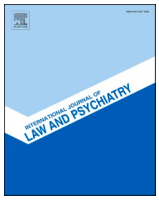
International Journal of Law and Psychiatry 90 (2023) 101918

Contents lists available at ScienceDirect

International Journal of Law and Psychiatry

journal homepage: www.elsevier.com/locate/ijlawpsy



Contextual factors influencing the use of coercive measures in Portuguese mental health care

Deborah Oyine Aluh [a,b,c,*], Margarida Santos-Dias [a,b], Manuela Silva [a,b], Barbara Pedrosa [a,b], Ugnė Grigaitė [a,b], Ricardo Caetano Silva [d,e], Maria Ferreira de Almeida Mousinho [f], João Paulo Antunes [g], Mariana Remelhe [h], Graça Cardoso [a,b], José Miguel Caldas-de-Almeida [a,b]

[a] Lisbon Institute of Global Mental Health, Lisbon, Portugal
[b] Comprehensive Health Research Centre (chrc), NOVA Medical School, NOVA University of Lisbon, Lisbon, Portugal
[c] Department of Clinical Pharmacy and Pharmacy Management, University of Nigeria Nsukka, Nigeria
[d] Serviço de Psiquiatria e Saúde Mental de Adultos, Hospital de Egas Moniz, Centro Hospitalar de Lisboa Ocidental, Lisbon, Portugal
[e] Nova Medical School, Lisbon, Portugal
[f] Department of Mental Health, Unidade Local de Saúde do Baixo Alentejo, Beja, Portugal
[g] Unidade de Internamento do Serviço de Psiquiatria e Saúde Mental de Adultos - Departamento de Saúde Mental do Hospital Professor Doutor Fernando Fonseca
[h] Centro Hospitalar De Vila Nova De Gaia/Espinho, E.P.E.| V. N. Gaia/Espinho Hospital Centre

ARTICLE INFO

Keywords:
Coercion
Contextual factor
Involuntary admission
Restraint
Portugal

ABSTRACT

The use of coercive measures in mental health care is an important indicator of the quality of care being provided, and non-patient-related factors are increasingly recognized to contribute to their use. The study aimed to explore the perspectives of mental health care professionals who have first-hand experience with the use of coercion on the contextual factors that influence the use of coercion in the Portuguese mental health care. Five focus group discussions were conducted among 23 doctors and 17 nurses from five psychiatric departments in urban and rural regions of Portugal. Discussions were audio recorded, transcribed, and analyzed with the aid of MAXQDA. Four broad themes related to insufficient resources, staff-related factors, inefficient services, and socio-legal factors were derived. Participants highlighted how inadequate structures, staff shortages, staff attitudes, a lack of training, restrictive ward rules, an inefficient organization of services, the mental health legislation, and public attitudes contributed to the use of coercive measures. The COVID-19 pandemic complicated existing shortfalls in the system and increased the use of coercive measures. The study confirms that the use of coercive measures in mental health care is influenced by factors that are independent of patient characteristics. Addressing existing systemic problems is crucial for the successful implementation of interventions to reduce coercion in mental health care.

1. Introduction

Coercion has been defined as "the act or practice of using force or threat to persuade a person to do something" (Szmukler, 2015). In mental health care, the concept encompasses a wide range of activities, spanning from subtle persuasion to overt compulsion, which may involve the use of restrictive devices. (Gooding, McSherry, & Roper, 2020; Szmukler & Appelbaum, 2009). A country's mental health legislation usually regulates formal coercive measures like involuntary treatment. The United Nations human rights system is divided on the question of whether coercive psychiatric care, can ever comply with human rights standards. Some believe that coercive care can be justified in life-threatening situations if certain criteria are met and legal safeguards are in place, while others believe that it is never justified (Martin & Gurbai, 2019). This disagreement led to the "Geneva impasse". Despite these debates, the use of coercion in mental health care is apparently on the rise (Sashidharan & Saraceno, 2017), and there is a consensus to reverse this trend.

