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Medical personnel's opinions on difficulties in applying measures of coercion – a research report (Part 2)

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ABSTRACT

Introduction: The objective of this research was to identify legal and practical challenges in the application of means of coercion based on the opinions of medical staff.

Materials and methods: A cross-sectional study was conducted using an original survey questionnaire among 205 medical staff (nurses and doctors) from 3 hospitals in Poland in 2019–2020.

Results: The vast majority of survey participants found the use of coercion in their workplace to be challenging (38% always difficult, 51% sometimes difficult). Immobilization was identified as the most difficult measure to apply (45.86%). The majority of respondents rated the preparation for the use of coercion in their workplace as "poor", "very poor", or nonexistent in terms of procedures, personnel numbers, training, and equipment (with ratings ranging 60–90%). Most respondents expressed a desire for more frequent cooperation with external institutions. Among the socio-demographic variables analyzed, only age was significantly associated with difficulty in using coercive measures, with older participants (M = 50.00 years) reporting more difficulty.

Conclusions: The respondents generally applied coercion in accordance with Polish legislation, though several difficulties were noted in practice. These challenges may be due to shortcomings in workplace preparation for the use of coercion or inadequate cooperation with external institutions. Consequently, medical staff may resort to coercive measures that are not ideally suited to the patient but are feasible to apply. The greater difficulty reported by older respondents may reflect a higher awareness of practical issues in applying coercion. There is an urgent need to align legal requirements with practical realities, ensuring adequate funding for services.

Keywords: coercion; movement restraint; seclusion; compulsory medication; behaviour control; aggression.

INTRODUCTION

The Mental Health Act of 19 August 1994 [1] introduces protective regulations concerning individuals with mental disorders, outlining the rules of coercion, which legalize the use of specific means of coercion, including movement restraint, immobilization, isolation (seclusion), and forced medication (compulsory medication). These rules emphasize several key aspects:

- staff training,
- forewarning the person with a mental disorder before applying coercion,
- choosing the least burdensome means of coercion for the individual,
- the possibility of using more than 1 means of coercion,
- applying coercion only until the reasons for its use are no longer valid,
- a final assessment of the appropriateness of coercion by someone other than the individual who ordered it,
- documenting all actions in a coercion sheet [2].

Superficial or incomplete application of these rules – such as irregular staff training, use of certain measures due to the unavailability of others, or assessing the reasonableness of coercion based on incomplete documentation – should be considered inappropriate and dangerous for both the patient and others [2].

According to the Mental Health Act, 3 groups of medical staff are authorized to apply direct coercion: doctors, nurses, and individuals managing medical emergency actions. Typically, a doctor makes the decision, determining the type of measure and personally supervising the procedure (Article 18, Section 2 of the Act) [1]. In psychiatric hospitals and social welfare units, if a doctor is not immediately available, a nurse may decide to apply coercion but must inform the doctor without delay. Similarly, in medical rescue operations, a paramedic can make the decision but must notify the emergency medical dispatcher immediately.

The objective of this research was to identify the legal and practical challenges in applying means of coercion, based on the perspectives of medical staff.

MATERIALS AND METHODS

The study involved 205 healthcare employees (180 women and 25 men) aged 21–66. The vast majority of respondents had a university degree (109 people), while the remainder reported having secondary education (55 people), post-secondary

education (30 people), and 3 individuals held a doctoral degree or higher. Our study included 170 nurses, 23 doctors, and 7 individuals from other health professions. The respondents worked in various hospital care units, with the majority employed in psychiatry departments. Detailed demographic data can be found in part 1 of the study – "Application of direct coercive measures. Report of medical staff's opinions (Part 1)" [3].

Procedure and tools

The medical staff opinion survey was conducted using a questionnaire-based approach in late 2019 (November–December) and early 2020 (January–February) across 3 publicly funded hospitals in Poland, located in Szczecin, Gorzów, and Przemyśl. The study employed an original survey questionnaire that was modified and validated by a regional advisory board of specialists from various fields. The questionnaire was developed in accordance with the provisions of Polish law regarding the use of direct coercion.

