

Substance use disorder and compulsory commitment to care: a care-ethical decision-making framework

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In the era of deinstitutionalisation of psychiatric patients, steady or even increasing rates of compulsory commitment to care (CCC) are an intriguing phenomenon to analyse. From a clinical, legal and ethical perspective, CCC continues to be a controversial practice in psychiatry, and perhaps even more so when applied to patients with severe substance use disorder (SUD). Several reasons make it controversial. The lack of consensus about the benefits of CCC and professional disagreement about what mental illness and autonomy mean in the case of SUD make it difficult to apply ethically sound clinical decision-making in CCC. Also, the medico-legal framework underlying CCC use sometimes appears to foster the use of reductionist clinical evaluation. Layered on top of these issues is how stakeholders view coercion. There is a discrepancy between clinicians' and patients' perception of coercion, which leads to clinician–patient differences on whether CCC is necessary. Moreover, the way in which the evaluation is typically carried out influences patients' perception of coercion and subsequently their motivation for

participating fully in treatment. In this article, we explore the value of care ethics, often applied to care practices such as nursing, when applied to more procedural medical practices, such as decision-making regarding CCC. The care-ethical approach views decision-making as part of a dynamic care process, within which the lived experience, interpretative dialogue and promotion of dignity are core features. Embracing this new framework means a paradigm shift in when the therapeutic relationship begins, namely, investing in it occurs *while* conducting an evaluation for a possible CCC procedure. Unlike in current typical evaluations, early cultivation of the therapeutic relationship enables the patient to participate in the definition of his needs, reduces perceived coercion and negative emotions and enhances treatment motivation. Finally, implications of this novel approach for clinical practice are formulated and discussed.

Keywords: substance use disorder, substance abuse, addiction, psychiatry, compulsory commitment to care, involuntary hospitalisation, coercion, care ethics, ethical dilemma, procedural justice.

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Introduction

Despite the deinstitutionalisation of psychiatric patients, compulsory admission rates have remained mostly steady or may even have been increasing over the past few years. Rates vary greatly across European countries, ranging from 6 to 218 per 100 000 inhabitants (1). The legislative criteria for compulsory commitment to care (CCC) of a patient are the presence of a mental disorder and associated lack of decision-making capacity. Additional prerequisites are a need for care and the strong

likelihood of imminent danger to themselves or others (2). CCC remains a highly controversial practice in modern psychiatry (3–5).

Even more questioned is its use for the subgroup of patients with severe substance use disorder (SUD). Due to their high-mortality risk and their treatment reluctance, even when critically necessary, patients with SUD are likely to be subjected to CCC (4). However, from a clinical, legal and ethical perspective, CCC continues to be a controversial topic for SUD patients. First, outcome research on the use of coercion for SUD patients compared to voluntarily and nonvoluntarily treated patients has yielded inconsistent results (6). This is reflected in the lack of agreement among psychiatrists about the issue (5). Second, from a legal perspective, international consensus is lacking on whether invoking CCC in the case of SUD is on firm legal ground, compared to invoking it in

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the cases of cognitive, affective or psychotic disorders (7). Third, important ethical challenges exist regarding the care of patients in need of coerced treatment. Ethical tension exists because of the conflicting duties of the clinician: respecting the patient's autonomy, on the one hand, and protecting the patient in order to control and minimise harm to himself and others, on the other hand (7, 8). Moreover, sound ethical deliberation before invoking CCC is more difficult when it involves SUD patients, as reality testing is not grossly distorted – in contrast to patients with other psychiatric disorders like psychosis. In effect, then, SUD patients still have partial decisional capacity (4). Layered on top of the ethical dilemma is that good clinical care is hindered because clinical practice recommendations regarding CCC are lacking (9). Practical difficulties such as the nature of the setting, availability of beds and patients' negative attitudes also appear to play an important role in decision-making (10). These clinical, legal and ethical deficiencies appear to leave decision-making regarding CCC of SUD patients in a state of flux and confusion.

