Ethics Column

‘You need to meet with the psychologist before you can have any leave’: Reflections on ‘coercion’ in a secure forensic setting

Helen Miles

The British Psychological Society’s Code of Ethics and Conduct (2009) for psychologists, Section 1.4, notes the importance of the standard of self-determination. Specifically, psychologists should: ‘Endeavour to support the self-determination of clients, while at the same time remaining alert to potential limits placed upon self-determination by personal characteristics or by externally imposed circumstances.’ And: ‘Ensure from the first contact that clients are aware of their right to withdraw at any time from the receipt of professional services or from research participation.’ (p.14)

Psychologists should also: ‘Take particular care when seeking the informed consent of detained persons, in the light of the degree to which circumstances of detention may affect the ability of such clients to consent freely.’ (Standard 1.3 (viii), p.13)

Clinical (and forensic) psychologists working within forensic secure settings, however, can sometimes face systemic challenges around their clients’ self-determination or informed consent with regard to their engagement in psychological assessment and treatment. As a psychologist working within low and medium secure forensic settings for over a decade, I have observed that it is often the case that many detained individuals with psychiatric diagnoses and forensic histories have little or no desire to meet with a psychologist and discuss the reasons for their admission. Often, these (or the process of discussing them) may be traumatic, confusing, distressing, shaming or embarrassing. A clinical psychologist working in a non-forensic community setting is perhaps less used to ‘coercion’ within the therapeutic relationship, as their clients, by attending the session, are actively consenting to engage. I am constantly struck by how much ‘coercion’ exists within the therapeutic relationships with individuals within forensic secure settings, and as a consequence I have remained interested in the notion of ‘coercion’ throughout my professional working life.

Given the collaborative nature of the therapeutic relationship, I am uncomfortable with any ‘coercion’ given to individuals to engage with me, and have always sought to mitigate these as far as possible within my practice. However, I have also become aware that within this setting, without this element of ‘coercion’ few of those referred actually wanted my help or would actively seek it themselves. Often, following this initial ‘coercion’ to engage, anecdotally, many individuals indicated more willingness to participate in psychological work, and appeared to evidence reduced distress and risk, enabling them to move on from forensic secure settings into meaningful lives within the community. Was this initial ‘coercion’ therefore worth it? Or was I falsely justifying this ‘coercion’ because of these perceived benefits? And how did this fit with the psychologists’ code of ethics? Moreover, were these ‘benefits’ lasting or could the use of such ‘coercion’ lead to other negative outcomes.

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such as distrust in psychology or forensic mental health services in the future?

For many decades, the role of ‘coercion’ within mental health treatment has been the subject of debate (Greer et al., 1996). The balance between an individual’s right to make autonomous decisions, not influenced by the circumstances of their hospital detention – to choose not to engage in the process of psychological work versus the importance of such interventions to reduce future risk and protect the public (or the individual) – is a challenge to all psychologists working in forensic secure settings. Although Appelbaum (1985) observed that ‘in the absence of judicious coercion, patients will not receive needed care’ (p.306), psychologists must remain mindful of the ethical considerations surrounding ‘coercion’ within their practice.

‘Coercion’ has been defined as a subjective state within an individual that is reached after consideration of their environment and situation (e.g. Rhodes, 2000; Szmulker & Applebaum, 2008). Arguably, this exists on a continuum (e.g. Diamond, 1996) that includes friendly persuasion, interpersonal pressure, control of resources, and use of force. At the informal end of any continuum, ‘coercion’ includes friendly persuasion and interpersonal pressure from the clinical team that engagement with the psychologist will improve an individual’s understanding of their risk behaviours and mental health needs, as well as providing them with ways to moderate or manage these. However, at the other end, formal ‘coercion’ may include the use of resources or withholding of rewards (e.g. leave) as leverage, or being told that refusal to comply will prevent them from moving through their care pathway towards discharge. Most extremely (e.g. administration of depot medication), ‘coercion’ can involve the use of restraint and force, so individuals are often acutely aware of the consequences of ‘non-compliance’ with care plans and treatment goals.

