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Experience of coercion among nursing professionals in a medium-stay mental health unit: A qualitative study in Spain

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Accessible Summary

What is known on the subject?

- Coercive measures represent an ethical conflict because they limit the person's freedom, compromising their personal autonomy, self-determination and fundamental rights.
- The reduction of the use of coercive measures implies not only regulations and mental health systems, but also cultural aspects, such as societal beliefs, attitudes, and values.
- There is evidence about the professionals' views on coercion in acute mental health care units and community settings, but they remain unexplored in inpatient rehabilitation units.

What the paper adds to existing knowledge?

- The knowledge about coercion varied from not knowing at all the meaning of the word, to a proper description of the phenomenon.
- Coercive measures are considered a necessary evil or normalized in mental health care and considered implicit to daily practice.

What are the implications for practice?

- The perceptions and attitudes towards coercion might be influenced by the knowledge about the phenomenon. Training of mental health nursing staff in non-coercive practice could help professionals to detect, be conscious towards, and question coercive measures, thus orienting them to the effective implementation of interventions or programmes with evidenced effectiveness to reduce them.

Abstract

Introduction: Creating a therapeutic and safe milieu with the minimum coercive measures requires knowing professionals' perceptions and attitudes towards coercion, but they remain unexplored in medium and long-stay inpatient psychiatric rehabilitation units.

Aim: To explore the knowledge, perception and experience of coercion among nursing staff at a rehabilitation medium-stay mental health unit (MSMHU) in Eastern Spain.

Method: Qualitative phenomenological study including 28 face-to-face, semi-structured interviews based on a script. Data were analysed using content analysis.

Results: Two main themes were found: (1) therapeutic relationship and treatment in the MSMHU, which included three subthemes: qualities of the professionals for building the therapeutic relationship; perceptions about the persons admitted to the MSMHU; views of the therapeutic relationship and treatment in the MSMHU; (2) Coercion at the MSMHU, comprising five subthemes: professional knowledge; general aspects; emotional impact of coercion; opinions; alternatives.

Discussion: Coercive measures are often normalized in mental health care and considered implicit to daily practice. A proportion of participants who did not know what coercion is.

Implications for Practice: Knowledge about coercion might influence attitudes towards coercion. Mental health nursing staff could benefit from formal training in non-coercive practice, facilitating the operative implementation of effective interventions or programmes.

KEYWORDS
coercion, mental health nursing, nursing staff, psychiatric rehabilitation, qualitative research

1 | INTRODUCTION

Coercive measures have been justified as a means of protection in psychiatric facilities (Hotzy et al., 2018) when service users become a potential danger to themselves or others (Fletcher et al., 2017). However, coercive measures imply an ethical conflict because, although they intend to protect or benefit the service user they also limit the person's freedom, compromising their personal autonomy (Guzmán-Parra et al., 2019; Hem, Gjerberg, et al., 2018; Hem, Molewijk, et al., 2018), self-determination (Hotzy et al., 2018) and fundamental rights (Aguilera-Serrano et al., 2018; Gooding et al., 2018; United Nations Human Rights Council, 2017).

There is no widely accepted definition of coercion, but since 1978 it is described by the Medical Subheadings of the National Library of Medicine as "the use of force or intimidation to obtain compliance". In mental health, different forms of coercion exist as measures to limit the autonomy and freedom of service users, and they can be categorized into two main types: formal and informal. Formal coercion is regulated by legislation, protocols and mental health professional guidelines (Paradis-Gagné et al., 2021). Examples of formal coercive measures are involuntary admission, seclusion or isolation, physical restraint and forced medication (European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, 2017). Informal coercion is equally relevant and inflexible, but less visible and explored and the purpose of which is not so clear (Andersson et al., 2020; García-Cabeza et al., 2017; Hotzy & Jaeger, 2016). Informal coercion can be applied even when a person is receiving treatment voluntarily (Paradis-Gagné et al., 2021). Examples of informal coercion cover a range of more subtle practices based on communication within the therapeutic relationship, whether that be through persuasion, interpersonal influence, threats, negative pressure or professionals' stigmatized attitudes towards service users (Elmera et al., 2018; García-Cabeza et al., 2017; Hotzy & Jaeger, 2016).