In the following section, we will first briefly discuss the clinical aspects related to a patient's dangerousness and treatment refusal that influence decision-making involving SUD patients. Second, we will illustrate how clinicians and patients differ in their perspectives about CCC procedure. We will discuss the negative consequences of coercion on patients' experience, and specifically on treatment motivation in the case of SUD patients.

The aim of this paper was to explore the value of care ethics as a guidance for decision-making regarding CCC of SUD patients. We focus on SUD patients as a subgroup of patients because they are being subject to CCC given their symptom profile but are less likely to benefit from it. We start from this clinical and ethical dilemma to explore whether care ethics can provide guidance. Although care ethics has been applied to the field of psychiatric care, in general (11), and in particular to prevention of seclusion (12), it has not been applied to more procedural clinical practices, such as decision-making regarding CCC. We argue that several core aspects of care ethics make it a promising candidate framework to deal with the manifold difficulties regarding decision-making regarding CCC laid out above. The proposed care-ethical interpretation views decision-making as a dialogical and interpretative *care* process, starting from the perspective of the patient's vulnerability and with the aim of promoting the patient's dignity. Finally, implications for clinical practice will be formulated.

Clinical perspectives on dangerousness and care refusal

Possible reasons why SUD patients are being subjected to CCC despite the controversies are the intermittent but

serious threat these patients pose to themselves or to others and because of their care refusal. There are specific types of danger that are typically associated with a severely drug-addicted patient, and these differ from the dangers often associated with a psychotic or severely depressed patient. In addicted patients, dangerousness can occur at multiple levels: danger to oneself (e.g. acute intoxication or withdrawal, self-inflicted harm, suicide attempt); danger to others (e.g. physical harm through impulsive and violent behaviour); and danger to society (e.g. property damage, road traffic accidents) (13). Besides the risks related to disinhibited and violent behaviour, specific additional complications may emerge during intoxication, such as psychotic, affective or cognitive disorders; serious cardiovascular complications; Wernicke encephalopathy; or convulsions (14). Similarly, acute withdrawal often is associated with psychiatric and medical risks, such as delirium, seizures, hyperthermia and cardiac arrhythmia, or even cardiac arrest (14).

SUD patients often present with negative, reluctant and impulsive behaviour, and often refuse care. This can be understood medically as a consequence of impairments in emotional and motivational processes associated with SUD (14). The core clinical symptoms of addiction include an enhanced incentive for drug taking (craving), impaired self-control (impulsivity and compulsivity) and increased stress reactivity (15). These symptoms are related to reduced activity in core brain areas involved in self-control and emotional reactivity, such as the prefrontal cortex, anterior cingulate and striatum (15). From a neurobiological perspective, desensitisation of the brain's reward system occurs (16). This means that as affected individuals increasingly crave a drug, the reward response for a given dose decreases, leading the user to seek ever-increasing doses to achieve the same reward response. Functional brain imaging research in addicted patients shows an abnormal salience attribution (i.e. to the drug) and weakened cognitive control (17). These in turn lead to motivational impairment, wherein an individual's desire to obtain drugs overpowers the drive to attain nondrug-related long-term goals (18). This mechanism, among others, explains the ambivalence or refusal of addicted patients to enter treatment voluntarily.

Clinicians' and patients' perspectives on decision-making and use of coercion

Coercion as defined in psychiatric practice is often interpreted rather broadly, and it can be used both in the subjective and objective sense (19). The term coercion includes compulsion, but encompasses a broader range of practices (20). However, in this paper, we will focus on coercion as the result of a compulsory action. We will further elaborate on the differences between clinicians' and patients' perspectives on the use of coercion, in this

case CCC, as a starting point for a care-ethical analysis. The empirical literature often refers to 'perceived coercion' to designate the subjective experience arising from compulsory actions (19, 21, 22). It has been shown that a discrepancy exists between the clinicians' and the patients' perspectives regarding the decision-making process in the context of CCC (23, 24). Clinicians tend to rate the decision-making process more positively than patients, and they tend to perceive a higher level of procedural justice than patients do (23). Procedural justice is defined as the transparency and fairness of a procedure and is manifested by freedom of bias and patient participation in the decision-making process, both of which validate an open and constructive dialogue (24).