Portugal is a southwestern European country with a total resident population of about 10.5 million. Efforts developed since the 1970s led to the creation of mental health centres in the community and greater articulation of specialized mental health care with primary care. In

* Corresponding author at: Lisbon Institute of Global Mental Health, Lisbon, Portugal.
E-mail addresses: do.aluh@ensp.unl.pt, aluhdeborah@yahoo.com (D.O. Aluh).

https://doi.org/10.1016/j.ijlp.2023.101918
Received 16 June 2023; Received in revised form 28 July 2023; Accepted 28 July 2023
Available online 2 August 2023

1992, the integration of community-based services in general hospitals and the strengthening of psychiatric hospitals led to a step backward in the process of modernizing mental health services. However, since 1995, a new mental health law has been passed and a mental health policy has been in place, with the goals of advocacy, promotion, prevention, treatment, and rehabilitation, as well as a strategy to ensure the transition to community-based mental health care. Although Portugal's National Mental Health Plan (2007–2016) enabled important advances in the restructuring of mental health care from hospitals to outpatient community-based services, hospital care continued to consume most of the resources allocated for mental health and is still the mainstay of the Portuguese mental health system (Brown, 2018; Caldas-de-Almeida, n.d.). The economic crises of 2008 had significant impacts on the implementation of the mental health plan, with consequent insufficient funding for community-based services. This weakness is particularly worrisome given that Portugal has one of the highest prevalence rates of mental disorders in Europe (Caldas-de-Almeida, n.d.). The mental health law of 1998 (Law 36/98) defines the principles governing the compulsory detention of people with mental disorders and their rights (Almeida & Molodynski, 2016). The criteria for compulsory detention and treatment are that the person has a serious mental disorder by which they pose a risk to themselves or others, refuses to consent to the required medical care, lacks the mental capacity to understand the meaning and implications of consent, and that the absence of treatment could cause their condition to significantly worsen.

Data on the use of coercive measures in Portugal are scarce, and not many studies have explored the prevalence and risk factors for coercion in mental health care in Portugal. The available study on the risk factors for involuntary admissions in Portugal identified having a psychotic disorder, being male, and having secondary and higher education as variables that increased the risk of being admitted involuntarily (Silva et al., 2021). The study found a variation among psychiatric services, implying that factors other than those related to patients may have influenced the rate of involuntary hospitalizations (Silva et al., 2021). For coercive practices to be minimized, it is important to identify the factors that increase the likelihood of their use in the care of patients in the specific context in which they occur. Although patients' sociodemographic characteristics and clinical characteristics are well-documented risk factors for the use of coercion (Beames & Onwumere, 2021; Walker et al., 2019), non-patient-related factors such as service-related characteristics and characteristics of the mental health care providers seem to be implicated in the problem (Dahan et al., 2018; Mann et al., 2021; Wierdsma & Mulder, 2009). It is crucial to recognize these contextual factors because they are more modifiable and could guide the development and implementation of interventions to reduce coercion in the setting. The accounts of mental health professionals who have first-hand experience with the use of coercion could significantly contribute to our understanding of the problem in the Portuguese context. The current study aimed to qualitatively explore the perspectives of Portuguese mental health care professionals on the contextual factors that influence the use of coercion in mental health services.

2. Methods

2.1. Study design

The study employed a qualitative design to allow in-depth exploration of the problem in the study setting. The assumption underlying a qualitative approach is that knowledge and reality are complex and impacted by the sociocultural setting as well as personal values, beliefs, and opinions (Pereira, Ii, Teresa, & Campos, 2008). Focus groups were chosen as the appropriate method for exploring the opinions of mental health professionals since they encounter the phenomenon of coercion in the natural setting and context in which it occurs (Prieto Rodríguez & March Cerdá, 2002). Focus groups open up many channels of communication, allowing members to express their thoughts and opinions in the presence of others who have had similar experiences (Schulze & Angermeyer, 2003). A synergistic effect of the group setting is that it stimulates thoughts and verbal contributions. Reporting of the methods follows the recommendations of the consolidated criteria for reporting qualitative studies (COREQ) (Tong, Sainsbury, & Craig, 2007).

2.2. Recruitment of study participants

Doctors and nurses who had worked for at least six months in the selected psychiatric departments were eligible to participate in the study. Participant recruitment for the study was purposive taking into account gender and years of professional experience. The participants were selected by key contacts (a mental health professional co-opted into the research team in each hospital) in such a way as to favor the richness and heterogeneity of the discussion. (See Table 1).

2.3. Study setting

Five psychiatric departments serving different catchment areas of three regions of Portugal were purposively selected to reflect different mental health service organizations serving different populations. One of the psychiatric departments was from the rural region of Alentejo, while the other four were from the urban metropolitan regions of Lisbon and Porto. All the psychiatric departments are part of general hospitals and have a varying range of community mental health teams.