Coercive practices in mental health services violate the liberty and human rights of those admitted, such as locked doors, or the confiscation of clothes and belongings (Cowman et al., 2017; Norvoll & Pedersen, 2016; Verbeke et al., 2019). Coercive measures, like mechanical restraint or forced medication, are still used to resolve conflicts in psychiatric wards, but scientific evidence has shown that otherwise effective interventions, adequate staff training and appropriate skills can provide a solution to these situations reducing the need for coercion (Gooding et al., 2018).

In recent decades, most developed countries have implemented new initiatives and changed their regulations to reduce the use of coercive measures, increase user autonomy and develop coercion-free mental health services that are respectful of human rights (Gooding et al., 2020; Kalisova et al., 2009; McSherry, 2017; Sampogna et al., 2019; Sugiura et al., 2020; World Health Organization, 2019). European directives and regulations concerning mental health have attempted to develop policies to improve practice and standards to reduce the use of coercive measures (Cowman et al., 2017; Gooding et al., 2020). Among these initiatives, some stand out due to the available evidence of their effectiveness: models such as Safewards (Bowers, 2014; Bowers et al., 2015; Fletcher et al., 2017), programmes like the Six Core Strategies (Gaynes et al., 2017; Gooding et al., 2018; NASMHPD, 2008), and precise interventions, for example open-door policies (Hochstrasser et al., 2018; Kalagi et al., 2018; Schneeberger et al., 2017), or de-escalation techniques (Fröhlich

et al., 2018; Richmond et al., 2012; Vieta et al., 2017). To regulate coercive measures, not only are regulations and mental health systems relevant, but cultural aspects, such as societal beliefs, attitudes, and values, are also fundamental because they sustain stigma, justifying a biomedical approach, paternalistic attitudes and the use of coercive measures (United Nations Human Rights Council, 2017).

According to some authors, conflict prevention could be among the foci of nursing staff in psychiatric wards, as it favours a therapeutic milieu and a safe environment with the minimum coercive measures possible (Bowers, 2014). To achieve this balance through the design and implementation of alternative measures, it is necessary to know professionals' and service users' perceptions and attitudes towards coercion.

To the best of our knowledge, studies exploring knowledge, perceptions and attitudes of professionals concerning the use of coercion in mental health services have been developed purely in acute care units (Doedens et al., 2020) or community mental health services (Aguilera-Serrano et al., 2017; Corring et al., 2018), and most of the evidence is focused on formal coercive measures, more commonly used there. However, the views of professionals working in medium and long-stay inpatient psychiatric rehabilitation units, where the use of formal coercive measures is less common, have not been explored. Accordingly, the aim of the present study was to explore the knowledge, perception and experience of coercion among the nursing staff of an inpatient medium-stay mental health unit (MSMHU) in Eastern Spain.

2 | METHODS

2.1 | Design

This is a qualitative study with data collected using face-to-face, semi-structured interviews. The purpose of describing the perception of coercion from the point of view of each participant and the collectively constructed perspective, led us towards a phenomenological design, using interviews as a means of collecting data (Neubauer et al., 2019). The study methods and results are reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist (Tong et al., 2007). The COREQ Checklist for this manuscript is available as File S1.

2.2 | Researchers' reflexivity

The present study arose in response to the professional concerns of MAC and VSM. After years of practice as mental health nurses and contact with persons with mental health problems, they wished to explore the nursing staff's knowledge, perception and experience of coercion in a psychiatric medium-stay unit in Spain. They designed the study, collected and analysed the data described herein. The study was developed in the MHMHU, where MAC worked as a mental health nurse, so a proportion of the participants had met her before.

