When all negotiating has failed and there seems to be nothing else that can be tried, the last resort is Justifying and Taking Coercive Action (Table 3).

The nurses believe that medication is an effective treatment and if all their efforts to gain the patient’s acceptance seem futile, they are willing to resort to coercion. Coercive actions may include: threatening the patient, filing a petition for a Riese hearing, testifying at the hearing, involuntary oral administration of medication and forcible IM administration of medication. Justifying a particular coercive action is both an internal decision-making process and an external explaining and documenting process that enables the nurse to convince both self and others that there was no other choice. Justifying occurs prior to, simultaneous with and after the actual coercive action. Justifying Coercion, both internally and externally, and taking coercive action are two sub-processes of a single stage. They are inextricably connected. Internal justification almost always precedes coercive action, but external justification is likely to both precede and follow coercive action. While the internal justifying that brings the nurse to the point of coercive action is not in itself coercive, the external justifying involved in convincing the physician, providing written documentation of necessity and testifying in a hearing,

can be coercive. Petitioning for a medication capacity hearing is simultaneously a justification of and an initiation of a formal coercive action.

Table 3

### Justifying Coercive Action and Taking Coercive Action

Property of Stage	Definition	Codes Illustrating Property
Justify Internally	The nurse's personal conviction that coercion is the right thing to do at this time	"I feel fully justified" "I think it's necessary" "I don't have a lot of doubt"
Document Necessity (Externally Justify)	Provide records that show that the conditions were met	"Document offer and refusal" Describe patient's symptoms
Legal Action (Formal Coercion)	Begin formal proceedings to get legal permission to act coercively	"Initiate Petition" "Testify at hearing"
Other Coercive Action	Use of force or threats to make people do things against their will	Threaten legal action "Give Medication" "Give IM" "Do what you have to do"
Give Reasons (Externally Justify after acting)	Justification after the fact that coercion was necessary	"Explain Again" "Document what happened" "Debrief"

#### *Justifying Coercive Action*

At the point the nurses believe themselves to be forced to take coercive action the nurses feel fully justified. One nurse says,

We use this as a last resort, you know. We try, but if all the effort fails, then that's just like the last resort. So usually by that point it's totally justified. I feel comfortable; I think it's necessary. I feel good about the decision-making. That's why very rarely we've got denied, you know. Most of the ones we've gone through the process with the court agrees the patient really needs it so . . .

And another states,

And then you go through your thinking process and say, yep, this patient is a danger to herself and she's a danger to her baby and then you're like emotionally and intellectually satisfied that you've met that criteria and then you're there.

The nurses come to a point where the perceived need for medication and the belief that the medication will really make a difference outweighs the need to protect the patient's autonomy. They say, "I do what I have to do."

The nurses interviewed are very committed to helping their patients. They are also very concerned about their advocacy role and the principal of nonmaleficence. "First do no harm." They believe that violating the patient's autonomy presents a very real danger of doing harm and that they have a duty to prevent the patient from coming to harm. However they have very real concerns about safety for the particular patient, other patients, staff, and the community if the patient goes untreated. They have a need to be able to justify any involuntary procedures they participate in.

The two main justifications are "need" (defined as relief from "suffering" or deterioration) and safety. If the nurse cannot justify a procedure based on one of these two perceived conditions then the imperative of advocacy takes over and the nurse actively resists taking part in such procedures going over physicians' heads, protesting, refusing, doing whatever is necessary to protect the patient from what is seen as harmful. If they fail to advocate or fail in their advocacy they feel guilt. The nurses who could not remember taking part in an involuntary procedure they disagreed with were absolutely relieved to be able to report that and quickly moved to tell of a circumstance in which they prevented an "unnecessary" involuntary procedure.

A shared perspective on involuntary psychotropic medication administration was evident among the participants in the study. One nurse has her justification very clear.

I would be very, very upset if it came to the point where, and it's been talked about, where people would never be Riesed in these situations; where they would continue to have a right to refuse their medications. It's not that I want to force medications on people. It's just that the difference is so dramatic when you take medications. It ends the suffering. I mean, the suffering. That's the bottom line the suffering. It's inhumane not to give treatments to people when there's a high likelihood that one of these medications is going to at least help them get out of this acute state. . . . we would go back to the old snake pit then. If you -- if you couldn't, if it came to the point where you couldn't medicate people who didn't want medication. I, I just don't think I could do it any more.

Another said,

And the Riese hearing is important in my opinion because, in my experience so far, most patients who need to be Riesed are the ones that are truly appropriate, that need to take medication desperately. I think the doctors, most doctors, are doing a very, very good job on that. I don't have much question or doubt or concern about the Riese. If the doctor would go all the way, to have to go through the court - to go through so many steps to fight to get the patient to take medication that pretty much says how much they think the patient needs medication. So I support that. I think it's being done appropriately and it's necessary and then patients really benefit from taking medication. And you see the results of them taking medication.

Belief in efficacy is crucial to justifying coercive action. Nurses tell prototype stories of "miracles": situations in which they made a difference by getting a patient to take meds and there was a dramatic change. This belief is backed up by research (Baldessarini, & Tondo, 1998; Lehman et al., 1995) as well as experience but challenged intermittently by the patient who fails to respond. It is the expectation of improvement with medication that drives the nurse to try everything and allows him/her to participate in coercion. They say, "They do improve!"

The nurses tell me that in general most patients,

"Come to see" that medication is needed. Most of them at some point, "get it" to some degree that whatever they were doing before wasn't working. . .

There's a few who probably beginning to end say it's so and so's fault, I have nothing to do with it. I would say most of them at some point realize that we're trying to help them and that they need to look at alternatives.

Several nurses said they had never had an involuntary patient who failed to respond to any medication. It is the nurses' belief that once the medications take effect, a patient feels better and is grateful for having the medication. If a patient does not improve the nurses believe that the wrong medication was prescribed, not that they should not have given the medications.

Overall, the nurses tell many stories about when interpersonal negotiating brought about changes in the patient's behaviors, relatively few about needing to justify coercion. They tell about responding to the patient's signals and "knowing what to do". They also speak of inspirations that worked out well. When pressed they will tell you of a patient who was very resistant and had to be medicated unwillingly. These stories are always substantiated with elaborate explanations of how ill the patient was and how much treatment he or she needed.

#### *Taking Coercive Action.*

Once an impasse has been reached and coercion is necessary, the nurse has the responsibility of actually implementing the coercive procedures.

"The decision has been taken away, about whether they take their medicine."

Some of the coercive action takes place outside the patient's purview. "Talking to the doctor" and documenting a patient's refusal of medication may initiate the coercive action but are not necessarily identified with a particular nurse. Unless the nurse actually testifies at the Riese hearing, the patient may not be aware of the nurse's participation. Involuntary administration of medication is a coercive action that involves the nurse directly with the patient. The nurse does his or her best to mitigate the coercion by trying to protect the patient from loss of dignity and public humiliation. Nurses describe,

“Trying to not make it a big scene if possible. I mean there are some people where we do have to get back up and hold somebody down. Uh, but usually I try to do it with as few people as possible.”

I would basically say I have to give you the medication, so I can give you the medication which is me, myself and you, or if you're going to struggle against it, I'm going to have get some help and we're going to have to hold you down, and give you the medication, and I'd rather not go that route, but that's what we would have to do. And sometimes people just say, okay, and other times they just fight you, and then you have to get somebody.

“Especially if once they're Riese they won't take the po meds. Ends up being injection. Just, doing it, then get a chair, be with them.”

As soon as an IM dose has been given, it's back to “trying everything “ as forced medications are an occasion for anger and increase the possibility of a reduction in safety. So the nurse debriefs the patient and tries to convince the patient not to refuse the oral medication again.

I try to explain to them that this is going to happen again if medications are ordered twice a day. You don't take it by mouth; this is going to happen again. And the way my PA says it, is a bunch of big ugly snowy hairy guys are going to come and are going to have hold you down while we give you a shot. And uh, sometimes, with most of the patients I've discovered when we do a Riese, it's usually one to two days of shots and then they start complying with the pills.

But some patients continue to refuse.

“He has to be given a shot everyday, because he refuses, he doesn't like the pills.”

The process moves back and forth between “interpersonal negotiating” and “Justifying and Taking Coercive Action” until the patient accepts medication or leaves the facility. Each time the nurse will again assess the need but in the light of repetitive episodes the Assessment of Need stage may be markedly truncated. In the case above, the patient never acquiesced to the medication and received IM injections daily for over a month.

#### *Summary of the Process*

The psychiatric nurses who participated in this study use the nurse-patient relationship as their primary intervention. They are convinced that if they succeed in establishing a trusting relationship resorting to coercion does not significantly affect that relationship. They begin interaction with their involuntary patients, as with all patients, by assessing the patient and attempting to establish rapport. If the patient does not meet criteria for involuntary treatment justification is not possible. In this case the participating nurses would act to get the patient to agree to voluntary hospitalization or talk to the psychiatrist about discontinuing the involuntary hold so the patient will no longer be subjected to involuntary treatment. If the outcome of the assessment is a determination that the patient is legitimately in need of psychiatric treatment on an involuntary basis the nurses have begun "Justifying Coercion" by justifying the involuntary status of the patient. They have accepted that the patient should be "held" in the hospital and that efforts should be made to treat the patient.

If the patient remains involuntary, although the participants may distance themselves from the initial decision (made by someone else) to involuntarily hospitalize in order to facilitate building rapport, they are participating in the coercion involved in involuntary care. Some patients will acquiesce to this care and accept, however reluctantly, the treatment offered. No further justification of coercion will be necessary for the nurse and those patients will be treated essentially as if they were voluntary patients unless they attempt to leave. Other patients will resist treatment and refuse whatever psychotropic medication has been ordered. For some patients refusal of treatment is transitory, persisting only a few shifts. Other patients persist in refusing



medication for many days. Persistent refusal is labeled in the literature “non-trivial refusal” (Susman, 1994; 1998).

If the nurse establishes that the patient is “really” mentally ill and “needs” treatment the patient does not want, the patient and nurse have reached a critical juncture. The nurse may simply explain the legal situation, offer medications as prescribed, and document what happens or actively engage in “Interpersonal Negotiation”, which is a significant effort to establish a therapeutic nurse-patient relationship and use it to influence the patient to accept treatment. If the “Interpersonal Negotiation” does not lead to acceptance of medication, the nurse and patient have reached an impasse. The process continues to “Justifying and Taking Coercive Action”. In this stage the nurse determines, usually in collaboration with other members of the nursing staff, that it is time to recommend a capacity hearing to determine if the patient is capable of informed consent. The outcome of the hearing determines if the patient can be forcibly treated with psychotropic medications without the existence of a psychiatric emergency. At this point the nurse’s behavior is contingent on the nurse’s belief in three things: (a) the patient “needs treatment”, (b) the treatment will work and benefit the patient (One of the participants says clearly, “They do improve!”), and (c) further efforts at negotiation will probably not result in voluntary acceptance of medication and coercion is now “necessary” and “justified”.

In California, where the study took place, the legal procedures (Appendix A) are such that formal coercive measures to involuntarily administer medication cannot be executed until the patient has been hospitalized involuntarily for 5-6 days. However, informal coercion through threats of instituting legal procedures and statements that the

patient will be held longer if treatment is not agreed to may take place any time the nurse perceives that she and the patient have reached an impasse. History of non-trivial refusal and improvement with involuntary medication in a previous hospitalization may influence the nurse to justify coercion more rapidly. Safety concerns also influence the nurse's timing of the point of justification.

Once the court has ruled that a patient must accept the prescribed medication, the nurse no longer has a choice about coercive action. The medication must be given as prescribed. If possible the medication will be given orally. The nurses continue "Interpersonal Negotiation" to avoid forcible IM administration of medication. One nurse says,

"For some patients it's like dose to dose negotiating. But sometimes you actually start to get enough on board and the patient starts making the decision to go ahead and comply."

Each time that medications need to be given the nurse gives the patient the option of accepting an oral dose rather than be forcibly medicated. The hope is that after a while the patient is no longer being medicated involuntarily. So the process cycles back to Assessment of Need for each particular action, and continues with interpersonal negotiating followed by justifying another dose of medication until the patient comes to acceptance or leaves the unit. Some patients remain adamant in their refusal. Such patients usually end up being placed on a conservatorship and transferred to a different facility. But most of the patients that the study nurses work with eventually comply.

## CHAPTER FIVE

### DISCUSSION

This study explored the experiences of psychiatric nurses to identify a process of caring for involuntary patients. Treatment of involuntary patients creates a context in which there is a conflict between the ethical values and the duty of the psychiatric nurse to treat certain mentally ill patients against their will. The profession values patient self-determination, autonomy, respect, human dignity, the nurse-patient alliance, and patient advocacy (ANA, 2000; 2001). Involuntary treatment challenges all of these values. Grounded theory methodology was used to uncover how psychiatric nurses resolved this conflict. Findings support a substantive grounded theory of “Justifying Coercion” within the context of the nursing care of involuntary patients. The data grounding the theory focused primarily upon the nurses’ experiences of administering medication to resistant involuntary patients. Medication administration is expected to occur several times each day, in contrast to other involuntary procedures, such as seclusion and restraint, which occur infrequently.

The ethical conflict that psychiatric nurses experience when involuntarily medicating patients occurs in the context of a larger ethical debate over involuntary treatment of the mentally ill. This debate has continued for over a century in the United

States. The societal attitude in the United States has shifted several times (Durham, 1996). Significant legal regulation changes to reduce coercion and ensure procedural justice in psychiatric care were enacted in the late 1960s and early 1970s. Legislative initiatives to ease the restrictions on involuntary inpatient treatment, expand involuntary outpatient commitment, and require compliance with medication occurred in many states in the 1990s (Durham, 1996; Hiday, 1992). They continue in this decade with California which originally led the way in restricting involuntary treatment (Davis et al., 1997) passing outpatient commitment legislation in 2002 (AB1421, AB1424). Legal scholars, courts and legislatures as well as those who provide psychiatric care struggle with the issue of when coercion of the mentally ill is necessary and legitimate (Appelbaum, 1994; Maloy, 1996; Sales & Shuman, 1996; Winick, 1997). The nurses who care for involuntary patients must carry out the involuntary procedure of forcible medication without any general consensus about whether it is justified. Each nurse must act within his or her own values and justify the actions taken on a case-by-case basis.

The participants negotiated the ethical dilemma of medicating involuntary patients on an individual case basis using the basic social process of Justifying Coercion. This chapter will discuss the properties of the process across the three stages of “Assessment of Need”, “interpersonal negotiating” and “Justifying and Taking Coercive Action”. The substantive theory arising directly from the interview data and limited to the context of acute psychiatric units will be discussed first. Process properties will be addressed in relation to ethics, legal requirements, treatment efficacy, nurse’s self image, nursing strategies and health care system constraints. The wider implications of Justifying

Coercion as a basic social process particularly within the context of international relations and the potential for formal theory development will also be discussed.

### Ethical and Legal Considerations

The substantive theory of “Justifying Coercion” in psychiatric nursing has the potential to be developed into a formal theory of “Justifying Coercion” across many contexts. “Justifying Coercion” is a basic social process that is not confined to psychiatric nursing or to nursing. Television and newspaper reports in the last months of 2002 relating to the United States initiating a war with Iraq and literature on coercion provided data that the BSP was also used in international relations. It appears that “Justifying Coercion” is a process that is invoked whenever a person, a group, or a government decides that an entity (person, group, organization or government) must do something that the entity refuses to do but the actions required to force the entity are contrary to the values held by the agent charged with carrying them out. “Justifying Coercion” also takes place when an individual, agency, or government is called upon to account for coercive actions. Thus a theory of “Justifying Coercion” in medicating involuntary psychiatric patients has potential as the basis of a more general formal theory. However, before venturing into formal theory it is necessary to consider the substantive theory, which is grounded in data collected and analyzed in the context of psychiatric nursing with involuntary patients.

### *The Ethical Conflict*

The basic ethical conflict in Justifying Coercion within psychiatric nursing is a conflict between beneficence and autonomy. The principle of beneficence is that people have a duty to actively do good to others (Davis et al., 1997). For nurses this duty is

ultimately about advancing the psychological and physical health of patients. Nurses are expected to do everything in their power to enable patients to gain or regain health. The assumption is that nurse and patient ultimately believe that the same outcomes are “good” or share a common value system. Husted and Husted (1995) discuss the “agreement” between nurse and patient and say “The nature and terms of the agreement between nurse and patient are generally not made explicit for the participants. However, the terms of this agreement are generally known and accepted” (p. 50).

A fundamental principle of nursing practice is that nurses should treat patients with dignity and respect (ANA, 2001). Respect involves accepting the patient’s values as valid and shaping the plan of care in congruence with those values. The intersystem model (Artinian & Conger, 1997) explicitly addresses the potential for a difference in values and calls for a process of values negotiating. The expectation is that the nurse and patient can reach mutual agreement on what is good. With a psychotic patient, who by definition has disturbances in thought content and process (APA, 2000), this expectation is often untenable. Failing a successful values negotiation “the practice of beneficence assumes that the professional knows with greater accuracy and certainty than do patients themselves what is in their best interest” (Gadow, 1989 p. 536). When patients persist in resisting the professionals’ definition of their best interests and the professionals resort to coercion, beneficence becomes paternalism. Some ethicists (Davis, et al., 1997; Gadow, 1989) take the position that paternalism is to be avoided. In the case of psychotic psychiatric patients, Hummelvoll (1996) presents a case for either “genuine” or “solicited” paternalism for patients lacking the capacity to exercise autonomy.

Autonomy can be defined as an individual's right to self-determination (Arnold & Boggs, 2003), a principle explicitly endorsed in the ANA (2001) *Code of Ethics*.

However the standards of psychiatric nursing (ANA, 2000) recognize some limits on the right to self-determination,

An essential aspect of the patient's response is the right to exercise personal choice about participation in proposed treatments. The responsible use of the nurse's authority respects the patient's freedom to choose among existing alternatives and facilitates awareness of resources available to assist with decision-making. However as mental health law recognizes, there are situations in which mental health professionals must decide to set aside the patient's choices for the sake of the patient's own safety or the safety of others. In these situations, the psychiatric-mental health nurse strives to protect the rights of the patient as much as possible, and works to ensure that the patient's right to choose is restricted only as necessary. (p. 27)

Autonomy as a right is restricted by the need to maintain safety. Limitations may be imposed "when one individual's autonomy interferes with another's rights, health or well-being" (Aiken, 1994, p.23).