2.4. Data collection

The focus group discussions were conducted between February 2022 and February 2023. Each discussion lasted between 45 and 60 min and was facilitated by a semi-structured guide that functioned as a flexible framework for exploring study questions using open-ended questions to elicit unconditioned responses. The guide also helped each focus group discussion to be conducted uniformly. The focus groups took place in halls within the hospitals outside the wards. The focus group discussions were facilitated by a trained research assistant and were audio-recorded. The conversations were characterized by fluidity and dynamism, with sufficient interaction among the participants. The questions focused on what factors, other than the patients' characteristics, contributed to the use of coercion. Coercion in the study's context included involuntary admission, and the use of mechanical and chemical restraints. Seclusions were not routinely practiced in the services included. Memos were made throughout the data collection and data analysis to reflect thoughts and ideas about the discussions, interpretation of preliminary findings, and

Table 1
Socio-demographic characteristics of Focus Group participants.

S/N	Variable	Frequency	Percentage
1	Gender		
	Male	18	45.0
	Female	22	55.0
2.	Profession		
	Doctor	23	57.5
	Nurse	17	42.5
3	Friend/Relative with Mental Health Condition		
	Yes	24	60.0
	No	16	40.0
4	Involved with a coercive measure in the past 6 months		
	Yes	33	82.5
	No	7	17.5
5	Received any training on reducing coercion		
	Yes	7	17.5
	No	33	82.5
		Mean	SD
6	Age	36.69	9.52
7	Years of Experience	10.98	9.21

documentation of the research process (Tobin & Begley, 2004).

2.5. Data analysis

Thematic analysis was employed. Audio-recordings of the focus group discussions were transcribed and translated from Portuguese to English language. A thorough reading and rereading of the transcripts was followed by the coding, synthesizing, and integration of text fragments into categories based on similarity of meaning. The data were coded using a standard inductive approach, and the coding process was continued until no new concepts could be derived from the data. Similar codes were grouped together and themes were identified. After discussion between two authors, the theme was confirmed and coding consistency was checked to verify trustworthiness. The themes were also checked by some focus group participants to ensure that no information was misrepresented. Quotes were selected to exemplify each theme and to support the study findings (Eldh, Årestedt, & Berterö, 2020). All data were analyzed with the aid of MAXQDA (Software, 2022).

2.6. Research team and reflexivity

The research team is comprised of both clinician researchers and non-clinician researchers, and most of the authors have a keen interest in mental health and human rights. In keeping with a reflexive thematic analysis (Braun & Clarke, 2006, 2019), we have made a conscious effort to maintain self-awareness and transparency regarding how our roles, perspectives, and experiences may have impacted our work (Braun & Clarke, 2019). Data was collected and analyzed by non-clinician researchers.

2.7. Ethical approval and conduct

The Research Ethics Committee of Nova Medical School, Nova University of Lisbon (100/2021/CEFCM), and the Ethics committee of each participating hospital gave their approval for the study and all documented procedures. Before the discussion started, each study participant provided written informed consent.

3. Results

Table 1: Sociodemographic characteristics of Focus Group Discussion Participants.

The study participants ranged in age from 64 to 24 years old and had practiced for between six months and 38 years. More details about the study participants can be found in Table 1. Four broad themes were derived from the focus group discussions; inadequate resources, staff-related factors, inefficient services and socio-legal factors. Quotes were selected to exemplify each theme.

3.1. Inadequate resources

Most professionals felt that inadequate resources to respond to the demands of service users was a significant contextual factor that led to the employment of coercive measures in mental health care.

3.1.1. Structural resources

A central theme across all the services was how inadequate infrastructure contributed to the use of coercion. The participants felt that the physical spaces and architecture within the mental health services were not ideal for psychiatric admissions. Patient's anxiety and feelings of being trapped were exacerbated by a lack of outdoor space and opportunities for activities. Lack of space in the wards also meant that patients had to share rooms with reduced privacy and increased possibilities of conflict, resulting in the use of coercive measures.

"*…the infrastructure of the service is not the most adequate nor was it designed for a psychiatric, mental health service (…) the term they use the most. "I feel trapped here and this is worse than a prison." In a prison they have exits to the yard.*" (FGD 1, Nurse).

*"When these patients have criteria for admission, (…), they can't get admitted (sic) because there are no vacancies. So, the patients stay in the emergency room throughout the days. It also increases the likelihood of more coercive practices, doesn't it?" (*FGD 5, Doctor*).*

3.1.2. Human resources

Low staff-to-patient ratios resulted in less time being invested in verbal de-escalation. They noted that there were few nurses with specialization in mental health, and other mental health professionals like occupational therapists, psychologists, and social workers. Sometimes, nurses had to undertake the duties that belonged to these auxiliary professionals, which left them with less time to build interpersonal relationships with their patients. Heavy task loads could result in treatment delays and, consequently, increased agitation, leading to the use of coercive measures. Some professionals also mentioned how poor remuneration decreased motivation and job satisfaction.