2.3 | Participants and study context

The study population was the nursing staff of the MSMHU of Padre Jofré Hospital, in Valencia, Spain. Of 36 potential participants, 28 were eventually included, as five did not meet the inclusion criteria and three declined the invitation. Among the 28 participants, 27 were women and 13 were nurses. The mean age was 51.53 years (standard deviation 9.58), within a range of 23 to 64 years. The mean professional experience in the unit was 6.47 years (standard deviation 5.33), ranging from 6 months to 15 years (that is, since the hospital's opening).

The inclusion criteria were at least 6 months of experience working as a nurse or care assistant in the MSMHU, the ability to communicate in Spanish, willingness to participate and signed informed consent. There were no exclusion criteria.

Padre Jofré Hospital opened in October 2005, offering outpatient care in the day hospital and inpatient care in the psychiatric rehabilitation MSMHU. This unit consists of two wards, each with 25 beds. In each ward, there is a multidisciplinary team composed of eight nurses, 10 care assistants, a psychologist, and a social worker, and the two wards share three psychiatrists and three occupational therapists.

The MSMHU is a healthcare resource for people who require hospital admission due to persistent symptoms that go beyond the care possibilities of the outpatient setting, or for those who, following acute psychiatric admission, might benefit from a longer stay, of 4–6 months, in order to allow a comprehensive and individualized rehabilitation program to be implemented.

2.4 | Procedure

Before initiating data collection, a clinical session was organized to present the study protocol to all the nursing staff working at the Padre Jofré Hospital MSMHU. In this session, staff received information regarding the study design, were invited to ask questions and were requested to participate if they met the inclusion criteria. All the professionals meeting the inclusion criteria and who agreed to participate signed the informed consent form and were subsequently interviewed. Those who did not volunteer to participate did not provide their reasons. To facilitate participation, interviews were scheduled with each participant at their convenience.

Each interviewee independently completed their sociodemographic data questionnaire. In the first four interviews, MAC and VSM, both female, were present in order to standardize the approach to the interviewees. VSM guided two interviews while MAC was present, and MAC guided two interviews while VSM was present. Subsequently, the rest of the interviews were conducted by MAC, who took field notes when she considered it necessary to relate the

use of non-verbal language with silence or certain verbal expressions. Interviews were conducted between March 10th, 2020, and December 23rd, 2020. The restrictions announced as a result of the COVID-19 pandemic affected the unit's functioning, and as a result no interviews were carried out between mid-March and July 2020.

All the interviews were audio-recorded after the participant read the information sheet, agreed to participate and signed the informed consent form. Interviews were anonymised with a two-figure code that corresponded with the order of participation. The sociodemographic data questionnaire and the notes taken during each interview were kept together to avoid mislaying any information.

A script, previously designed and approved by both authors (File S2, Interview script), included open questions to invite the participants to describe their views on what good care in the MHMSU is and their knowledge, perception and experience of coercion. If the researcher considered it necessary to allow the participants to clarify their answers, or to explore a relevant aspect, additional questions were asked. If a participant did not know what coercion was, a definition was provided. Data saturation was determined when three consecutive interviews provided no new information, which occurred after interview 26. Nevertheless, all 28 interviews were included in the data analysis. The interviews were carried out in the hospital, in meeting rooms that were available at the time and offered reduced external stimuli, that is, silence, a comfortable temperature and with nobody else present. The interviewers created an atmosphere of trust and confidentiality with an assertive, but respectful and open attitude, and strove at all times to favour communication with the interviewee. The interviews lasted between 25 and 45 min.

2.5 | Data analysis

The interviews were transcribed verbatim and identified with a code to maintain confidentiality. Data were analysed using qualitative content analysis (Graneheim & Lundman, 2004). The pre-analyses were carried out through several independent readings by both researchers of the interviews to obtain an in-depth understanding of their contents. The analysis was performed in three consecutive stages. First, open coding was carried out, during which the researchers re-read the transcripts independently and selected meaning from paragraphs, sentences or words related to the topic of the study and assigned them codes. Second, each author independently grouped their codes into themes, subthemes, and categories. Finally, through an interpretative process during team meetings, the authors discussed and agreed on the final codes and the definitive classification of the themes, subthemes, and categories. The analysis content was supported by the software ATLAS.ti, version 9.0 (Scientific Software Development GmbH).