Autonomy also has been defined as a virtue or an element of a persons' character. "The ability to sustain one's unique and rational nature – those qualities of character that enable a person to be the person one desires to be" (Husted & Husted, 1995, p.23). Davis et al. (1997) outline some of the components of autonomy as being: voluntary (free) action, authenticity, effective deliberation, and moral reflection. In psychotic patients there are questions about the patients capacity to exercise any of these aspects of

autonomy. Swartz, Vingiano and Perez (1988) say that clinical autonomy requires a person “who can act independently and who demonstrates a capacity for self-governance and knowledge of his own beliefs” (p. 196). They concluded in their study that medication refusal did not constitute an autonomous decision. Much of the conflict related to involuntary treatment rests on the distinction between autonomy as a right and autonomy as a state or virtue. When involuntary treatment is based on danger to others, the individual’s right to autonomy is circumscribed by other persons’ rights to be free from harm. However when involuntary treatment is based on the individual’s danger to self or inability to care for self, the issue becomes whether the individual has the capacity to be autonomous.

When is it acceptable to override an individual’s self-determination and require a person to accept treatment? Is it only when the person presents a danger? May a health professional use coercion to require that the patient do something that the health professional believes will be to the patient’s benefit even though the patient disagrees? Although most states’ involuntary hospitalization laws are based in the police power of the state and require that the criterion of danger be present, it is well known that in the absence of imminent threat it is almost impossible to predict dangerousness and neither predictions of danger to others nor those of danger to self are at all reliable (Davis et al., 1997) Hospitalizing the mentally ill is a way of controlling unacceptable behavior that may or may not be dangerous (Davis et al.). The involuntary confinement of patients raises ethical concerns around issues of freedom that can make nurses question the basis of certain involuntary holds. Participants in the study reported that they will seek to get the hold dismissed if the evidence of danger is weak or missing.



The first question the nurse asks is: “Do this patient’s symptoms create a danger?”

If danger is clearly present, the need to protect the patient and others from harm is operative and safety outweighs freedom. The participants are absolutely clear and unanimous that they have a responsibility to prevent patients and staff from physical injury. Nonmaleficence or the duty to do no harm and to actively prevent harm is the principle that governs when the issue is actual physical injury. Patients who are admitted on the basis of suicide attempts, or after physically threatening others, do not pose much of a dilemma. Although some individuals may privately believe that individual autonomy includes the right to commit suicide, the professional duty is clear. Nurses may not participate in facilitating suicide (ANA, 2001). Likewise patients who are actively assaulting others on the unit rarely create a significant ethical problem in terms of whether or not they should be stopped, although there are questions about to what extent coercion is necessary.

The issue of autonomy becomes more prominent in the decision making in the case of the gravely disabled patient whose only danger is to him or herself, and then only over the long term. Does walking the streets wearing filthy clothing and hallucinating constitute danger? If not, does anyone have the right to intervene? Should that person be hospitalized against his or her will? That is a difficult question, which poses an ethical dilemma. Should the person be medicated over his or her protests in the hope that the medication will control these behaviors? Involuntary medication treatment that is not given in an emergency to sedate a dangerous patient cannot be justified in terms of immediate danger. Under what circumstances is it justified? Participants call these

situations “a gray area” in which there is no clear-cut right or wrong answer for every patient.

The nurses in the current study did not label the problem of administering involuntary medication an ethical dilemma, nor use terms like autonomy, self-determination or beneficence, which are associated with scholarly discussions of ethics, but they did express the conflict in moral terms. They used words like respect and dignity, and referred to not medicating as inhumane. They talked of respecting the patient’s decisions and needing to hear the patient’s reasons for their refusals. They also spoke of patient advocacy, which along with preserving dignity is an important element in the *Code of Ethics* (ANA, 2001). They spoke of “hating” to give forcible intramuscular (IM) injections and of “violating” a patient’s rights.

Although the need for the patient to accept medication and the strategies to induce the patient to take medication without coercion were expressed and experienced as clinical problems, if asked the nurses might well have labeled them ethical problems. There is evidence in the literature (Fry & Damrosch, 1994; Grace, Fry, & Schultz, 2003) that psychiatric nurses when asked about ethical problems identify coercion as an ethical issue. Maryland psychiatric nurses identified patient autonomy/advocacy concerns equally (57.9%) with problematic staffing patterns as the most frequently encountered ethical and human rights issues (Fry & Damrosch, 1994). When Grace, Fry, and Schultz (2003) surveyed New England nurses about their experience with ethical and human rights issues, the subset of nurses identifying themselves as Psychiatric-Mental Health Nurses or Substance Abuse Nurses identified “protecting patient rights and human dignity” as the most frequently (61.7%) encountered ethical and human rights issue (p.

19). The participants in the current study clearly saw forcible medication as offending patient dignity. The second most frequently reported issue was “providing care with possible health risks to RNs health (e. g., tuberculosis, HIV, or violence)” (p.19). Issues of safety clearly were related to this study’s participants’ willingness to use coercion. Grace et al. reported that “use/nonuse of physical/chemical restraints” was the third (40.1%) and “respecting/not respecting informed consent to treatment” was the fourth most frequently encountered ethical issue (38.3%) for their sample (p.19). This fourth issue is the primary issue in involuntary medication. Their sample was drawn from a variety of settings, only 31% of which were identified as inpatient psychiatric settings. It is possible that with a sample drawn exclusively from inpatient units caring for involuntary patients the frequency of encountering “respecting/not respecting informed consent” would have been higher.

The participants in the current study explicitly expressed perceiving a dilemma between satisfying legal requirements and doing what their clinical judgment indicated. They referred to the need to make a “good clinical decision” and complained that it did not always coincide with what the law demanded. In particular, the strict requirements of being unable to obtain and use food, clothing, and shelter to be considered Gravely Disabled under California Law caused distress when they saw patients released that they thought needed to stay in treatment.

The other legal parameter that they found difficult was the initial wait for a medication capacity hearing and the need to repeat the process every time the patient’s legal status changed. Once they had gone through the stages of Justifying Coercion and believed involuntary medication was necessary, they wanted to be able to act. The time

required for External Justification was experienced as frustrating once they had identified an Impasse.

### *The Decision to Use Coercion*

When there is a consistent refusal to accept recommended medication by a gravely disabled involuntary patient, the choice is to: (a) seek a court order to compelling the patient to take medication and then implement the order by forcibly injecting the medication; or, (b) allow the patient to refuse medication and continue to exhibit symptoms of mental illness. This is a difficult dilemma. The nurse is not alone in resolving the dilemma, but nursing actions and communications to and about the patient frequently determine both the extent of and the resolution of the dilemma (Davis et al., 1997). The participants generally see psychotropic medication as being good and getting the patient to accept medication as beneficent, but they see coercion as bad and use of force as harmful. The ethical question in each particular case is: Is the patient's mental illness sufficiently harmful to the patient and the potential benefit of the medication sufficiently assured to compensate for the harm involved in coercion? "The use of medication in the treatment is so well accepted by mental health professionals that it is now considered unethical not to use medication if its use appears warranted" (Johnson, 1998, p.253).

Legal permission for involuntary administration of medication is based on a judicial determination of whether the patient has the capacity for informed consent. During the capacity hearing, the hearing officer makes the legal determination of whether the patient possesses the capacity to recognize the mental illness and weigh the risk and benefits of accepting medication, freeing the clinical staff from some of the responsibility

for formal coercion. However, the capacity for informed consent is never questioned for a consenting patient. It is only when a patient persists in refusing medication that the court is asked to make a determination. The nursing staff and psychiatrist will have assessed the patient's capacity and documented evidence about lack of capacity prior to submitting a petition for a hearing. The clinical staff's testimony and the documentation found in the nurses' entries in the medical record are crucial to the legal determination. Therefore, the legal justification for coercion must be documented before the psychiatrist has grounds to initiate a petition for a capacity hearing.

The decision to petition is made first by an assessment of the necessity to override the patient's refusal on clinical grounds, and then by an assessment of whether evidence exists for lack of capacity. Sometimes, if the legal criteria cannot be met, the patient will be discharged without ever receiving the prescribed medication. This causes distress to the nurses who genuinely believe medication is necessary for that patient. The ethical dilemma weighs benefit versus harm but the clinical/legal dilemma is whether the clinical evidence that convinces the nurse that coercion is justified is sufficient to satisfy the requirements of the law.

The decision to hospitalize a patient involuntarily is a coercive act in itself but one that takes place prior to the unit nurses' interaction with the patient. As a general principle however, all the participants expressed a belief that involuntary hospitalization was justifiable if an individual was "really mentally ill" and "met criteria". Those participants credentialed to write holds and involuntarily admit patients expressed a need to justify every hold they wrote. Participants do not express a need to justify involuntary hospitalization initiated by others although they may assume an advocacy role to undo

involuntary holds, which they judge unjustified. While the issue of involuntary hospitalization being justified in general was resolved, individual cases could present a dilemma. A typical response to questions about involuntary treatment in general was,

I think that the idea of involuntary hospitalization is basically needed. You have to have that. The question really is when and how and that's always been a problem. If you go by very, very strict LPS (criteria), actually a very small percentage would meet the criteria. And as it is there are many people who need involuntary hospitalization but don't get it because they don't meet the LPS criteria, so I think it's needed. The problem is how you balance the patient's rights thing and how you balance someone's ability to make a decision for their own self. And that's very, very difficult because basically you are saying he can't make the decision or she can't make the decision for themselves and that's always a tough thing. But you know that if they take medicines they'll be a lot better and they'll be grateful, you think.

Their process of Justifying Coercion after the patient has been admitted is described by the participants as taking place in two very different circumstances: (a) dangerous behavior necessitating seclusion and/or restraint (an emergency IM dose of psychotropic medication is a chemical restraint) and (b) non-trivial treatment refusal requiring involuntary medication administration. The first only rarely constitutes an ethical dilemma but procedurally demands justification. The second is frequently a dilemma. Seclusion and restraint decisions explicitly demand that there be an emergency and a clear danger of harm. Under such conditions the need for justification is well established and the process spelled out in policy and procedure. When justifying seclusion or restraint ethical concerns relating to autonomy and freedom become secondary to the rights of all involved to be free from harm. Since the profession has articulated its standards on seclusion and restraint (ANA, 1999; APNA, 2000; ISPN, 2000) there is guidance available to determine the basis for Justifying Coercion.

Involuntary medication administration is much more ambiguous ethically. Professional standards on involuntary medication are not articulated and the decisions are not made on an emergency basis so the process of Justifying Coercion when giving medication requires more elaboration, although the stages of the process are the same. This discussion will briefly consider the process as applied to seclusion and restraints before focusing on the more complicated and challenging form of the process involved in Justifying Coercion in the involuntary administration of psychotropic medication to involuntary patients.

### *Justifying Seclusion and Restraints*

Professional associations and regulatory bodies agree that seclusion and restraints are coercive practices to be avoided unless there is no other intervention possible that will secure the safety of the people involved. Fisher's 1989 California study found that definitions of dangerousness and decisions to act were highly dependent on unit and institutional culture rather than professional education and Mason (1997) found that nurses in a British forensic psychiatric unit balanced peer expectations with administrative dictates. However, current use of seclusion and restraint in the United States is highly regulated and facility accreditation is dependent on documentation of appropriate decision-making (JCAHCO, 2000). After the change in Health Care Financing Administration regulations in 1999 requiring facilities receiving federal money to adopt new procedures on seclusion and restraint, the culture in most facilities requires justifying seclusion and restraint by showing that no less restrictive interventions have resolved the danger and documenting that all the criteria have been met. Regular staff training on the procedures is mandated.

All study participants had been involved in their facilities' re-examination of seclusion and restraint practices. They had each developed a clear personal definition of what "last resort" meant in regard to seclusion and restraint. When they have to resort to seclusion and/or mechanical restraint or an emergency IM injection that is being used as a chemical restraint they feel fully justified. One nurse says,

Well you try and weigh everything that is happening, all the factors. And of course, the final thing you weigh is that question, is this an emergency? Is this person a danger to himself or a danger to others? And then you go through your thinking process and say, yes, this patient is a danger . . . then you're emotionally and intellectually satisfied that you've met that criteria.

And another says,

I don't have to struggle - like you know - why am I doing this? I don't have a lot of doubt or anything like that because I'm confident and I kind of feel a trust in my judgment.

Although several nurses expressed reservations about the safety of some of the changes, others were very gratified with the reduction in seclusion and restraint use that had resulted from the changes.

I'm glad to see that there has been less use of restraints. We've always been a facility here that's been really proud of our low usage. But even our usage has become less. I see national statistics that show there's been a decrease; and I think that's a good thing.

If other interventions had been used, we could have avoided the seclusion or restraints. I don't see that so much any more because not only am I more experienced and more confident about what I'm doing, but that's what has to be. We use the seclusion and restraint less often. We're trying; we're making a conscientious effort not to. So we're trying other avenues. I can't think of anything lately that I've done that I didn't feel we should have.

There is a conscious process of Justifying Coercion when implementing seclusion and restraint that includes all of the stages of the BSP. The process takes place in a relatively short timeframe and under considerable pressure. However the rules are clear:



All less restrictive measures are to be utilized before restraint/seclusion is initiated. . . Restraints and seclusion shall only be used as emergency measures to protect patients from injury to themselves or others. . . . when the patient's mental condition and behavior is such that there is a substantial risk of the patient harming himself/herself or others in the unit. Substantial risk shall be interpreted to mean only the serious imminent threat of bodily harm. . . . (Los Angeles County Department of Mental Health, 1998, p.122) (California law had these provisions prior to the HCFA and JCAHO regulatory changes.)

“Assessment of Need” is essential but the criteria are well established and not at all ambiguous. The decision to intervene is impelled by the nurse's responsibility to maintain unit safety and control violent behavior. The need for “Interpersonal Negotiation” of a change in behavior is mandated by the requirement to use all less restrictive measures. In addition to the internal motivation to do what is right there is a consciousness that the decision will be reviewed and that the coercive action must be justified to prevent criticism (Mason, 1997). An ethical dilemma does not arise unless there are questions about the assessment of danger or failure to engage in negotiation.

The participants speak of situations in which their negotiation skills prevented “unjustified” use of seclusion and restraint and other times when they were unable to avoid “justified” use. They describe other nurses who in their perception fail to adequately justify coercion before using seclusion and restraints. Clearly they experience all the stages of Justifying Coercion when involved in implementing seclusion and restraints. Since the researcher theoretically sampled for descriptions of coercion related to medication administration rather than seclusion and restraint, descriptions of seclusion

and restraint episodes are not as rich. Frequently participants describe situations in which coercion was prevented and the process did not reach the final stage. Further research focused on justifying seclusion and restraint might elaborate more fully on the process of Justifying Coercion in that context.

#### *Justifying Involuntary Medication Administration*

The psychiatric literature (Appelbaum & Hoge, 1986; Gutheil & Appelbaum, 2000; Schwartz et al., 1988; Winick, 1997, Zito et al., 1985) since the court decisions (Rennie v. Klein, Rogers v. Commissioner, and Rivers v. Katz cited in Schwartz et al., 1988) that instituted procedural hearings for patients refusing medication includes great detail about the issues of autonomy and competence, or capacity to make informed decisions. Gutheil and Applebaum (2000) summarized the literature and the supporting research from the United States. They reported that, although clinicians were reluctant to participate in legal proceedings, the majority of reports indicated that psychiatrists were convinced that for the most part psychotic patients were incapable of autonomy and needed to be medicated whether or not they refused. When a non-trivial refusal was brought to a hearing, the psychiatrists prevailed in approximately 95% of the cases. Similar attitudes towards using coercion to medicate psychotic patients have been found in Israel (Roe, Weishut, Jaglom, & Rabinowitz, 2002) and the Nordic countries (Olofsson & Norberg, 2001).

Patel and Hardy (2001) describe an active campaign to overcome psychiatrists' resistance to resorting to formal coercion in an Illinois State hospital and report an increase from 97 in the year preceding the project to 192 during the following year. They report decreased use of seclusion and restraint and reduced length of stay in that same

time period. Although not claiming a cause and effect relationship, Patel and Hardy clearly imply that coercion in medication administration is justified for their population of SPMI patients.

There was no recent research about United States psychiatric nurses' attitudes about involuntary medication administration prior to the current study. In the current study there was general agreement that antipsychotic medication and mood stabilizers are effective and necessary for SPMI adults. There were some caveats concerning medicating children and adolescents.

### *The Basis for Justification*

In California involuntary treatment after the initial 72-hour hold requires that the patient having been advised of the need for treatment has not been willing or able to accept treatment on a voluntary basis (LACDMH, 1998). The participants attribute this inability to accept treatment to lack of insight. They recount instances where they have been able to "get the patient to see" that they needed treatment. In their accounts and in the researcher's clinical experience it is clear that involuntary treatment most often ends before the initial 72 hours is up, and medication refusal rarely persists long enough to require a petition for a capacity hearing. It is only those patients who are unable to acknowledge that they are ill and in need of treatment that require coercive measures to get them to accept medications. Medication refusals on the basis of intolerable side effects or lack of previous efficacy are dealt with by problem solving rather than coercion. Justification for coercion requires that the nurse believe that the patient by virtue of his or her illness is unable to apprehend reality.

The participants are able to empathize with the patients who do not accept the idea that they have a mental illness. They understand that mental illness is a stigmatizing diagnosis that results in a discredited identity (Goffman, 1963). They can accept patients' and families' resistance to accepting an explanation for the patient's behavior that involves a permanent label of mental illness. Accepting antipsychotic medication involves acknowledging that one does not experience reality in the same way as others and that others' perceptions of reality may be correct. Goffman (1961) indicates that to accept this perception of oneself is to acknowledge that one has "failed in some over-all way . . . being hardly capable of acting like a full fledged person at all"(p. 152).