Statistical analysis

The statistical analysis was conducted using Statistica v. 13.3 software. The χ^2 test was applied to compare independent groups, with statistical significance set at $p < 0.05$.

RESULTS

The survey participants were asked whether they found the use of coercion in their workplace difficult. The vast majority responded affirmatively, with 80 participants (38.65%) stating, "yes, it is always difficult", and 107 participants (51.69%) responding, "yes, it is sometimes difficult". Only 7 individuals (3.38%) reported that the use of coercion did not pose any problems, while the remaining participants were unsure.

Among the reasons for difficulties in using coercion, the following were identified: fear for personal safety (160 participants; 77.29%), fear for the patient's safety (141 participants; 68.12%), insufficient knowledge of the rules governing coercion (9 participants; 4.35%), and lack of clarity in coercion procedures (10 participants; 4.83%). Additionally, 19 respondents cited other reasons, such as technical challenges, staff shortages during on-call hours, and emotional difficulties.

According to the survey participants, the most difficult coercive measure to apply was immobilization (97 participants; 45.86%), followed by forced medication (56 participants; 27.05%) and movement restraint (61 participants; 21.47%). Seclusion was the least frequently cited as the most difficult measure (35 participants; 16.91%).

The need to involve external services, such as the police, fire brigade, or emergency medical services, during the application of coercion was reported by 84 participants (40.58%). Only 2 participants mentioned that these services refused to assist when needed. Table 1 outlines patient behaviors that required the involvement of external institutions, most commonly relating to aggression toward others that posed a risk to their life or health (88 participants; 42.51%).

TABLE 1. Self-aggressive/aggressive behaviours requiring a call to external institutions

Self-aggressive/aggressive behaviour	n	%
The patient was aggressive towards other people, putting their life or health at risk	88	42.51
The patient was violently damaging or destroying objects in their surroundings	70	33.82
The patient was aggressive towards themselves, which put their health or life at risk (active self-aggression)	61	29.47
The patient was seriously disrupting or hampering the functioning of the medical facility where they obtained mental health care services, another medical facility, or a social welfare unit	37	17.87
The patient was refusing meals, medication, or other services necessary to maintain their health or life (passive self-abuse)	11	5.31
I have never used/witnessed it	87	42.03

The respondents were also asked about the frequency of contact with external institutions. Only a few participants indicated that cooperation with these institutions was too frequent. The majority of respondents expressed a desire for more frequent cooperation, particularly with hired security (66.67% citing infrequent contact), the fire brigade (83.54% citing infrequent contact), social welfare institutions (74.36% citing infrequent contact), and the police (57.94% citing infrequent contact) – as shown in Table 2.

The respondents were also asked to assess the quality of the regulations on the use of coercion in the Mental Health Act. According to 32 respondents (15.46%), these regulations are insufficient, and 31 (14.98%) believed they are poorly designed. In an open-ended question, respondents suggested that the regulations should be more specific, the documentation simplified, and the coercion sheet improved. Additionally, 16 respondents (7.73%) indicated that the Act on Upbringing in Sobriety and Counteracting Alcoholism, along with its implementing acts, contains too many regulations on the use of coercion, while 13 respondents (6.28%) felt there were too few regulations. The remaining respondents (175; 84.54%) had no opinion on the matter.

The respondents were also asked about their opinion on the number of regulations related to the use of coercion under the Act on Counteracting Drug Addiction and its executive acts. Of these, 12 respondents (5.80%) felt there were too many regulations, and 8 respondents (3.86%) believed there were too few.

The survey concluded with a question about how respondents assessed the preparation for the use of coercion in their workplace. The results are presented in Table 3.