2.6 | Ethics

The study was conducted following the ethical principles for medical research involving human subjects described in the Declaration of Helsinki (World Medical Association, 2013) and was approved by the Research and Ethics Committee of Padre Jofré Hospital. The study protocol was also approved by the hospital's medical director and supervisors of the nursing staff.

A procedure to manage situations in which the interviewee might need emotional support was designed. However, none of the participants required an intervention during the interview despite some of them verbalized to have experienced distress being present in one or more precise situations.

3 | RESULTS

The sociodemographic characteristics of the participants are described in Table 1. Through content analysis 1248 quotations were identified, which were grouped into 334 codes. Most of this information referred to the description of the context and functioning of the units where the research was carried out. For this reason,

TABLE 1 Sociodemographic characteristics of the participants.

Identification number	Age	Profession	Years of service
1	39	Nurse	0.5
2	57	Care assistant	2
3	58	Care assistant	15
4	49	Care assistant	5
5	34	Nurse	3
6	57	Care assistant	2
7	57	Care assistant	11
8	48	Nurse (male)	5
9	46	Care assistant	4
10	56	Nurse	15
11	45	Care assistant	4
12	56	Nurse	4
13	56	Care assistant	6
14	57	Care assistant	15
15	57	Care assistant	7
16	58	Care assistant	15
17	63	Nurse	9
18	52	Care assistant	2
19	39	Nurse	1
20	57	Nurse	0.5
21	64	Care assistant	15
22	23	Nurse	0.5
23	56	Care assistant	0.66
24	55	Nurse	1
25	58	Nurse	4
26	56	Care assistant	11
27	54	Nurse	10
28	36	Nurse	13

TABLE 2 Themes, subthemes and categories.

Themes	Subthemes	Categories
Theme 1. Therapeutic relationship and treatment in the MSMHU.	Personal and professional qualities of the professionals for building the ideal therapeutic relationship	Personal abilities and characteristics
		Professional competence
	Perceptions about the persons admitted to the MSMHU	Negative or stigmatizing perceptions
		Positive descriptions
	Views of the current therapeutic relationship and treatment provided in the MSMHU	Appropriate treatment
		Occasional handling
Theme 2. Coercion at the MSMHU.	Professionals' knowledge	Professionals' knowledge
	General aspects	Triggers
		Justification
		Use of coercive measures in the MSMHU
	Emotional impact of coercion	Emotional impact of coercion
	Opinions	For
		Against
	Alternatives	Verbal de-escalation
		Training and knowledge
		Other

only the 54 codes that corresponded with our objectives were analysed in depth and classified into 14 categories, eight subthemes and two themes: therapeutic relationship and coercion. These two themes are relevant because the nursing staff's interpretations of good care could reflect their positions on the biomedical model and paternalistic attitudes, which may relate to their views and experience of coercion. This structure is described in more detail in Table 2.

3.1 | Theme 1. Therapeutic relationship and treatment in the MSMHU

The participants highlighted the relevance of the therapeutic relationship in mental health care settings. Three subthemes were identified: personal and professional qualities of the professionals required for an ideal therapeutic relationship; perceptions about the persons admitted to the unit; and views of the current therapeutic relationship and treatment provided in the MSMHU.

When asked about staff qualities that are essential to provide optimal care and treatment, the participants described both personal abilities and characteristics and professional competence:

P8: In the time I have been working in mental health services, I have realised that patients react quite differently when they are well treated; that is, with kindness and respect. You don't have to make a big deal out of it, you don't have to give them a bow; just treat them like persons and it makes an enormous difference.

In terms of personal characteristics, empathy, patience, and closeness were the most frequently mentioned.

P22: Mainly empathy, much empathy. Sometimes, users are not well understood.

P5: Patience, as in certain moments they could drive you mad, and situations that you don't know how to deal with, so a lot of patience…

P26: Much patience and tolerance, and much self-control.

