The Role of Ethics in Reducing and Improving the Quality of Coercion in Mental Health Care

Abstract

Coercion in mental health care gives rise to many ethical challenges. Many countries have recently implemented state policy programs or development projects aiming to reduce coercive practices and improve their quality. Few studies have explored the possible role of ethics (i.e. ethical theory, moral deliberation and clinical ethics support) in such initiatives. This study adds knowledge to this subject by exploring health professionals' descriptions of their ethical challenges and strategies in everyday life to ensure morally justified coercion and best practices. Seven semi-structured telephone interviews were carried out in 2012 with key informants in charge of central development projects and quality-assurance work in mental health services in Norway. No facilities used formal clinical ethics support. However, the informants described five areas in which ethics was of importance: moral concerns as implicit parts of local quality improvement initiatives; moral uneasiness and idealism as a motivational source of change; creating a normative basis for development work; value-based leadership; and increased staff reflexivity on coercive practices. The study shows that coercion entails both individual and institutional ethical aspects. Thus, various kinds of moral deliberation and ethics support could contribute to addressing coercion challenges by offering more systematic ways of dealing with moral concerns. However, more strategic use of implicit and institutional ethics is also needed.

Key words: coercion, ethics, clinical ethics support, mental health policy, quality improvement and research

Introduction

Use of coercion in mental health care is one of the more serious deprivations of individual liberty a society may impose. The serious effects of coercion on individual autonomy and liberty make coercion an inherently value-laden practice (Wertheimer 1993; Hoyer 2000). Consequently, there has been much debate on the ethical justifications for and the best practices of coercive interventions.

Previous research has shown that coercion is a complex phenomenon comprising both formal coercion (e.g. involuntary hospitalisation, seclusion and mechanical restraints) and informal coercion (e.g. pressure and threats to induce compliance) (Kallert et al. 2011). Practitioners are, as moral actors and health professionals, often faced with the practical challenge of trying to determine whether coercion is morally and clinically justified (e.g. being beneficent for the patient or avoiding harm) and limiting the use to only morally justified cases. These challenges have recently surfaced in several state policy initiatives and development projects to reduce coercive practices and improve their quality, for example, by avoiding unnecessary and hard-handed use of physical force or forced medication with heavy side effects, securing patients' legal rights and providing respectful care. Such state policy programmes exist particularly to the Nordic countries, the Netherlands, the United States and Canada (Scanlan 2010; Gaskin et al. 2007; Voskes 2014), while other countries, such as New Zealand, Australia and Germany, express similar aims (Steinert and Lepping 2011). Many interventions have been successful in reducing coercion while maintaining a safe environment, thus demonstrating the potential for reduced coercion (Gaskin et al. 2007; Scanlan 2010).

Although much research addresses moral concerns, few empirical studies have looked at how ethics (i.e. ethics theory, moral deliberation and various types of clinical ethics support [CES]), can contribute to reducing coercive practices in mental health care and improving their quality (Hem et al. 2015). An exception is the Netherlands, where dialogical ethics, moral deliberation and normative criteria development have been core strategies of the state's policy to reduce and assure the quality of coercion, particularly seclusion (Abma et al. 2008; Landeweer et al. 2011; Voskes 2014). Dutch research has found that systematic and facilitated moral deliberation contributes to improved staff awareness of ethical dilemmas, moral competence, conflict solutions, interdisciplinary collaboration (Molewijk et al. 2008) and reduced seclusion – but not as the only measure (Voskes 2014).

Research aims

This article aims to increase understanding of how ethics can contribute to reducing coercive practices and improving their quality through a qualitative study of key informants from development projects and facilities in Norway that use little coercion. The study will explore how the morality of coercion unfolds in everyday life in mental health care, including how health professionals' reflect on and address ethical challenges regarding coercion, and which strategies they use to accomplish the professional and policy goal of restricting coercive practices to morally and clinically justified situations and to determine the best practices for carrying out coercion. The implications of these findings for the role of ethics in such initiatives, in particular CES, are then discussed. This knowledge could be useful in developing more systematic and explicit use of ethics to improve coercive practices and reduce the moral stress of staff that use coercion (Wojtowicz et al. 2014; Pauly et al. 2012).

