

Development of Human Rights-Based Practices in Psychiatry from People Living with Mental Health Problems During Involuntary Hospitalization or Treatment – A Secondary Publication

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Abstract: This article presents the research protocol of an interpretative phenomenological study that aims to understand the lived experiences of coercion and human rights-based practices in psychiatry from the perspectives of people living with mental health problems during involuntary hospitalization or treatment. This qualitative study used an interpretative phenomenological analysis design. In-depth, one-on-one interviews along with a socio-demographic questionnaire were conducted with approximately 10 participants. Data analysis was followed by an iterative and hermeneutic emergence coding process. By centering human rights-based practices on the lived experiences of people living with mental health problems who encountered coercion, this study highlighted the contributing and limiting factors to the recognition of human rights in nursing practices. This study also promoted the development of nursing knowledge and practices that can significantly contribute to an individual's recovery process.

Keywords: Mental health; Coercion; Support; Human rights; Users

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1. Introduction

There is a global increase in the use of coercion in psychiatry, particularly through involuntary hospitalization or treatment. Like many other Canadian provinces, Quebec is no exception. However, the therapeutic outcomes of these measures are questioned when compared to voluntary care. Given the infringement of human rights and freedoms, coercion in psychiatry has been contested by many organizations, including the World Health Organization (WHO). Human rights-based practices have been recognized as an important nursing role in Quebec. However, these practices are often informal and poorly documented in scientific literature. In Canada,

as elsewhere in the world, incidences of coercive practices targeting people living with mental health problems are on the rise, and these people experience difficulty having access to health care and services^[31,41]. Coercion in psychiatric care has been receiving worldwide attention and is one of the concerns of the WHO. Involuntary hospitalization and treatment are common coercive practices that violate the fundamental rights of those who undergo them^[27,47]. Yet, their therapeutic effects are no better than that of voluntary care^[12,40].

In Quebec, involuntary hospitalization is used to compel a person to remain in the hospital for observation due to a perceived risk of harm to themselves or others^[24]. Voluntary treatment is carried out when a person is incapable of consenting to care required by his or her state of health and categorically refuses it^[23,25]. Recourse to the courts is generally required for either of these legal procedures. This judicialization of psychiatric care is seen as a means of protecting these people and society^[8]. This literature also addresses the stakes involved, as the infringement upon the human rights of people undergoing coercion, notably the right to freedom and integrity, is real, persistent, and scientifically and ethically contested^[36]. When asked about this, individuals who experienced involuntary hospitalization or treatment believe that timely access to mental health services and the quality of relationships with healthcare professionals, rather than coercion, are among the factors conducive to resettlement^[12,37].

Every day, nurses must deal with the complexity of laws authorizing coercion in psychiatric care, seeking to strike a balance between infringing one's fundamental rights and providing safe, quality care^[16,37]. These ethical and clinical issues raise questions about how the concerned individuals perceive nursing interventions. Studies have reported positive experiences, such as a sense of care and safety^[43,49]. Coercive practices also have negative consequences, such as loss of autonomy and freedom and feelings ranging from anxiety and humiliation to feelings of being controlled^[5,15,32]. Additionally, both positive and negative effects on the risk of suicide have been documented^[17,20].

Support for the exercise of rights is essential in this context, as it helps individuals exercise their rights and recourses when they are subjected to coercive measures^[29]. In addition, this support promotes access to relevant information on human rights and provides an adapted accompaniment during medico-legal procedures. This support also aims to promote access to a legal representative or an independent advocacy organization while involving the individual's family^[28]. Support for the exercise of rights is inspired by the concept of advocacy, which is central to nursing practice, promoting the autonomy and empowerment of patients in their care, thereby preserving and respecting their fundamental rights and freedom^[11,28,29]. Such supportive practices are recognized as an important role for nursing staff in the "Reference Framework for The Application of The Act Respecting The Protection of Persons Whose Mental State Presents A Danger to Themselves Or Others," and are among the values of the Interministerial Mental Health Action Plan (2022–2026)^[28,29]. However, these practices are currently uninformed and poorly documented in the scientific literature.