Note the high number of "very poor" ratings for aspects such as procedures (89 respondents; 43.00%), equipment (85

TABLE 2. The respondents' self-assessment of the frequency of cooperation in the workplace with selected institutions

Institution	Rating scale									
	definitely too rarely		too rarely		often enough		too often		far too often	
	n	%	n	%	n	%	n	%	n	%
Police	**26**	**24.30**	**36**	**33.64**	41	38.32	1	0.93	3	2.80
Fire brigade	**35**	**44.30**	**31**	**39.24**	13	16.46	0	0.00	0	0.00
Emergency medical services	**21**	**21.88**	**27**	**28.13**	46	47.92	2	2.08	–	–
Court	**31**	**38.75**	**23**	**28.75**	24	30.00	1	1.25	1	1.25
Hired security	**39**	**40.63**	**25**	**26.04**	30	31.25	1	1.04	1	1.04
Social assistance institutions, e.g. Crisis Intervention Centre	**33**	**42.31**	**25**	**32.05**	17	21.79	2	2.56	1	1.28

TABLE 3. The respondents' self-assessment of the preparation for the use of coercion in their workplace

Aspect	Rating											
	very good		good		sufficient		poor		very poor		no aspect	
	n	%	n	%	n	%	n	%	n	%	n	%
Procedures (regulations, documentation)	1	0.48	0	0.00	10	4.83	32	15.46	**89**	**43.00**	**62**	**29.95**
Number of personnel (use and control of coercion)	4	1.93	8	3.86	52	25.12	59	28.50	**46**	**22.22**	**24**	**11.59**
Internal training	8	3.86	1	0.48	21	10.14	42	20.29	**74**	**35.75**	**47**	**22.71**
Equipment (belts, medication)	2	0.97	7	3.38	26	12.56	43	20.77	**85**	**41.06**	**32**	**15.46**
Isolation site (very good rating when with monitoring)	**51**	**24.64**	18	8.70	26	12.56	**30**	**14.49**	**35**	**16.91**	**26**	**12.56**

respondents; 41.06%), and internal training (74 respondents; 35.75%). The "poor" ratings for all aspects also stand out, as well as the choice of the answer "no aspect" (Tab. 3). The majority of respondents, therefore, gave negative assessments regarding the preparation for the use of coercion in their workplace.

The relationship between the age of the respondents and their assessment of the difficulty in using direct coercion was also analyzed. The data in Table 4 confirmed significant differences within the study group ($p < 0.05$). The use of direct coercion was particularly difficult and consistently challenging for the oldest participants (M = 50.00 years). In contrast, the youngest participants (M = 42.50 years) reported fewer difficulties in applying coercion.

Age differences are also shown in Figure 1.

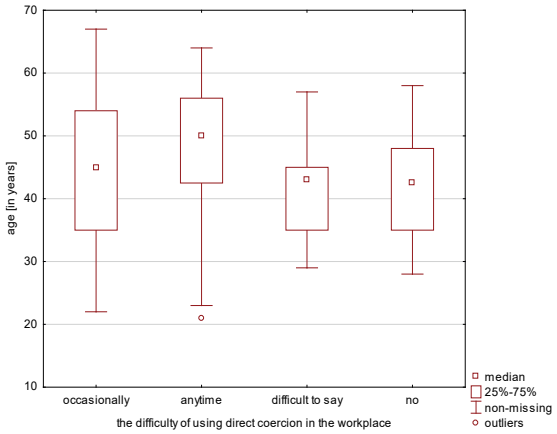

FIGURE 1. The difficulty of using direct coercion in the workplace vs. age

TABLE 4. The respondents' self-assessment of the difficulty of using direct coercion in the workplace vs. their age

Using direct coercion vs. age	n (%)	Me ±SD	M	Q1–Q3	Min.–max.
Occasionally	101 (52.06)	43.69 ±11.76	45.00	35.00–54.00	22.00–67.00
Anytime	72 (37.11)	48.53 ±10.20	50.00	42.50–56.00	21.00–64.00
Difficult to say	13 (6.70)	41.23 ±8.23	43.00	35.00–45.00	29.00–57.00
No	8 (4.12)	42.13 ±9.82	42.50	35.00–48.00	28.00–58.00
Total	194 (100.00)	45.26 ±11.15	47.00	38.00–55.00	21.00–67.00

H = 11.136; p = 0.011
Me – median; SD – standard deviation; M – average; Q1–Q3 – minimum value–maximum value

Next, the hypothesis that there is no relationship between education level and difficulty in applying direct coercion was tested. The data in Table 5 support the accepted research hypothesis ($p > 0.05$). However, it is worth noting that the highest percentage of respondents who reported no difficulty in applying direct coercion was among those with higher education (15.52%).