"*…even the lack of staff I think influences a lot because having 6 doctors and a nurse in an emergency room with 15 patients doesn't make much sense* (…) *and maybe due to staff turnover in recent years, right? But maybe it's all connected*" (FGD 3, Doctor).

"I think that where we work there is clearly a shortage of professionals who deal with the occupational activity part (…) that's a factor, in my opinion, that contributes a lot, yes." (FGD 2, Doctor).

"….. and the professional also has to be remunerated in a way that he feels values his work. If the professional doesn't feel well, in any area, you will be badly served…" (FGD 4, Doctor).

3.2. Staff-related factors

It was acknowledged that factors related to the mental health professionals themselves were relevant to the problem. In all the focus group discussions, a lack of training on dealing with aggression and alternative strategies to coercion was reiterated as a factor contributing to the use of coercion.

3.2.1. Lack of training

All the professionals unanimously reported a lack of training on strategies to reduce the use of coercive measures. They affirmed that being trained in dealing with aggression could avert the use of coercive measures and increase confidence in maintaining safety during aggressive episodes. They emphasized the need for training and support, especially for new staff, the police, and general health care staff, who may be the first to have contact with patients with psychiatric emergencies.

"…professionals sometimes, due to lack of training, end up, instead of starting a negotiation, starting this type of measure right away." (FGD 4, Nurse).

"…on the technical level, the policemen come, some are sensible, some are not, because they are not trained." (FGD 1, Nurse).

"I don't think anybody received training in this sense (…) we know that there are techniques that work and techniques that don't work, decrease the tension and decrease the amount of coercion…I don't think any of us have received training" (FGD 2, Doctor).

3.2.2. Attitudes & subjectivity

The participants noted that staff experience, personality, and emotions can all have an impact on how coercion is used. Staff may be more

vigilant and prone to using coercive measures as a result of previous violent incidents. A lack of objective criteria to use coercive measures meant that using them was left to the discretion of the staff. Some professionals noted that stigma among staff could play a role in the use of coercive measures.

> *"For example, I don't know, I've had situations throughout my professional experience where personal emotion was affected by the work… Two people came in in the same week, more or less the same story, this one would be compulsive, this one isn't."* (FGD 3, Nurse).

> *"The clinician may (…), having knowledge that the patient has already needed a compulsory admission, has already needed coercive measures, may be something that awakens in us the need to act more in this sense."* (FGD 3, Nurse).

> "*…plus, the health professionals' own stigma, we are people with our limitations, prejudices, stigma (…) and this is sometimes reflected in the way we approach patients"* (FGD 4, Doctor).

3.3. Inefficient services

The use of coercive measures was also impacted by the organization of mental health services, the emergency room setting, and restrictive ward rules that created conflicts and raised the likelihood of using coercive measures to preserve safety.

3.3.1. Mental health system organization

The organization of mental health services and poor integration with social services were implicated in the employment of coercive measures. Having just one central psychiatric emergency room as the key unit in the pathway to all admissions was notably a factor in a particular region of the country. Professionals also observed that the mental health system's bureaucratic procedures constituted major barriers to early help-seeking, and that inadequate service integration and poor involvement of primary health care meant that entry into mental health care was frequently through emergencies. Disruptions in treatment for discharged patients due to the inadequately developed community mental health services, lack of housing, and employment opportunities were also highlighted as significant factors that increased the likelihood of relapse and subsequent involuntary admissions.

> *"So I think that this aspect, this organization of the Emergency Department in a single place, I have always been very critical about this ….. It's one thing to have a patient get to know you, and receive him on admission, and he gets to know us, and this facilitates some decisions."* (FGD 3, Doctor).

> *"I mean, so, our role in the community is fundamental and I think there is a failure -uh failure? (…) The Mental Health Nurse in the community is extremely important."* (FGD3, Nurse).

> *"…there are few resources in society for the occupation and even for the professional training of our patients often leads them to spend their days unoccupied, literally speaking. (….) the re-admissions were more and more and in a shorter period of time. Why? Because they spent 24 hours without any kind of occupation, without any kind of responsibility, which also ends up promoting (…) destructive behaviors."* (FGD 1, Nurse).

3.3.2. Emergency room environment

Coercion was most widespread in emergency settings, where acute cases arrived first. Patients typically met non-specialist healthcare professionals who had little to no experience handling psychiatric emergencies and often resorted to coercion because the psychiatric emergency area was typically located in the general emergency area. The fact that many of those brought to the emergency room had no prior contact with services or professionals contributed to increased agitation and aggression, which is typically managed with coercive measures, especially when there are several patients presenting at the same time. Lack of space in the emergency area also meant that many patients with differing severity of symptoms had to be kept in the same open area. Particularly for services in urban areas, patients in need of admission had to wait for some days in the emergency room until a bed was available in the ward.