In terms of professional competence, the most frequently cited as being essential were communication skills and training and knowledge about mental health.

P1: Listening to them a lot. They are grateful to be listened to, with active listening.

P6: Knowledge, of course. If you work here, and, as in my case, you have no preparation, many situations slip through your fingers… you must know the speciality to manage situations better.

The professionals' perceptions and opinions about the people they care for were grouped. The participants sometimes expressed negative or stigmatizing perceptions about service users; for example, that they were unstructured people, with very low self-esteem, helpless, manipulative or naturally demanding.

P26: The psychiatric patient is naturally manipulative, it's not that they have bad intentions, it's because of their illness.

In contrast, there were also positive descriptions. For example, some participants considered the people they cared for to be grateful, highlighting that they possess the same rights as any others and that they are people to learn from, thus breaking pre-existing stigmas thanks to contact and experience with the service users.

P8: They are incredibly grateful people; you give them little, and they think you have given them the world, and maybe there is a middle ground there, where what we offer them is good and, above all, they are grateful and value it.

The professionals' perceptions of the therapeutic relationship and the treatment in the MSMHU included the detection of attitudes or

behaviours towards service users they considered to represent occasional malpractice, and these ranged from favouritism, stigma and paternalism to abuse. Most participants qualified these attitudes and behaviours as potential triggers for a worsening of the service users' clinical condition. Some examples are described below:

P17: You really empathise more with some people, and, because of this, you sometimes treat them differently.

P2: That habit we have of scolding them as if they were small children, continuously "now get dressed, take this, do this…". As if we were talking to our small children, completely infantilising care.

P27: I think some professionals sometimes assume we are the authority here. So it's a bit like "you have to do what I say, because I say so and I'm the one who's wearing the white uniform".

All the participants described the therapeutic relationship as close and positive, except in exceptional situations in which mistreatment occurred. These were reported to have been punctual and caused by countertransference.

P22: If the health professional is interested in the patient's improvement, which I think most people here are, and the patient is interested in getting better, in most cases a very good therapeutic relationship is maintained.

P28: I saw a bad professional performance and reported it. A bad relationship had already been identified between a patient and the care assistant, and I think this did not help … I believe in that case the bad therapeutic relationship played a role and that the situation could have been managed differently.

3.2 | Theme 2. Coercion at the MSMHU

This theme contains five subthemes, eight categories and 24 codes.

One of the subthemes was the professionals' knowledge about coercion. Ten participants (six care assistants and four nurses) said they had never heard about it or did not know what it was, six related it to duress or restriction, and the rest provided different definitions of their idea of coercion, of which some examples are cited below:

P8: Coercion would be trying to stop the patient from engaging in certain behaviours by using a range of means, from words to restraint, pharmacological or mechanical …

P22: For me, coercion is any act that ultimately violates a person's rights.

The second subtheme was certain general aspects about coercion, such as the triggers for applying coercive measures, their justification and the current use of coercion in the MSMHU. Agitated behaviour, risk of self-injury and potential damage to other people were described as common triggers for the use of formal coercive measures.

P8: Coercion would be trying to stop the patient from engaging in certain behaviours by using a range of means, from words to restraint, pharmacological or mechanical …

P22: For me, coercion is any act that ultimately violates a person's rights.

P14: When someone says "I want to throw myself out of the window", or starts breaking things, or they are very psychotic and out of control, normally some coercive measure is applied.

The professionals explained that coercive measures were triggered by behaviours that could harm the person or others, and that this justified their use. Some participants named other justifications, such as making the service users aware that their actions have consequences; the most referred reason was that it was the service user's best interest.

P4: "Blessed" is involuntary admission if it's for their own good. Forcing someone to do something… is not right (pause)… but if it's for their own good, then it's fine.

The professionals with more experience working in the unit (over 5 years) agreed that coercion was more common years ago and that coercive measures are now applied only when there is no other option. Some of the participants focused on the use of mechanical restraints.