2. Purpose of this article and research objectives

This article presents the research protocol for a qualitative study to be conducted in Quebec, Canada. It aims to understand how support for the exercise of rights is experienced by people living with mental health problems and who have an experience of coercion in psychiatric care. The first objective is to examine the experience of human rights violations by individuals with mental health problems who have experienced coercion. The second objective is to describe the experience of support for the exercise of rights in psychiatric care as experienced by these individuals. To the best of our knowledge, this is the first Canadian study to examine the experience of rights support in psychiatric care. The research protocol presented in this article discusses the methodological innovations sensitive to the experiential knowledge of individuals living with mental health problems in the

development of new nursing knowledge and practice. Finally, it underlines the importance of practices that support the exercise of rights in the actualization of the role of mental health nurses.

2.1. Research questions

This project aims to answer the following research questions:

1. What are the experiences of human rights violations as experienced by people hospitalized or treated against their will in psychiatric care?
2. How is the support for the exercise of rights experienced by people hospitalized or treated against their will in psychiatric care?
3. What factors facilitate and constrain support for the exercise of rights in psychiatric care?

3. Methods

To ensure the rigor and transparency of the presentation of the relevant elements of this research protocol, a list designed for qualitative research was used, namely the Standards for Reporting Qualitative Research ^[34]. In addition, before the development of the methodology, the principal researcher was situated about his or her research object. Indeed, the principal researcher has over 10 years of clinical experience in forensic psychiatry. In the course of their clinical practice, they encounter situations where people with mental health problems are hospitalized or treated against their will. This positioning of the researcher is important to clarify given the methodology used, as he will be actively involved in the collection, analysis, and interpretation of the results of this research.

4. Research design

The methodological approach adopted for this study was that of interpretive phenomenological analysis (hereafter IPA) developed by Smith *et al.* ^[45]. This qualitative-phenomenological approach enables us to understand, discover, and explain the phenomenon of support for the exercise of rights, based on the experience of people living with mental health problems ^[6,13]. This methodological approach was commonly used in nursing, particularly in the field of mental health, to advance nursing knowledge ^[9,30]. The foundations of application programming interfaces (API) were based on phenomenology, hermeneutics, and an idiographic approach ^[45]. Its phenomenological foundation was influenced by the descriptive current of phenomenology, being sensitive to people's experiential knowledge, as expressed, rather than to preconceived theories or categories ^[45]. The importance attached to subjectivity favors a description of the participant's lived experience that was as close as possible to the personal meaning attributed ^[2,44]. The hermeneutical foundation of IPA was influenced by the interpretative current of phenomenology, with the interpretive approach involving a process of double hermeneutics ^[46]. This double hermeneutic translated into the researcher's involvement in interpreting the participant's lived experience, but also into the participant's involvement in interpreting and putting into discourse their own experience ^[2,44]. This approach was also di-ideographic, since it encourages a rich and detailed analysis of the lived experience of a particular phenomenon, by a particular participant, in a particular context ^[2,44].

4.1. Target population and sample

This study focused on people with mental health problems aged 18 and over, who have had an experience of coercion in psychiatric care in the past 10 years. The coercion must include at least one experience of hospitalization or involuntary treatment in psychiatric care. People who are currently hospitalized are excluded

because of the ethical issues related to recruitment and the free and informed consent of the participants to the research. A convenience sample was chosen to identify participants. Community organizations offering support and accompaniment services for people with mental health problems were approached. These organizations disseminated recruitment information, enabling those who wish to do so to contact the researcher to take part in the research ^[10].

An approximate sample of 10 participants was envisaged. This sample size was common according to a review of the scientific literature using this methodology and a recent meta-synthesis of phenomenological studies ^[15,44]. The IPA did not aim for data saturation, but rather a small, homogeneous sample that facilitated a rich and detailed description of experiences associated with coercion in psychiatric care while highlighting their similarities and differences ^[2,45]. It is therefore important to study a sample of participants with a particular perspective on the same phenomenon, namely the use of coercion in psychiatric care ^[22,46]. As the participants in this study share a common life history of hospitalization or involuntary treatment in psychiatric care, this specific context offers a guarantee of homogeneity ^[2,39].

4.2. Study setting and recruitment

This study took place in the community. Recruitment was carried out in collaboration with community organizations concerned with mental health issues, including the defense and promotion of human rights. These organizations were contacted by e-mail in various regions of Quebec. By agreeing to place the recruitment material on their premises, these organizations facilitated the initial approach to their clientele to outline the project. For reasons of confidentiality, recruitment was not carried out via social media. Information about the project was then sent by e-mail to potential participants, including the contact details of the researcher in charge. Interested individuals were contacted by phone to obtain their consent to complete a socio-demographic questionnaire and an individual interview was conducted ^[10]. The place and time of the interview were determined by the participants to ensure confidentiality and \$20 was paid to them. In the current context of COVID-19, interviews complied with Quebec health regulations. They were conducted in person whenever possible, but may also be conducted via a secure videoconferencing application. Handwritten notes were systematically taken during interviews. A digital voice recorder was also used, with the participant's consent.