Although psychiatric units are no longer the "total institutions" of Goffman's day and to some extent the stigma of being a psychiatric patient is less than it was 40 years ago, it is still true that it is the job of the nursing staff to get an involuntary patient to accept the staff's judgment that he or she is indeed mentally ill and in need of the treatment ordered. If the nurse cannot legitimately support the judgment that the patient is mentally ill or that the care being recommended will be helpful, the nurse cannot sustain the role of a professional nurse providing care based on the patient's needs.

#### The Therapeutic Relationship as Context and Strategy

The process of "Justifying Coercion" in this study takes place in the context of inpatient psychiatric nursing. This means it is a process that takes place with certain patients within the larger ongoing processes of psychiatric nursing with all the patients on a psychiatric unit. The two primary processes basic to all nursing are: (a) "The Nursing Process" consisting of assessment, diagnosis, outcome identification and planning, implementation, and evaluation (ANA 2000; Arnold & Boggs, 2003); and (b) the "Nurse-

Patient Relationship” consisting of orientation, identification, exploitation and resolution (Peplau, 1952). In describing the nurse-patient relationship sometimes identification and exploitation are combined and labeled the “working phase” and resolution is labeled “termination” (Arnold & Boggs, 2003). Regardless of the terminology, in psychiatric nursing the nurse-patient relationship is considered the primary therapeutic process (Forchuk & Brown, 1989; Townsend, 2000). Justifying Coercion is a process that develops within the nursing care that is given to the resistant involuntary psychiatric patient, but the ongoing processes of the nursing process and the nurse-patient relationship are omnipresent in their care as well, beginning before, continuing through and persisting after Justifying Coercion. In this context, properties of Justifying Coercion are also properties of the other two processes and do not exist independently (figure 3).

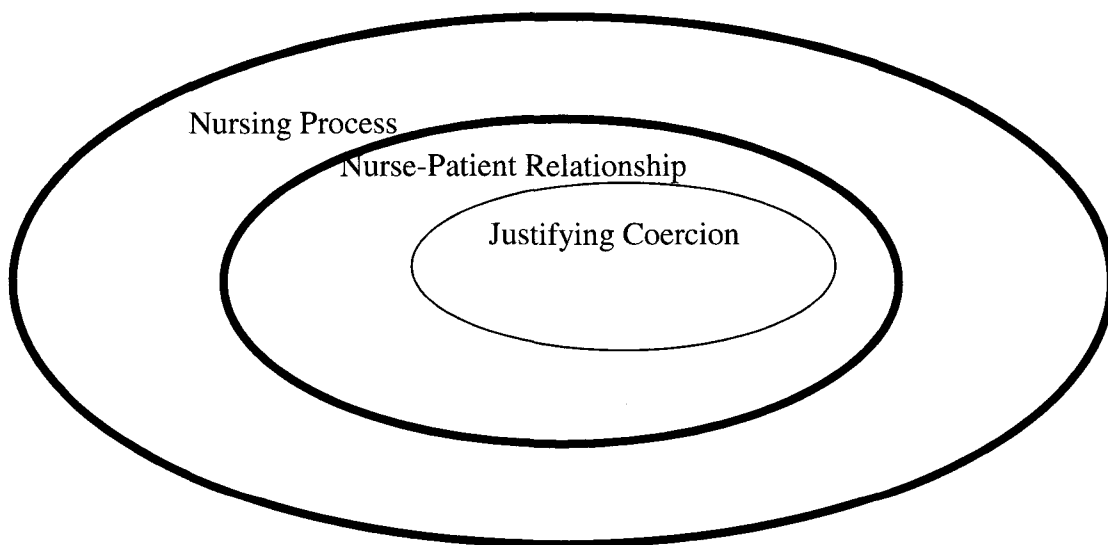


Figure 3: **Justifying Coercion in Context**

The nursing process is an organizing structure for all clinical nursing practice and the stages of the process correspond to the stages of the nurse-patient relationship. The relationship “affects every aspect of the nursing process which in turn provides the basic format for all activities carried out in the relationship” (Arnold & Boggs, 2003, p. 36). For the purposes of this discussion, the nursing process will be understood as integral to psychiatric nursing and thus an essential context for the substantive theory of Justifying Coercion within the context of psychiatric nursing care of involuntary patients. Explanation of the nursing process is beyond the scope of this paper; however the particular properties of the psychiatric nurse- involuntary patient relationship are part of the data grounding the theory of Justifying Coercion and as such must be explored to comprehend the process.

#### *Establishing Rapport*

Pescosolido et al. (1998) describe coercive entry into the mental health system as actively negating the role of the individual and representing social control that propels the patient “into treatment despite their continual and active resistance” (p.281). Goffman (1961) describes it as an act of betrayal. The participants understand that on entry into the system the involuntary patient is upset, often angry and often confused. In order for a therapeutic nurse-patient relationship to develop, in the initial orientation phase “the patient needs to recognize and understand his difficulty and the extent of need for help” (Peplau, 1952, p.22). The nurse needs to be identified as a helping agent. The participants try various strategies to bring this about but in general they label their initial moves “establishing rapport”.

The nurses try to take the patient's perspective and maintain the patient's dignity and respect. They wish to be seen as caring, helpful and trustworthy. In order to assist the patient to understand the necessity of accepting medication the nurse must be seen as a credible source of accurate information. The nurses start by explaining what has happened and what the unit is all about. They provide introductions to other patients and staff, orient the patient to the space, the rules, the routines and the expectations, and ask the patient what he or she needs. They listen to the patient's story and do their best to understand what has occurred that brought the patient to them as an involuntary patient. They try to be available. Being available means spending time with the patient who is based on the patient's readiness and willingness to engage. They avoid the appearance of being rushed. These strategies are not different from the strategies used in the orientation phase with voluntary psychiatric patients but resistant involuntary patients require more energy, and an ability to engage repetitively in the face of anger and rejection.

They express guilt and frustration if the time required by other duties or the severity of the patient's illness prevents a therapeutic relationship from developing. One of the subjects in Breeze and Repper's (1998) study of care for difficult psychiatric patients said, "It's this sense that nurses have that they should heal all patients, and know all about the best way to help that patient" (para. 12). The nurses do their best to establish a therapeutic relationship, to do otherwise challenges their competence.

Part of this initial orientation phase is establishing the nurse as an advocate. They speak to the doctor on behalf of the patient. They give the patient directions on how to navigate the system. They make a genuine attempt to empower the patient. In this study, as in other studies (Breeze & Repper, 1998; Hummelvoll & Severinsson, 2002; Olofsson,

et al., 1998; Olofsson & Norberg, 2001), the nurses believe in the therapeutic value of the nurse-patient relationship. In order to justify coercion they have to believe that they have competently engaged the patient and done everything in their power to engender trust.

### *Negotiating Values*

The intersystem model (Artinian & Conger, 1997) describes the task of the orientation phase of the relationship to be the nurse and patient together clarifying the understandings of both and negotiating mutually agreed upon goals. This is called “negotiation of values”. The model calls for the nurse to compensate for the imbalance in power between nurse and patient by taking great care that the patient’s knowledge and values are an important part of the input. With the resistant involuntary psychiatric patient this becomes a great challenge. Research indicates some nurses do it very well. In Breeze and Repper’s (1998) study the difficult patients described “good” nurse-patient relationships where they were treated as valued persons, allowed some meaningful control over their care by incorporating their own goals into the care plan, listened to and believed. Susman’s (1994, 1998) study showed that when nurses bargained with patients for medication acceptance patients felt treated fairly even when ultimately coerced into taking medication. The critical element appears to be that the patient has a “voice”. The participants in the current study, as part of their relationship building, made attempts to do this.

Part of the necessity for negotiating values is that in the participants’ experience patients who do not come to eventual acceptance of the treatment plan do not follow the plan after discharge. The participants say, “They will come back.” The justification for coercion is that the good for the patient will outweigh the harm. If the outcome is only



that the patient gains sufficient control of his or her behavior to be released and then repeat the behavior, what good has been accomplished? The nurses believe that whatever coercion takes place is usually only a temporary measure until the medication reduces the symptoms sufficiently for the patient to make use of the learning that takes place within the nurse-patient relationship. Therefore it is important that the patient be treated with respect and dignity so that the patient can believe that the nurse is someone who cares and is able and willing to do what is right.

Another aspect of negotiating values is helping the patients come to terms with the reality of the rules and laws that govern the nurse's actions and the patient's involuntary status. The nurse does not have the final say about the patient's admission, discharge or medication. It is not just what each participant in the relationship wants to happen that governs what will be. The psychiatrist, the hospital, and the other members of the health care team all make decisions that determine what the treatment plan will be. Negotiation of values requires a common definition of what the situation is. In the intersystem model this is called a "negotiated awareness context" (Artinian & Conger, 1997).

In the process of "talking with" the patient the nurse listens to the patient's version of the situation they are in and describes the information about the situation that has come to the nurse from other sources. The negotiated awareness context ideally becomes a mutual understanding that because there are power differentials, the official version is likely to carry more weight than the patient's version but that the nurse is willing to consider what the patient has to say.

*Being a Good Psychiatric Nurse*

From their responses participants appear to agree with the Davis et al (1997) discussion of behavioral control that says,

Once a person enters the mental health system as a patient, the nurse becomes a major source of information regarding that person's behavior. . . . Many decisions regarding treatment occur in team meetings, and the nurse affects the discussion by either providing information or withholding it. If he or she provides information, what is reported and how it is said influences the perceptions of the patient by others. . . . Nurses also have a great influence about decisions on drugs, such as type, dosage and frequency. (pp. 203-204)

The participants readily acknowledge influencing the psychiatrist's decision to petition for a Riese hearing to determine the patient's capacity to consent to medication. They are clear that some patients are justified in their refusals, some need to be medicated but don't need to be forced, and some will not take needed medications without coercion. They feel responsible for assisting the patient in negotiating with the physician when the patient has legitimate concerns about side effects.

The participants acknowledge their participation and responsibility in coercing patients to take medications. Their perceptions resemble that of the researcher Jack Susman (1994) who indicated that in psychiatric institutions medication refusal is primarily handled by the nursing staff. In his study of non-trivial refusals, the nurses' bargaining resolved twice as many refusals (28 vs. 14) as the formal hearing procedures. He did not include the many one or two day refusals that the nurses resolved without conflict.

The psychiatrist and court are involved only when efforts by the nursing staff fail. Because the nurses have a degree of responsibility for the decisions, they have a need to justify the actions taken to initiate formal coercion. Because they also believe that, in many cases they can, through expert nursing interventions, eliminate the need for forcible medication even in the context of a court order to medicate; they express a pressing need to justify IM injections.

The researcher has known nurses (through over 30 years of psychiatric nursing practice) who have not been particularly concerned about Justifying Coercion on a case-by-case basis. Once they had accepted the overall premise that involuntary hospitalization and involuntary medication administration was legal and justifiable, their concerns shifted to documenting the criteria, not avoiding coercion. During the interviews this lack of concern was not evident. While it is possible that the participants concealed such attitudes during the interviews to avoid appearing uncaring, it is more likely that nurses who agreed to participate in research about involuntary procedures without any benefit to themselves genuinely have ethical concerns about coercion. They had opportunities to describe situations in which people other than nurses were responsible for the coercion that patients experienced and indeed did make references to other people being too ready to resort to involuntary procedures, but they made it clear that they themselves felt responsible for preventing coercion if at all possible. They were very clear that they “hated” participating in forcible IM medication of resisting patients. To do such a thing required them to have justified the action to themselves.

### *Maintaining the Nurse's Self Image*

Symbolic Interactionism holds that individuals judge themselves by what they perceive to be the standards of their reference group (Charron, 1998). To sustain a self-identity of a “good” psychiatric nurse, the nurse must see him or herself as acting in the patient’s interest. Smith and Godfrey (2002) examined American nurses’ conceptions on what constitutes a “good nurse”. They found that, for nurses, caring and competence were intertwined and that the good nurse critically examined what was needed and did the right thing. They said that their findings might indicate that, “in these nurses’ minds, there was a strong connection between being a good nurse and doing the right thing” (p. 308). The nurse makes his or her own judgment of what is the right thing to do. To sustain their self-identities they need to justify to themselves any actions that might seem to be “bad” or “wrong”. In addition, with the need to convince the patient who what is being done is “right”, the nurse must have enough faith in the rightness of the action to sustain a convincing argument for the action against the patient’s resistance.

One participant spoke of the difficulty in providing care when she didn’t agree with the psychiatrist’s decisions.

There were cases that I was dealing with that I didn’t necessarily 100% agree with the necessity to put that patient on the hold. Thank God I didn’t run into that very often, otherwise it would create - it would be a problem for me because I think we have to respect patient’s decisions. If they are not really, really a potential danger to themselves, others or gravely disabled; you know if they really can be treated on a less restricted kind of environment I think we need to respect that and support that and try to make that happen.

### *Maintaining the Relationship*

Emphasis on maintaining trust and a therapeutic nurse-patient relationship persists throughout the entire process of Justifying Coercion. The participants believe that if a

patient trusts the nurse to care for him and advocate for his interests, coercive actions by the nurse will be seen from that perspective and will not damage or impair the relationship. They place a special emphasis on not abandoning the patient after coercion takes place. They believe that it is important to spend time and be with them, to explain again and be available. They are particularly concerned that the coercion not be seen as punitive, but as an attempt to help. They concur with the nurses from Olofsson and Norberg's (2001) study that the important factor mitigating the use of coercion was human contact and a mutual relationship.

### *Efficacy*

The nurse needs to justify the care provided and legitimize his or her role as a psychiatric nurse. This requires a belief in psychiatric disorders as "real" illnesses in need of treatment. To persuade patients that they should take the medications being ordered, the nurse must believe in the efficacy of the medication in general and the appropriateness of the medication for this patient in particular. This accounts for the emphasis in the assessment period on the patient being "really" sick and the repetitive reports of medication being helpful to particular patients that they convinced to try it. The clinical guidelines for treating schizophrenia and bipolar disorder (APA, 1994, 1997) indicate that by administration of antipsychotics and mood stabilizers a minimum of 80 percent of patients will experience marked improvement and that without treatment a patient will face substantial and prolonged distress and impairment. These guidelines inform the perspective that psychiatric nurses share with psychiatrists and other members of the treatment team. With new medications being approved regularly, nurses believe that, except for a very small group of patients, a medication will be found that will reduce

their psychotic symptoms or failing that ECT will induce remission. Several of the participants had never had a patient who failed to improve on medication.

In addition to a belief in the correctness of the purposed treatment and the illness as being responsible for the patient's inability to comprehend this "truth", the nurse must also believe that the patient's illness is so severe that either the nurse cannot "get the patient to see" or the symptoms are so deleterious that the time required to achieve patient agreement would cause undue "suffering".

The nurses believe that most patients, if they "give them time and space" and educate them sufficiently, will acquiesce to taking prescribed medication. They object to hurrying the process and resorting to coercion before they have a chance to negotiate an agreement. In general they do not consider "persuading" or "pointing out reality" to be coercion, but do acknowledge the sort of informal coercion involved in holding out earlier discharge, or more privileges, if the patient will accept medication. Getting the patient to agree by using inducements and indicating the probability of a longer hospital stay if the patient does not agree is justified by the patient being "really sick" and meeting criteria.

Justification of formal coercion, in the form of petitioning for a court order and actual use of force subsequent to the court order, requires that the nursing staff have failed in Interpersonal Negotiation with the patient. The nurses believe that holding the patient down and forcibly injecting the patient with medication can only be justified if all other possibilities have been exhausted and the patient's condition is such that to not medicate the patient would be to do the patient harm. Their accounts accord with Benjamin and Curtis' (1986) description of three conditions for justification for

“parentalism” (the authors’ term for paternalism) which are: (a) the patient’s capacity for rational reflection is significantly impaired, (b) the patient is likely to be significantly harmed unless action is taken, and (c) it is reasonable to assume that the patient will with the recovery of his or her capacity for rational reflection ratify the decision. They are convinced that when they participate in coercing the patient they have met these conditions. They describe the patients as “Suffering terribly” or in “desperate need.” They offer descriptions of patients being markedly better after being medicated and being “grateful” for the intervention. In this they resemble the Swedish nurses in Olofsson et al.’s (1998) study in needing to be seen as having done good for their patients when they had to resort to coercion although, unlike the Swedish nurses, they were not unquestioning of the inevitability of coercion.

Psychosis impairs reality testing and hinders the ability of a nurse and a psychotic patient to come to a mutual understanding of what the patient’s problem is and what the patient needs. In Watters’ (2000) study of Australian nurses attempting to teach patients about their psychiatric medication the nurses used a social control process called “Regulating” to attempt to bring the patients to agree with the nurses’ perception. The nurses in the current study had the same goal of bringing the patient to a common understanding of the problem and the proposed treatment but used fewer controlling strategies in the initial phase of the relationship.

Watters calls the first phase of Regulating “Inducting”. Inducting incorporates “Confining” and “Orienting”. Confining strategies consist of restricting movement, withholding privileges, and increasing medications; orienting strategies include introducing, establishing rules and regulations, and sanctioning consequences. Orienting

is very similar to the “explaining” described above, although except for assaultive behavior the participants in the current study did very little sanctioning consequences. However, in the less paternalistic settings in which the nurses in the current study practiced there were almost no examples of confining. Involuntary patients are restricted in their movement by the nature of their involuntary confinement but the participants do not endorse withholding privileges as a way to negotiate values. Increasing medication is an alternative not available in the study settings. The participants in this study preferred advocacy and spending time building the relationship, positive inducements to consider adopting the nurses’ values, to the more negative controlling strategies. They believe that if the patients come to trust them, the patients will also come to accept that their situation requires ongoing treatment with medication.

Supporting these beliefs are their reports of the patients coming back to them, apologizing for resistant behavior and thanking them for their actions. In the Olofsson and Norberg study, six patients were among the participants and two of them endorsed being grateful later for the coercive actions of the staff. The patients in that study also reported the importance of the nurse–patient relationship, particularly receiving explanations and human contact, when being subject to coercion. Patient participants in the Breeze and Repper (1998) study of difficult patients valued nurses “just being there” and equated spending time with them to caring. These same patients valued the nurses’ explanations for the actions that were taken.