P15: Now… well… I imagine that the patients haven't changed; the patients are the same, it's more to do with our understanding of psychiatry, because it is evolving for the better, there is more active listening and the service users are approached in a different way.

A participant explained that she noticed a big difference between the previous coercion and the current *freedom*.

P26: The rules in this unit are too flexible now.

In the months during which data collection was taking place, the MSMHU adopted an open-door policy from 8 am to 8 pm. This provoked polarized reactions among staff, who were clearly either for or against leaving the doors of the unit open. Some participants believed the measure was feasible if vigilance or security staff were increased.

P6: I thought it was going to be a more contentious issue. I don't really feel uneasy about leaving the doors of the unit open. It seemed a bit crazy to me… but the truth is that I'm quite calm now. I'm coping well.

P24: To me, the idea that they can enter, leave… that you don't even know where they are or where they might be, seems very risky, but on the other hand, it hasn't gone wrong… So, I find a lot of differences in coercion before and now.

P26: It is reckless to leave the doors open; it is reckless not only because our personal belongings are in danger, but because the patients could get into the into the nursing station and ingest

medication, or anything… I think it is unacceptable to leave the doors open.

The third subtheme was the emotional impact of coercion. The professionals commented on unpleasant experiences with negative emotional impact when applying or witnessing two precise formal coercive measures, mechanical restraint and forced medication.

None of the participants expressed any emotional impact related to the use of informal coercive measures.

The fourth subtheme were opinions or points of view on coercion, which were divided into those for and those against. The opinions supporting coercion included those in which user freedom was perceived as negative and coercion was described as a positive prescribed measure or was seen as normalized in the psychiatric care context. In contrast, when opinions considered coercive measures to be avoidable, obsolete and the very last option to be employed, they were classified as being against coercion.

P21: It [mechanical restraint] is a positive measure because it is necessary in that moment… you can't let a person hurt themselves. They are not in control or lucid in that moment, for whatever reason, and you can't let them injure themselves.

P14: Restraining someone should be the last thing to happen because you are taking away their freedom and that cannot be tolerated.

P22: I believe that restraint can be avoided most of the time. There are cases that either because of the pathology or because of the person, there is no other option, but I believe that 99% of these extreme situations can be avoided.

P8: In this hospital, what we try is dialogue, dialogue, dialogue, and if it does not work, medication. I am glad I have never had to use mechanical restraint here, because it is the last option.

The fifth subtheme was alternatives to coercion. The professionals mentioned verbal de-escalation as the first option to manage conflict and reduce the need for coercion, followed by staff training and knowledge, and a good therapeutic relationship and the need for voluntary admissions in the MSMHU.

P16: It is true that it [de-escalation] is exhausting for the worker, but it is also true that it works, and sometimes it allows you to avoid the need for pharmacological restraint. The thing is, it can take hours… I admit that it may be exhausting, but I think that it is one of the things that enriches you the most when it works out well. That's what gives you the most as a professional.

P20: I do believe that if there is a good relationship and good communication, in the end you won't need any coercive measures, neither mechanical nor verbal, or anything else.

P27: Creating a therapeutic environment greatly influences and benefits the relationship between the user and the staff, and it is feasible… not everything can be solved by pills. If you manage to create that bond and that person maybe tells you what is happening to them, then you can help them without medication.

P27: That's why voluntary admission is also very important; a voluntarily admitted person, because forcing someone to be here is not a good idea….

Connections between the participants' interpretations of the therapeutic relationship and their views on coercion are reflected in the citations. Some participants, like P8 or P22, described empathy and closeness as the staff's characteristics for building the ideal therapeutic relationship and provided positive descriptions of the users, as worthy of respect as any other person. They were able to define coercion and described attitudes against the use of coercive measures, considering them the very last option. In contrast, a few other participants, like P26, focused on patience, determination and self-control as staff characteristics for building the ideal therapeutic relationship. They described perceptions of the users as demanding and manipulative persons who believe they are always right. These views could be reflected in practice by paternalism or abuse and positive attitudes towards using coercive measures.