4.3. Data collection

Four strategies were implemented for data collection. Firstly, participants completed a socio-demographic questionnaire including data such as age, gender, social status, and services currently received. Next, a semi-structured interview, lasting approximately 60 to 120 minutes, was conducted with each participant, respecting the phenomenological and idiographic foundations of IPA ^[2,6,45]. By encouraging in-depth discussion, this type of interview provides access to the participant's experiential knowledge of coercion and support for the exercise of rights in psychiatric care, while giving them the time needed to think and express their feelings. In this context, the role of the researcher was to facilitate reflection by creating a space for dialogue, allowing the participants to deepen, clarify, and freely describe their experiences. A semi-directed interview guide including open-ended questions was used to facilitate interaction with the participant, stimulating their reflexivity in exploring and expressing their experiences. At the same time, an analysis of Quebec jurisprudence over the past 10 years concerning hospitalization and involuntary treatment highlighted the involvement of nurses in practices that support the exercise of human rights and related this to the data collected. Many of these judgments contained a detailed description of what led to one's hospitalization or involuntary treatment and what was done to avoid recourse to these exceptional measures. It was also possible to find testimonies, notes, or descriptions of nursing interventions in the evidence presented. The 10-year interval was chosen because it coincided with the report,

“Difficulties in Applying The Act Respecting The Protection of Persons Whose Mental State Presents A Danger To Themselves or Others”^[38]. This eventually led to numerous changes in psychiatric intervention procedures and practices. Finally, post-interview reports were written by the principal researcher following each interview and a logbook was kept to complement the field notes and facilitate connections between the literature, case law, and data collected from the participants.

4.4. Data analysis plan

The sample was described using the data collected in the socio-demographic questionnaire. Interviews were transcribed verbatim and field notes as text. The NVivo 12 software was used to facilitate the data analysis and coding process. Analysis of the IPA interviews focuses on highlighting the points of convergence and divergence between participants’ experiences, thus providing a rich and detailed description of the coercion and support for the exercise of rights in psychiatric care^[45]. The IPA analysis process was carried out using the hermeneutic circle, which considers the experience as a whole to understand its specific characteristics, and ultimately understand the overall experience. The use of bracketing was also specific to API. This strategy requires the researcher to be aware of his or her preconceptions, judgments, and knowledge, and their influence on the interpretation process. However, IPA moves away from the concept of bracketing initially described by Husserl, which presupposes a suspension of the researcher’s a priori, as Antoine and Smith recognized the essential contribution of the researcher’s knowledge and presuppositions in data analysis^[2]. This specificity was also criticized by Gyollai, who argued in favor of a theoretical contribution to analysis and interpretation^[14]. The data analysis process of this research protocol has been adjusted to meet these criticisms of the IPA. Researchers remained sensitive to the influence of their prior experience of the phenomenon, as well as to the emergence of sensitizing concepts likely to influence their interpretation^[3].

Smith *et al.* proposed a rigorous 6-step approach that begins with listening to, reading, and rereading an interview to promote immersion in the data and delve into the participant’s lived world^[45]. The second stage consisted of an initial annotation of the transcripts with descriptive, linguistic, and conceptual comments. The development of emerging themes from these annotations constitutes the third stage and takes into account both the participant’s discourse and the researcher’s interpretative approach. In the fourth stage, the search for links between these emerging themes helped identify important aspects of the participant’s discourse and experience. Using the Hermeneutic Circle, the fifth stage involved applying the previous 4 stages to a new transcription until all interviews have been analyzed. Finally, the search for links between the different interviews and the grouping of themes that have emerged comprise the last stage of data analysis. Following the API’s idiographic foundation, the analysis process was complemented by a contextualization approach based on the Quebec jurisprudence of the last 10 years concerning hospitalization or involuntary treatment. These data provided valuable information about the social world in which the participant’s experiences occurred^[18]. This way, various links between the situated experience of participants can be established, and themes concerning support practices for the exercise of rights and the role of nursing staff in the implementation of medico-legal procedures can emerge.