Several reasons might explain why perception of procedural justice is higher in clinicians. First, legal criteria require clinicians to internalise the law's demand during clinical evaluation and act accordingly (25). Indeed, with CCC, some researchers propose that a cognitive shift from a medically paternalistic approach to a legalistic one occurs in clinicians. In the former, the clinician defines what the patient's best interest is. However, in the latter, the clinician first needs to discern an objective truth about the patient in order to assess whether legal or clinical criteria can apply (26, 27). In the latter scenario, an independent expert offers neutral and value-free evaluation, resulting in decision-making that is free of bias and is theoretically fair and just, hence conveying to a perception of procedural justice in clinicians.

From the patient's perspective, perceived coercion appears to be linked to the experience of 'not being listened to', resulting in the patient powerless, humiliated and disrespected (8). In the context of CCC, patients report experiencing negative emotions, for example stigma, shame, disempowerment and self-contempt (28). How patients perceive coercion depends less on the specific kind of coercion used and more on the manner in which patients are treated (29). When patients do not understand the reasons for their admission, or when they are not informed, they appear to feel powerless and subjected to an arbitrary decision (30). On the contrary, having the opportunity to participate in the decision-making process has a positive influence on patients' evaluation (8). Patients, then, view involuntary treatment as a needed treatment and as protection and guidance (30).

The degree of procedural justice present, the extent to which the patient is included in decision-making and the quality of the therapeutic relationship can influence clinical treatment outcome (24). In the specific case of SUD patients, their motivation to accept treatment appears to be inversely related to their perception of coercion in the situation (31). If patients are given the opportunity to participate in the care and decision-making process, their perception of coercion lessens, leading to heightened

motivation to explore and accept treatment options. However, achieving this outcome is a difficult task in patients whose core symptoms include lack of self-control and emotional reactivity, which instead leads them to refuse care. Indeed, there is an apparent discrepancy between coercing someone into treatment and engaging him in the care process.

Starting from the discrepant clinicians' and patients' perspectives on CCC, we argue in favour of a paradigm shift in which CCC is not a momentary, rule-governed decision made by an individual expert but instead is a relational practice that includes the patient embedded in a dynamic care process.

A care-ethical analysis

Care ethicist Carol Gilligan described two different approaches to moral problems, which can be applied to the specific issue of CCC. The first is a universalistic approach, which is translated into medico-legal requirements and an impartial expert opinion (32). The second is a particularistic approach, which takes into account the partiality and contextual embeddedness of care practices (32). These two approaches are not mutually exclusive, but are complementary. In fact, ethical decision-making requires different perspectives: context sensitivity, impartial reasoning, emotional involvement and motivation (33). Knowledge-based impartial reasoning is a fundamental requirement for decision-making, from which care practice emerges, as well as the capacity for emotional involvement, and Hume's notion of motivation to act in a morally sensitive way (33, 34). In the context of ethics applied in the clinical context, the top-down approach has been defined as the application of knowledge in a process of deduction in light of relevant empirical facts, and in an impartial and value-free manner (35). But ethical deliberation should occur both top-down (here, according to the legal criteria that apply in the institution where the decision-making takes place) as well as bottom-up, in connection to the care practice (36, 37). The care practices in which decision-making about CCC is embedded emerge from the relationship between the care receiver and caregiver. CCC should not only proceed as a top-down expert intervention that directs the needs of the recipient of care, but simultaneously as a process that includes the care receiver's bottom-up participation in defining his¹ needs as an integral part (34, 38). The bottom-up participation in the decision-making also allows the care receiver to take responsibility in the process. Therefore, the question is not whether we should use coercion and how that decision can be justified based on universal medico-legal principles, but instead how we should come to that decision within the patient-caregiver relationship and how the decision is implemented in particular care practices (39) (Fig. 1).