4 | DISCUSSION

This study explored MSMHU professionals' experience of coercion in Spain. Approximately one third of the participants did not know the meaning of the word coercion, but all described having seen or participated in situations perceived by them as either coercive or unfair, and where they considered the admitted person's rights and freedom to have been violated. Situations reflecting informal coercive measures were described as the most common in the MSMHU, with professionals appearing to be only partially conscious of them being forms of coercion. Participants with more professional experience in the MSMHU perceived a notable difference between the more general use of coercion in previous years and a much less frequent use at the time of the interviews. Some believed this could be related to a positive evolution, a paradigm shift in psychiatric care.

The participants with longer professional trajectories had a more normalized perception of coercive measures than those who were less experienced and who tended to be more critical of coercion. This finding is in contrast with the literature. Vandamme et al. (2021) suggested that professional experience did not influence the staff's views of coercion. Krieger et al. (2021) concluded that more experienced mental health professionals expressed a more critical view of coercion. These divergences could be explained by the fact that the participants in our study were all nursing staff and that regulations regarding mental health care vary among cultural contexts.

The participants highlighted the relevance of the therapeutic relationship and the treatment applied when caring for persons with mental disorders as factors that can reduce coercion. How professionals interact with service users makes a difference to a therapeutic relationship, as service users recognize when they are well or badly treated. In a recent qualitative study, Spanish mental health service users perceived that professionals' prejudice, paternalism

and abuse were an obstacle to the creation of an optimal therapeutic relationship (Martínez-Martínez et al., 2021).

Different views on coercive measures were expressed in the interviews we conducted. As in previous research, most of the professionals prioritized safety and described coercion as unwanted but necessary to maintain a safe milieu (Doedens et al., 2020; Gerace & Muir-Cochrane, 2019). Some participants were ambivalent about what does and does not constitute coercion, and spoke of the fine line between the violation of service users' rights and necessary measures for their own good. Other professionals unconsciously recognized applying coercive measures, either because they were not familiar with the word coercion or because coercion is so deeply rooted in mental health care that it has become normalized. In addition, they encountered difficulty when deciding if the use of extreme coercive measures was justified or not. As in previous studies (Hem, Gjerberg, et al., 2018), the primary justification for any coercive measure was that it was for the good of the person. This reinforces the impression that the use of coercion in mental health care is related with ethical and moral dilemmas, contributing to feelings of conflict and distress among professionals, as concluded by previous research (Helmchen, 2021; Mellow et al., 2017). It would seem that dilemmas emerge when assessing the balance between promoting good (beneficence) and inflicting harm (maleficence); that is, professionals experience doubts or uncertainty about what is right or most appropriate (Hem, Gjerberg, et al., 2018).

The participants in our study described the emotional impact caused by the application of coercive measures such as mechanical restraint, expressing grievance for the harshness of the situation, but no emotional impact was related to the use of informal coercion. They tended to justify the application of coercive measures with three reasons: the lack of alternatives to coercion, considering there was no other way to act; the certainty that, if these measures had not been applied, the user would have self-injured or hurt others; or that these measures were applied "for the user's good", as a way of helping them to improve clinically. Indeed, all these justifications were described in a recent review by Chieze et al. (2021). However, Paradis-Gagné et al. (2021) described coercion as an instrument of the philosophy of control and discipline, and a way of ensuring compliance with institutional regulations.

An alternative to coercion are the open-door policies adopted by some mental health units. The definition of open doors ranges from vaguely defined policies to explicitly defined periods of time in which the unit is open. Different studies report reductions in the use of coercive measures as part of open-door policies and no adverse effects as a result (Steinert et al., 2019). Open doors were implemented in our MSMHU after data collection had begun, which allowed us to register early perceptions and opinions about the policy. The views ranged from calm and positive expectation to considering it reckless due to the surrendering of control it implied, in line with that reported by Kalagi et al. (2018).