Theoretical framework

Ethics is defined as systematic reflection on or theory about morality (i.e. normative considerations of attitudes and actions as right or wrong, good or bad), including, for example, moral reasoning and principles. Common approaches within health services are moral deliberation and CES (e.g. joint moral inquiry, clinical ethics committees or ethics rounds). Our analyses of the informants' moral perceptions on and strategies for coercion use draw on insights from naturalised and institutional ethics. These perspectives emphasise the socially situated aspects of moral concerns and evaluation practices in everyday life (Lindemann et al. 2009; Walker 1993; Austin 2007). Moral reflection and practice often unfold as on-going, collaborative and negotiable social practices within health institutions, and they are deeply enmeshed in professional knowledge and practical skills. Morality concerns arise on both the individual level (e.g. moral reasoning and moral integrity) and the institutional level (e.g. organisational ethics, implementation of ethical guidelines, ethics training and developing CES). The institutional level addresses the 'moral habitability' of health care environments (their climates, cultures and structural traits) and interchanges between 'moral communities' inside and outside a single institution (Austin 2007;

Walker 1993). Consequently, it is important to investigate what clinicians actually do when engage in morally challenging practices and moral reflection, thereby helping to create and facilitate a moral space within institutions that encourages critical, reflective and collaborative moral thinking among all stakeholders. Further, there is a need to address the institutional processes that shape and constrain moral concerns, ethical dialogue and practice. This could be through a variety of ethics support inquiries and methods (Widdershoven et al. 2009; Austin 2007; Walker 1993) and also more implicit processes.

Methods

Study context

Mental health care in Norway is publicly funded and organised as 'specialised health services' – that is, as hospital trusts (hospitals and outpatient clinics) and community health services (general practitioners, local emergency services and home care). Formal coercion is mainly performed by specialised health services, though community health services can request involuntary hospitalisation. Norwegian state policy initiatives to reduce and improve coercive practices (sometimes referred to as 'secure proper use of coercion') began in the late 1990s and have included several national strategies or action plans primarily directed at hospital trusts but also at community services requesting involuntary hospitalisation. Yet, as in other countries, the aim of reducing coercion is controversial (e.g. Happell and Harrow 2010), as is the definition of 'proper use of coercion'.

Following the Dutch example, Norwegian health authorities have recently addressed the ethics of coercion more explicitly through the on-going 'PET-project',[1] which explores the ethical challenges of coercion and possible solutions to them from all stakeholders' perspectives. This article reports the findings of an introductory PET-project study aimed to gather experiences, and learn from, mental health facilities that intended to reduce or improve coercion use, with a special focus on the role of ethics.

[1] The English name for 'PET' is 'mental health care, ethics and coercion'.

Sample and recruitment

A combination of purposive and snowball sampling was used to find mental health facilities and stakeholders. We were particularly interested in key stakeholders from facilities that have worked to ensure the quality of coercive practices since they could serve as experienced and well-informed informants' suitable for our research aims (Kvale and Brinkmann 2009). Inclusion criteria were mental health facilities that either used little coercion according to national statistics or were well known for their development projects on coercion. Since no national overview of development projects on coercion exists, the sample is based on our knowledge of the field from similar projects, advice from national experts and web searches. Twelve informants from various services were invited to participate by e-mail or telephone, and seven accepted. The others did not respond; hence, their reasons for non-participation are unknown.

The informants came from various parts of Norway and comprised two psychiatrists and five nurses from a total of six mental health hospitals (mostly acute wards), one district psychiatric centre, one municipal emergency unit and one psychiatric ambulance.[2] Of these, five informants were managers (two head psychiatrists and three head nurses) and two were in charge of clinical development work (nurses). All held central positions in development work regarding coercion and served as local driving forces behind it.

Data collection and analysis

Semi-structured telephone interviews lasting from 30 to 50 minutes were conducted from May through June 2012. The interview guide was influenced by our previous knowledge of international and national initiatives on coercion and included questions about development projects, factors influencing the use of coercion and respondents' views on the state policy aims of reducing and improving coercion use, as well as the contributions of ethics to those aims. The informants knew ethics from their professional education and were refreshed on the definitions of ethics and formal clinical ethics support both orally and in writing.

[2] Some key informants held double positions.