The quote in the title of this article, explicating, encouraging or ‘coercing’ engagement with the psychologist in order to obtain leave privileges, is perhaps more common within clinical team meetings in forensic secure settings than within other settings. Even if not that explicit, implicitly implied ‘coercion’ is common, either through verbal persuasion of the benefits of engaging with the psychologist or through the process of detention and the corresponding sense of powerlessness within a secure hospital, often for prolonged periods. As one individual recently remarked to me within his Care Plan Approach Review: ‘The group starts tomorrow... If I had a choice I wouldn’t do it, but I know I have to do it to progress.’

A recent Care Quality Commission annual report (2012/13) into the Mental Health Act reveals increases in ‘coercion’ within general psychiatric services. Highlighting, for example, a 10 per cent increase in use of community treatment orders, which require individuals’ within the community to comply with treatment or be compulsorily readmitted to hospital. Therefore, an element of ‘coercion’ is perhaps an essential part of treatment under the Mental Health Act (MHA, 1983, 2007), although this is not without criticism and may impact on ‘trust’ and ‘care’ within the mental health system (e.g. Pilgrim et al., 2010), with little positive impact on clinical outcomes (e.g. Swatz et al., 1999). Nevertheless, detention under a MHA Section is by definition the deprivation of an individual’s liberty for the protection of themselves or others, and the application (sometimes against an individuals’ will) of appropriate care and treatment in order to reduce identified risks. Almost all individuals within a forensic secure setting are detained under the MHA, and often such detention is under a criminal (i.e. Section 37) not civil (i.e. Section 3) order, with accompanying restrictions (i.e. Section 41) ensuring all ‘freedoms’ must be further authorised by the Ministry of Justice. ‘Coercion’, across the continuum, is often present within forensic secure settings by their very nature and the governing legal constraints, as well as the relationship of these services to the state (i.e. care and con-
trol are devolved to mental health services from criminal justice services as a surrogate for custodial detention).

However, psychologists have an important role in recognising why ‘coercion’ should be avoided if possible. As noted previously, our ethical code is clear that we should respect an individual’s autonomy, and to deny this can be distressing in its own right. Bentall (2013) argues ‘compulsory admission to hospital is often experienced as traumatic, sometimes leading to the same kind of post-trauma symptoms experienced by victims of assault or life-threatening events. Of course, many psychiatric patients have previously experienced physical and sexual abuse, bullying and other kinds of victimisation – that is often why they develop psychiatric problems in the first place – so coercion by services adds to a burden of adversity that is already too great to bear’. As a psychologist, ‘coercion’ can also be damaging to therapeutic relationships, and whilst there is little empirical evidence, many individuals have described to me previous negative experiences and distrust of mental health services leading them to avoid seeking help until their risk has increased significantly, leading to damaging consequences to themselves or others.

More recently, forensic secure services have been encouraged to focus on the ‘Recovery’ model, through the ‘My Shared Pathway’ initiative and collaborative risk assessment processes. These challenge the idea of ‘coercion’ by encouraging individuals to become active agents in their care and treatment, and are applicable within forensic settings despite some initial concerns (Drennan & Alred, 2012). However, whilst empowerment and self-determination are key within the recovery model, these can struggle to be fulfilled because forensic secure settings commonly still function around and focus upon risk management. Coercive practices (e.g. restrictions, monitoring and enforced treatments) may be viewed as part of the essential management of risk and the protection of the public, and psychologists working in these settings often have a key role in risk assessment and management.

Psychologists working in other settings may see individuals with the aim of reducing distress, whilst psychologists working within forensic settings are often tasked with the primary aim of assessing and reducing risk, before any consideration of distress per se. This ‘dual’ role of care and control has been noted elsewhere (e.g. Ellis, 2013).