*Nursing Strategies Across the Stages**Assessment of Need*

During the initial and recurrent assessment phase of the nursing process, in addition to gathering and recording data for the medical record and formulating a nursing care plan, the nurse is assessing the need for involuntary procedures. The nurse collects and analyzes data from the initial written hold document, from the family and attending psychiatrist reports of the patient's recent behavior and from old medical records when those are available. Data from those sources help the nurse to understand the reasoning that guided the decisions about involuntary treatment. However, when it comes to justifying the nurse's participation in coercion the nurses describe their own interactions with and observations of the patient.

They attend to how well the patient is able to care for him or herself. An initial observation of "filthy and disheveled" can be mitigated or confirmed by the patient's response to the nurse's offer of a hot shower and clean pajamas while the dirty clothes are being washed. A patient who can't accept such an offer is seen as suffering from "self-degradation" and as being "really sick". A patient's ability to eat and sleep is also monitored. A patient who is dehydrated and not eating or drinking, or a patient who is up all night pacing and muttering is seen to be "suffering".

The nurses attend to the patient's ability to share in the common reality. Severe delusions or hallucinations, inability to respond to staff's attempts to orient or reassure them, emotional responses of fear, anger, hostility, or marked anxiety without apparent cause, and inability to communicate the reasons for reactions and behaviors lead to a judgment of "really psychotic" and "in desperate need of treatment." The nurses do not

accept anyone else's judgment. "I have to see the patient and judge for myself." If the patient is clearly displaying symptoms that the nurse deems dangerous or damaging to the patient or to the patient's ongoing ability to sustain him or herself in the community, then the nurse feels that treatment is needed and justified.

The basic premise is that these symptoms cause suffering and that to allow them to go untreated is harmful to the patient. The nurses in Hummelvoll and Severinsson's (2002) study of caring for manic patients expressed similar ideas as did Krauss (2002) in an editorial in *Archives of Psychiatric Nursing*. All agree that the nurse's primary obligation to the patient is to attempt to relieve suffering. If the patient is unable to understand what will help then the nurse must first try to assist the patient to understand and failing that demonstrate what will help by overriding the patient's refusal and relieving the suffering by administering appropriate treatment.

What is appropriate treatment? The other part of Assessment of Need is the determination that the symptoms causing the suffering will be relieved by the proposed treatment. The participants in this study believe that generally "medications will help" and patients "do benefit" from taking the medications prescribed. However they are not totally convinced about electro-convulsive treatment (ECT) and several of them told me stories of preventing psychiatrists from going ahead with ECT when the patients did not want it. They are also selective, if they think the patient's resistance is so strong that it will undermine any benefit from the medication, they cannot justify coercion. When they have a patient who's symptoms appear to be related to a significant loss or stressor rather than a biologically based psychiatric illness, they will advocate for delaying coerced

medications and allowing time for relationship-based therapy to relieve some of the symptoms. To justify coercion, the nurses must believe that the patients will benefit.

The participants distinguish between patients requiring the safety of the hospital and patients requiring psychotropic medication. While the participants believe that antidepressants are effective and helpful, the long delay before onset of action and the need for the patient to continue taking medication for months to obtain maximal benefits make them unwilling to coerce depressed patients into taking medication. They will work to keep suicidal patients in the hospital and subject them to very intrusive one to one observation to prevent them from killing themselves, but can't justify involuntarily medicating such patients. The depressed patient will benefit only from continual voluntary compliance with antidepressants. The nurses do not believe coercing the patient to take them while in the hospital will achieve this goal. They do believe however that involuntary administration of antipsychotics and mood stabilizers will bring psychotic symptoms rapidly under control and tell of the "complete turn-around" and "miracles" that they have seen that support this belief. So Assessment of Need justifies coercion in two ways. It establishes the harm that lack of treatment will do and it establishes the probability of good resulting from coercion. Justification requires both.

#### *Decision to Engage*

The Registered Nurse may be required to assess the patient every shift and document the patient's status but he or she is not required to engage in the delicate give and take of giving time and space and then spending time. Getting to know the patient well enough to get the timing right means lots of observation, making oneself available

and going back repeatedly not just spending ten minutes at the end of the shift to do an RN assessment.

In the facilities employing the nurses in the study and in other similar California facilities the ratio of Registered Nurses to patients varies from one RN to six patients on units where all the licensed staff were RNs to one RN for 20 patients in some facilities that use Licensed Psychiatric Technicians (LPTs) and Licensed Vocational Nurses (LVNs) in addition to RNs. The work load of an individual RN may require that he or she can invest in only one or two very resistant patients at any given time. There are multiple opportunities for Interpersonal Negotiation that can be seized or avoided. Each nurse makes choices regarding the benefit of engaging in interpersonal negotiating with particular patients.

Hess (1996) discusses engagement as a synthesis that transcends the issue of coercive power by bringing the voice of both patient and nurse into the definition of good and the identification of the means for achieving the good. She says, "Engagement is an ideal, not an obligation like compliance or a duty like respect for the principals of autonomy and beneficence " (p. 25). Hess indicates that engagement involves an invitation to the patient as well as the nurse to engage. She says that while the patient if he chooses not to engage, cannot be forced, the nurse is morally obligated to remain in the relationship, be authentically there, and serve as a sounding board for the patient's voice (p.26).

An ideal situation would have it that every resistant patient would have at least one nurse actively engaged with him or her in Interpersonal Negotiation, but the reality is that some patients are subject to coercion after only the most rudimentary negotiation.

Other patients may be discharged untreated because their resistance is so great that it is believed that it is not worth the time and effort necessary to obtain legal permission to medicate only to have the patients discontinue the medication immediately after discharge. The nurse weighs the intensity of the patient's need, the responsiveness of the patient to initial attempts to establish rapport, the depth of the patient's resistance, and the nurse's availability before deciding to engage with a particular patient.

### *Interpersonal Negotiation*

Fisher and Ury describe negotiating as "a basic means of getting what you want from others" (1983, p. xi). Strauss (1978) describes it as one means of getting things done when you have to work with other people to accomplish your tasks. In both books negotiation is identified essentially as a means to an end. Strauss, in particular, indicates that any particular ongoing group requires continuous negotiating to derive social order. Negotiating can be about distribution of work or property, it can be about definitions, and it can be about the legitimacy of actions or identities. In the process of Justifying Coercion interpersonal negotiating is about the legitimacy of the staff's definition of the patient as mentally ill and in need of treatment and patient acceptance of a particular treatment. The primary tactics used in Interpersonal Negotiation are giving explanations of behavior and symptoms and spending time listening to other explanations. Since an involuntary patient has limited experience of the psychiatric unit's social order and no particular reason to seek to maintain it, another part of interpersonal negotiating is what Strauss labels "implicit bargaining" in which one side accepts certain behaviors or claims or limits in order to keep things going smoothly without ever actually agreeing. Baer and Murray (1999) describe this process in their study of insight into schizophrenia. In their

study patients who denied having the illness still took medication for the illness because it kept them out of trouble or it was a requirement to participate in the program. Nurses will present some patients with reasons for taking medications totally unrelated to the illness and need for treatment. They will say, “Your mother wants you to do this” or “It will show your doctor you are ready to leave the hospital.”

Kritek (1995) says that negotiating is the nature of nursing, that it is so central that it is an unstated assumption, an invisible skill, particularly when it is done well. She writes of the subtle studying nurses do of the perceived reality of others as they deliberately strive to understand and integrate competing perceptions. It is an informal personalized and individualized process.

When nurses set priorities for what can reasonably be done in a given situation, they do so by viewing the patient as a whole, with all the diverse responses people have to a health event. They perceive all the dimensions of the patient’s reality as important and germane. Nurses know that real healing for every patient involves a return to wholeness for this very specific and unique individual human. That is why nurses worry about the many elements of the patient’s context and why they negotiate with so many people on the patient’s behalf, addressing the human dimensions of health in all their interactive complexities. Often, when there is no science to guide them, they operate from a base of finely honed intuitive skills, which the tools of science are inadequate to either describe or measure. (Kritek p.211)

To categorize the strategies of interpersonal negotiating described by the participants, proved almost impossible. How do getting bottled water for the patient

whose refusal was based on the unpleasantness of washing down pills with tap water, sitting with the patient for an hour, letting the patient stay alone instead of going to group, and setting firm limits that require a manic to ask appropriately before taking him on a smoke break relate to one another? They are all negotiating techniques designed to get the patient to acquiesce to the treatment plan. These and many, many more specific actions constitute the strategies the nurses use to negotiate. Some of them involve therapeutic communication techniques, some involve nonverbal actions; some are done with the patient, some with others on the patient's behalf. Sometimes the nurse draws closer and engages the patient; sometimes the nurse steps back and waits for the patient to engage the nurse. Sometimes the nurse stays with the patient, sometimes the nurse comes back every five or ten minutes and sometimes the nurse waits hours before approaching. One nurse says, "It's tricky." There is no one right way. What became apparent in the data was that once the nurse decided to engage in Interpersonal Negotiation the nurse used every strategy in the nurse's repertoire to get the patient to comply.

*Offering options.* Offering options or choices was identified as an important technique of Interpersonal Negotiation. Nurses saw this as providing opportunities for a patient to maintain a degree of autonomy. Giving options when the patient really has a range of choices can be empowering, but choosing between giving in and suffering consequences is not really a free choice. It is actually the beginning of informal coercion. In Hummelvoll and Severinsson's (2002) study the participants specify that although the patient's freedom is reduced, the reduction in freedom of choice is motivated by caring. The article calls it "caring deprivation of liberty". The participants in the current study

saw giving the patient options as maintaining the patient's dignity by giving them an opportunity to save face by choosing to go along rather than be forced. The patient participants in other studies (Breeze & Repper, 1998; Prescolido et al.; 1998) described these sorts of options as staff controlling them and did not see them as real choices.

Watters (2000) described the same concepts in a somewhat different order without addressing any need for his nurse participants to define their action as caring rather than controlling. Many of their strategies appear to be similar, but without the apparent need to be justified. He attributes this to the paternalistic setting and the lack of mental health education for the participants in his sample. In Watters' study, "negotiating" included (a) "investigating", which is parallel to the "finding out why" that is part of "Assessment of Need" in the present study, (b) "resourcing" which involved bringing other people in to support and reinforce the nurses, (c) "acquainting" an information giving or educating process which included the sub processes of "persuading", "coercing" and "nominating options". He describes persuading as convincing, reassuring, and counseling. The participants in the current study included persuading among their strategies. Watters makes the comment that persuading is a slow process and that the nurses often chose to exercise coercion instead because it is quicker. His definition of coercion is: forcing someone to conform or comply. Interestingly "nominating options" follows coercion rather than preceding it. One of that study's participants said, "Nominating options did not box people into corners with no alternatives". Watters' next phase is "taking charge" which is actual use of force. Sub processes are "threatening" and "constraining".



Participants in the current study perceive giving the patient the option to decide as empowering the patient rather than coercing. Even if the whole team was gathered and ready to use force, granting the patient time to take the medication on his or her own was seen as a negotiating strategy to avoid coercion. The threat exists, but the nurse participants in this study echo those in Olofsson and Norberg's (2001) study who said the way to avoid coercion was to wait and see rather than act. Justification of Interpersonal Negotiation strategies is based on: (a) stabilization of patient behavior, (b) avoidance of formal coercion, (c) mitigation of informal coercion by maintaining the patient's dignity and opportunity to make the right choice, and (d) success.

*"Persistently trying" and "staying with"*. Whatever the eventual outcome of involuntary administration of medication, antipsychotic medication and mood stabilizers take time to work (APA, 1994; 1997). In the immediate aftermath of the coercive action the patient will be upset, angry and perhaps afraid. The nurses stress the importance of "staying with" the patient and not abandoning them. They tolerate any angry words and explain over and over what was done and why. Sometimes they leave the patient alone to calm down but they make it clear they are available and keep coming back. They want to justify the coercion to the patient as well as themselves. They want the patient to understand that the coercion is meant to help. They hope for the patients to eventually be grateful. It is by "staying with" the patient who the nurse maintains whatever rapport has been established and continues the working phase of the nurse-patient relationship. Further coercion is likely to be necessary and so the nurse "negotiates dose by dose" hoping that soon the patient will no longer need to be coerced. If the nurse is unable to maintain a therapeutic relationship with the patient it diminishes the nurse's perception of

self as a caring professional and turns the nurse into “an enforcer”, a role the participants want very much to avoid.

In Watters’ (2000) study, he calls the act of involuntary administration of medications “constraining” and does not discuss how nurses justify that action to themselves or the patients. His final phase of regulating he labeled “disengaging”. He identifies a temporary disengagement he calls “respiting” in which the nurse minimizes contact and has no discussion with the patient for a period of time. The other process of disengaging is labeled “abandoning” and consists of: (a) “rejecting”, (b) “discharging to the community”, (c) “transferring to another institution” and (d) “committing to an approved hospital” (p. 426). In this study, although some patients who remain resistant to treatment and never come to a mutual agreement with the staff may eventually be transferred to a lower level of care in a locked intermediate facility or to a long-term highly structured unit at a state facility, the participants were adamant about the unacceptability of abandoning patients. The power to discharge and transfer is the psychiatrist’s and in California such a transfer requires the approval of a court appointed conservator so that form of abandonment is not open to the participants. It is not beyond the power of the participants to reject patients, but they consider doing so after they have participated in coercion harmful.

Abandonment after Interpersonal Negotiation has failed and coercion has resulted is essentially a betrayal of the nurse-patient relationship. If the message has been “I care about you and the only reason I am doing this is to help you”, to abandon the patient after doing it turns the message into a lie. The nurses need to maintain the relationship to avoid the coercion being interpreted as punishment and further limiting the possibilities

of reaching mutual agreement. The participants in this study manage “respite” without “abandoning” by sharing responsibility for interpersonal negotiating with other members of the nursing staff and taking turns caring for a particular patient. They justify doing so by citing the need for the patient to not be dependent on just one nurse. It is also true that to disengage the nurse must have engaged in the first place and the participants in this study do not always make that choice. Watters’ study seems to support the strategies used in interpersonal negotiating but does not explore the process of Justifying Coercion.

*Impasse: Reaching the Last Resort*

The forcible administration of medications is clearly a severely coercive act. If it is not adequately justified it is an act of battery (Aiken, 1994). The participants believe it is demeaning and humiliating for the patients. There is no question in their mind that it is harmful. They only find it justified if there is a clear and present danger or they have determined to their own satisfaction that the patient “needs” the medication. The determination is based on the assessment that the patient is “really sick” and “truly suffering” and that the nurses have exhausted their repertoire of negotiating strategies without breaking the impasse. When they are convinced that there is nothing more they can do to gain consent they still need to also be convinced that the involuntary administration of medication will actually help reduce the symptoms and alleviate the suffering.

More experienced nurses have a wider repertoire and resist believing themselves and the patient at impasse. Like the more experienced nurses in Holzworth and Wills’ (1999) study these participants were slow to call for coercion and actively intervened to prevent coercion, when possible.

*Justifying and Taking Coercive Action*

Once impasse has been reached the duty to alleviate suffering takes priority over autonomy. The nurses believe they have powerful reasons (Hess, 1996) to resort to coercion. They trust that the psychotic symptoms they are observing are treatable and that the medication they give will work. They empathize that the patients “do get better”. Without this belief a conscientious and caring ethical psychiatric nurse could not participate.

Some of the less experienced nurses do not seem to have examined this belief very extensively, but among the participants there were nurses with more than thirty years of experience who had clearly thought their position through. They had remained in the profession and continued to work with involuntary patients because of a combined belief in their own competence to avoid coercion if at all possible or to mitigate coercion when it was impossible to avoid and in the effectiveness of medication to treat psychotic illness. Involuntary administration of medication is a last resort, but when done it has been justified to the satisfaction of the nurses participating in the administration. Unlike the Swedish nurses in the studies by Olofsson et al. (1998) and Olofsson and Norberg (2001) who were troubled by but unquestioning of coercion, these California nurses were neither unquestioning nor unaware of alternatives. They actively reflected on ways to improve their care to avoid coercion. Justifying Coercion for the participants in the study was a conscious and thoughtful process. Justifying involuntary administration of medication was painful and seen as a partial failure. Only a clear conviction that in some cases mental illness makes it impossible for patients to understand and respond to the nurses' best efforts eased their distress over needing to take part in something so opposite

to what nursing stands for. Like the Swedish nurses they attempted to mitigate the coercion when coercion was unavoidable, but they did not see mitigation as sufficient to satisfy their vision of a “good” psychiatric nurse.

#### Generalizability of Justifying Coercion

One of the qualities of a basic social process is that it is not limited to the substantive area in which it is discovered but is generalizable across many fields of inquiry (Glaser, 1978). Once the process is stabilized in an emerging theoretical framework, it is appropriate to look for evidence of the process outside the substantive area of inquiry. As the data were being analyzed and the substantive theory was developing, the theory language was being used daily in the national media to report on the United States government’s decision to take military action against Iraq. The process of Justifying Coercion was underway in the United States Congress, the United Nations and throughout the world (Figure 4).

The United States’ Assessment of Need was portrayed using the properties of dangerousness, world safety, refusal to agree to act to reduce the danger and the suffering of Iraq’s people. Documentation was demanded to show that Iraq “really” had weapons of mass destruction and that Saddam Hussein was “really” likely to use them. The United States was unwilling to engage in further negotiations with Iraq, citing earlier failure of Iraq to comply with demands for disarmament and failure of economic sanctions to bring Iraq to comply. The United Nations required renewed negotiations with weapons inspections and diplomacy. Military action was described as the “last resort”.