The interviews were digitally recorded but *not* stored on a computer. The first author transcribed the interviews in an anonymous way and deleted the files. Thereafter, we conducted an inductive, thematic content analysis of the transcripts (Kvale and Brinkmann 2009). Both manifest (explicit) and latent (implicit) statements about ethics were included (Graneheim and Lundman 2004). Nvivo 10, 2012, was used. Data analysis was conducted in two phases. First, all authors read through the transcripts to obtain an overall impression and agree on the main findings. Central meaning-units were identified from with explicit statements and coded into eight preliminary thematic categories (the background, content and achievements of initiatives; respondents' views on coercion and patient/family involvement in care; influential factors; ethical challenges; and the use of clinical ethics support). The coded data were put into data matrixes for continuous comparison and cross-validation. Second, the transcripts were re-analysed considering implicit statements on the general role of ethics in development projects. This data was coded into broader categories. Finally, to secure the meaning context, the analysis was validated as related to the text as a whole and to naturalistic ethics. The findings from both phases were synthesised into five significant ethical themes and are presented in the findings section of this article.

Research ethics

Written and oral information and consent and confidentiality as required by the Helsinki Declaration were secured. Because this project did not involve personal data being processed in computer-based equipment or manually stored, it did not require notification or approval according to Norwegian legal regulations.[3] Further, since the study did not include patients, it was not necessary to seek approval from the Regional Committee for Medical and Health Research Ethics.

Findings

The informants' descriptions show that moral considerations on the use of coercion were an on-going activity in their daily lives. The role of formal ethics support was marginal, but moral issues and moral

[3] Norwegian Social Science Data Service (NSD 2015), http://www.nsd.uib.no/personvern/en/notification_duty/meldeskjema?eng).

deliberation were often informally integrated into development projects and quality assurance of coercion. The contribution of ethics was especially discussed in relation to five main themes concerning ethical challenges and strategies for ensuring the qualitative use of coercion, as elaborated below.

Moral concerns as implicit parts of quality development and assurance work

As seen from the overview in Table 1, the local development projects or quality assurance work included various interventions addressing both formal and informal coercion. No facilities used formal kinds of CES. However, as discussed below, the informants said that many interventions involved moral concerns, such as increasing patient autonomy, sharing decision-making and cooperation, reducing prejudices and stereotypes, improving ward cultures and staff attitudes toward and relations with patients, and increasing staff reflexivity, empathy and dialogue.

INSERT TABLE 1

Moral uneasiness and idealism as motivation for change

The informants reported that development work was a result of external and internal 'pushes' to change coercive practices. External pushes came from the wider society, such as new research, professional and health policy discourses or bad publicity on high levels of coercion (compared with other hospital trusts) that influenced thinking inside the hospital. For example, one manager from an acute ward said that after bad publicity staff started to ask critical questions about whether they were using the best methods. The development work was based on staff's willingness to critically evaluate their own practices instead of just defend them, as well as a need for more research input on and critical evaluation of their daily practices. Internal pushes came from individual or general staff self-reflection on their experiences. Many of these internal pushes were explicitly or implicitly described as arising from moral distress in daily work, moral uneasiness about the organisation or culture or a desire to meet certain moral ideals.

Feelings of moral distress in daily work

For example, many informants said that local initiatives arose from feelings of moral unease or distress in their daily work due to observing low-quality treatment or violations against coerced patients.

Moral unease could unfold on both an individual and a collective level. For example, one psychiatrist said that his commitment to change arose from his moral concerns about the use of coercion:

> *I have always found coercion to be the most uncomfortable part of my work, and I have been very scared of causing harm to myself and others for, how do you say, for philosophical reasons (…) And my doubts about knowing too well what others benefit from has made it hard for me to conduct coercion when I have been uncertain whether I'm right (…). And over the years, I have seen quite a lot of sad examples of what coercion is doing to people and how it contributes to undermining trust in mental health services and making people who are in need of help afraid of contacting us. So, I'm thinking that coercion is a kind of 'high-risk-game'; you might succeed if you are lucky, but the risk of doing more harm is severe.*

Likewise, one head nurse reported that their changes in seclusion practices were a consequence of collective worries and staff discussions about coercive practices that had no positive treatment outcome:

> *Then we had this long history of applied coercion that we found fruitless. I mean heavy use of coercion, as I remember it retrospectively. So that was the background for it. We wanted a change, and that desire was quite widespread among many of the most central staff members on the ward.*

Moral uneasiness regarding the culture and organisation of care

In practice, important sources of moral uneasiness were the structural and cultural traits of the mental health services. According to several informants, these could contribute to the unnecessary use of coercion, dehumanising attitudes or low-quality treatment.