Lived experience and vulnerability

Within the care perspective in health care, care is viewed as embedded in a relational web comprising all involved parties, wherein lived experiences of a patient’s vulnerability are central (33, 40). A person is considered to be an embodied identity embedded in a particular relational and social context (34). According to care ethicist Chris Gastmans, care processes should begin with a consideration of the concrete lived experiences of all the people involved (40); this is the first dimension. This step corresponds to Joan Tronto’s first dimension of care, referred to as ‘caring about’ and to the related moral attitude of attentiveness (41). When initiating care, it is important to note the existence of a need and to evaluate it in its particular context, especially in situations where it might not be obvious. For example, a patient’s impulsive behaviour affects not only him but also others. Vulnerability dominates the lived experience of all involved. Others find it impossible to relate to or to have contact with the patient in a reciprocal way. For relatives, their capacity to support the patient is severely taxed in this situation, and in the case of SUD, there is the intense burden of repeatedly facing the patient’s intoxication, withdrawal, aggression and impulsive behaviour, or health problems. Further increasing their vulnerability is the fact that relatives often feel estranged from the patient when CCC is invoked (42). Others, or even society as a whole, are made vulnerable through the potential danger and threats the patient represents. Another expression of the shared lived experience of vulnerability is the patient’s failure to meet social, financial or occupational responsibilities as a result of SUD. These relational and social problems can be reinterpreted as representing the extent

of damage not only to the shared life of the patient with family and friends, but also to society (11).

Care as a moral practice takes place through a process that reacts to vulnerability (43). Vulnerability of a fellow human being prompts us to care for the ‘other’; it reveals ethical appeal. The ‘other’ (e.g. patient, family, society), as described by Levinas, sets the norm for the caregiver in the care process (44). Hence, the first step in the care process for SUD patients is noting and correctly interpreting the lived experience of all those who participate in the care process, in particular the vulnerability and the related ethical appeal of the patient. We can note that care ethics, invoking the lived experience as a first step in ethical decision-making, has a common ground with practical hermeneutics, which emphasises the embeddedness of deliberation in the experience of the persons involved (37).

Interpretative dialogue and care process

The second dimension in Chris Gastmans’ care framework consists of the actual care process that is developed by means of an interpretative dialogue. In order to find the best care scenario that meets the needs of the patient, the different viewpoints of the parties involved should be gradually interpreted. Ethically sensitive decision-making involves evaluating principles, such as beneficence, non-maleficence and the principle of proportionality. Assessment of the patient’s needs and the corresponding individualised care programme should serve the patient’s best interest (beneficence), while limiting as much as possible negative effects (nonmaleficence). To serve the ethical principles of beneficence and nonmaleficence, one needs to identify the patient’s needs. According to