> *"Regarding the emergency services…. the environment has a great influence on the management of the acute illness of the psychiatric patient. When we don't have places prepared to go with tranquility, without being involved in the "confusion" of an emergency service, it becomes more and more difficult to act within this area. And yes, we often use these coercive attitudes just to guarantee security and to ensure, many times, that the patient is observed."* (FGD 5, Nurse).

> *"In truth, the conditions, at least here in the North (…) are very complicated (…) the physical space does not allow it, in our emergency room … On our part, we also have pressure to observe patients, because we have several patients waiting, …, it's difficult to verbally restrain them, which is the first line of action. And often, this attempt, due to… the reduced space and the team, puts the patient at risk or puts others at risk. So, naturally, it ends up being the strategy that is used because, unfortunately, we have no other available.*" (FGD 3, Doctor).

> *"…. factors that perpetuate that patients stay in the emergency room, which is often the lack of social resources that allow for quick discharge from the hospitalization and that make the emergency room more overcrowded and more difficult after admitting the patient without delays."* (FGD 1, Doctor).

3.3.3. Restrictive ward rules

Professionals from all five services agreed that stringent rules in the ward led to conflicts, agitation and aggression which contributed to the use of coercive measures. Restricted access to phones, limited visitations from family and friends, and the hospital policy of wearing pajamas in the wards all contributed to feelings of dehumanization and frustration in the patients.

> *"Communication with the family, it's just one hour (…) the depersonalization of people, hospital uniforms, often in poor conditions, or sometimes they are cold, the conditions are not the best."* (FGD 5, Doctor).

> *"…the importance of simple things like: a coffee, the various trips to smoke, increase a little bit the phone time, things that obviously not only produce comfort but also confidence…".* (FGD 4, Doctor).

> *"Psychiatric internment is sometimes very restrictive in terms of measures, the patient can't have a telephone, patients can't have a bed, they are denied a series of things, they can't have their own clothes, they can't, they can't, they can't, they can't, it's a whole series of things that they can't do…."* (FGD 2, Doctor).

3.4. Socio-legal factors

This theme reflects how mental health laws, public attitudes, and the pandemic contribute to the use of coercion in mental health care.

3.4.1. Mental health legislation

Many professionals felt that the existing laws related to compulsory admission and treatment were not specific enough and gave room for subjectivity in interpretations, while other professionals felt that the laws justified the use of coercive measures to ensure safety.

> *"This happened with the current Law (…) one thing is written, and a judge from there understood one thing, a doctor from there understood the opposite."* (FGD 4, Doctor) _.

> *"I think that the application of the Mental Health Act in the internment… diverges a little bit between professionals due to the subjectivity that is*

inherent to the Mental Health Act itself. I have felt this ambiguity in the application of compulsory internment." (FGD3, Doctor).

"I must emphasize that the coercive measures are to protect the person, third parties of course, but the person, essentially… and they have to exist, however much it pains us to introduce them sometimes, but they have to exist and are part of a work that was developed in 1998 with the Mental Health Law to protect these people." (FGD 2, Doctor).

3.4.2. The pandemic effect

The COVID pandemic had a significant impact on the delivery of mental health care by reducing available human resources and increased restrictions for patients already on admission. At the point of admission, patients were forced to isolate to reduce the risk of infecting others in the wards.

"There has been an unfavorable evolution, especially when it comes to human resources and the emergency service. Regarding the fact that there are fewer people to do shifts." (FGD 1, Doctor).

"One factor to the hospitalization that I think has been a facilitator to coercive measures has been the 5- and 7-day isolations that are forced on the users that come in and it has been a great difficulty for the teams to deal with that… the absence of meetings with relatives or reference persons of the patient has also made this very difficult." (FGD 2, Nurse).

Following the pandemic, there were long term patients with chronic psychoses who were lost in the middle of the pandemic, their appointments were cancelled, etc… many of them spent several months without taking medication, without even being seen by a relative, let alone a health professional…. the pandemic increased the use of compulsory internment here. (FGD 4, Doctor).

3.4.3. Public attitudes and stigma

The stigma and negative attitudes towards psychiatric care were identified as barriers to early help-seeking. Conversely, increased awareness of mental health problems could have contributed to greater demand for mental health services without a corresponding increase in resources. The stigma associated with psychiatric admissions was noted to be reinforced by the way police officers transported patients to the emergency room, prompting them to become more aggressive and increasing the risk of deploying coercive measures.