So how can psychologists mitigate against ‘coercion’ within forensic secure settings? I have some suggestions, which are not exhaustive or prescriptive. Indeed, I hope this column provokes debate and further reflection. Firstly, I believe that psychologists working in forensic settings should feel able to have explicit conversations about ‘coercion’ and challenge examples of coercive practices that may be divisive, re-traumatising or unhelpful. For example, I often highlight that an individual’s engagement in psychological work alone should not be framed as directly resulting in increased leave. Rather, engagement helps to reduce an individual’s risk to themselves or others, which in turn may increase leave or support progression towards discharge. Moreover, being explicit about the power imbalances inherent in a forensic secure setting and facilitating reflection on any ‘coercion’ is critical, both within staff reflective practice groups and directly within psychological work with individuals. Given psychologists’ knowledge of the damaging impact of power imbalances and coercive practices, the psychologist’s voice in challenging the narrative of the wider forensic system is good ethical and evidence-based practice.

Secondly, the importance of informed consent is central to ethical practice and mitigating against ‘coercion’ within a forensic secure setting (Adshead & Brown, 2003). The process of obtaining explicit consent for psychological assessments or treatments is important each and every time an individual might meet with the psychologist for a set piece of work. Giving an individual time to consider why an assessment or intervention has been recommended (e.g. relating it to their goals or risk formulation) – and allow-

Informed consent is central to ethical practice.
ing the right to withdraw with a full understanding of the consequences of such withdrawal – is critical. Willingness to participate cannot be assumed just because of detention within a forensic secure setting. This can mitigate against some of the inherent power imbalances within the therapeutic relationship, and result in more informed choice by the individual and a duty to inform from the psychologist. However, I continue to question whether the process of seeking informed consent serves only to ease some of my own discomfort about the unavoidable elements of ‘coercion’ inherent within forensic secure settings.

Third, consideration of the individual’s stage in their care pathway is useful. In the early stages of an admission an individual may be less willing to engage because they lack insight or motivation, or are too distressed to benefit. Pressure from other stakeholders (e.g. clinical team, tribunals, commissioners, bed managers) to complete psychological work within a prescribed time period often fails to appreciate an individual’s ability to benefit from a particular psychological intervention at a particular time. Supervision to support psychologists to acknowledge and address this pressure is central in ensuring an individual is not coerced to engage prematurely and possibly detrimentally. Moreover, considering whose needs (i.e. an individual versus other stakeholders) are targeted first can reduce the sense of perceived ‘coercion’. For example, prioritising addressing areas that are distressing to the individual before more difficult or shaming risk behaviours can improve the therapeutic relationship and decrease the ‘coercion’ to engage with the psychologist. Fourth, any sense of ‘coercion’ may be reduced by psychologists offering as much control and responsibility to the individual regarding the psychological work as possible (e.g. timing or length of sessions being more responsive to individual needs rather than environmental or staffing constraints). Ellis (2013) notes that engagement in psychology increased in response to choices about attending but decreased if individuals’ felt ‘coerced’. However, one must remain mindful that any lowering of perceived ‘coercion’ coupled with ‘care’ can be confusing to the individual, who despite engagement on their terms within psychological work, still lacks any real control over many aspects of their daily life or treatment within the forensic secure setting.

In summary, ‘coercion’, even at the most implicit end of the continuum, is difficult to avoid in a forensic secure setting by its very nature – which may have lasting or damaging consequences in terms of trust in mental health services. This ethical dilemma therefore remains central to the psychologist’s role within this therapeutic environment – although perhaps one must accept this when working within such settings? Nevertheless, psychologists should attempt to mitigate the most damaging potential consequences of ‘coercion’ in forensic secure settings, and this area is worthy of significant future psychological research and reflection. However, as Bentall (2013) has argued, perhaps ‘in the long term, the solution of the problem of coercion…is to design services that patients find helpful and actually want to use.’

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Acknowledgements
Many thanks to the forensic colleagues who shared ideas and reviewed an earlier draft of this column, as well as to the individual within my local forensic secure setting who gave permission to include his comment.

References


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