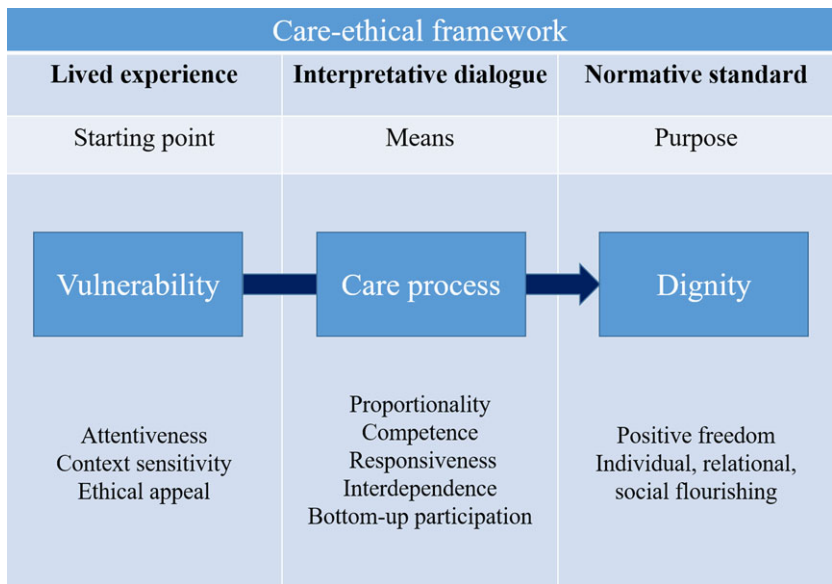


Figure 1 Care-ethical framework on CCC. Adapted from Gastmans (2013).

Tronto, this involves competence (41). Given the lack of consensus on the outcome of using CCC in SUD patients, caution should prevail (39). The principle of proportionality requires that the care-associated extent of damage (i.e. coercion) is proportional to the patient's clinical status and to the treatment's expected therapeutic benefit. In other words, the level of coercion applied should be proportional to the harm that would be caused to the person's integrity or health (45). Hence, with a person having partial decision-making capacity, such as an addicted patient with acute intoxication, coercion can be justified only if the bodily and/or psychological integrity of that person or of another person are seriously threatened.

Even given the above considerations, interpretative dialogue cannot exist without the dimension of mutual responsiveness being present. Tronto defines responsiveness as how a patient responds to given care and how this response is influenced by the shared interdependence of caregiver and care receiver (38). The care receiver depends on the caregiver, who can become vulnerable and dependent through feelings of helplessness and even moral distress when the patient refuses care. From the caregiver's perspective, responsiveness constitutes embracing an attitude of openness and being motivated to respond to the appeal of the patient, independent of the emotions the encounter evokes. From the care receiver's view, responsiveness means that he or she is responsible for participating in the care process as much as possible. However, responsibility implies possessing a certain degree of mental capacity. Although SUD patients may temporarily lack decision-making capacity (e.g. during intoxication or withdrawal) and therefore may be incapable of participating in a responsible and responsive manner, they are still considered by clinicians to be more responsible than patients with other kinds of disorders, for both the onset and recurrence of their condition (46).

Normative standard and dignity

Finally, the aim of the care process is to maintain, protect and promote the patient's dignity. In care ethics, dignity does not emerge from an individual-focused anthropological framework, in which autonomy is interpreted in the traditional liberal sense of self-sufficiency and independence. On the contrary, the relational anthropological framework of care ethics focuses on the mutually interdependent partners in the care process as being the normative ground for clinical-ethical deliberation (47).

The use of CCC, and the infringement of one's freedom that results, might seem to be a paradoxical way to enhance a patient's dignity. However, this is not the case if we consider care to be a moral practice that aims at the enhancement of the patient as a human being in all his

dimensions. This means not only as an individual subject but also as a relational and social human being. Humanising the patient and respecting him as a person in need of care, and not as an object of harm reduction, is the goal of the caring process. Care should strive to promote the person's self-realisation and provide meaning to one's existence. This is defined as positive freedom: the capacity of developing meaningful and flourishing relationships (11). This view is in opposition to what is referred to as negative freedom (self-determination), being able to act without interference from others (48). Hence, the crucial question from a care-ethical perspective is not whether the use of CCC is legitimate – being a hindrance for the person (i.e. negative freedom) – but whether the provided care adequately promotes the person's positive freedom. In other words, 'dignity-enhancing care' should enable the patient to achieve a sense of self in order to promote his self-realisation as an individual, relational and social human being. The emphasis on patient's dignity is consistent with Fulford's values-based practice in psychiatry, a patient-centred model in which the values of the individual are central to evidence-based clinical decision-making (49).

Implications for clinical practice

What does this care-ethical interpretation mean for clinical practice regarding CCC for SUD patients? We discuss next the implications according to the three dimensions of our care-ethical framework.

