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When People Lose Autonomy:

The Case for Coercion and the Moral Responsibility Crisis Clinicians Have to Society

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Abstract

The present article explores the responsibility of mental health crisis management clinicians around the world in the context of ethical practice. Concepts of suicide, autonomy, coercion, and civil commitment are defined through the lens of crisis intervention. Historical background and development of community-based crisis management in the United States, mental health crisis assessments, interdisciplinary crisis ethics, and a continuum of coercion in crisis intervention are discussed. The authors then lay out three clinical crisis case vignettes to demonstrate three levels of risk to safety and the appropriate implementation of the three levels of the continuum of coercion. Finally, a discussion follows on the interplay of professional ethics in the crisis vignettes, the academic debate on the use of coercion, as well as moral distress and clinician burnout. We posit that crisis clinicians, like law enforcement and other professional entities involved in mental health crisis management, bear the social responsibility of making difficult and morally ambiguous decisions for individuals who have lost their autonomy to a mental health disorder.

Keywords: mental health crisis management, civil commitment, autonomy, coercion, ethics, moral distress.

When People Lose Autonomy:

The Case for Coercion and the Moral Responsibility Crisis Clinicians Have to Society

Starting in the 1960s, *community mental health* emerged as a way to define mental health service provision in the United States and around the world. Baker and Schulberg (1967), in an early attempt to operationalize this ideology, suggested that the growing community mental health care movement represented a concern for individuals' psychological and economic well-being, employed a sense of intimacy with modern communication techniques, and controlled the social environment in a way that served society's best interests. In examining the extant literature, they found five principles governing the new movement: Mental health workers extended their focus beyond the identified individual to the entire population; workers concentrated on prevention rather than simply reacting to mental disorder in a population; workers downplayed individual pathology and instead helped individuals adjust to social life; mental health workers advocated for comprehensive and integrated continuity of care, so that an individual can be helped to move and navigate the network of services provided; and mental health workers liaised with other service providers and served as catalysts for total community involvement in the individual's life.

While these principles continue to define contemporary community mental health, the world has changed greatly since the 1960s with the realization of global interdependence, the evolution of technology, and the rise of multiculturalism, and so the concept of community mental health has been added to and redefined. There have been updates such as *global-community psychology* that is "based on multicultural, multidisciplinary, multisectoral, and multinational foundations that are global in interest, scope, relevance, and applicability" (Marsella, 1998, p. 1282) and *public mental health* that deals with "mental health promotion, prevention of mental disorders and suicide, reducing mental health inequalities, and governance and organization of mental health service provision" (Wahlbeck, 2015, p. 36). Community mental health, concerned with basic principles of nuanced and contextual care for individuals and informed by expansive updates, is the minimally acceptable standard for population-level mental health treatment in the United States and around the world (Wahlbeck, 2015).

Community mental health encompasses a multitude of psychological services, including the crucial component of multidisciplinary mental health crisis management. One group of professionals who intervene for crisis management for the best interest of individuals and society is community-based crisis clinicians. The emphasis on "community" is an important one, demonstrating the interdisciplinary and multi-faceted nature of crisis work, as it involves physicians, social workers, counselors, nurses, law enforcement officers, emergency medical service providers, and service recipients' families.

The work undertaken by the interdisciplinary team of crisis workers is an essential one. The basic productivity and wellness of society is greatly impacted by mental health crises, since people who suffer from untreated acute and persistent mental health disorders often find themselves out of work and otherwise unable to contribute to society (Jenkins & Minoletti, 2013). "Health in All Policies," a political push at the world level, for instance, has gained momentum, stressing that mental health policies are not isolated to the realm of mental health professionals, but rather pertain to general governance as mental health crises can constitute a threat to the health of society and must be addressed in policy-making (McQueen, Wismar, Lin, Jones, & Davies, 2012). For example, suicide and suicide attempts—common mental health crises dealt with by community-based crisis clinicians—cost the United States alone $93.5 billion in 2013 (Shepard, Gurewich, Lwin, Reed Jr., & Silverman, 2016). This figure, taken in tandem with the rising rate of suicide and suicide attempts worldwide over the last 50 years—including the staggering figure of 800,000 yearly deaths by suicide around the world (World Health Organization[WHO], 2014)—indicates the need for crisis intervention around the world. In order to understand the role of crisis intervention, it is first important to agree upon common terms and their usage throughout this article, which are described next.

