

Role of consumers in the organisation: Moderating coerciveness in the involuntary treatment/coercive practice to enhance the consumer's satisfaction in community mental health settings

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Abstract: *In mental health treatments, the recovery procedure of patients could be affected by multiple factors, such as their satisfaction toward the diagnosis, mental health conditions and willingness to receive the treatments. However, in Australia, the balance between patient-centered care and the coercive practices from the clinic has rarely been focused. Therefore, in this study, the author tries to address the gap between the ideal participation of patients in mental health treatments and real situations the author experienced. To achieve this objective, two case studies combined with literature reviews are utilized. The author concludes that playing the role of coordinators, advocating the consumer's rights to express their true thoughts, maintaining the patient-centered practices and making efforts to refine related official documents should be considered in future mental health treatments.*

Keywords: *Mental health treatment, Involuntary treatment, Consumer's satisfaction, Recovery procedure*

1. Introduction

As Lammers and Happell (2003) introduced, the role and the participation of mental health services' consumers are experiencing considerable changes with widespread changes in the structure and delivery of mental health services for years. The view about consumers' role in mental health services has been gradually changed from the traditional perspective that consumers were considered as patients in mental health settings whose role was recipient only with passive treatment and no or limited power to engage in their treatment decision making to the up-and-coming perspective that consumers are expected to be provided with more opportunities to participate in their treatment decision-making processes and other aspects in the care. Although the new perspective has been gradually formed, whether the renewed consumers' role in the daily mental health practice has been actually presented is still remained as a problem to be explored. It will hereby be discussed in this essay with its argument based on Jones and May's statement that "in many human service organisations there is a wide gap between the rhetoric of consumer participation and the realities of service provision"(1995, p.341), which cannot be agreed by the author anymore with a clear awareness that mental health services are experiencing a dilemma that managing the balance between patient centred care and use of the coercive practice which is against consumers' wills and rights to achieve the community treatment expectation (Maylea, 2017). This essay aims to clarify how the coercive practice causes limitations to consumers' participation and rights and brings the consumers' role back to the 'patient', a passive recipient, instead of a consumer, in the mental health service through the discussion of the gap between the rhetoric of consumer participation and the realities of service provision. As Brophy et al. (2016) stated in 1993, Australian Human Rights and Equal Opportunity Commission had raised the discussion about the use of coercive practice in mental health services to highlight the potential harmful situation of consumers in the treatment. Concerns were raised about disturbance of consumers' personal integrity, restriction of liberty and no respect to the consumer's right and dignity. And the discussion is still hot today.

In the first part of the essay, the author will illustrate two cases about the real experience as the intern clinician when working in the mental health clinic to explain why the author agrees with Jones and May's point of view and believes the wide gap existing between the described consumers' participation and the real situation in which consumers are involved during the treatment period. The author will explore what

factors have caused the mentioned gap in the mental health service with literature reviews by expounding those cases. In addition, the solution on how mental health social workers and medical clinicians contribute to narrowing the gap will be discussed in the second part of this essay.

2. Case Study with Literature Review: How the coercive practice causes limitations to consumers' participation and rights

As McSherry et al. (2013) discussed although a great amount of institutions explicitly announced that they were committed to working in partnership with consumers and their families or carers during their treatment, the coercive practice seemed not to be properly managed in mental health service nowadays. There are still a good amount of consumers acting as 'passive recipients' who are asked to take medication and accept daily home visits, intimidated if they refuse to take the medicine, and taken to the hospital for admission. As Creswell (1998) mentioned, in-depth and face-to-face discussions and conversations with participants is a very effective way to study the real experience of consumers in the human services. However, there are limited opportunities for consumers to participate in the decision making of their treatment and care plans. Here are two typical cases to prove McSherry et al.'s discussion and Jones and May's statement.