4.5. Scientific criteria

To ensure methodological rigor, the following criteria of scientificity in qualitative research were considered: credibility, reliability, transferability, confirmability, and reflexivity^[7,26]. Credibility was supported by data triangulation with journaling, interview transcripts, and case law analysis, as well as by the use of verbatims^[33,42]. Reliability was ensured by repeatedly listening to the recordings and rereading the transcripts and logbook^[48]. External validation with consensus decision-making was also used, followed by a debriefing by a researcher

who was experienced with the methodology^[10]. A rich and exhaustive description of the research approach, its context, the participants, and the process of analyzing lived experiences will ensure the transferability of this research^[33]. Confirmability was supported with feedback from participants regarding the identified themes, as a validation process, which took place after data analysis^[48]. Finally, reflexivity was described by Darawsheh as the researcher's self-reflexive process of becoming aware of their emotions and actions during the course of the research^[7]. This demonstrates the intersubjectivity of the data analysis process when a phenomenological approach is employed^[1]. Reflexivity is a particularly important criterion of scientificity to consider when the researcher has prior clinical experience of their research object, as is the case in this present study^[21].

4.6. Ethical considerations

This project was approved by the University of Quebec in Outaouais Research Ethics Board on September 9, 2021. The ethical considerations of this study followed the criteria established by the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans^[4]. Information about the research project, purpose, and risks was shared with the participants during the initial telephone validation and at the beginning of the interview. Participation in this study is voluntary and participants were free to withdraw their consent at any time, without consequence. A fair and equitable selection of participants was ensured by precise inclusion criteria, as well as additional efforts devoted to the inclusion of participants under protective supervision, such as those under curatorship. Participant confidentiality was preserved by using pseudonyms and by anonymizing the data collected. Data was stored on a password-protected computer and destroyed 10 years after the end of the research project confidentially and securely.

As the interviews draw on past experiences of coercion, some of the questions asked may cause discomfort to the participants. The clinical experiences of the researcher in charge will enable them to be more sensitive and attentive to the emotions of the participants during the interview. Necessary steps were taken to reduce discomfort. For example, participants were offered a break during the interview. If the discomfort persists, the participant was given the choice to stop the interview and even withdraw from the study. Finally, with the participant's consent, the researcher can also refer them to a local counselor or psychological help if necessary. A list of help and listening resources was given to the participants before each interview.

5. Discussion and conclusion

The chosen design for this study has certain limitations that require consideration. Participants were expected to verbalize their experiences so that the researcher could receive these experiences with awareness of their preconceptions, and with coverage^[13]. Re-experiencing emotions related to the phenomenon under study may influence the participant's responses, which must be taken into account during interviews^[10]. To protect themselves from unpleasant emotions, some participants may adopt a more general discourse, distancing themselves from the particularity of their experience. To address these limitations, a relationship of trust must be established from the initial contact with the participants and before the interviews. The participant's right to privacy and time for reflection must be respected so that they can open up their minds. In addition, the recruitment strategy employed may encourage the documentation of experiences characterized by the absence, rather than the presence, of support for the exercise of rights. Finally, the research project was influenced by the legal framework in Quebec and Canada, which differs from that in other countries. Legislation authorizing hospitalization and involuntary treatment will need to be presented to contextualize the application of these measures.

Support for the exercise of rights is recognized as an important step in the mental health nursing process, yet a recent meta-ethnography on this topic suggests that practices to support the exercise of rights are still

poorly integrated into intervention practices when coercive measures are applied ^[28,37]. To the best of our knowledge, this is the only Canadian study dealing specifically with this subject. The latest WHO guidelines stated that experiential knowledge must be promoted to improve respect for the rights of people living with mental health problems. This was also advocated through nursing research in Quebec ^[19]. By giving a voice to the people concerned, this project describes the complexity of supporting the exercise of rights in the context of coercion in psychiatric care. It will serve as a basis to guide future research aimed at mapping and identifying the characteristics, principles, and factors contributing to the effectiveness of these practices in mental health. It will also contribute to international efforts to preserve and support the rights of these people and document the impact of laws and coercion on their life trajectories. Finally, it will contribute to the development of a culture sensitive to the experiences of people targeted by coercion in psychiatric care, to evolve the advocacy practices of nursing staff and fill the gaps in current practices within establishments in the Quebec healthcare network.

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Disclosure statement

The authors declare no conflicts of interest.

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