"…many times, the idea of having to stay in a psychiatric hospital leads the person and the family to refuse, forcing them to take a coercive measure, due to their own perception of what it means to be hospitalized in psychiatry." (FGD 2, Doctor).

"There's more and more awareness and there's more talk about mental health. People know that even if the person doesn't want to go, they can ask the doctor and the doctor informs them, i.e. activates the means for the person to be seen in the emergency room." (FGD 5, Doctor).

"…and the fact that the police come to the door of the person, uniformed, with some apparatus, many times <noticeable> to the neighbors and to the people that live near the patient, also makes this a very intense experience, quite unpleasant, quite stigmatizing, and also promoting some agitation (…) that has to end in a physical and chemical restraint, (…), upon arrival at the emergency room." (FGD 1, Doctor).

4. Discussion

The relevance of context in understanding the phenomenon of coercion in mental health care has been highlighted by previous studies (Boumans, Egger, Souren, Mann-Poll, & Hutschemaekers, 2012; Hachul et al., 2010; Mann et al., 2021) A contextualized analysis of this issue in Portugal is important to identify the specific range of influencing factors that contribute to the use of coercion in mental health care in the country as well as the precise ways to reduce it. This study explored the views of mental health professionals on which contextual factors contributed to the use of coercive measures in Portuguese mental health care.

Insufficient resources were highlighted as significantly contributing to the use of coercive measures in the study setting. In addition to having a relatively low GDP per capita in comparison to other European countries, Portugal was greatly affected by the Great Economic Recession and adopted several austerity measures, including a tighter public health budget. However, the significant increases in psychiatric service utilization, use of psychotropic medications, (Silva et al., 2020a) and involuntary admissions (Silva et al., 2021) during this recession suggest that demand for services exceeded the supply of resources. The relationship between adverse economic conditions and coercive measures is well documented (McFarland & Collins, 2011; Smith et al., 2020). Some participants in this study cited inadequate compensation as a factor influencing the use of coercive measures, which is consistent with the suggestion that inadequate payment mechanisms of Portuguese mental health care providers may be a significant barrier to best practices and the full realization of proposed mental health plans (Perelman, Chaves, de Almeida, & Matias, 2018). The structural deficiencies, such as the lack of outdoor spaces, could be because some of the psychiatric departments were not designed for psychiatric care but rather adapted for use when the country integrated mental health facilities into general hospitals. While this action is laudable and in keeping with international recommendations, more work needs to be done to make the environment more appropriate for psychiatric care. Low staff-to-patient ratios were notably influential to the use of coercive measures. Although a Japanese study (Fukasawa, Miyake, Suzuki, Fukuda, & Yamanouchi, 2018) found that in reality both seclusion and mechanical restraint were used more frequently in wards with more nurses, mental health professionals from studies conducted globally consistently feel that coercive measures are associated with low staffing levels (Aluh et al., 2023; Krieger, Moritz, Lincoln, Fischer, & Nagel, 2021; McKeown et al., 2019). Staffing levels are related to perceived concerns with the causes and responses to conflict and aggression (McKeown et al., 2019). Additionally, low staff-to-patient ratios lead to limited opportunities for establishing a therapeutic alliance and engaging in collaborative decision-making, resulting in patients feeling more coerced (Prebble, Thom, & Hudson, 2014; Sheehan & Burns, 2011). Patients themselves have highlighted that effective communication with mental health professionals can help prevent the need for coercion (Olofsson & Jacobsson, 2001; Stylianidis et al., 2017). The two opposing trends of funding cutbacks with subsequent staff shortages and increasing pressure to reduce the use of coercive measures despite these insufficiencies have been brought to light in previous studies (McKeown, Wright, & Mercer, 2017; Mick McKeown et al., 2019).

Theoretically, the country's mental health plan outlines an efficient pathway to care through referrals from primary health care and a network of community mental health teams. In reality, most psychiatric admissions are through emergency settings, bypassing primary care, community mental health care and the outpatient clinics in each psychiatric service (Ramos, Santos, Jorge, Maia, & Cardoso, 2015). The emergency care pathway is not optimal because a lack of familiarization between patients and staff causes heightened agitation on the part of patients and hypervigilance on the part of professionals who want to maintain safety. Resolving this problem could significantly reduce the need for coercive measures. Stringent ward rules were also identified as a contributing factor. This may have a cultural undertone reflecting the remnants of the country's fascist era, which was characterized by strict rules for the entire population; however, in the context of limited human and structural resources, as well as a lack of training, staff are understandably more likely to enact restrictive rules as a safety net to protect themselves and other patients. Restrictive ward rules have been documented to lead to increased use of restraints within wards and a negative ward milieu (Alexander & Bowers, 2004). Restrictive rules without

clarity are known to increase feelings of being incarcerated, trapped, dehumanized, and stigmatized among patients (Alexander & Bowers, 2004). An Italian study found that patients and staff members' perceptions of safety were affected by ward rules, in particular the number of visiting hours and possibility of having a smartphone (Corbetta, Corso, & Camuccio, 2022). Although the study did not seek to compare the views of doctors and nurses, it was interesting to find that more doctors (who typically spend less time in the wards with patients) than nurses felt that the ward rules were restrictive and contributed to the use of coercive measures.