Seeking the lived experience

The first element of our ethical framework consists of the clinician being attentive to the SUD patient's vulnerability and related ethical appeal, striving to understand his symptoms and placing the immediate emergency situation within his personal, relational and social context. For instance, the clinician should interpret symptoms related to the patient's failure to meet social, financial or occupational responsibilities as a result of SUD as an expression of the shared lived experience of all parties involved. Hence, the clinician being attentive and being sensitive to context also apply on a relational level; that is, the clinician should be alert to detecting a possible weakening of the relatives' capacity to support, including that arising from disruptive events, such as the ending of a patient's relationship or his recent dismissal from a workplace. Therefore, an attentive care practice takes these into consideration and involves family members in the decision-making process in order to decrease the relatives' burden related to feeling estranged towards the patient.

Clinicians need to perceive and correctly interpret environmental cues before engaging in the decision-

making process. In this context, this means not only being more acutely aware but also being able to perceive and comprehend cues commonly ascribed as being 'negative', such as a patient's care refusal, irritability, ambivalence, and unpredictable or 'antisocial' behaviour. Similarly, suicidal thoughts or acting-out behaviour might be a proxy expression of hopelessness that the patient cannot express overtly at that particular moment. Moreover, the clinician should discern complex emotions and attitudes of family members. Often, feelings of anger and rejection prevail in a crisis situation. Context sensitivity means understanding that genuine but frustrated concern, care and love are 'on the other side of the coin'. If the clinician is aware that these positive feelings and attitudes are present, but masked, it helps to bring them back into the foreground. Because of the layered complexity comprising the patient, the family, the caregiver and in the interaction between all parties involved, it is important for clinicians to resist the temptation of *masking* one's own sense of vulnerability by adopting a paternalistic top-down attitude towards defining the patient's needs. In other words, even though top-down clinical reasoning is necessary for making a judgement, these top-down reasons should not be *misused* to justify actions that arise from a shared vulnerability in the relational encounter.

Supporting the interpretative dialogue

In order to foster a dialogical interpretative process, several initiatives can be taken. First, all potentially useful information about the patient's situation should be collected from different sources (e.g. relatives and general practitioner). Being aware of and considering different perspectives of the situation and about the patient make it easier for aspects of the patient's life and lived experiences of all parties to be acknowledged and understood. This leads to a better interpretation of the patient's present situation and desires and leads to a more confident determination of his treatment needs. It is important to understand that the interpretative dialogue involves more than just the patient and his relatives. The dialogue should also be established and fostered *among* healthcare professionals. An interdisciplinary collaboration among psychiatrists, emergency physicians and nurses is important, with each having their own role in the care process. For example, emergency physicians are needed for the medical management of critical clinical issues, such as haemodynamic instability or cardiac abnormalities due to severe intoxication or withdrawal. General practitioners are better equipped to assess the patient's past clinical history and the impact of a particular treatment course on the patient's life, both valuable elements for appropriate decision-making. Psychiatric nurses can provide useful information on how the patient behaves 'here and

now', in stressful or embarrassing situations in which he feels vulnerable or humiliated.

A second initiative that can be taken is to make efforts to integrally embed the actual evaluation and decision-making on CCC within the dialogical interpretative care process. This implies that the timing of evaluation should be carefully chosen. Information and clinical evaluation from healthcare professionals other than the evaluating clinician is important to have in hand first in order to correctly interpret the patient's symptoms and current clinical status. A patient might seem very irritable and agitated, expressing uncharacteristic antisocial behaviour. Therefore, it is imperative to consider all available information first in order to establish whether the patient is in the *best possible condition* to be clinically evaluated. Consultation with emergency room physicians can help in applying a phased approach to evaluation; that is, giving priority to clinically stabilising the patient in the case of intoxication/withdrawal so that he may be put in the best possible state to be receptive to care and be able to *participate* in it in a responsible way. Since acute intoxication, substance withdrawal, concomitant use of benzodiazepines or fluctuating consciousness hinders the patient from engaging in an interpretative dialogue, a decision on whether to invoke CCC should be postponed, and priority should be given to medical management and resolution of the intoxication or withdrawal. This includes pharmacological management of acute agitation, if present.