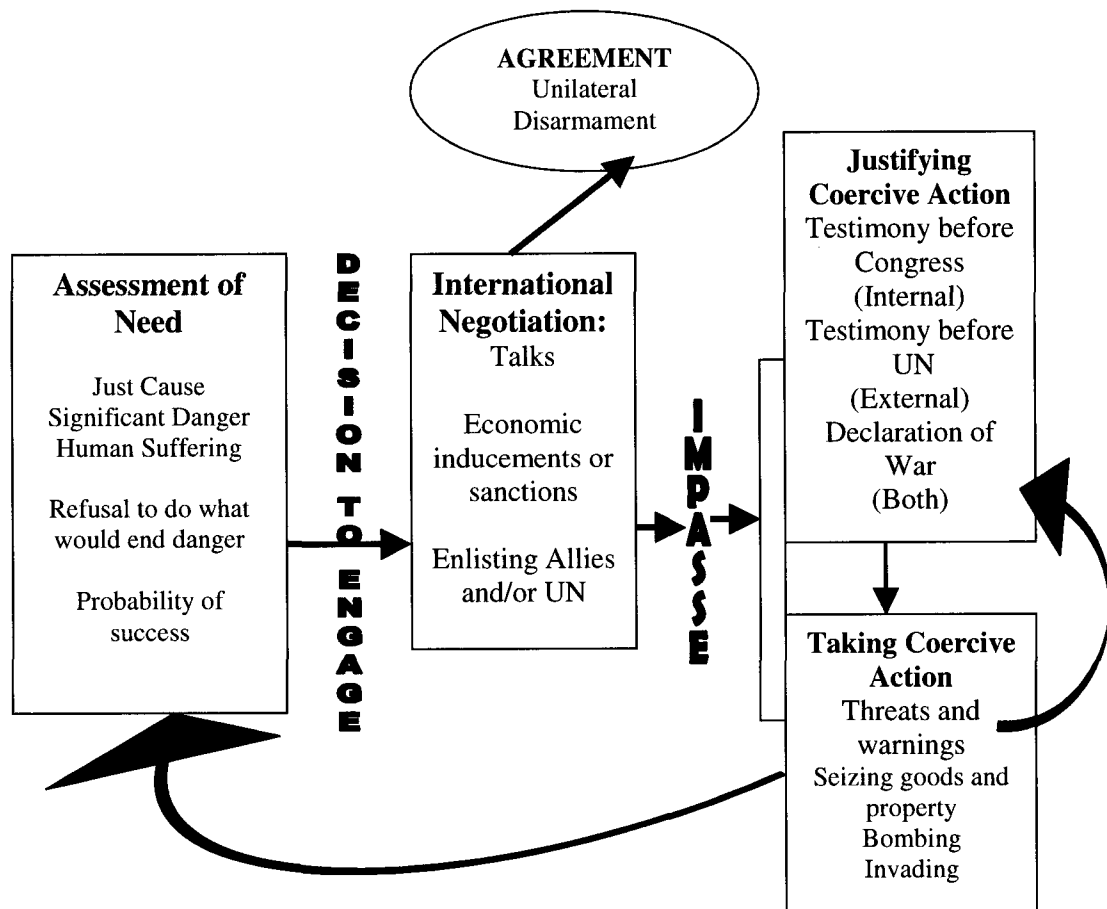


Figure 4: **Justifying Coercion in War**

As this report is being written, the debate throughout the world is whether Impasse has been reached. The United States government believes it has justified its position, but most of the world disagrees (Farley & Chen, 2003). The coercion of threats has resulted in Iraq allowing the weapons inspectors to return, but the United States does not believe it has disarmed. Military action has not yet commenced as another United Nation's resolution is being pursued, but President Bush insists that he will use force to disarm Iraq (Farley & Chen). President Bush has stated that if it comes to war there will be a "just cause" and the war will be fought by "just means" (Elshtain, 2003). Elshtain specifies the criteria necessary to justify war.

The just-war tradition insists that a war must be openly and legally fought; it must be a response to a specific instance of unjust aggression or to the certain threat of such aggression; it must be a last resort, meaning all other avenues have been considered; and there must be a strong probability of success. (B15)

These criteria, when compared to the criteria for justification found in the substantive process of Justifying Coercion in involuntary medication administration, provide evidence that the same process is operating in international affairs.

Further evidence of Justifying Coercion in international affairs was found in an article discussing grounds for “humanitarian intervention” into the affairs of other countries. Evans and Sahnoun, (2002) redefine intervention as protection and indicate sovereign states have a responsibility to protect not only their own citizens both those of other states because no state has unlimited power to do what it wants to its own people. Their definition of compelling need, which would justify coercive action, including political, economic, judicial and military action, they label “just cause”.

The article (Evans & Sahnoun, 2002) outlines six principles for the just cause threshold. First is serious and irreparable harm in one of two ways, large-scale loss of life, actual or anticipated, and the other is “ethnic cleansing”, actual or anticipated. These have clear parallels to the danger to self or others criteria of involuntary hospitalization. The second is right intention, which must be to halt or avert human suffering. Suffering is one of the criteria for justification clearly defined in the substantive theory. The third principle is that of “last resort” with military intervention justified only “when every nonmilitary option for the prevention or peaceful resolution of the crisis have been explored, with reasonable grounds for believing lesser measures would not have

succeeded” (Evans & Sahnoun, 2002, para. 15). This principle requires the reaching of an impasse.

The fourth principle is “proportional means” which requires that only the minimum coercion necessary to achieve the purpose be used. The fifth principle is “reasonable prospects” defined as a reasonable chance of halting or averting the suffering and with the consequences of the action not likely to cause worse harm than the consequences of inaction. Both of these principles are used when Justifying Coercion in involuntary medication administration.

The final principle is “right authority” which the authors designate to the United Nations. In California the “right authority” to permit involuntary medication is the hearing officer or judge designated by state law and by the court to have such authority. Right authority for seclusion and restraints and for initiating holds is also clearly delegated by state law (LADMH, 1998). The parallels between justifying military intervention and justifying involuntary medication administration are striking and provide data that Justifying Coercion is a basic social process that occurs in more than one substantive field.



## CHAPTER SIX

### **Conclusions And Implications**

Justifying Coercion is a process that happens when there is a need or desire to take a coercive action and coercion is perceived as ethically “wrong” either by the entity proposing the action or by some other entity (the employer, the government, other governments) that has the power to judge and sanction the action. In the case of involuntary treatment of psychiatric patients, nurses need to both satisfy themselves that their actions are justified to maintain their identities as ethical or “good” nurses and to satisfy their employers, regulatory agencies, and the mental health courts that they have complied with all the rules that limit coercive treatment of psychiatric patients. State laws make exceptions to the requirement of informed consent for treatment for psychiatric patients who lack the capacity to make an autonomous decision, but require proof of the necessity. Accreditation bodies (JCAHCO, 2000) and federal regulatory agencies (HCFA, 1999) have strict requirements for the conditions under which coercive treatment of patients is allowed.

Psychiatric nurses in California justify coercion of involuntary patients during medication administration by a process that has three stages: Assessment of Need,

137

Interpersonal Negotiation and Justifying and Taking Coercive Action. These stages take place in the context of the nursing process and the stages of the nurse-patient relationship

that are the basis of psychiatric nursing care. Justifying activities occur in all three stages, but the strategies and behaviors are different.

There are two distinct turning points or “critical junctures” at which the nurse has adequate justification to proceed to the next stage. The first occurs after determination of need when as the nurse decides to engage the nurse enters the next stage. The second turning point is the determination that the nursing staff has exhausted their repertoire of interventions and has reached an impasse in negotiations with the patient and coercion is the only remaining choice. Really sick is based on the nurse’s assessment that the patient has sufficient symptoms to support a diagnosis of a psychotic illness, and those symptoms are so severe that the patient has lost the capacity to make decisions and is “suffering” because of a genuine impairment in the ability to manage the necessities of life. Impasse is determined by the perception that sufficient time has been spent and that everything possible has been tried so that further efforts will be futile.

“Justifying Coercion “ is a basic social process that allows the nurse to sustain an identity as an ethical nurse and resolve the dilemma of beneficence versus autonomy by invoking the principle of nonmaleficence. The perspective that psychotic illness is primarily biological in origin and the only reliable treatments are medications allows the nurse to continue working in involuntary settings without violating his or her integrity. Examining other studies (Breeze & Repper, 1998; Hummelvoll & Severinsson, 2002; Olofsson et al., 1998, Olofsson & Norberg, 2001; Watters, 2000) the researcher can infer that Justifying Coercion occurs in other psychiatric settings. Participants in this study required more than the general perspective that involuntary treatment and coercion are justifiable, which seemed sufficient for participants in other studies, to justify

involuntarily administering medication. They needed to have themselves identified and used strategies of Interpersonal Negotiation with a particular patient or have evidence that trusted colleagues had tried everything possible to believe that coercion was justified. Since the participants in this study were volunteers self selected from a variety of agencies, it is possible (perhaps probable) that the extent of justification they required is not generalizable to another group of psychiatric nurses but undoubtedly the process. Justifying Coercion can be seen in a variety of settings from justifying involuntary hospitalization to justifying war. The coercive action justified and the specific negotiating strategies used differ but the basic social process is the same.

### *Implications*

Justifying Coercion is an ethical theory of resolving clinical dilemmas in which the client is resistant to needed care and there is a conflict between autonomy and beneficence. Nursing has few specific ethical theories and this substantive theory has the potential to provide a basis for other grounded ethical theories for managing nursing dilemmas involving other principles.

Psychiatric nurses use a process of Justifying Coercion to resolve the ethical dilemma of using coercion within a caring relationship. They maintain their commitments to advocacy, care, and healing by careful assessment and persistently trying a wide range of interventions to avoid coercion. The nurses do their best to assure that involuntary patients get the treatment they need and retain their dignity in spite of their resistance. They do this by providing competent and compassionate care using principled reflection to determine when coercion is necessary and when it can be avoided. The theory of

Justifying Coercion is consistent with Peplau's (1952) Interpersonal Relations Model and Artinian and Conger's (1997) Intersystem Model.

The process of Justifying Coercion reveals that ethical psychiatric nursing practice requires competence in Assessment of Need for particular treatments and Interpersonal Negotiation. Knowing the basis of mental illness and the research findings on medications is not sufficient. Only the individual nurse-patient relationship skills that allow the nurse to establish rapport and present him or herself as a caring, as well as competent caregiver can limit the need for coercive actions. Even then the nature of psychosis may require involuntary treatment for certain patients. Ethical nurses need better guidelines for when they have reached the "last resort". The seclusion and restraint guidelines have worked to limit use of seclusion and restraint, but no specific guidelines are available for giving medication not used as a restraint. There needs to be a more coherent set of criteria than "really". Every participant had a different definition of what constituted need for involuntary treatment for patients who fall into the "gray area".

Justifying Coercion requires that all available alternatives be attempted. This requires time and energy. Staffing patterns that provide adequate numbers of registered nurses to build relationships with our most resistant patients are essential. Current patterns allow nurses to make the choice to engage with only a few. More clinical time and precepting are needed for students and new staff. Negotiating is limited by the nurse's repertoire. Current exposure in nursing school to competent psychiatric nurses and the interventions required to get a psychotic patient to recognize illness is limited. New psychiatric nurses do not have a sufficient repertoire of skills to deal with these difficult situations. They learn these skills on the job. Preceptors who are allowed

sufficient time with the new nurses to model these interventions or formal internship programs are needed. For a nurse with limited skills, “I’ve done all I can” comes very quickly and patients are subject to unnecessary coercion.

Finally, there needs to be discussion and consensus building among psychiatric nurses on the obligations of the nurse to a patient with whom it is impossible to form an alliance. The participants reject abandoning patients with whom they are engaged, but what about the patients never engaged with because of time constraints or the strength of their resistance or a multiplicity of other reasons. What is the nurse’s responsibility to those patients for whom biological treatments are ineffective? What should nurses do when coercion has no benefit? Psychiatric nurses need to participate in the policy discussions on outpatient commitment, assertive case management, and funding for psychiatric services.

#### *Recommendations for Further Research*

The current study is limited to the particular context of psychiatric nursing in a few facilities in California. This study did not develop a theory of preferred strategies of Interpersonal Negotiation or patterns of successful intervention to prevent coercion. There is still not enough evidence to move from case-by-case ethical decisions to general guidelines for use of coercion with involuntary patients. Intervention research needs to be done to determine not just how nurses justify coercion but how they are successful in avoiding it. Which strategies are most effective? Additional research on the sub-process of Staying With as an effective strategy for mitigating coercion would help to explain the lack of impact of coercion on the therapeutic relationship.

Research is needed concerning the Decision to Engage to determine what conditions of practice facilitate this decision, what characteristics of patient and nurse make it likely that engagement will take place, and what outcomes result if the decision is not made. Descriptive studies to determine the proportion of patients that receive this ideal form of eliciting compliance followed by outcome studies to determine if engagement makes a measurable difference reaching agreement or long-term compliance would inform psychiatric nursing practice and provide evidence upon which to base ethical decisions. The outcomes of ethical choices in psychiatric nursing and in nursing in general have not been extensively studied. Nurses in the United States could follow the lead of their Nordic colleagues (Hoyer et al, 2002) and participate in multidisciplinary studies of bioethical issues.

Assessment of Need for coercion in psychiatric care should be studied in more depth. Guidelines will not be forthcoming without more knowledge of the costs and benefits of coerced care. Nursing outcome research to explore the effects of the time element in Interpersonal Negotiation is indicated. Does more time lead to avoidance of coercion or simply delay the inevitable? The theory of Justifying Coercion is not sufficiently developed for quantitative verification research. Each of the properties involved needs further qualitative exploration before they can be used as variables.

The nursing experience of Justifying Coercion in involuntary medication administration has now been explored but the patient experience of being subject to involuntary medications is yet to be studied in depth. How does the patient move from compliance to adherence when subject to coercion? Studies are needed to explore if different diagnoses or cultures impact the experience of coercion. Patient experience of

involuntary medication should be given the same scrutiny as patient experience of seclusion and restraint. The “grateful later” phenomenon should be explored to determine the differences between patients that “are” and “are not” ultimately convinced that coercion was in their best interest.

The process of Justifying Coercion needs to be studied in a wider context. Coercive practices can be found in pediatric nursing, in chemical dependency nursing, in emergency rooms, and medical surgical units. Coercion is found in parenting, police work, law making, employment practices and international relations. Research on coercion outside of health care is required to develop a formal theory of Justifying Coercion.

For the researcher, however, the development of a formal theory is not as important as determining the most effective way for nurses treating involuntary patients to promote long term adherence to treatment. She envisions a program of research that studies the outcomes of nursing interventions, including use of coercion, in the care of involuntary patients. Initially the studies would continue to be qualitative and exploratory. Once the concepts were sufficiently defined to be used as variables for descriptive correlational studies, a series of studies identifying relationships between nursing interventions and adherence could be undertaken. Eventually a path analysis of psychiatric nursing contributions to SPMI patient adherence might be possible.

The next study in this program is envisioned as a retrospective grounded theory study of patients’ experience of involuntary medication administration. The participants would be individuals who were once medicated involuntarily but are currently functioning in the community and voluntarily adhering to treatment. Using this

population as informants reduces but does not eliminate the concerns about informed consent in studying a vulnerable population. The initial participants would be recruited from individuals diagnosed with bipolar affective disorder. Descriptive studies of individuals subjected to involuntary medication indicate this population is more likely than other SPMI populations to experience both involuntary medication administration and subsequent voluntary adherence (Hiday, 1992; Nicholson et al., 1997). Later, theoretical sampling of other diagnostic groups and, if possible, individuals who had not become adherent would be appropriate. The interview guides would include questions about nurse engagement, specific negotiating strategies, and coercion mitigating factors.

Next a concurrent study of the experiences of involuntary inpatients that initially refuse medications and the nurses who are caring for them would be in order. Again, focus would be on engagement and negotiating strategies. For a concurrent study of inpatients and their nurses and subsequent prospective correlational studies one or more psychiatric facilities willing to serve as a study setting will be necessary. Entry into appropriate agencies should be sought while the retrospective qualitative work with outpatients is underway, as research about involuntary care is sensitive and research with vulnerable populations has many restrictions that might limit the availability of settings. Further specific development of the design of studies in the research program will be dependent on the findings of the initial studies.

### *Summary*

A study that began as a search for the processes used by nurses intervening with involuntary psychiatric patients evolved into a grounded theory of “Justifying Coercion” in the context of involuntary medication administration to involuntary psychiatric



patients. Justifying Coercion in this substantive area is a process within the context of the processes of the nursing process and the nurse-patient relationship. The stages of the process are Assessment of Need, Interpersonal Negotiation and Justifying and Taking Coercive Action. Each stage includes specific nursing interventions and particular beliefs about the nature of psychiatric illness, the obligations of psychiatric nurses, and the effectiveness of treatments. Progression from one stage to the next is determined by the critical junctures of Decision to Engage and Impasse.

Justifying Coercion permits an ethical psychiatric nurse to participate in the care of involuntary patients without violating the nurse's integrity. It protects the nurse when the nurse's actions are reviewed by others and lends conviction to the nurse's attempts to convince patients to agree to a plan of care. The implications of the theory are that facilities need adequate psychiatric nursing staff to effectively treat involuntary patients and that a mentoring or preceptorship program is indicated for novice psychiatric nurses.

Justifying Coercion appears to be a basic social process that exists in other nursing contexts and in contexts outside of health care. The potential for developing formal theory could be determined by further data collection in a variety of contexts known to be occasions for coercion. More research needs to be done to further develop the substantive theory within psychiatric nursing by exploring patients' and nurses' experiences with each of stages. A research program building on this study would start with a grounded theory study of patient's experiences of being involuntarily medicated.