Such concerns are apparent in descriptions of starting establishment of a psychiatric ambulance. For instance, staff members worried about unnecessary use of police during involuntary admissions, which would increase the burden placed on patients and their families. Further, many informants voiced moral concerns about the organisation of hospital services, particularly the locked wards. One informant described the hospital as a repressive and restriction-oriented system. This contributed to reduced patient autonomy and made it difficult for staff to promote voluntariness and patient participation. Others pointed to the problem of cumbersome decision-making routines on the ward that created unnecessary frustration and conflicts with patients and increased the use of coercion.

Another example was the informants' descriptions of development work to reduce seclusion or 'shielding'[4] (Table 1). These initiatives came from moral unease about the lack of active, professional treatment during seclusion due to the role of custodial staff in the seclusion unit. Furthermore, an overly 'static' way of conducting seclusion could result in poor treatment outcomes, conflicts with patients and increased use of coercion. Another problem was a culture of stereotyping patients as dangerous. One nurse in charge of a development project described his reasons for initiating changes as follows:

> *Well, these 'misunderstood ways of thinking about security' as I call them actually gave me a sense of discomfort. Sometimes, I was left with this feeling of, 'Are all patients equal'? As a student, I worked in a seclusion unit for two and a half years. While I was sitting there, I tried to figure out what works and what doesn't. And gradually, these misunderstood ways of thinking about security gave me severe feelings of discomfort, like:* This is not right.

Moral uneasiness and distress were reinforced by listening to complaints from secluded patients and by personal or professional desire for more supportive and dialogical approaches toward patients.

Many informants also found the coercion-oriented and paternalistic culture of mental health care, particularly in hospitals, to be morally problematic. The long tradition of compulsory care in psychiatric hospitals was regarded as a major reason for the unnecessary use of coercion. This tradition has also produced what one informant labelled a '*paternalistic heritage*'. This heritage makes '*health personnel*

[4] 'Shielding' is the main kind of seclusion in Norway. It differs legally from isolation in that it requires the continuous presence of staff.

think that they know better than the patient what is best for them' and leads to a lack of service orientation towards patients. The long tradition of compulsory care also contributes to a culture of habitual coercive practices that are rash and unreflective. As one psychiatrist argued: '*If you are only socialised into one culture, then you believe that your judgement is right. You don't think there is any room for change*.' Moreover, frequent use of coercion can lead to reduced empathy, which can become a cultural problem. As one informant described it:

> *If you make a thousand decisions about coercion over a year, then it cannot hurt as much every time. (...) And then, gradually, a part of our empathy erodes. Coercion quickly becomes a habit. (...) Well, my tip is that environments that frequently use coercion find it easier to use more coercion, and that they do it with a lesser degree of reflection than they actually ought to. They are also less prepared to consider human rights and protecting the integrity of the patient. I think some damaging things happen when you live in environments that use force regularly. And, it's quite practical and easy to use as well. Use of force maintains peace and order. I think we have a substantial cultural problem here.*

The cultural problem of habitual coercive practices made increased staff reflexivity on coercive practices important (Table 1).

Moral idealism: Desire for quality improvement of mental health care

Several informants emphasised the importance of morally inspired motivation for change, meaning an idealistic wish and enthusiasm to improve the quality of mental health care. For example, the informants stated that they or their colleagues really '*wanted'* more humane practices and to reduce coercive practices that they considered unethical. They were also '*burning for*' a reduction in unnecessary coercion and a strengthening of patient autonomy and treatment quality, resulting in better patient care. Several also desired less use of force and more dignified patient care, and regarded these as core elements of good care and professionalism. They said that health care personnel should '*not only be custodians, but helpers and fellow humans*'. Moreover, dialogue and participation should be a basis for collaboration and trust, stimulating voluntary patient assistance.