2.1. Case study one

In Case 1, the author once made a placement in one of the public mental health services to consumers with major mental illness who reside in the cities of Melbourne, together with an experienced mental health nurse home visited a single mother who was diagnosed with depression. Although she looked very tired, she still communicated with us in clear sentences, saying that she had no thoughts of self-harm or hurting others. She also reported that she took medications on time everyday except those causing her headache, and were able to take care of her daily life independently with improved self-care. She herself had also proved the fact that the patient-centred theory and practice were highlighted by the mental health clinic whose aim to work with consumers, their families and carers to identify and achieve their goals. However, the author as a mental health social worker was shocked by the nurse when she coercively asked the consumer to take the medicine that caused her headache in front two of us when there was no further assessment provided for her mental status and the suitability of the medication, which was kind of forcing the consumer to take the medicine in front of us with teary-eyed. It is obvious in this case that the consumer is still simply treated as patient only with passive treatments in the actual practice, rather than a person who is committed by the mental health institution to establishing some partnership between the consumer and the practitioner. In Weller's (2013) discussion, statutory framework has stated that 'an individual has the right to make freely formed, information-based decisions about health care'. In addition, Currier (2003) and Raboch et al. (2010) also have discussed that forced medication and seclusion are preferred for condition management for emergencies only and used to control patients with mental illness to stop harming themselves and others. Moreover, practitioners need to be clear that although forcing consumers to use mandatory medications is to protect them and the people around, coercive practice would restrict the consumer's freedom and often violate their wills, and place the consumers and the practitioners in opposite positions to be against each other at the same time. Therefore, it is worth of thinking critically about why the consumer was still forced to take the medicine after she showed her preference clearly with improved mental health. In addition, Lammers and Happell's studies have pointed out an argument that could be taken into consideration, namely, because of lacking rules and explicit guides on the use of coercive practice in the mental health service, many practitioners use coercive practice based on their own working experience and institutional cultures. Some practitioners tend to work with 'hard-line' working methods by using coercive practice to reduce risks for the patients with mental illness. When risk management is considered as the primary treatment goal in the community treatment, consumers' willingness and interests will be easily ignored, with their opportunities of participating in the care plan discussion left behind in the basket (2003). Meanwhile, Tobin et al. (2002) have illustrated that participants in the mental health service usually express their willingness to be valued by the program and well-respected by the service provider. However, most of them reflect that in process of delivering the service, there are many barriers hindering them from establishing such sense of involvement and participation. In details, their personal demands are not responded with their human rights infringed by the practitioners' coercive medical treatments in addition to the attitude of many service providers which are considered as a major barrier, leading to their doubts about the announcements made by the mental health institutions on respecting the consumers' individualization and personal interests, which in their opinions, only exists in rhetoric. Furthermore, Tobin et al.'s studies

have been closely reflected in the second case.

2.2. Case study two

In Case 2, the author experienced a home visit with a mental health clinician. The consumer was from Pakistan. He called the clinic, saying that he had a bad toothache and hoped to sleep during day time without any disturbance, therefore he requested to postpone the home visit. The clinician asked the consumer to wait for us, saying we had arrived at the corner of his apartment. However, the real situation was when we received the call, we just came out of the clinic. Then when we arrived, we found the consumer was in a very low mood, saying the toothache had seriously affected his sleep last night so he really needed some sleep. He also reported he didn't want to take the medicine during the day time since the medicine would make his mind active. However, the clinician, after hearing his story, still tried to convince him to take the medicine, and then required him to do so in front of us. From the two cases above, it is enough for us to believe that in the clinical practice, mental health practitioners prefer to use coercive practice based on institutional cultures and traditions to relieve the patients' symptoms of mental illness, however, the patient's own demands and preferences would be easily ignored (Georgieva et al., 2012). Furthermore, Campbell et al.'s (2006) studies have highlighted that a great proportion of consumers who have been required to accept coercive practices and put on Community Treatment Order (CTO) are those with multi-cultural and linguistic backgrounds. In summary, it is worthy of mentioning that in today's mental health services, although most organisations claim to provide non-discriminatory and non-prejudice services, practitioners' prejudice and improper working attitude toward the minority community is still an under-table issue that should be considered based on the findings of Campbell et al.'s studies together with the two cases mentioned above. Besides, groups with multicultural backgrounds are more easily to be forced to use coercive medications. Consequently, the gap illustrated by Jones and May is formed between the expectation of consumers' participation and the real situation based on those factors mentioned above.