## References

- AB1800*. (2000, May 31). California Assembly. Retrieved June 16, 2000 from  
[http://info.sen.ca.gov/pub/bill/asm/ab\\_1751-1800/ab\\_1800\\_bill\\_20000526\\_amended\\_asm.htm](http://info.sen.ca.gov/pub/bill/asm/ab_1751-1800/ab_1800_bill_20000526_amended_asm.htm)
- AB1421*. (2001, February 23). California Assembly. Retrieved May 9, 2001 from  
[http://www.leginfo.ca.gov/pub/bill/asm/ab\\_1401-1450/ab\\_1421\\_bill\\_20010430\\_amended\\_asm.htm](http://www.leginfo.ca.gov/pub/bill/asm/ab_1401-1450/ab_1421_bill_20010430_amended_asm.htm) and September 27, 2002 from  
[http://www.leginfo.ca.gov/pub/bill/asm/ab\\_1401-1450/ab\\_1421\\_bill\\_20020829\\_enrolled.html](http://www.leginfo.ca.gov/pub/bill/asm/ab_1401-1450/ab_1421_bill_20020829_enrolled.html)
- AB1424*. (2001, February 23). California Assembly. Retrieved May 9, 2001 from the World Wide Web: [http:// www.leginfo.ca.gov/pub/bill/asm/ab\\_1401-1450/ab\\_1424\\_bill\\_20010405\\_amended\\_asm.htm](http://www.leginfo.ca.gov/pub/bill/asm/ab_1401-1450/ab_1424_bill_20010405_amended_asm.htm)
- Aiken, T. D. (with Catalano, J.T.). (1994). *Legal, ethical and political issues in nursing*. Philadelphia: F. A. Davis.
- Allport, G. W. (1955). *Becoming: Basic considerations for a psychology of personality*. New Haven, CT: Yale University Press.
- Amador, X. F., Andreasen, N. C., Flaum, M. Strauss, D. H., Yale, S. A., Clark, S., & Gorman, J. M. (1994). Awareness of illness in schizophrenia, schizoaffective and mood disorders. *Archives of General Psychiatry*, 51, 826-836.
- American Nurses Association. (1999). *Testimony presented to the Joint Commission on the Accreditation of Health Care Organizations Behavioral Healthcare Restraint Task Force*. Retrieved from the World Wide Web July 16, 2000:  
<http://nursingworld.org/readroom/bhcre.htm>

- American Nurses Association. (2000). *A statement on psychiatric-mental health clinical nursing practice and standards of psychiatric-mental health nursing practice*. Washington, DC: American Nurses Publishing.
- American Nurses Association. (2001). *Code of ethics for nurses with interpretive statements*. Washington, DC: American Nurses Publishing.
- American Psychiatric Association. (1994). Practice guideline for the treatment of patients with bipolar disorder. *The American Journal of Psychiatry*, 151(12, Suppl.).
- American Psychiatric Association. (1997). *Practice guideline for the treatment of patients with schizophrenia*. Washington, DC: Author.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders, fourth edition, text revision (DSM-IV-TR)*. Washington, DC: Author.
- American Psychiatric Nurses Association. (2000). *Position statement on the use of seclusion and restraint*. Retrieved from the World Wide Web July 16, 2000:  
[http://www.apna.org/professional\\_resources.htm](http://www.apna.org/professional_resources.htm)
- American Psychiatric Nurses Association Task Force on Involuntary Outpatient Commitment. (2000, October). *Involuntary outpatient commitment: A task force update*. Report presented at the annual conference of the American Psychiatric Nurses Association, Washington, DC.
- American Psychiatric Nurses Association Task Force on Involuntary Outpatient Commitment. (2001, October). *Involuntary outpatient commitment: A task force update*. Report presented at the annual conference of the American Psychiatric Nurses Association, Reno, NV.
- Anderson, J., & Eppard, J. (1995). Clinical decision making during assessment for involuntary

- psychiatric admission. *Psychiatric Services*, 46, 727-728.
- Appelbaum, P. S. (1994). *Almost a revolution: Mental health law and the limits of change*. New York: Oxford University Press.
- Appelbaum, P. S., & Hoge, S. K. (1986). Empirical research on the effects of legal policy on the right to refuse treatment. In D. Rappaport & J. Parry (Eds.), *The right to refuse antipsychotic medication* (pp. 87- 96). Washington, D.C.: American Bar Association.
- Arnold, E., & Boggs, K. U. (2003). *Interpersonal relationships: Professional communication skills for nurses* (4<sup>th</sup> ed.). St Louis, MO: Saunders.
- Artinian, B. M., & Conger, M. M. (Eds.). (1997). *The intersystem model: Integrating theory and practice*. Thousand Oaks, CA: Sage.
- Baier, M., & Murray, R. L. E. (1999). A descriptive study of insight into illness reported by persons with schizophrenia. *Journal of Psychosocial Nursing and Mental health Services*, 37(1), 14-21.
- Baldessarini, R. J., & Tondo, L. (1998). Recurrence risk in bipolar manic-depressive disorders after discontinuing lithium maintenance treatment: An overview. *Clinical Drug Investigations*, 15(4), 337-351. Retrieved June 12, 1999 from the World Wide Web: <http://www.medscape.com/adis/CDI/1998/v15.n04/cdi1504.bald/cdi1504.04.bald.html>
- Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. New York: International Universities Press.
- Benjamin, M., & Curtis, J. (1986) *Ethics in nursing*, (2<sup>nd</sup> ed.). New York: Oxford University Press.
- Boyd, M. A. (2002). *Psychiatric nursing: Contemporary practice* (2<sup>nd</sup> ed.). Philadelphia: Lippincott.

- Bowden, C. L. (1998). Key treatment studies of lithium in manic-depressive illness: Efficacy and side effects. *The Journal of Clinical Psychiatry*, 59 (suppl. 6), 13-19.
- Breeze, J. A., & Repper, J. (1998). Struggling for control: The care experiences of “difficult” patients in mental health services. *Journal of Advanced Nursing*, 28(6), 1301-1311.  
Retrieved July 21, 2002 from <http://www.apollolibrary.com:2242/ovidweb.cgi>
- Buchanan, A. (1992). A two-year prospective study of treatment compliance in patients with schizophrenia. *Psychological Medicine*, 22, 787-797.
- Charmaz, K. (2000). Grounded theory: Objectivist and constructivist methods. . In N. K. Denzin & Y. S. Lincoln (Eds.). *Handbook of qualitative research* (2<sup>nd</sup> ed., pp. 509 - 535). Thousand Oaks, CA: Sage.
- Charon, J. M. (1998). *Symbolic interactionism: An introduction, an interpretation, an integration*. Upper Saddle River, NJ: Prentice Hall.
- Center for Ethics & Human Rights. (2000). *Selected Bibliography: Psychopharmacology*. Retrieved from the World Wide Web August 17, 2000:  
<http://nursingworld.org/ethics/epsybib.htm>
- Chafetz, L. (1996). The experience of severe mental illness: a life history approach. *Archives of Psychiatric Nursing*, X (1), 24-31
- Chenitz, W. C., & Swanson, J. M. (Eds.). (1986). *From practice to grounded theory*. Menlo Park, CA: Addison-Wesley.
- Davis, A. J., Aroskar, M. A., Liaschenko, J., & Drought, T. S. (1997). *Ethical dilemmas and nursing practice* (4th ed.). Stamford, CT: Appleton & Lange.
- Dunbar-Jacob, J. M., Schlenk, E.A., Burke, L. E., & Matthews, J. T. (1998). Predictors of patient adherence: Patient characteristics. In S.A. Shumaler, E. B. Schron, J. K. Ockene, & W. L.

- McBee (Eds.), *The handbook of health behavior change* (2nd ed., pp. 491-512). New York: Springer
- Durham, M. L. (1996). Civil commitment of the mentally ill: Research, policy and practice. In B. D. Sales & S.A. Shah (Eds.), *Mental health and law* (pp.17-40). Durham, NC: Carolina Academic Press.
- Ellis, A. (1973). *Humanistic psychotherapy: The rational-emotive approach*. New York: McGraw-Hill.
- Elshtain, J. B. (2003, February 19). Will it be a 'just war' or just a war? [Commentary]. *Los Angeles Times*, p. B15.
- Encarta® world English dictionary (North American ed.)*. (2003). Retrieved February 6, 2003 from <http://Encarta.msn.com/encnet/features/dictionary/>
- Engleman, N. B., Jobes, D. A., Berman, A. L., & Langbein, L. I. (1998). Clinicians' decision making about involuntary commitment. *Psychiatric Services*, 49, 941-945.
- Erickson, H. C., Tomlin, E. M., & Swain, M. A. P. (1983). *Modeling and role modeling: a theory and paradigm for nursing*. Lexington, SC: Pine Press.
- Evangelista, L. E. (1999). Compliance: A concept analysis. *Nursing Forum*, 34(1), 5-11.
- Evans, G., & Sahnoun, M. (2002, Nov/Dec). The responsibility to protect [Electronic version]. *Foreign Affairs*, 81(6), 99-111. Retrieved February 1,2003 from EBSCO Host database.
- Faloon, I. R. H. (1999). Optimal treatment for psychosis in an international multisite demonstration project. *Psychiatric Services*, 50(5), 615-618.
- Farley, M., & Chen, E. (2003, February 19). U.S. is firm Bush insists. *Los Angeles Times*, pp. A1, A8.
- Fawcett, J. (1995). Compliance: Definitions and key issues. *The Journal of Clinical Psychiatry*,

56 (Suppl.1), 4-10.

- Fenning, S., Rabinowitz, J., & Fennig, S. (1999). Involuntary first admission of patients with schizophrenia as a predictor of future admissions. *Psychiatric Services, 50*, 1049-1052.
- Fenton, W. S., Blyler, C. R., & Heinssen, R. K. (1997). Determinants of medication compliance in schizophrenia: Empirical and clinical findings. *Schizophrenia Bulletin, 23*(4), 637-651.
- Fisher, A. (1989). The process of definition and action: The case of dangerousness. *Dissertation Abstracts*. (University Microfilms No. 8917915).
- Fisher, F., & Ury, W. (1983). *Getting to yes: Negotiating agreement without giving in*. New York: Penguin Books.
- Fisher, R., & Brown, S. (1988). *Getting together: Building a relationship that gets to yes*. Boston: Houghton Mifflin.
- Flynn, L. M. (1994). Schizophrenia from a family point of view: A social and economic perspective. In N. C. Andreasen (Ed.), *Schizophrenia: From mind to molecule* (pp. 21-30). Washington, DC: American Psychiatric Press.
- Forchuk, C., & Brown, B. (1989). Establishing a nurse-client relationship. *Journal of Psychosocial Nursing and Mental Health Services, 27*(2), 30-34.
- Frank, A. F., & Gunderson, J. G. (1990). The role of the therapeutic alliance in the treatment of schizophrenia. *Archives of General Psychiatry, 47*, 228-236.
- Frisch, L. E. (1998). Ethical and legal bases for care. In N. C. Frisch & L. E. Frisch, *Psychiatric mental health nursing: Understanding the client as well as the condition* (pp. 131-146). Albany, NY: Delmar.
- Frisch, N. C. & Frisch, L. E. (1998). *Psychiatric mental health nursing: Understanding the client as well as the condition*. Albany, NY: Delmar.

- Fry, S.T., & Damrosch, S. (1994). Ethics and human rights issues in nursing practice: A survey of Maryland nurses. *The Maryland Nurse, 13*(7), 11-12.
- Gadow, S. (1989). Clinical subjectivity: Advocacy with silent patients. *Nursing Clinics of North America, 24*(2), 535-541.
- George, R. D., & Howell, C. C. (1996). Clients with schizophrenia and their caregivers' perceptions of frequent psychiatric rehospitalizations. *Issues in Mental Health Nursing, 17*, 573-588.
- Glaser, B. G. (1978). *Theoretical sensitivity*. Mill Valley, CA: Sociology Press.
- Glaser, B. G. (1992). *Basics of grounded theory analysis*. Mill Valley, CA: Sociology Press.
- Glaser, B. G. (1998). *Doing grounded theory: Issues and discussions*. Mill Valley, CA: Sociology Press.
- Glaser, B. G. (2002). Conceptualization: On theory and theorizing using grounded theory. *International Journal of Qualitative Methods, 1*(2). Article 3. Retrieved June 18, 2002 from <http://ualberta.ca/~ijqm/>
- Goffman, E. (1961). *Asylums*. Garden City, NY: Doubleday.
- Goffman, E. (1963). *Stigma*. Englewood Cliffs, NJ: Prentice Hall.
- Goldberg, J. (1997). The cost of bipolar disorder. *Medscape*. Retrieved June 12, 1999 from the World Wide Web: <http://www.medscape.com/Medscape/CNO/1997/APA/CME-Select/05.20/IS12D.keck.html>
- Grace, P. J., Fry, S. T., & Schultz, G. S. (2003). Ethics and human rights issues experienced by psychiatric-mental health and substance abuse registered nurses. *Journal of the American Psychiatric Nurses Association, 9*(1), 17-23.
- Gutheil, T. C., & Appelbaum, P. S. (2000). *Clinical handbook of psychiatry and the law* (3<sup>rd</sup> ed.).



Philadelphia: Lippincott, Williams & Wilkins.

Haynes, R. B., McKibbin, K. A., & Kanani, R. (1996). Systematic review of randomized trials of interventions to assist patients to follow prescriptions for medications. *Lancet*, *348*, 383-386.

Health Care Financing Administration (HCFA). (1999). Medicare and Medicaid programs; hospital conditions of participation: Patient rights. *Federal Register*, *64*(127), 36,070-36,089.

Hellinghausen, M. A. (2000, June 5). Leaps and bounds: Legislature focuses on overhauling mental health care system. *NurseWeek*, *13*(12), 26.

Hess, J. D. (1996). Ethics of compliance. *Advances in Nursing Science*, *19*(1), 18-27.

Hewison, A. (1995). Nurses' power in interactions with patients. *Journal of Advanced Nursing*, *21*(1), 75-82.

Hiday, V. A. (1992). Coercion in civil commitment: Process, preferences and outcome. *International Journal of Law and Psychiatry*, *15*, 359-378.

Hobbs, H., Wilson, J. H., & Archie, S. (1999). The alumni program: Redefining continuity of care in psychiatry. *Journal of Psychosocial Nursing and Mental Health Services*, *37*(1), 23-29.

Hoge, S. K., Lidz, C. W., Eisenberg, M., Monahan, J., Bennett, N., Gardner, W., Mulvey, E. P., & Roth, L. (1998). Family, clinician, and patient perceptions of coercion in mental hospital admission: A comparative study. *International Journal of the Law and Psychiatry*, *21*(2), 131-146.

Holzworth, R. J., & Wills, C. E. (1999). Nurses' judgments regarding seclusion and restraint of psychiatric patients: A social judgment analysis. *Research in Nursing and Health*, *22*,

189-201.

- Hopton, J. (1995). Control and restraint in contemporary psychiatric nursing: Some ethical considerations [Electronic version]. *Journal of Advanced Nursing*, 22(1), 110-115.  
Retrieved July 20, 2002 from Ovid database.
- Hornung, W. P., Klingberg, S., Feldmann, R., Schonauer, K., & Schulze Monking, H. (1998). Collaboration with drug treatment by schizophrenic patients with and without psychoeducational training: Results of a 1-year follow-up. *Acta Psychiatrica Scandinavica*, 97 213-219.
- Hoyer, G., Kjellin, L., Enberg, M., Kaltiala-Heino, R., Nilstun, T., Sigurjonsdottir, M., & Syse, A. (2002). Paternalism and autonomy: A presentation of a Nordic study on the use of coercion in the mental health system. *International journal of Psychiatry and the Law*, 25, 93-108.
- Hughes, D. H. (1999). Acute psychopharmacological management of the aggressive psychotic patient. *Psychiatric Services*, 50(9), 1135-1137.
- Hummelvoll, J. K. (1996). The nurse-client alliance model. *Perspectives in Psychiatric Care*, 32(4), 12-20.
- Hummelvoll, J. K., & Severinsson, E. (2002). Nursing staffs' perceptions of persons suffering from mania in acute psychiatric care. *Journal of Advanced Nursing*, 38(4), 416-424.
- Husted, G. L., & Husted, J. H. (1995). *Ethical decision making in nursing* (2<sup>nd</sup> ed.). St Louis, MO: Mosby.
- Hutchinson, S. (1993). Grounded theory: The method. In P. L. Munhall & C.O. Boyd (Eds.), *Nursing research: A qualitative perspective* (pp. 180-212). New York: National League for Nursing Press.

- Inderbitzin, L. B. (1990). The treatment alliance. In S. T. Levy & P.T. Ninan (Eds.). *Schizophrenia: Treatment of acute psychotic episodes* (pp. 139-159). Washington, DC: American Psychiatric Press.
- International Society of Psychiatric-Mental health Nurses (ISPN). (2000). *A position statement on the use of restraint and seclusion*. Philadelphia: Author.
- Jarboe, K. S. (2002). Treatment nonadherence: Causes and potential solutions. *Journal of the American Psychiatric Nurses Association*, 8(4), S18-S25.
- Johnson, D. L. (1998). The right to refuse medication: Freedom and responsibility. *Psychiatric Rehabilitation Journal*, 21(3), 252-254.
- Joint Commission on Accreditation of Health Care Organizations (JCAHCO). (2000). *Revised restraint and seclusion standards*. Retrieved May 3, 2000 from the World Wide Web: <http://www.jcaho.org/news/nb262.html>
- Joseph-Kinzelman, A., Taynor, J., Rubin, W. V., Ossa, J., & Risner, P. B. (1994). Client perceptions of involuntary hospitalization. *Journal of Psychosocial Nursing and Mental Health Services*, 32(6), 28-32.
- Jourard, S. M. (1964). *The transparent self*. New York: Van Nostrand Reinhold.
- Kapp, M. B. (1996). Treatment and refusal rights in mental health: Therapeutic justice and clinical accommodation. In B. D. Sales & D. W. Shuman (Eds.). *Law, mental health and mental disorder* (pp.279 - 293). Pacific Grove, CA: Brooks-Cole.
- Krauss, J. B. (2002, April). The relief of suffering in mental illness [editorial]. *Archives of Psychiatric Nursing*, 16 (2), 49-50.
- Kritek, P. B. (1995). Nursing: Negotiating at an uneven table. In L. J. Marcus (with B. C. Dorn, P. B. Kritek, V. G. Miller, & J. B. Wyatt), *Renegotiating health care: Resolving conflict*

- to build collaboration.* (pp. 207-236). San Francisco: Jossey-Bass.
- Lanterman-Petris- Short Act, CA Welfare and Institutions Code §§5000-5585 (2002).
- Lehman, A. F., Carpenter, W. T., Goldman, H. H., & Steinwachs, D. M. (1995). Treatment outcomes in schizophrenia: Implications for practice, policy and research. *Schizophrenia Bulletin*, 21 (4), 669-675.
- Lehman, A. F., & Steinwachs, D. M., (1998). Patterns of usual care for schizophrenia: Initial results from the Schizophrenia Patient Outcomes Research Team (PORT) client survey. *Schizophrenia Bulletin*, 24, 11-20.
- Leininger, M. (1994). Evaluation criteria and critique of qualitative research studies. In J.M. Morse (Ed.), *Critical issues in qualitative research methods* (pp.95-115). Thousand Oaks, CA: Sage.
- Leung, W.– C. (2002). Why the professional–client ethic is inadequate in mental health care. *Nursing Ethics*, 9(1), 51-60.
- Liashenko, J. (1995). Ethics in the work of acting for patients [Electronic version]. *Advances in Nursing Science*, 18(2), 1-12 Retrieved July 21, 2002 from Ovid database.
- Lidz, C. W., Coontz, P. D., & Mulvey, E. P. (2000). The pass-through model of psychiatric emergency room assessment. *International Journal of Law and Psychiatry*, 23, 43-51.
- Lincoln, Y. S., & Guba, E. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.
- Lincoln, Y. S., & Guba, E. (2000). Paradigmatic controversies, contradictions, and emerging confluences. In N. K. Denzin & Y. S. Lincoln (Eds.). *Handbook of qualitative research* (2<sup>nd</sup> ed., pp. 163 - 188). Thousand Oaks, CA: Sage.
- Los Angeles County Department of Mental Health (LACDMH). (1998). LPS designation handbook. Los Angeles: Author.