Creating a more explicit normative basis for the development projects

A key theme in the interviews was the importance of moral values, ethical principles and informal moral deliberation in creating an explicit 'normative basis' for development projects and ensuring morally justified coercion in individual cases. One important contribution of ethics was to establish a vision of the development work. Shared values also helped unite the staff in the implementation and realisation of desired changes, which often required hard work. Important guiding ethical principles and values described by informants were securing patient autonomy, avoiding harm or distrust, using proportional coercion and showing humility, empathy, reciprocity and acknowledgement.

Alongside this, some informants underlined the importance of ethical principles and moral deliberations for increasing staff awareness of their underlying views on the humanity of patients. As one nurse described regarding seclusion: *'And when I think about what has been important for us in this development work, then I conclude with our views of humanity*.' Staff members' views of humanity were said to affect their perspectives on patients and their preconceptions of situations, hence influencing their approaches to patients in their daily work. Moreover, humane views were considered vital for creating a more humble and emphatic attitude towards patients as co-humans. As stated by another nurse: '*What I think is important in this work is to possess humility towards the human beings we encounter. It could have been me sitting there*.'

Another important contribution of ethical principles and moral deliberations was to help transform national policy into local mental health practice. The informants said that controversy about coercive practices within the wider society could create moral uncertainty and disagreements among staff. There were also uncertainties about how the national policy aim of 'proper use of coercion' should be operationalized in practice and balanced with other concerns (e.g. liberty and security) in individual patient situations. Consequently, development projects and quality assurance work included ethical considerations and moral discernment and deliberation among staff about how to apply key norms and principles in concrete moral dilemmas. Still, many informants reported a lack of moral consensus about the aims of reducing coercion locally, sometimes generating conflict among staff.

Value-based leadership

Many informants also highlighted the importance of value-based leadership. Leadership was important for actualising the vision of reducing and improving coercive interventions by implementing changes in everyday practice, such as by developing strategic plans, allocating necessary resources, increasing staff competence and undertaking strategic recruitment of qualified staff (Table 1).

Manager were considered important '*culture-bearers'* and a driving force in upholding values, maintaining ambitions and supporting staff in difficult situations. As one manager from a facility with little use of coercion described it:

> *I think that one of the most important things that we have in this place is our culture. We have some attitudes that are basically suitable for the business we're running (…). And this is cultural work; I am head of culture in the field of psychiatry. It is me who actually decides what is acceptable, the right attitudes and suitable actions. And I have to take that responsibility (…). And in my definition of responsibility, the dignity of the individual and the right to self-determination are very important.*

Leadership also helped curb the tendency to revert to old coercive practices. As described by one head nurse:

> *Coercion is a continuous issue on the ward. It is not something that fades away. It is present all the time. I think this is due to the quality of those who work here. And also that we, the management, never let it go either. We never give in. It would have been much easier sometimes to go for the intensive, old fashioned use of coercion, but we don't allow it. (…) And honestly, this wouldn't have worked if we hadn't anchored it in management.*

Further, leadership was necessary for dealing with staff resistance to change, for example, reducing coercion and increasing patient participation.

Increased staff reflexivity concerning coercive practices

Many informants considered reflexivity to be important in avoiding habitual coercive practices, improving decision-making processes and supporting staff in difficult and complex situations. Further,

reflexivity contributed to team building, increased staff confidence and reduced stress. They also considered that ethics theory and moral deliberation could support professional competence and reflexivity by increasing staff's awareness of and ability to describe their underlying assumptions and reasons for acting.

Many informants spoke about the importance of creating a reflexive local culture regarding coercive practices and to stimulate a shared '*solution-oriented culture*' that aims to prevent coercion (Table 1). Good quality coercive practices were seen to require on-going considerations and discussions, as well as managers who encourage critical thinking. As described by one head nurse:

> *Overall, they are constantly encouraged to be critical. I am currently interviewing temps who are going to be here this summer, and they are constantly pushed towards being critical. We don't mind them being novices and without experience; we want to know what they think. We are trying to make [critical thinking] permeate the whole organisation. It's not always easy, but at least we are trying.*

Some informants also described the significance of a staff culture that allows staff members to provide continuous feedback in a safe way. This was seen to prevent the silencing of discussion on unethical practices due to collegial loyalty.