3. Discussion

Firstly, in mental health services, coercive practice is used to respond to emergencies of the patients with mental illness to reduce the risk of self-harm or harm to others. Mental health social workers are likely to be involved in using the coercive power as the authorised mental health practitioners do, by which the social work ethics asking the social workers to respect and value the clients' interests will be violated. Therefore, social workers should consistently make efforts to accommodate those opposite orientations. Instead of completely rejecting to use coercive practice or abandoning social work ethics, social workers should play the role of coordinators to enhance the relationship between consumers and service-providers while assessing the applicability of the mental health treatment to the consumers with consideration of consumers' demands and preference (Maylea, 2017).

Secondly, social workers should advocate the consumers' rights of expressing their true thoughts and feelings in their treatment. Georgieva et al. (2012) have discussed that consumers may feel angry or dissatisfied with the forced medications, however, they usually choose to accept the coercive practice with discomfort, questioning their human rights and beliefs because they are more afraid of causing more serious consequences if they refuse to do so, for example, being admitted in the hospital or annoyed or abandoned by the service-provider. In the two cases above, the author discussed the preferences of the two consumers were not respected and listened to by the practitioners. Rather than passively accepting the forced medication as 'patients', consumers should be reminded that their satisfaction with the service and their queries toward the service-providers' treatments and attitudes are also valued by the agency. Social workers should advocate the consumers' rights of speaking out their real thoughts and feelings with education on the correct way of reporting their dissatisfaction with the treatment plans to the agency.

Thirdly, mental health social workers should strongly maintain the patient-centred practice in the mental health clinical services. Patient-centred theory should be highlighted in the social work practice, asking the social worker to respect the clients' personal demands and interests and support them to develop the knowledge, skills and confidence to manage their own health and healthcare plans. As Georgieva et al. (2012) pointed out, the importance of using patient-oriented practice and valuing consumers' own preferences should be taken into account seriously in the mental healthcare. On one hand, with patient-oriented mental healthcare, not only patients' safety, compliance and satisfaction will be enhanced, but also the quality of treatment will be increased. On the other hand, with patient-centred practice, the consumers' individual interests and choices will be taken into consideration in their

participation. As Kingdon et al. 's studies (2004) discussed, taking patients' personal choices into consideration can be viewed as the most rational way to intervene the practice when no effective measure with least restriction has been found and proved objectively and scientifically by studies where coercive measures are used in clinical practice. Therefore, social workers should emphasize the importance of respecting consumers' individualization in institutions and coordinate with the medical teams to provide consumers with more empathic practice. Meanwhile, consumers who have received the mental health services have the right to individualize their treatments (Kingdon et al. 2004).

In addition, mental health social workers should seek consumers' ideas about their care plans and help them with the discussion on their individual needs with the medical team. Furthermore, mental health social workers should also work with other qualified staffs to review and revise consumers' care plans and treatments regularly with the respect to their appropriate preference and needs. Fourthly, mental health social workers should make efforts to establish and improve the rules and guidance documents on the use of coercive power for mental health practitioners, indicating the gap caused by the lack of evidence-based use of coercive practice in the mental health service, by which the abuse of the coercive power will be effectively reduced. Meanwhile, mental health social workers could try to figure out unified standards on using such power by mental health groups. Also, mental health agencies could establish evidence-based mechanism through creating rules and guidance to radically reduce the harm and negative influence due to the inappropriate use of the coercive power by the clinical practitioners with different clinical cultures and traditions when carrying out the coercive practice based on their working experience and different levels of knowledge.

4. Conclusion

To sum up, the wide gap existing between the expected consumers' participation and the real situation in which consumers are involved during the treatment period is formed due to the lack of respecting consumers' individualization and preferences by the practitioners with different clinical cultures and traditions who carry on the coercive power based on their working experience and different levels of knowledge. In order to narrow the said gap, four solutions could be taken into consideration by the mental health clinician during their practice, namely, playing the role of coordinators to enhance the relationship between consumers and service-providers; advocating the consumers' rights of expressing their true thoughts and feelings in their treatment; strongly maintaining the patient-centred practice in the mental health services; and making efforts to establish and improve the rules and guidance documents on the use of coercive power for mental health practitioners.

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