The study participants acknowledged the role of attitudes of mental health professionals in the problem. Staff attitudes regarding coercion and personality traits are known to influence how aggression is managed, however, this is a complicated topic with mixed results (Aasland, Husum, Førde, & Pedersen, 2018; Krieger et al., 2021; Morandi, Silva, Mendez Rubio, Bonsack, & Golay, 2021; Rose, Evans, Laker, & Wykes, 2015). Lack of training on alternative strategies to coercion was echoed by all the professionals as a significant factor in the problem. Although staff training offers the strongest evidence of effectiveness in minimizing the use of coercion in mental health treatment, it is challenging to execute these alternative strategies in the context of limited human resources, as highlighted by a previous study conducted in England (McKeown et al., 2019). Participants emphasized the importance of providing training to all key stakeholders, including police officers and non-medical workers involved in mental health care. A previous study in Portugal reported that police officers had negative perceptions of those with mental health conditions but acknowledged the need for specialized training in handling those in mental health crises (Soares & Da Costa, 2019). Public attitudes and stigma were also mentioned as influencing factors in the use of coercive measures. Stigma is known to be a significant barrier to early help-seeking, precluding the need for coercive measures (Antunes, Silva, Azeredo-Lopes, Cardoso, & Caldas-de-Almeida, 2022; Silva et al., 2020b). Stigma has also been linked to the endorsement of coercive measures in mental health care (Lauber, Nordt, Falcato, & Rössler, 2002; Steiger et al., 2022). Thus, stigma reduction must be integral to the movement towards reducing coercive measures in mental health care.

More doctors cited the country's legislation as an influencing factor. This is not surprising since the country's current legislation regulates involuntary admissions, but not other coercive measures commonly used by nurses but which must be approved by the doctors, such as the use of restraints and seclusion. The view on subjective interpretations of the law points out the need for more explicit policies and guidelines on the use of coercive measures in the country. A previous study among Portuguese nurses reported low levels of knowledge of the indications, implementation, and legal framework of the use of physical restraint and chemical restraint on patients (Cunha et al., 2016) buttressing the need for guidelines and training on the use of coercive measures for both doctors and nurses. Currently, a new legislation is underway that regulates the use of restraints and includes mechanisms such as advanced care planning and shared decision-making. This is a commendable move with compelling evidence on reducing coercion (De Jong et al., 2016), but without a parallel increase in mental health care human resources, this could mean additional administrative work for already overburdened mental health care practitioners, which could have a boomerang effect.

The findings of this study are notable for demonstrating how interwoven the contextual factors that contribute to the use of coercion in mental health care are (Fig. 1). Insufficient resources are reflected in the inadequate space available for patients, low staff-to-patient ratios, and the lack of training of staff. The inadequacy of resources was compounded by the COVID-19 pandemic, and probably by earlier economic recessions in the country. Lack of training of staff is reflected in restrictive ward rules, mostly made to promote safety in wards but ironically promotes conflicts that need to be resolved by coercive measures. Lack of staff training is also evident in the different attitudes and subjectivity of staff when confronted with similar aggressive episodes. The mental health legislation is closely related with how the services are organized and was particularly noted to be inefficient in one of the northern regions of the country. The mental health legislation also justified the use of coercive measures for some staff and has been reported to influence the endorsement of coercive measures in studies conducted in the United States (Brooks, 2006, 2007).

The study findings present important policy implications. To avoid emergency admissions being the first route of entry for mental health care, primary health care collaboration in mental health care should be strengthened. Specific measures, such as assertive community treatment and improved collaboration with social services and local sociocultural organizations, should be implemented to encourage continuity of care, earlier detection and referral of patients. This approach aligns with the patients' desire for alternative crisis intervention methods that avoid hospitalization. A recent meta-aggregation of qualitative studies on patient experiences of coercion revealed that patients appreciate the ability to stay in their familiar environment, surrounded by their relatives, when dealing with crisis situations (Silva et al., 2023). These will require more human resources for mental health care, especially nurses