It was also considered important that managers create opportunities for the staff to report and discuss incidents that give rise to moral distress. This can be seen from a head nurse's description of an episode of forced medication:

> *And then we had this second episode of medication, which according to those [staff] who participated in it, felt like a catastrophe. You had to hold this old lady quite firm and partly undress her upper body. We managed to give the injection; that didn't pose any big problem. But then, the following morning, one staff member reported that he found this [episode] disconcerting. It had left a bad taste in his mouth because the lady was full of bruises. And then we had a discussion about it (...) and ended up not giving any more injections. (...) So, you get all these kinds of discussions, and they come up in situations filled with doubt, and then*

everybody is very clear about the fact that if something happens that feels bad, then we have to consider doing something else instead.

Use of moral deliberation to increase reflexivity

None of the respondents' facilities used formal CES. According to informants, this was due to financial and practical reasons or because it was an unconventional way for practitioners to work with moral problems. Some also thought it would be more fruitful to integrate ethical considerations and support into daily clinical work.

However, as mentioned earlier, ethical considerations and moral deliberations were often enmeshed in other activities, such as in regular staff teaching, supervision or study groups, or as part of on-going discussions in daily work (Table 1). Furthermore, professional discussions and ethics were often intertwined. As one nurse said: '*But as to whether it is professional guidance or ethics? I guess it is a combination. Usually, we discuss a case and then both the professional and ethical aspects will be discussed*.' Furthermore, some informants reported that they initiated processes that pushed the staff to systematically and continually address their attitudes toward and reflections on their reasons for using coercion. This could be through the use of statistics in local seminars documenting divergent practices, individual feedback from managers or decision-making processes integrated into regular meetings of the head psychiatrist group or ambulance personnel (Table 1). One nurse also mentioned that he found emotional and physical discomfort to be significant signs of moral problems, and he would ask staff whether they had experienced either lately. The informants reported positive experiences with these more implicit ways of working through ethical challenges and considerations. However, some also saw the benefits of more explicit and structured ways of working with ethical dilemmas.

Discussion

Methodological considerations

This study has used interviews to explore the possible role of ethics in reducing and improving the quality of coercive practices in mental health care. The study shows that practitioners' face many practical,

everyday problems in trying to determine what coercion is morally justified in daily practice, and that they use various strategies to make this determination and ensure best practices. It also confirms the need to provide staff opportunities to increase their awareness of their daily practices and to discuss the ethical challenges of their 'lived experiences' regarding coercion (Smith and Herber 2015; Happell and Harrow 2010). Hence, ethics could offer important support for professionals in their efforts to handle moral concerns regarding coercion in everyday practice.

However, our findings are based on a small sample and cannot be generalized. Further, we only have data on the participants' views and descriptions and do not have observations or sufficient information about actual practice or the effects of the strategies described, or about the staff's or patients' views. Consequently, more comparative and larger studies are needed to evaluate the role of ethics and the use of ethics interventions. Still, the collected material was rich in data, offering varied and detailed information about the topics we aimed to investigate.

How can ethics contribute?

The informants' broad and integrated understanding of morality revealed a wide range of potential roles for ethics in reducing and improving coercive practices. Ethics can contribute to increasing awareness of potential patient violations and ethical challenges regarding coercion, as well as to developing a language to address such concerns. This process can open up local practices to critical reflection and discussion since consciousness is important for developing moral perceptions and empathy towards patients (Vetlesen 1994),

Furthermore, as found internationally (Abma et al. 2008; Dauwerse et al. 2013; Pelto-Piri 2015), many ethical challenges regarding coercion are closely related to systemic and cultural concerns and to professional work and teamwork. This underlines the need to address the moral habitability of healthcare, ethical leadership and moral communities as part of policy programmes and quality development work. Ethics might respond to these needs by offering systematic ways of working with moral issues regarding coercion on all organisational levels. Further, the study shows that ethics can contribute to reducing moral stress by addressing institutional changes that can enable professionals to act in accordance with their

values in patient care or by making active use of staff's moral uneasiness and idealism to inspire and inform quality improvements in clinical practice (Deady and McCarthy 2010; Pauly et al. 2012).