Terminology.

Suicide.

Within the context of this article, suicide comprises definitions of the term itself and of suicidal behaviors, as both constitute serious risk to mental wellness. WHO (2014) defines suicide as, "the act of deliberately killing oneself" (p. 12), while suicidal behaviors is a more encompassing term that includes thoughts of suicide, making plans for suicide, and attempting suicide, and suicide itself.

Autonomy.

Autonomy "is essential to the full functioning and mental health of individuals and optimal functioning of organizations and cultures" (Ryan & Deci, 2006, p.1559) and has been defined as "the ability of an individual to be his or her own person, to make his/her own choices on the basis of his/her own motivations, without manipulation by external forces" (WHO, p.28, 2015). In healthcare, practitioners give service recipients room to exercise autonomy by properly informing them of treatments/services and giving them the decision to accept or decline such treatments/services, which follows the doctrine of informed consent (Faden & Beauchamp, 1986). Another matter, then, arises of an individual's ability or capacity to make informed and responsible decisions. Decision-making capacity through the lens of "external rationality," or simply "the ability to make rational decisions" (Charland, 2015, para. 28) plays an important role in assessing autonomy within the crisis care continuum utilized in this article. We take the external rationality approach to decision-making capacity, rather than internal rationality, because in crisis situations individuals may operate with impaired or disordered internal rationality due to distorted, delusional, or otherwise disordered thought processes. Following this logic, an individual with a disordered thought process who is unwilling or unable to make responsible decisions to seek treatment has lost their autonomy to mental disorder.

Coercion.

A simple definition of coercion is the act of an agent using a technique or method "to get other agents to do or not do something" (Anderson, 2017, para. 1), which can be seen as infringing on an individual's freedom by constraining choices. A common coercive technique used in crisis work is to utilize a threat of involuntary treatment to encourage the service recipient to accept a less restrictive treatment or service. Wertheimer (2014) argues that a threat is used to warn the recipient that he or she will be worse off if he or she does not comply, especially when the coercer proposes that he or she will violate the recipient's rights. In the context of crisis work, crisis specialists often act as coercers in efforts to get treatment for service recipients, and at times employs a threat that generally follows an "if-then" formula. For example, a crisis specialist may say to an individual, "If you do not agree to voluntary treatment, then you will be forced to go to a psychiatric hospital for treatment."

Continuum of Coercion.

Inspired by Werthheimer (2014), we have created a "continuum of coercion": Conversing (light use of coercion limited to persuasion); Convincing (moderate use of coercion including threats); and Compelling (heavy use of coercion including civil commitment and involuntary hospitalization). This heuristic will be used throughout our article, in particular in discussing mental health crisis vignettes.

Commitment and involuntary admission/hospitalization.

A simple but operational definition of commitment is as follows: "the imposition of mental hospitalization over the expressed wishes of a patient" (Monahan et al., 1995, p. 249). Conditions for commitment are dictated regionally by legislation which establishes criteria, typically involving

"dangerousness," or risk of harm, to self and others (Wynn, 2018; Testa & West, 2010). Internationally, criteria for involuntary admission varies widely, and there is no established universal standard (Zhang, Mellsop, Brink, & Wang, 2015), due in part to differences in language and legislation (Wynn, 2018). The above definition highlights the coercive nature of commitment, as it directly infringes on the notion of service recipient autonomy in favor of securing treatment/services to promote wellness in accordance with beneficence. This conflict of ethical values creates an ethical challenge which makes it difficult for a clinician to discern the best way to proceed (Hem, Gjerberg, Husum, & Pederson, 2018). Beyond ethical concerns over the use of commitment and involuntary treatment, the issue of efficacy is also noteworthy. Some research indicates that compulsory psychiatric treatment is overall ineffective (Strauss et al., 2013), though such findings are not replicated consistently (O'Donoghue et al., 2015) and research on service recipients' feelings and perceptions on compulsory treatment provides mixed results (Lorem, Hem, & Molewijk, 2014). The use of coercion and commitment in crisis management is a source of conflicting views and ethical debate.