The main reason to maintain the doors to mental health units locked has always been safety; that is, to prevent aggressive behaviour. Restrictions can aggravate violent behaviour and, thus, lead to the use of coercive measures (Schneeberger et al., 2017). However, there is growing evidence that locked-door policies in mental health care units do not offer safer environments than open doors in terms of suicide, absconding, aggression and substance, and that they instead contribute to a more authoritarian and less therapeutic milieu (Fröhlich et al., 2018; Hochstrasser et al., 2018). Moreover, previous studies suggest that the opening of doors in mental health care units reduces the use of coercive measures—particularly seclusion—in a statistically significant manner (Hochstrasser et al., 2018).

5 | STRENGTHS AND LIMITATIONS

This study followed a rigorous methodology. The analysis of themes, sub-themes, categories and codes was carried out independently by each author and then agreed by both. However, this is a qualitative study, and as such, its results cannot be generalized. Moreover, the fact that different countries offer mental health care in different settings limits the comparison and generalization of our findings.

6 | CONCLUSION

Some nurses still consider certain coercive measures to be a necessary evil, while expressing the need for less intrusive procedures that are more respectful of the rights and dignity of people with mental health problems. We should emphasize the proportion of participants who did not know what coercion is, despite having worked in mental health for years, and the assumption that coercive measures in mental health care are normal and implicit to daily practice as relevant findings of this study. Our work reflects perceptions and opinions regarding the application of alternatives to coercion, such as open-door policies, and highlights the importance of working to build a good therapeutic relationship in order to achieve coercion-free units.

7 | IMPLICATIONS FOR PRACTICE

The perceptions and attitudes towards coercion might be influenced by the knowledge about the phenomenon. Training of mental health nursing staff in non-coercive practice could help professionals to detect, be conscious towards, and question coercive measures, thus reducing its use. The training should: (1) raise awareness of the existence and application of formal and informal coercive measures; (2) address the ethical principles linked to mental health care; (3) instil awareness of all ethically acceptable approaches to a given situation in order to always respect the well-being and rights of the individual; and (4) provide skills to achieve an optimal therapeutic alliance and to manage conflict verbally in order to reduce the use of coercive measures.

The acquisition of knowledge about coercion could make mental health nursing staff more able to efficiently implement some precise

interventions with evidenced effectiveness, such as open-door policies or de-escalation techniques, models such as Safewards, or programmes like the Six Core Strategies.

Despite international regulations, there is still much to be done to ensure that respect for mental health service users' human rights is guaranteed. The development and implementation of new policies to supress coercion and strategies or interventions to improve the therapeutic relationship and treatment are essential.

8 | FUTURE RESEARCH

Future research should focus on exploring the experiences of professionals and service users in units where alternatives to coercion are applied, to explore their effectiveness. It is important to further study informal coercion, which seems to be the most commonly applied, and perhaps the best way to do this would be through participant or non-participant observation studies.

9 | RELEVANCE STATEMENT

This qualitative study examined the views on coercion of the nursing staff working in a medium-stay inpatient psychiatric rehabilitation unit. Associations between the staff's perceptions of the therapeutic relationship and their attitudes towards coercion were found. Some participants were aware of coercion and expressed attitudes against coercive measures, while others did not know what coercion is, and they expressed that coercive measures are often normalized in mental health care and implicit in daily practice. Knowledge about coercion may influence the attitudes towards coercion, so mental health nursing staff might benefit from formal training in non-coercive practice, orienting them to implement effective interventions or programmes.

AUTHOR CONTRIBUTION

MAC and VSM were involved in study design, data collection and analysis, manuscript preparation and approval of the final version.

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CONFLICT OF INTEREST STATEMENT

The authors have no conflict of interest to declare.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

ETHICAL APPROVAL

The study was conducted following the ethical principles for medical research involving human subjects described in the Declaration of Helsinki and was approved by the Research and Ethics Committee of the Padre Jofré Hospital (Valencia). The study protocol was also approved by the hospital's medical director and supervisors of the nursing staff. Prior to each interview, the participant received a document describing the details of the study and was encouraged to ask the researchers to resolve any queries. She/he then signed the informed consent form and gave their permission for the interviews to be audio recorded.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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