A third initiative relates to ethical deliberation. Once it is established that the patient is in a sufficiently stable condition to be evaluated *and* to participate in the care process, the principles of competence and proportionality should be applied. The clinician needs to determine whether there is a causal relationship between the threat the patient represents and his current clinical status (14) in order to properly evaluate the proportionality of CCC. That is, the use of coercion should take into account the partial decision-making capacity of the SUD patient, be in proportion to the patient's status (whether it is causally related to the danger he represents) and the treatment's expected therapeutic benefit.

The evaluating clinician therefore plays a dual role: the clinician acts as an independent expert and as a patient-centric caregiver. Indeed, the criteria are difficult to interpret, if not also from a value-laden point of view (26). Care philosopher Kari Martinsen illustrates this dual perspective of the clinician as being a 'recording eye', on the one hand, neutral, classifying and differentiating. On the other hand, it can be understood as a 'perceiving eye', characterised by an attitude of openness, being in touch and being emotionally involved (50). In psychiatry, Karl Jaspers drew a similar distinction in his famous phenomenological method for assessing values and subjectivity taking into account the scientific method: the

distinction between explaining (*erklären*) and understanding (*verstehen*) (51). Jasper's phenomenological dual approach allows exploring the patient's values, experiences and behaviour, where these are the basis of psychopathology (49).

But how should the clinician apply this dual role when facing a patient who refuses to participate in the care process? It is extremely important for the clinician in this situation to understand the shared dependence that becomes explicit when encountering a patient who refuses care. Care refusal, especially in a patient who lacks obviously disrupted reality testing, illustrates how responsiveness in a care process is not reciprocal. When a patient is unwilling to accept care as we would expect or wish, he is essentially undermining our position as clinicians. It can then be tempting to internalise the norm provided by the legal requirements and view the patient's refusal of care as a clinical sign of poor judgement, illness severity or his inability to cooperate. However, from a care-ethics perspective, refusal of care is not just a given determined by the addiction. Refusal of care cannot be separated from the relational care encounter.

The way a clinician approaches the patient influences his response. For example, focusing too much on the patient's addiction and behaviour can induce or amplify defensive responses, possibly resulting in care refusal. Moreover, clinicians should express their own feelings of helplessness or moral distress, which reflects their own relational and embodied identity. By understanding the addictive behaviour as a defence against emotional pain (e.g. shame, ambivalence, feelings of failure, loss, helplessness, guilt, emptiness, inadequacy or inability to cope and change) underlying the patient's behaviour, defences can be lowered, creating openness towards voluntary care. Alternatively, a *prima facie* refusal of care in an individual interaction with the patient can be overcome in a broader interaction involving the patient and his closest relatives. Furthermore, the perspective of the next of kin counteracts mechanisms of denial, such as minimising the addiction and fleeing in unrealistic hopes (e.g. getting better without help).

Finally, refusal of care can be the *result* of the interaction with a caregiver, in which the patient feels that his concerns, needs and wishes are insufficiently taken into account. But if the patient's concerns (e.g. sleeping problems, pain, depressive feelings, anxieties, or bodily complaints) are explored and satisfactorily addressed, if possible, he may be more open to accepting further care.

Promoting dignity

The process of arriving at a decision to use CCC should entail more than aiming simply to interrupt this vicious seek-use-see cycle (e.g. protecting the patient from his own dangerous behaviour), but also should strive to