- Maloy, K. A. (1996). Does involuntary outpatient commitment work? In B. D. Sales & S.A. Shah (Eds.), *Mental health and law* (pp.41-74). Durham, NC: Carolina Academic Press.
- Marder, S. R., Mebane, A., Chien, C-p., Winslade, W. J., Swann, E., & Van Putten, T. (1983). A comparison of patients who refuse and consent to neuroleptic treatment. *American Journal of Psychiatry*, *140*, 470-472.
- Mason, T. (1997). An ethnomethodological analysis of the use of seclusion. *Journal of Advanced Nursing*, *26*(4), 780-789.
- Milleken, P. J., & Schreiber, R.S. (2001). Can you “do” grounded theory without symbolic Interactionism? In R. S. Schreiber & P. N. Stern (Eds.), *Using grounded theory in nursing* (pp. 177-190). New York: Springer.
- Miklowitz, D. J., & Goldstein, M. J. (1997). *Bipolar disorder: A family-focused treatment approach*. New York: Guilford.
- Mohl, P. C., Martinez, D., Ticnor, C., Huang, M., & Cordell, L. (1991). Early dropouts from psychotherapy. *The Journal of Nervous and Mental Disease*, *179*, 478-481.
- Moller, M. D., & Murphy, M. F. (1998). *Recovering from psychosis: A wellness approach*. Nine Mile Falls, WA: Psychiatric Rehabilitation Nurses.
- Monahan, J. Lidz, C. W., Hoge, S. K., Mulvey, E. P., Eisenberg, M. M., Roth, L.H. et al. (1999). Coercion in the provision of mental health services: The MacArthur studies. In J. P. Morrissey & J. Monahan (Eds.), *Research in community and mental health: Vol. 10. Coercion in mental health services – International perspectives* (pp. 13-30). Stamford, CT: JAI Press.
- Morse, J. M. (1994). Emerging from the data: The cognitive processes of analysis in qualitative inquiry. In J.M. Morse (Ed.), *Critical issues in qualitative research methods* (pp.23-43).

- Thousand Oaks, CA: Sage.
- Morse, J. M., & Field, P. A. (1995). *Qualitative research methods for health professionals* (2<sup>nd</sup> ed.). Thousand Oaks, CA: Sage.
- Morse, J. M. (2001). Situating grounded theory within qualitative inquiry. In R. S. Schreiber & P. N. Stern (Eds.), *Using grounded theory in nursing* (pp.1-17). New York: Springer.
- National Alliance for the Mentally Ill. (1999). *PACT across America*. Retrieved from the World Wide Web June 21, 1999: <http://www.nami.org/about/pactacross.html>
- National Alliance For the Mentally Ill (NAMI). (2001). *Platform 8. Legal issues: 8.2 Involuntary commitment/Court-ordered treatment*. Retrieved February 3, 2001 from <http://ocd.nami.org/update/platform/legal.htm>
- National Mental Health Association. (n.d.). *Involuntary treatment: The role of involuntary commitment*. Retrieved July 29, 2002 from <http://www.nmha.org/positions/ps36.cfm>
- Nicholson, R. A., Ekenstam, C., & Norwood, S. (1997). Coercion and the outcome of psychiatric hospitalization. *International Journal of Law and Psychiatry*, 20, 201-217.
- Noureddine, S. (2001). Development of the ethical dimension in nursing theory. *International Journal of Nursing Practice*, 7(1), 2-7.
- Olofsson, B., Gilje, F., Jacobsson, L., & Norberg, A. (1998). Nurses' narratives about using coercion in psychiatric care [Electronic version]. *Journal of Advanced Nursing*, 28(1) 45-53. Retrieved July 21, 2002 from Ovid database.
- Olofsson, B., & Norberg, A. (2001). Experiences of coercion in psychiatric care as narrated by patients, nurses, and physicians [Electronic version]. *Journal of Advanced Nursing*, 33(1) 89-97. Retrieved July 21, 2002 from Ovid database.
- Oriol, M. D., & Oriol, R.D. (1986). Involuntary commitment and the right to refuse treatment.

- Journal of Psychosocial Nursing and Mental Health Services*, 24(11), 15-20.
- Pages, K. P., Russo, J. E., Wingerson, D. K., Ries, R. K., Roy-Byrne, P. P., & Coeley, D. S. (1998). Predictors and outcome of discharge against medical advice from the psychiatric units of a general hospital. *Psychiatric Services*, 49, 1187-1192.
- Patel, M., & Hardy, D. W. (2001). Encouraging pursuit of court-ordered treatment in a state hospital. *Psychiatric Services*, 52, 1656-1657.
- Peplau, H. E. (1991). *Interpersonal relations in nursing*. New York: Springer. (Original work published in 1952)
- Peplau, H. E. (1997). Peplau's theory of interpersonal relations. *Nursing Science Quarterly*, 10(4), 162-167.
- Pinikahana, J., Happell, B., Taylor, M., & Keks, N. A. (2002). Exploring the complexity of compliance in schizophrenia. *Issues in Mental Health Nursing*, 23, 513-528.
- Playle, J., & Keeley, P. (1998). Noncompliance and professional power [electronic version]. *Journal of Advanced Nursing*, 27(2), 304-311. Retrieved July 20, 2002 from Ovid database.
- Pescosolido, B. A., Gardner, C. B., & Lubell, K. M. (1998). How people get into mental health services: Stories of choice, coercion and "muddling through" from "first-timers". *Social Science and Medicine*, 46(2), 275-286.
- Prochaska, J. O., & Norcross, J. C. (1994). *Systems of psychotherapy: A transtheoretical analysis* (3<sup>rd</sup> ed.). Pacific Grove, CA: Brooks/Cole.
- QSR International Pty Ltd. (2001). Q.S.R. NVivo® (Version 1.3). Donchester, Victoria, Australia: QSR International.
- Rand Corporation. (2001). *Research brief: Does involuntary outpatient treatment work?*

Retrieved February 22, 2001 from the World Wide Web:

<http://www.rand.org/publications/RB/RB4537/>

Roe, D., Weishut, D. J. N., Jaglom, M., & Rabinowitz, J. Patients' and staff members' attitudes about the rights of hospitalized psychiatric patients. *Psychiatric Services*, 53(1), 87-91.

Rogers, C. (1961). *On becoming a person*. Boston: Houghton-Mifflin.

Sales, B. D., & Shuman, D. W. (Eds.). (1996). *Law, mental health and mental disorder*. Pacific Grove, CA: Brooks-Cole.

Sandelowski, M. (1993). Rigor or rigor mortis: The problem of rigor in qualitative research revisited. *Advances in Nursing Science*, 16, 1-8.

Schwartz, H. I., Vingiano, W., & Perez, C. B. (1988). Autonomy and the right to refuse treatment: Patient's attitudes after involuntary medication. *Hospital and Community Psychiatry*, 39, 1049-1055.

Segal, S. P., Akutsu, P. D., & Watson, M. A. (1998). Factors associated with an involuntary return to a psychiatric emergency service within 12 months. *Psychiatric Services*, 49, 1212-1217.

Smith, C. A. (1995). Use of involuntary outpatient commitment in community care of the seriously and persistently mentally ill client. *Issues in Mental Health Nursing*, 16, 275-284.

Smith, K. V. & Godfrey, N. S. (2002). Being a good nurse and doing the right thing: A qualitative study. *Nursing Ethics*, 9(3), 301-312.

Strauss, A. L. (1987). *Qualitative analysis for social scientists*. Cambridge, MA: Cambridge University Press.

Stern, P. N. (1985). Using grounded theory method in nursing research. In *Qualitative research*



- methods in nursing*. New York: Grune & Stratton.
- Streubert, H. J., & Carpenter, D. R. (1995). *Qualitative research in nursing: Advancing the humanistic imperative*. Philadelphia: Lippincott.
- Stuart, G. W. (2001). Legal-ethical context of psychiatric nursing care. In G. W. Stuart & M. T. Laraia (2001). *Principles and practices of psychiatric nursing* (7<sup>th</sup> ed., pp. 161-183). St Louis, MO: Mosby.
- Stuart, G. W., & Laraia, M. T. (2001). *Principles and practices of psychiatric nursing* (7<sup>th</sup> ed.). St Louis, MO: Mosby.
- Sullivan, H. S. (1953). *The interpersonal theory of psychiatry*. New York: Norton.
- Susman, J. (1994, Spring). Resolving hospital conflicts: A study of therapeutic jurisprudence. *The Journal of Psychiatry and Law*, 22, 107-133.
- Susman, J. (1998). The role of nurses in decision-making and violence prevention. *Journal of Psychosocial Nursing and Mental Health Services*, 36(7), 18-26.
- Szasz, T. (1997, Spring). The case against psychiatric coercion. *Independent Review*, 1(4), 485-499.
- Tehrani, E., Krussel, J., Borg, L., & Munk-Jorgensen, P. (1996). Dropping out of psychiatric treatment: A prospective study of a first admission cohort. *Acta Psychiatrica Scandinavica*, 94, 266-271.
- Thatcher, V. S. (Ed.). (1971). *The new Webster encyclopedic dictionary of the English Language* (Vol.1). New York: Grolier.
- Thorne, S., & Paterson, B. (1998). Shifting images of chronic illness. *Image: Journal of Nursing Scholarship*, 30(2), 173 -178.
- Triesman, G. (1997). *A behavioral approach for the promotion of adherence in complicated*

*patient populations*. Retrieved June 12, 1999 from Medscape database :

<http://www.medscape.com/Medscape/HIV/TreatmentUpdate/1997/tu01/tu01-07.html>

- Van Dongen, C. J. (1997). Is the treatment worse than the cure? Attitudes toward medications among persons with severe mental illness. *Journal of Psychosocial Nursing and Mental Health Services*, 35 (3), 21-25.
- Varcarolis, E. M. (1998). *Foundations of psychiatric mental health nursing* (3rd. ed.). Philadelphia: Saunders.
- Vellenga, B. A., & Christenson, J. (1994). Persistent and severely mentally ill clients' perception of their mental illness. *Issues in Mental Health Nursing*, 15, 359-371
- Vuckovich, P. K. (1999). *Coerced compliance versus voluntary treatment adherence in the severely and persistently mentally ill*. Unpublished manuscript University of San Diego.
- Vuckovich, P. K. (2000). The ethics of involuntary procedures. *Perspectives in Psychiatric Care*, 36(4), 111-112.
- Watters, R. E. (2000). Regulating: The social control process registered nurses use to teach psychiatric patients about their medications. *Issues in Mental Health Nursing*, 21, 411-431.
- Weiden, P. J., & Olfson, M. (1995). Cost of relapse in schizophrenia. *Schizophrenia Bulletin*, 21(3), 419-429.
- Wilson, H. S. (1986). Usual hospital treatment in the United States community mental health system: A dispatching process. In W. C. Chenitz & J. M. Swanson (Eds.) *From grounded theory to practice*. (pp. 181-190). Menlo Park, CA: Addison Wesley. (Reprinted from *International Journal of Nursing Studies*, 20 originally published in 1983).
- Wilson, J. H., & Hobbs, H. (1995). Therapeutic partnership: A model for clinical practice.

*Journal of Psychosocial Nursing and Mental Health Services*, 33 (2), 27-30.

Winick, B. J. (1997). *The right to refuse treatment*. Washington, DC: American Psychological Association.

Zito, J. M., Routt, W. W., Mitchell, J. E., & Roerig, J. L. (1985). Clinical characteristics of hospitalized psychotic patients who refuse antipsychotic drug therapy. *American Journal of Psychiatry*, 142, 822-826.

## Appendix A

## Involuntary Procedures In California (Based on LACDMH, 1998)

*Grounds For Involuntary Hospitalization:*

For an adult to be held in a psychiatric facility involuntarily the law requires that a patient be as a result of mental disorder:

1. A danger to self: manifested by threats or actions indicating the intent to commit suicide or inflict serious bodily harm on self, or actions which place the person in serious physical jeopardy, if these actions are due to a mental disorder.

2. A danger to others: manifested by words or actions indicating a serious intent to cause bodily harm to another person due to a mental disorder. If the danger to others finding is based on the person's threats rather than acts, the evaluator must believe it is likely the person will carry out the threats.

3. Gravely disabled: condition in which a person as a result of mental disorder (rather than chosen lifestyle or lack of funds), is unable to provide for his basic personal needs for food, clothing or shelter and his family is unable or unwilling to care for him. (examples: person can't distinguish between food and non-food, endangers health by gross neglect of nutrition, is dehydrated; engages in public nudity or wears filthy or grossly torn clothes unsuitable to the climate; is unable to locate housing and make appropriate arrangements or accept assistance by others to do so, or is unable to manage own household in such a way as to avoid clear dangers to health.) Note: a transient lifestyle may be due to personal preference or finances and to qualify for gravely disabled the reason must be due to a mental disorder.

*Inebriates:* A psychiatric hospital is not a designated evaluation and treatment facility for inebriates. An inebriate is defined as a person who meets the criteria of being a danger to self or others or gravely disabled solely because of inebriation, rather than because of a mental disorder.

*72-Hour Hold (5150):*

Certain persons can be authorized to "upon probable cause" place persons in designated treatment facilities for up to 72 hours for the purpose of psychiatric evaluation and treatment. Persons so authorized must be one of the following: peace officers, persons directly authorized by the county, designated members of mobile crisis teams, designated members on the attending staff of designated treatment facilities.

Application must be made in writing to initiate a 72 hour hold and must include the circumstances, the specific criterion the individual is believed to meet, and the facts stated with sufficient detail to warrant the belief that the individual meets this criteria. Both the presence of a mental disorder and the evidence of the danger must be presented in language such that it makes sense to a reasonable layperson.

Before a person can be admitted to any facility, on a 5150, a person at the facility designated to write holds must assess the individual in person to determine appropriateness of involuntary detention. Patients may be accepted on valid holds written by designated individuals from outside the hospital. Inpatients placed on a hold after admission must be evaluated at the time the hold is written by designated attending staff. The time the hold starts must be identical with the time on the initial hold. Only one 72-hour hold is permitted within a hospitalization; if a patient formerly on a hold becomes

voluntary, some other form of involuntary detention (such as a 14 day hold) must be used to return them to involuntary status.

*72-hour hold advisement.* The individual writing the hold is responsible for advising the patient of the fact they are being held and other pertinent facts. This advisement or the reason the patient was not advised is documented on the hold itself. Once admitted on a 72-hour hold, unit staff is responsible for providing the patient with the following information both orally and in writing in a language the patient understands: (a) the criteria for the hold, (b) the facts on which the hold was based, (c) the length of time the hold will last, and (d) notification of the right to a hearing if the detention lasts more than 72 hours. This information is given using the involuntary hold advisement form. All 5150s and advisements should be logged.

#### *14-Day Certification For Intensive Treatment*

A patient who has been held on a 72-hour hold may be placed on a 14 day hold if:

1. The patient meets the criteria for involuntary treatment
2. The patient has been advised of need for but is unable or unwilling to accept voluntary treatment

In order to be valid the hold must be signed by two people: (a) A psychiatrist or licensed psychologist (with 5 years post-grad experience in mental health) who has participated in the evaluation and (b) A qualified individual who has been designated by the medical director of the hospital. The 14-day hold is not valid until both signatures are obtained which must be done prior to the expiration of the 72-hour hold.

*14-Day Hold Advisement:* The nurse must give the patient a copy of the signed certificate. This serves as a written advisement. The patient must be told that he has a

right to a certification review and judicial hearing and to the assistance of a Patients' Rights Advocate or attorney. The patient should be informed of the right to have family or other designated persons present at the hearing. The unit nurse should notify the Superior Court of the certification. Once the Superior Court has advised the unit of the hearing time, the nurse must notify the attending and anyone selected by the patient.

*Probable Cause Hearing:*

Within 7 days of the start of the 14-day hold, a probable cause hearing is conducted at the hospital by a hearing officer unless the patient demands a writ hearing before a judge. A Patients' Rights Advocate interviews the patient and presents the case on behalf of the patient. The attending, or in the absence of the attending, a hospital representative who is knowledgeable about the patient presents the case for the hold. The patient may call witnesses. NO ONE can waive the patient's right to a hearing. A probable cause hearing may be by-passed if a writ hearing has been scheduled. If the patient signs a voluntary admission agreement, the hold is discontinued. .In this case or when a physician releases the patient prior to the hearing, no probable cause hearing will take place. The hearing officer will decide if there is probable cause to continue the hold. If not, the patient must be discharged. If the patient is dissatisfied, a writ hearing may be requested.

*Writ Hearing:*

A Writ Hearing can be requested by any patient on a 14 day certification, a second 14 day for suicidal behavior, a 30 day hold for intensive treatment of the gravely disabled, or a temporary conservatorship. Any person besides the patient may file a petition for Writ of Habeas Corpus on the patient's behalf. An involuntary patient retains the right to file such

a petition at any time. Writ hearings are held in Superior Court. The patient, attending physician, and the chart must be in court. Nursing has the responsibility to notify the physician of the hearing, and arrange for transportation and escort for the patient.