TABLE 5. The respondents' self-assessment of the difficulty of using direct coercion in the workplace vs. their education

Using direct coercion vs. education	Anytime	Occasionally	No and difficult to say	Total
	n (%)			
Higher	40 (35.71)	61 (54.46)	11 (9.82)	112 (100.00)
Postsecondary	18 (51.43)	16 (45.71)	1 (2.86)	35 (100.00)
High school	21 (36.21)	28 (48.28)	9 (15.52)	58 (100.00)
Total	79 (38.54)	105 (51.22)	21 (10.24)	205 (100.00)

$\chi^2 = 5.816$; $p = 0.213$

The relationship between the respondents' sex and the difficulty of using direct coercion was also examined (Tab. 6).

TABLE 6. The respondents' self-assessment of the difficulty of using direct coercion in the workplace vs. their sex

Using direct coercion vs. sex	Anytime	Occasionally	No and difficult to say	Total
	n (%)			
Male	69 (38.33)	91 (50.56)	20 (11.11)	180 (100.00)
Female	10 (40.00)	14 (56.00)	1 (4.00)	25 (100.00)
Total	79 (38.54)	105 (51.22)	21 (10.24)	205 (100.00)

$\chi^2 = 1.226$; $p = 0.542$

The data in Table 6 indicate that there were no significant sex-related differences in the difficulty of using direct coercion ($p > 0.05$).

DISCUSSION

According to the latest systematic review, there has been a shift in the use of coercion from a therapeutic paradigm to a safety paradigm. It is now widely argued that coercion should not be employed as a form of therapy but rather as a procedure to ensure safety, applied only as a last resort and using the least invasive intervention possible [4]. In our study, immobilization was reported by participants as the most difficult means of coercion to apply (45%), followed by forced medication (27%) and movement restraint (21%). These findings align with other studies [5, 6], which reveal that patients generally prefer seclusion over other coercive measures like movement restraint or forced medication. This reluctance toward specific measures may lead to greater resistance from patients, contributing to the difficulties faced by medical staff. Nevertheless, in our study, immobilization was the most commonly used coercive measure (37%), while seclusion was the least common (6%). The question arises as to whether the higher frequency of immobilization and forced medication over seclusion was justified by a threat to the patient's health or life, or if it was due to personnel, equipment, or facility deficiencies. Unfortunately, this likely stems from a lack of personnel or equipment, as most respondents gave negative assessments regarding the preparation for coercive measures in their workplace. Notably, more than 30% of respondents rated the place of isolation as poor or very poor, and around 13% indicated that such a place did not even exist in their workplace.

Additionally, some respondents suggested changes to regulations, with approx. 15% each considering the current regulations insufficient or incorrectly designed. In our study, fear for one's safety (about 77%) and fear for the patient's safety (about 68%) were identified as primary reasons for difficulties in applying coercion. These findings correspond with other studies that show fear for safety leads staff to perceive coercion as necessary for restoring safety and, therefore, used more frequently [4]. However, defining and measuring a sense of safety is complex. In Vollema et al.'s study [7], nurses' sense of safety was assessed at the end of each shift, with higher levels of safety linked to fewer instances of seclusion. The sense of safety was negatively associated with patient characteristics [8], incidents of patient aggression [7], and inadequate workplace conditions (e.g., lack of protective equipment, low staff-to-patient ratios, and insufficient communication with hospital security). Conversely, factors such as aggression management training, work experience, and trust within treatment teams contributed to an increased sense of safety [8]. This research highlights how working conditions, broadly defined, can influence the sense of safety and, in turn, the use of coercive measures by medical staff.