Ethics might also contribute to the development of quality care and staff working conditions by supporting value-based leadership (Laukkanen et al. 2015) and encouraging reflexivity on coercive practices (Voskes 2014; Pelto-Piri 2015; Walker 1993). Moreover, ethics theory and joint moral inquiry might contribute to the shaping of a normative basis – or 'normative anchors' (Schomberg 2012) – for quality development work and practice innovation, given the moral complexity of the use of coercion. This might help avoid overly dogmatic attitudes by stimulating a normative stance that is open to including new practice experiences along the way.

Implications for CES

The findings support the need to develop a variety of implicit and explicit CES measures to address moral concerns in clinical practice (Dauwerse et al. 2013; Walker 1993). One strategy for opening up a moral space in the health care facilities might be a more explicit use of formal clinical ethics support. Another possible strategy is making more active and systematic use of implicit ways of working with moral concerns and ethical challenges in practice, such as team meetings, spontaneous discussions and teaching. Similar to the arguments from (Ho et al. 2016), we find that CES could profit from drawing more on the insights of those institutional ethical approaches that align with the ways professionals and institutions work in quality development more generally. 'Integrated ethics' (Fox et al. 2010), or 'responsible research innovation' (Schomberg 2012) might offer valuable contributions to CES. These approaches include systematic quality-development tools such as literature reviews of best practices, user participation and strategic programmes for desired changes. They also include preventive ethics directed at avoiding the occurrence of ethical dilemmas (e.g. by re-organising the services) and providing practical advice about value-based leadership and integrated ways of conducting moral deliberations, both of which were found to be important by this study. These ethical approaches in education and work life could contribute to reduced moral stress (Ho et al. 2016; Pauly et al. 2012).

Conclusions

This study indicates that ethics can contribute significantly to development projects and quality assurance about coercion by offering more systematic ways of dealing with moral concerns. The interrelatedness of organisational environments, professional aspects and moral issues underlines the need for integrated and process-oriented ethics. Further studies are needed to investigate how systematic use of various kinds of clinical ethics support could contribute to development work on coercion.

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Conflict of interests

The authors declare that they have no conflicts of interest.

References

Abma, T., Widdershoven, G., & Frederiks, B. (2008). Dialogical nursing ethics: The quality of freedom restrictions. *Nursing Ethics*, *15*(6), 789–802.

Austin, W. (2007). The ethics of everyday practice: Healthcare environments as moral communities. *Advances in Nursing Science*, *30*(1), 81–88.

Dauwerse, L., Weidema, F., Abma, T., Molewijk, B., & Widdershoven, G. (2013). Implicit and explicit clinical ethics support in the Netherlands: A mixed methods overview study. *HEC Forum*, doi:10.1007/s10730-013-9224-2

Deady, R., & McCarthy, J. (2010). A study of the situations, features, and coping mechanisms experienced by Irish psychiatric nurses experiencing moral distress. *Perspectives in Psychiatric Care*, *46*(3), 209–220, doi:10.1111/j.1744-6163.2010.00260.x

Fox, E., Bottrell, M. M., Berkowitz, K. A., Chanko, B. L., Foglia, M. B., & Pearlman, R. A. (2010). Integratedethics: An innovative program to improve ethics quality in health care. *Innovation Journal*, *15*(2), 1–36.

Gaskin, C. J., Elsom, S. J., & Happell, B. (2007). Interventions for reducing the use of seclusion in psychiatric facilities: Review of the literature. *British Journal of Psychiatry*, *191*, 298–303, doi:10.1192/bjp.bp.106.034538

Graneheim, U., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, *24*(2), 105–112, doi:10.1016/j.nedt.2003.10.001

Happell, B., & Harrow, A. (2010). Nurses' attitudes to the use of seclusion: A review of the literature. *International Journal of Mental Health Nursing*, *19*(3), 162–168, doi:10.1111/j.1447-0349.2010.00669.x

Hem, M. H., Pedersen, R., Norvoll, R., & Molewijk, B. (2015). Evaluating clinical ethics support in mental healthcare: A systematic literature review. *Nursing Ethics*, *22*(4), 452–466, doi:10.1177/0969733014539783

Ho, A., MacDonald, L. M.-H., & Unger, D. (2016). Preventive ethics through expanding education. *HEC Forum*, *28*(1), 69–74, doi:10.1007/s10730-015-9273-9

Hoyer, G. (2000). On the justification for civil commitment. *Acta Psychiatrica Scandinavica*, *101*, 65–71, doi:10.1111/j.0902-4441.2000.007s020[dash]16.x

Kallert, T. W., Mezzich, J. E., & Monahan, J. (2011). *Coercive treatment in psychiatry: Clinical, legal and ethical aspects*. Hoboken, NJ: Wiley.