*Additional Involuntary Treatment:*

At the end of the 14 day hold the patient must be one of the following: a) released, b) voluntary, c) on an additional 14 day hold for suicidal patients, d) on an additional 30 days intensive treatment for grave disability, e) on a temporary or full LPS conservatorship, f) or be on a 180 day post-certification for imminently dangerous persons. Preparations for extending the stay of patients who are going to require continued involuntary care must be begun shortly after the probable cause hearing as the court must receive notice and appropriate paperwork prior to the expiration of the hold. Please note: once a patient has been placed on involuntary status under no circumstances may they remain involuntary past the maximum legal time they can be detained if the involuntary status is continuous. If there is an interval of voluntary status, it is computed as if it were involuntary. If the maximum time has been exceeded, a patient may leave.

*Second 14-Day Hold:* Patients who were initially placed on a 14 day hold for danger to self and who at the end of the 14 days remain suicidal or involuntary patients who have attempted suicide while in the hospital may be placed on a second 14 day hold for suicidal persons. The hold form is very much like that for the initial 14 day hold and is treated the same. The one difference is that a probable cause hearing will not be held. If the patient requests it, a writ hearing must be held.

*Additional 30 Days Of Intensive Treatment For Grave Disability.* For gravely disabled patients there are two options, intensive treatment or conservatorship. The



choice is determined by expected prognosis. If the belief is that the patient is either chronically or permanently unable to manage food, clothing, and shelter without assistance, conservatorship proceedings should be instituted. If it appears that the disability is temporary and it is likely that the patient can resume management of his life within a few weeks more, the physician can petition for an additional 30 days of intensive treatment. The forms are more elaborate than those for a second 14-day hold, but all the same responsibilities apply. The forms must be forwarded to the probate court, the patient and designated others must be notified and given an explanation and copy of the forms and advised of the right to a writ hearing. A second probable cause hearing is required. If it turns out that a conservatorship must be initiated the patient may not be kept in the hospital beyond the specified 30 days.

*Probate Conservatorships.* Probate conservatorships are legal guardianship arrangements that allow designated people to manage the financial, living, and medical arrangements for someone who is not able to do so for him or herself. An individual cannot be admitted to a psychiatric facility or given psychotropic medications against their will because they are on a probate conservatorship.

*LPS Conservatorships:*

Individuals who are chronically mentally ill and in need of psychiatric treatment that they are unable or unwilling to accept may be placed on an LPS conservatorship. This designates another individual to make decisions for them about their psychiatric care and may also allow that designated person to manage their finances. LPS Conservatorships specify the powers of the conservator and must be checked for power to admit and power to make decisions about psychotropic medications. An LPS

conservatorship does not give the conservator the power to make decisions about medical care other than psychiatric such as forcing insulin or surgery.

To be placed on a LPS conservatorship, the individual must be gravely disabled and unable to accept food, clothing, and shelter even when provided by another unless treated. If the family says that there is no problem maintaining the person at home, there are no grounds for a conservatorship.

An individual does not need to be in the hospital for conservatorship proceedings to be instituted, or retained in the hospital until an LPS conservatorship that has been applied for is finalized. When it is necessary to retain a gravely disabled patient in the hospital beyond 14 days and a conservatorship is indicated, an application for a temporary conservatorship should be initiated well in advance of the expiration of the 14-day hold.

*Temporary Conservatorship (T-Con).* A temporary conservatorship is a device that allows a patient to be retained in treatment while an investigation for a permanent LPS conservatorship is underway. A formal petition outlining the grounds for grave disability and the psychiatrist's reasons for believing a conservator is needed is submitted to the probate court shortly after the PCH upholds the 14 day hold. If on reading the written record, the court accepts the petition, a temporary conservator, usually a member of the Public Guardian's Office is appointed. This conservator has the right to require that the patient remain in the hospital. The T-Con once established remains in effect until a permanent LPS conservatorship hearing is held. Usually this takes about a month. Once the petition is filed and the court date set the patient may be held in the hospital until the hearing. The temporary conservator does not have the power to require the patient to take

medications. A Riese hearing must be held and at that time the temporary conservator's power to sign for psychotropic medications is decided. The existence of a previous Riese hearing is irrelevant.

### Psychotropic Medications

Psychotropic medications are identified in the law as "antipsychotic medication" and are defined as "any drug customarily used for the treatment of the symptoms of psychosis and other severe mental and emotional disorders." Customarily, anxiolytic medication is not included in this definition. Identified medications include: neuroleptics, MAO inhibitors, other anti-depressants and lithium. Anticonvulsants are not identified but may be included as "other" when it makes sense to do so. Other medications used as mood stabilizers, Antibus and naloxone, CNS stimulants, and medications used for psychiatric purposes that are "off label" must also be consented to

All patients are entitled to knowledge of and choice regarding any type of treatment. In a life threatening emergency this right is suspended and the physician is entitled to take appropriate action. However, in general, it is expected that patients exercise this right by accepting or refusing offered medication when it is presented to them. The LPS act specifies a different mechanism for "antipsychotic medication."

#### *Informed Consent:*

The law requires that a person can be treated with the identified medications only after the physician has informed the patient of his or her right to refuse, the nature of the patient's mental condition, the reasons for the medication including likelihood of improving, reasonable alternatives, type, range of frequency and amount, method, duration of taking, probable common side effects, possible additional effects after three

months of taking (the patient must be informed about tardive dyskinesia if this is a possibility) and the right to withdraw consent at any time by notifying any member of the treating staff.

Before administering the medication the informed consent must be in writing on the consent form. In the rare case where all the conditions have been filled and the patient verbally consents, but is unwilling to sign, two staff must witness and document the consent. Involuntary patients, in addition to a signed consent, must have documentation that both the nurse and physician have given oral information and the DMH booklet.

*Medication Refusal:*

Voluntary patients have the right to refuse any and all medications except in a psychiatric emergency. Involuntary patients may refuse medication except in an emergency or if a hearing has been held and the patient ruled incompetent to give informed consent. A psychiatric emergency exists when there is a sudden marked change in the patient's condition so that action is immediately necessary for the preservation of life or the prevention of serious bodily harm to the patient or others and it is impractical to first obtain consent!

*Substituted Consent:*

Patients on LPS conservatorships whose conservators have been granted the right to require the conservatee to accept medication and minors not authorized by law to seek and consent to treatment do not have the right to refuse antipsychotic medications. In these cases the parent, guardian or conservator must provide "substituted consent" using the same forms as voluntary patients. The nurse still may not give the medication without signed consent. If the parent, guardian, or conservator is not able to come in person,

faxed or phone consents witnessed by two staff may be used temporarily. At the first opportunity, an original document must be signed and placed in the chart.

*Medication Capacity Hearings (Riese)*

If an involuntary patient refuses to consent to psychotropic medications and no emergency exists medication may not be given until a medication capacity hearing has been held and the patient ruled to lack capacity for informed consent.

Medication Capacity Hearings are held at the hospital after the physician petitions the Superior Court for a hearing and fills out a “Declaration Regarding Capacity To Give Informed Consent To Medication”. These forms may be faxed to the court and must be accompanied by phone notification of the court. Since a new hearing is required for each specific hold, Medication Capacity Hearings are generally held at the same time as Probable Cause Hearings.

The patient must be informed in writing, the same day the hospital notifies superior court, a) that a petition has been filed, b) a hearing will be scheduled within 72 hours, c) that an advocate will visit and assist them, and d) that they will be notified in advance of the hearing date and time. They are to be given a copy of the petition.

At the hearing, information must be presented by a treating physician who is a designated member of the hospital attending staff. Either party (facility or patient) may request a judicial review in the case of an adverse determination. This review will be held in Department 95 of the Superior Court within two judicial days of filing. A patient found to lack capacity to consent may be medicated prior to that judicial review.

## Appendix B Interview Guide

Tell me about an experience you have had with a patient who is resisting treatment.

Tell me about the most successful experience you have had with a resistant patient. Tell me about your worst experience.

Are there any specific techniques you use to avoid involuntary procedures?

Under what conditions do you allow patients to refuse treatments? (respect autonomy)

Under what conditions do you decide you must intervene?

If a patient initially refuses medication what do you do?

Then what?

When do you recommend to the physician that proceeding with an involuntary procedure is necessary?

Have you ever had the experience of carrying out an involuntary procedure that you did not agree with?

After you have had to medicate a patient against his/her will, what do you do/ how do you interact with the patient?

As a nurse, how do you see involuntary procedures impacting the nurse-patient relationship?

## Appendix C

## Demographic Data

Participant #

Sex

Age

Type of institution worked for:

Primary:

Second or third jobs:

Nursing Education

Initial:

When?

Highest level:

When completed?

Psychiatric Nursing Experience:

Number of years in psych:

Number of years with involuntary patients:

Types of positions in which dealt with involuntary patients:

Current positions:

Current amount of contact with involuntary patients:

## Appendix D

## Participant Demographics

Sex	Ethnicity	Settings	Contact	Patients	Initial Degree	Current Degree	Positions
12 F	8 Caucasian	10 private freestanding	11 Daily	11 Adults	2 LVN	5 AA	5 staff nurse
5 M	2 Hispanic	4 County	3 weekly	2 Child/Adol.	10 AA	4 Bach.	5 charge nurse
	1 Afro Am.	6 General Hospital	3 now minimal	4 Both	5 BSN	8 Graduate	4 supervisors
	2 Asian	2 Nursing School					2 educators
	1 Mixed	1 Jail					2 counselors
		1 HMO					1 CNO

Some categories have more than 17 entries because of multiple jobs

The ages of the participants ranged from 26 to 63 with a mean of 45.5.

The number of years experience working with involuntary psychiatric patients ranged

from 1.5 to 30 with a mean of 12.3.



Appendix F  
Consent to Participate in Research

A nurse researcher, Paula K. Vuckovich, RN, MSN, C. S., a doctoral candidate at the University of San Diego is doing an investigation into the experiences of psychiatric nurses with involuntary procedures. She is interested in how involuntary procedures impact patients, nurses, and the nurse patient relationship. She will be interviewing RNs about their experiences caring for patients requiring involuntary procedures.

Interviews will be unstructured tape-recorded conversations about the RN's experiences with involuntary procedures. Participants will be asked to share their thoughts about the immediate impact and the long-term effects of involuntary procedures. Participants will be asked questions about their ages, nursing education, and the amount and nature of their experience with involuntary patients. It is expected that interviews will take 45 to 90 minutes. All interviews will be tape-recorded. The tapes will be stored in a locked cabinet accessible only to the investigator. When no longer needed to verify transcripts, the tapes will be destroyed.

To maintain confidentiality only first names will be used on tape. Transcripts will be made from each tape and any information identifying an individual or a facility will be omitted from the transcripts. Only the transcripts will be used in any sharing of research data for educational and research purposes or publication about the research. Consent forms will be kept separately in a different locked cabinet.

As a participant in this study, I understand that several people will read the transcript of my interview. I understand that sections of what I say may be extracted and used in research reports or articles to illustrate an idea or theme but that identifying information will be removed and the findings presented in such a way that participants' and facilities' identities will not be revealed.

I understand that the only cost to me as a participant will be the value of the time I spend participating in the interviews. Anticipated risks include the possibility that an individual may reveal a situation that is reportable as abuse to dependent adults. The researcher is ethically obligated to report situations of abuse and there may be professional or personal consequences of such a report. Another possible risk is that talking about situations in which involuntary procedures were necessary may elicit memories provoking discomfort or anxiety. If I have such a reaction, I can stop immediately without penalty. The only benefit I expect from participation is the satisfaction of contributing to nursing knowledge.

I understand that participation in this research is voluntary and that I may withdraw without penalty at any time, even in the middle of an interview, if I no longer wish to participate. There is no agreement, written or verbal, between the participant and the researcher beyond what is recorded on this consent form.

I, the undersigned, understand the above explanations and on that basis, I give my consent to voluntary participation in this research.

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Location

\_\_\_\_\_  
Signature of Principle Researcher

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

For further information about the investigation, the nurse researcher, Paula K. Vuckovich may be contacted at 909-593-7044.

## Appendix G

### Information About the Research

A nurse researcher, Paula K. Vuckovich, RN, MSN, CS, PhD(c) is doing an investigation into the experiences of psychiatric nurses with involuntary procedures. She is interested in how the procedures influence the nurse-patient relationship and the eventual outcomes of hospitalization. She will be interviewing nurses about their experiences with caring for patients subjected to involuntary procedures. Interviews will be unstructured tape-recorded conversations about the nurse's experiences with involuntary procedures. Participants will be asked to share their thoughts about the immediate impact and the long-term effects of involuntary procedures. Participants will also be asked questions about their ages and the amount and nature of their involvement with the mental health system.

Individual interviews will take between 45 and 90 minutes and group interviews will take about two hours. Some individuals may be asked to participate in both individual and group interviews, others may be asked to participate in a short (less than 30 minute) follow-up interview after the initial interview in which they participate. All interviews will be tape-recorded and the tapes will remain in the possession of the researcher in a locked cabinet. Tapes will be retained until it is verified that all the material on tape has adequately been converted into writing; when no longer needed, they will be destroyed.

To maintain confidentiality only first names will be used on tape. Transcripts will be made from each tape and any information identifying an individual or a facility will be omitted from the transcript. Only the transcripts will be used in any sharing of research data for educational and research purposes or publication about the research. Consent forms will be kept in a locked drawer, in a separate cabinet from the tapes and transcripts.

For further information about the investigation, the nurse researcher, Paula K. Vuckovich may be contacted at 909-593-7044.

## Appendix H

## Samples of Memos

*Methodological Memos**Memo from interview*

## Negotiating 7/3/02

This participant uses the term “negotiating” in describing communication with a resistant patient. Unfortunately, I did not ask him to expand on what he meant by that word. Some of what he describes I have been calling “pointing out” but negotiating usually has a different definition. The dictionary defines it as “bringing about by conferring” which implies a give and take. I have put pointing out in the category of “talking to” but negotiating is more likely to belong in “talking with”. He uses the term several times later in the interview along with the word “arguing” to describe ways of getting a patient to bring their behavior under control or do what the staff believes is best.

*Follow up. 7/9/02 - 8:53:14 PM*

“Negotiating” is a term that is found in the literature to describe nurses’ ways of convincing patients to take their medications (I need to hunt for the specific reference). Susman (1998) in his article “The Role of Nurses in Decision Making and Violence Prevention” uses the term “bargaining” to describe the tactics of persuasion, bribing and threatening that nurses use to convince patients to take their meds and says that because this bargaining is a dialogue rather than an autocratic monologue patients perceive the eventual decision even if it is to implement involuntary administration of meds as “fair” because they had a voice. He also writes of politeness and tact. Bargaining in a polite and

tactful way fits my definition of negotiating but I think I will call the participant and check with him about his definition.

*Brief memo on ideas for follow-up:*

07-09 –02 Dialogue versus monologue is important in mutual decision-making. I need to explore when and where the nurse shifts from talking with to talking to and vice versa.

Follow up with references from Susman's 1998 article.

*Observational memo (Field notes)*

*Initial memo handwritten on the day of the interview:*

A nurse who worked herself up through the ranks, she started as a nurses' aide and became an LVN, LPT, and then an RN. Very nervous about being taped and several things about her practice and the facility she told me after the tape recorder was off. She was quite verbal and very forthcoming; has gotten in trouble with colleagues and supervisors for spending too much time with patients. Advocates directly for patients.

*Theoretical memos*

*Memo from a transcript:*

This is an example of getting a patient to justify for him or herself the need for the treatment. It is related to pointing out but it is more of a mutual process than simply talking to the patient about observations. The staff attempts to engage the patient in eliciting the memories that make the staff member's point. The object is to get the patient to make his or her own observations that validate the necessity of what is being done.

"But the other part is I like to get them to, if it's safe for the patient, in their minds re-experience what their horrible moments were like, because in their horrible moments, they're usually looking for an answer. They're looking for something that will make them feel better. Looking for hope. And that's one of the things I do, is try to remember

help them remember what the bottom was like. . . . It's very difficult. And so I try to take them back to that place, to see if they're willing to give it another go, instead of being there. And I try to remind them what it was like from our perspective; what I saw when they came in; when they were disheveled and malodorous. And not eating, or throwing their food around. All those things. By the time they're like saying I don't want to stay, don't want to take their meds, they're a bit more stable sometimes."

*Theoretical Memo 15*

February 24, 2002: Context or Condition? "Really"

One of the term that keeps being used as a descriptor is "really". Participants say the patient was "really psychotic," "really delusional", "really manic", and "really desperate". They also say things like "if the patient "really believes". Part of justifying what the nurse is doing with involuntary patients is substantiating with their own assessment that the symptoms and behaviors that the client is manifesting "really" warrant intervention. "Really" seems to imply both a degree of intensity and of duration. When asked about differences in relationships between voluntary and involuntary or doing things they did not agree with several participants answered "not really." One participant says that people don't take putting people on a hold seriously enough, that's a "really horrible thing to do." She goes on to say that people should be properly trained so they don't take it too lightly.

*Excerpt from a Coding Memo Showing Constant Comparison*

Interview 06: Raw Codes

Can take meds later (Also in 03)

Discover reasons (Also in 03)

Explain/teach (also in interviews 02,03, & 04)

Giving Time and Space (Also in 03)

Humane/Inhumane treatment or failure to treat

Keep coming back/try try again vs. giving up (also in 03)

Listening

Needs (also in 02 & 03)

Suffering (also in 02)

*Audit Memo*

Document: Audit Memo 3

Created: 7/12/02 - 2:50:06 PM

Modified: 7/12/02 - 3:05:57 PM

Description:

State of the project 7-12-02

Document Text:

7/12/02 - 2:50:21 PM

I have defined all free nodes and most of the tree nodes. All nodes have been browsed and recoded as necessary. Redundant nodes have been merged and most nodes that are both free and in a tree have been merged so that the tree nodes have all existing coding at a particular node. Node attributes have not yet been entered but many of the intended attributes have been identified in the descriptions. The hand drawn models of process from March have yet to be entered in the program otherwise all documents are entered and coded.