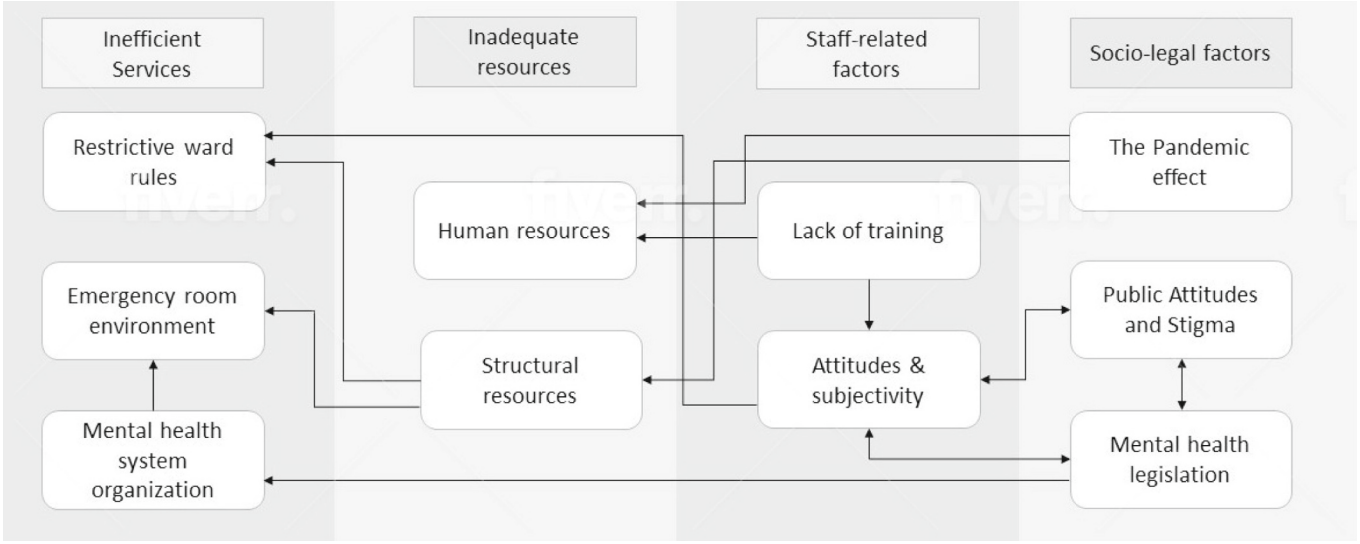


Fig. 1. A diagram of contextual factors at play in the use of coercion in Portuguese mental health care.

with a specialization in mental health, psychologists, and occupational therapists. Routine training of all professionals including the police and other non-medical staff involved in mental health care on communication skills, alternative strategies to coercion and the human rights approach should be implemented. Staff training will boost confidence and hopefully be reflected in more flexible ward rules that prevent conflicts and promote a better ward milieu. There is an urgent need for information systems to document coercive measures for regular monitoring and surveillance of coercive measures in Portuguese mental health services. Despite growing awareness of problems related to mental health, stigma towards more severe mental health conditions persists, emphasizing the need for the country to strengthen stigma reduction programs.

The strength of the present study lies in the inclusion of views of doctors and nurses from different regions of the country. Some limitations are acknowledged in the study. Although efforts were made to capture professionals from different services in urban and rural areas, it is possible that the study findings may not reflect the reality of all mental health services in the country. Informal coercive measures such as negotiations and leverage were not explored in this study.

5. Conclusion

The study demonstrates how the use of coercive measures in mental health care can be influenced by factors that are independent of patient characteristics. It highlights how insufficient resources, staff-related factors, including a lack of training, inefficient services, and socio-legal factors all contribute to the use of different coercive measures in mental health care. The COVID-19 pandemic exacerbated the underlying weaknesses of the mental health system, increasing the necessity for the use of coercive measures. Systemic problems in the mental health care system must be addressed for the effective delivery of high-quality mental health care and the successful implementation of strategies to reduce coercion.

Funding details

Deborah Oyine Aluh is a PhD student receiving the support of a PhD fellowship from “la Caixa” Foundation (LCF/BQ/DI20/11780013). Barbara Pedrosa and Ugnė Grigaitė are PhD students receiving financial support from the FCT – Fundação para a Ciência e a Tecnologia (UI/BD/151073/2021 and UI/BD/151072/2021).

Declaration of Competing Interest

The authors report there are no competing interests to declare.

Data availability

The data analyzed during the current study are available from the corresponding author on reasonable request.

Acknowledgements

The authors gratefully acknowledge the study participants who generously shared their time for this study. We also acknowledge Bruno Silva and Márcio Cabral for helping with the transcription and translation of the audio-recordings.

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