promote the patient's self-realisation. This proceeds by starting a care process that goes beyond the strict medico-legal procedure itself. Although the presence of dangerousness should be an additional requirement for deciding to use CCC, it appears now to be a main determinant in many countries (2). This current state of affairs stems from a historical shift towards focusing mainly on dangerousness as the legal standard for invoking CCC (4); that is, considering an imminent threat to one's safety or to that of others or society to be pre-eminent. However, prioritising the patient's self-realisation and dignity should ethically be placed over harm reduction, for two reasons. First, prioritising dangerousness is ethically problematic, as it tends to exclude other patients deserving care, who are less dangerous to society but nonetheless need treatment (52). For example, prioritising the dangerousness criterion in a care environment with limited resources means that sick elderly people or women, who tend to be less violent (i.e. dangerous), are excluded, or receive only delayed care. Second, emphasis on dangerousness, harm reduction, and benefit or protection of society over that of the individual may result in a treatment that is longer than strictly necessary (53). This is important, since a treatment that aims only at reducing harm without clear therapeutic purpose *from the beginning* might be experienced by the patient as an arbitrary, 'legalistic' decision, one in which the clinician acted primarily as a 'protector of society'. The patient can feel stigmatised and humiliated and can perceive this as an abuse of power by the clinician rather than a source of protection.

In order to maintain and promote the patient's dignity – understood as expressing his relational autonomy – it is important to give sufficient attention to the relational and social dimension of the patient. That is, the clinician needs to focus on cultivating the remaining positive and constructive elements of the patient's life as an expression of previously existing self-realisation projects (e.g. hobbies, interests). Focusing on positive elements, sense of accomplishment and self-efficacy throughout the entire care process (i.e. during the first encounter and later during the treatment process) is crucial. This approach is congruent with elements of motivational interviewing, an important evidence-based psychotherapeutic approach to treating addiction (54). Supporting patient self-efficacy during the early stages of decision-making – even though it could seem to be contradictory in the context of CCC – is essential for a successful care process that comes after CCC. With motivational interviewing, sense of accomplishment serves as the 'motor' for pushing the patient to adopt responsibility and for carrying out actions that change his behaviour. The psychotherapeutic intervention is based on the principle that in order to change behaviour, patients need to be able to see the discrepancy between their behaviour and its

(unwanted) consequences, on the one hand, and what they desire or aim at, on the other hand. Therefore, promoting dignity as a relational concept, in which the patient is able to restore the capacity of developing meaningful and flourishing relationships, starts with acknowledging his remaining (or temporarily lost) positive elements, desires and ambitions.

Conclusions

From a clinical, legal and ethical perspective, CCC continues to be controversial, especially when involving SUD patients. This analysis of CCC from a care-ethical standpoint shows that decision-making could benefit from application of care-ethical principles. Consistent with these principles, we argue in favour of a paradigm shift in deliberations about the application of CCC, one that fundamentally integrates the care-ethical perspective. We propose that the procedure should deeply invest in cultivating a therapeutic alliance among all stakeholders, even at an early stage, that is, during the decision-making process of whether to invoke CCC. Decision-making is viewed as an important part of a dynamic care process, wherein the lived experience, interpretative dialogue and promotion of dignity are core features. It is crucial to understand that we advocate giving real attention to the therapeutic relationships among stakeholders *while* conducting an evaluation for a possible CCC procedure, not after. This shift enables the patient to participate in the definition of his needs, reduces his perceived coercion and negative emotions and enhances his treatment motivation. These positive elements may be extremely

difficult to attain when CCC occurs before considering the patient's expressed needs and desires. With this new framework, CCC is not a 'necessary evil' designed to protect a patient and to enable a future process of care; rather, it is an essential and initial *part of* that same care process. In the future, this care-ethical perspective can be compared to other ethical approaches to determine the best way forward in disentangling the conflicting demands in the context of CCC.

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Conflict of interest

The authors declare no conflict of interest.

Author contributions

Marie Nicolini, Joris Vandenberghe and Chris Gastmans defined the scope of the paper. Marie Nicolini wrote the first draft of the paper; Joris Vandenberghe and Chris Gastmans provided important revisions and insights on subsequent drafts of the paper. Marie Nicolini, Joris Vandenberghe and Chris Gastmans approved the final draft for submission.

Note

¹Throughout this article we use the male pronoun, although the discussion applies equally to both genders.

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