Recent Historical Context

In the years since deinstitutionalization in the United States and around the world, the role of mental health crisis intervention took on greater importance because individuals who had previously been institutionalized because of acute and persistent mental illness were afforded the opportunity to lead their lives in community settings (Chow & Priebe, 2013;WHO, 2013; Liu et al., 2011; Priebe et al., 2005), though this has proven difficult in developing and low-income countries (Kohrt et al., 2015; Luitel et al., 2015; Thornicroft et al., 2010; Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009; WHO, 2008). This change began to take shape in the United States with the creation of the first successful anti-psychotic drug, Thorazine, the establishment of Medicare and Medicaid in 1960, President Kennedy signing the Community Mental Health Centers Act in 1963, and the standard-setting institution of commitment criteria involving "dangerousness" in Washington, D.C., in 1964 (Testa & West, 2010). These developments were further bolstered by the short-lived Mental Health Systems Act of 1980 signed by President Carter, which allocated grant funding to community mental health centers (Grob, 2005). Due in part to political differences, the Omnibus Budget Reconciliation Act of 1981 signed by President Ronald Reagan repealed the majority of the Mental Health Systems Act of 1980 with the notable exception of section 501, otherwise known as the Patient's Bill of Rights. This Bill of Rights states that service recipients must receive treatments which are "the most supportive of such person's personal liberty" while also authorizing action to "restrict such liberty only to the extent necessary [and] consistent with such person's treatment needs" (Mental Health Systems Act of 1980, §9501). These statements coupled together constitute the fundamental difficulty in crisis work: determining how safe an individual is or can be and what treatment most effectively addresses his or her needs. Crisis clinicians make this kind of clinical determination through assessment of risk and needs.

Civil commitment in the United States, otherwise known as involuntary hospitalization, places a temporary legal hold on an individual who has demonstrated, through psychological assessment, that he or she requires immediate psychiatric care due to imminent threat of harm to self and/or others (Testa & West, 2010). The United States is one of a number of nations that practices involuntary commitment, including the United Kingdom and other countries in Europe (Chow & Priebe, 2013). Assessment of adults in crisis takes into account several factors influencing the in-crisis individual's mental status including, but not limited to, relational stressors with family, friends, and significant others; logistical or everyday stressors involving finances, legal concerns, and discrimination/stigma; and psychological stressors such as traumatic events, substance abuse, psychosis, mental health diagnoses, and suicidal/homicidal ideations. When individuals demonstrate low or minimal danger to self/others they can, with the appropriate social supports in place, choose whether or not to seek voluntary treatment on their terms. Through community mental health centers, clients can receive voluntary inpatient and outpatient treatment to ensure wellbeing and, ideally, individuals in crisis can autonomously make decisions that move them toward wellness such as seeking treatment; however, many individuals in crisis are unable or unwilling to make such decisions (Testa & West, 2010) and require more than what

even the most well-intended therapeutic interventions like Psychological First Aid (Snider, Ommeren, & Schafer, 2011) can offer. It is when in-crisis individuals demonstrate moderate-to-high risk and unwillingness to seek treatment voluntarily that clinicians employ coercion and civil commitment.

Ethics of Coercion

Because mental health crisis intervention is by nature an interdisciplinary treatment (Balfour, Tanner, Jurica, Rhoads, & Carson, 2016; Murphy, Irving, Adams, & Driver, 2012), so too are the ethics. These respective ethical codes contain significant overlap, but they also demonstrate subtle yet noteworthy differences as well.