Several literature reviews [4, 9, 10] have shown that nurses often believe coercion is necessary and unavoidable, even though it can cause strong negative emotions for them as well. This is consistent with our findings, where the vast majority of participants reported difficulties in using direct coercion in their workplace (38% always found it difficult, and 51% sometimes found it difficult).

Regarding the influence of socio-demographic factors such as: age, sex, body build, education, and work experience on the use of coercion, the findings are inconclusive. The literature shows no clear association between sex, age, or body build and the use of coercive measures [4]. Some studies have suggested that the presence of female nurses is associated with a higher incidence of seclusion [11], while others have linked male staff with the use of seclusion [12, 13]. Post-2000 studies have also been inconsistent, with some associating female sex with higher use of seclusion [14] and others with male sex [15]. Attitudes toward coercive measures also vary by sex, with many studies indicating that female staff tend to have more positive attitudes towards the use of coercion [16, 17]. However, other studies show no sex-based differences in the application of coercive measures [18, 19].

The role of education in the use of coercive measures is also debated. Some studies have shown that higher education levels are linked to more frequent use of seclusion [15, 20], while others suggest the opposite. Bowers and Crowder, for example, found that the presence of nursing students was associated with a higher number of mechanical restraints [21]. Miodownik et al. reported that the presence of registered academic nurses was associated with shorter durations of coercive measures [22]. However, most studies that considered educational level found no significant association with the use of coercion [14, 18, 19, 23].

Regarding work experience, some studies suggest that professional experience is linked to a higher frequency of coercion, as familiarity with the practice may lead to its acceptance [4]. Early studies from the 1990s indicated that more experienced nurses used seclusion less frequently [13]. However, more recent studies have shown mixed results, with some associating nurse experience with less positive attitudes toward coercive measures [24, 25] and others showing a more positive attitude toward restraint among more experienced nurses [17, 26]. Some studies have shown that experienced nurses viewed seclusion as necessary [27], while other research has found no relationship between work experience and the frequency of coercion [14, 18, 19, 20, 23].

In our study, of the socio-demographic variables examined, only age played a significant role in the use of coercive measures. Older participants (M = 50.00 years) found the use of direct coercion particularly difficult and consistently challenging, while younger participants (M = 42.50 years) did not report such difficulties. Education was not significantly associated with difficulties in applying direct coercion, although the highest percentage of respondents who experienced no difficulty in applying coercion had a university education (15.52%). Additionally, no significant relationship was found between the sex of respondents and difficulties in using direct coercion.

LIMITATIONS

This study relied on a self-report survey, making it difficult to determine how much of the reported difficulties were related to actual problems with staff, premises, or other workplace factors. Future research could benefit from incorporating more precise measurements of the medical staff's sense of security, which is a key factor influencing the choice and use of coercive measures.

CONCLUSIONS

The respondents generally used coercion in accordance with Polish legislation and key international guidelines, although several difficulties in its application were noted. The procedures were challenging for most respondents, primarily due to concerns for their own safety and the safety of patients. This may be attributed to insufficient or poorly designed legislation, as indicated by the respondents, as well as issues such as: staff shortages, lack of clear internal procedures, inadequate training, and poor workplace preparation (e.g., unprepared isolation sites, lack of necessary equipment or medication). The higher age of respondents reporting greater difficulty in applying coercion may reflect a heightened awareness of the practical challenges involved in using these measures.

Periodic staff training, such as aggression management, is particularly important to address these challenges. Another potential source of difficulty is poor cooperation with external institutions, as many respondents expressed a desire for more frequent collaboration, especially with hired security, the fire brigade, and social care institutions. In some cases, an inappropriate coercive measure may be chosen – not because it is the best option for the patient, but because it is the only feasible option given the circumstances.

It should also be noted that this research was conducted in publicly funded hospitals, where staff shortages or inadequate facilities may be the result of insufficient funding. Therefore, it is urgent to align legal requirements with practical realities, which would ultimately benefit both patients and medical staff.

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