Kvale, S., & Brinkmann, S. (2009). *Interviews: Learning the craft of qualitative research interviewing*. Los Angeles: Sage.
Landeweer, E. G., Abma, T. A., & Widdershoven, G. A. (2011). Moral margins concerning the use of coercion in psychiatry. *Nursing Ethics*, *18*(3), 304–316, doi:10.1177/0969733011400301
Laukkanen, L., Suhonen, R., & Leino-Kilpi, H. (2015). Solving work-related ethical problems: The activities of nurse managers. *Nursing Ethics*, doi:10.1177/0969733015584966
Lindemann, H., Verkerk, M., & Walker, M. U. (2009). *Naturalized bioethics: Toward responsible knowing and practice*. Cambridge: Cambridge University Press.
Molewijk, B., Widdershoven, G., Verkerk, M., & Milius, H. (2008). Implementing moral case deliberation in a psychiatric hospital: Process and outcome. *Medicine, Health Care and Philosophy*, *11*(1), 43–56, doi:10.1007/s11019-007-9103-1
Pauly, B. M., Varcoe, C., & Storch, J. (2012). Framing the issues: Moral distress in health care. *HEC Forum*, *24*(1), 1–11, doi:10.1007/s10730-012-9176-y
Pelto-Piri, V. (2015). *Ethical considerations in psychiatric inpatient care: The ethical landscape in everyday practice as described by staff*. Örebro: Örebro University.
Scanlan, J. N. (2010). Interventions to reduce the use of seclusion and restraint in inpatient psychiatric settings: What we know so far a review of the literature. *International Journal of Social Psychiatry*, *56*(4), 412–423, doi:10.1177/0020764009106630
Schomberg, R. (2012). Prospects for technology assessment in a framework of responsible research and innovation. In M. Dusseldorp, & R. Beecroft (Eds.), *Technikfolgen abschätzen lehren: Bildungspotenziale transdisziplinärer methoden* (pp. 39–61). Wiesbaden: VS Verlag für Sozialwissenschaften.
Smith, J. P., & Herber, O. R. (2015). Ethical issues experienced by mental health nurses in the administration of antipsychotic depot and long-acting intramuscular injections: A qualitative study. *International Journal of Mental Health Nursing*, *24*(3), 222–230, doi:10.1111/inm.12105
Steinert, T., & Lepping, P. (2011). Is it possible to define a best practice standard for coercive treatment in psychiatry? In T. Kallert, J. E. Mezzich, & J. Monahan (Eds.), *Coercive treatment in psychiatry. Clinical, legal and ethical aspects* (pp. 49–56). Hobroken: John Wiley & Sons, Ltd.
Vetlesen, A. J. (1994). *Perception, empathy, and judgement: An inquiry into the preconditions of moral performance*. University Park, PA: Pennsylvania State University Press.
Voskes, Y. (2014). *No effects without ethics. Reduction of seclusion in psychiatry from a care ethics perspective.* Amsterdam: Vrije Universiteit Amsterdam.
Walker, M. (1993). Keeping moral space open – new images of ethics consulting, *Hastings Center Report*, *23*(2), 33–40.
Wertheimer, A. (1993). A philosophical examination of coercion for mental health issues. *Behavioral Sciences and the Law*, *11*(3), 239–258.
Widdershoven, G., Abma, T., & Molewijk, B. (2009). Empirical ethics as dialogical practice. *Bioethics*, *23*(4), 236–248, doi:10.1111/j.1467-8519.2009.01712.x
Wojtowicz, B., Hagen, B., & Van Daalen-Smith, C. (2014). No place to turn: Nursing students' experiences of moral distress in mental health settings. *International Journal of Mental Health Nursing*, *23*(3), 257–264, doi:10.1111/inm.12043