Consider first the mental health professionals who work as crisis intervention clinicians, primarily counselors and social workers. While the American Counseling Association [ACA] Code of Ethics (2014) and the National Association of Social Workers [NASW] Code of Ethics (2017) bear a superficial resemblance to each other with shared values of autonomy, justice, and integrity, the language and structure used to outline key ethical principles raises an issue of hierarchy or priority. For instance, both documents describe the importance of maintaining service recipient autonomy; however, autonomy sits atop the list of the ACA Code of Ethics and is mentioned in the NASW Code of Ethics in the third guiding ethical value. Further, ACA states autonomy as, "the right to control the direction of one's life," while NASW describes it as, "clients' socially responsible self-determination." The distinction between these two descriptions of autonomy is critical in crisis work, particularly in NASW's use of "socially responsible self-determination" whereas ACA makes no mention of social responsibility. This suggests that self-determination is legitimate if and only if it is socially responsible, that one's freedom to choose one's own course of action is acceptable as long as it is responsible to the rights of others.

Medical professionals such as physicians and nurses, who follow their own ethical codes and principles, also play a critical role in many mental health crises. We consolidate various medical practice ethics under the umbrella of biomedical ethics as outlined by Beauchamp and Childress (2001). Beauchamp and Childress (2001) state that biomedical ethics rest on the four pillars of beneficence, non-maleficence, autonomy, and justice. The similarity to the ACA Code of Ethics is readily apparent, though ACA lists autonomy first while Beauchamp and Childress list it third.

Further similarities and distinctions can be made among the ethical codes, as seen in Table 1, below.

Table 1. Crisis Provider Codes of Ethics

ACA Code of Ethics	NASW Code of Ethics	Biomedical ethics
Autonomy: fostering the right to control the direction of one's life	*Dignity and Worth of the Person*: respect the inherent dignity and worth of the person	*Autonomy:* ensure that patients have the right to choose, as well as the right to accept or decline information or treatment
Non-maleficence: avoiding actions that cause harm	*Importance of Human Relationships*: recognize the central importance of human relationships	*Non-maleficence:* do no harm
Beneficence: working for the good of the individual and	*Service*: to help people in need and to address social problems	*Beneficence:* do good

society by promoting mental health and well-being		
Justice: treating individuals equitably and fostering fairness and equality	*Social Justice*: challenge social injustice	*Justice:* distribute goods and service, including medical goods and services, fairly
Fidelity: honoring commitments and keeping promises, including fulfilling one's responsibilities of trust in professional relationships	*Integrity*: behave in a trustworthy manner	
Veracity: dealing truthfully with individuals with whom counselors come into professional contact	*Competence*: practice within areas of competence and develop and enhance professional expertise	

We must also look at the professional ethics for law enforcement due to their involvement in crisis intervention; this article uses the International Association of Chiefs of Police [IACP] Law Enforcement Code of Ethics established in 1957 as a baseline. This Code of Ethics reads more like a mission statement than the aforementioned codes. In its first sentence the document expresses that ethical law enforcement will "safeguard lives and property," "protect… the weak against oppression or intimidation and the peaceful against violence or disorder," and "respect the constitutional rights of all to liberty, equality, and justice" (IACP, 1957, para. 2). The guiding ethical values may be presented differently than in the other codes of ethics, but the core principles of autonomy, beneficence, non-maleficence, and justice are clear in all. The IACP also includes a statement on social and public responsibility which bears mentioning: "I recognize the badge of my office as a symbol of public faith, and I accept it as a public trust to be held so long as I am true to the ethics" (para. 5). Other ethical codes discuss social responsibility, but the IACP imbues the badge—an object prevalent in all professional roles in crisis response—with significance, which offers a concrete vehicle of responsibility that most of the professionals who work together in crisis management share.

In sum, the ethical codes which guide the various disciplines involved in crisis intervention overlap in key values, particularly in relation to autonomy, beneficence, non-maleficence, and justice. Conflicts emerge, though, in the disciplines' different interpretations of these key ethical principles, with particular attention paid to autonomy in light of coercive practices in crisis intervention such as civil commitment (Hotzy & Jaeger, 2016; Szmukler, 2015). To facilitate exploration of mental health crisis assessment, ethics, and the degrees of coercion used, consider the following cases.

Continuum of Coercion as Viewed in Three Vignettes

Phillip and Conversing

Case. Phillip, a 21 year-old college student who lives with his parents, presents at a community mental health walk-in center on a Tuesday afternoon due to suicidal ideations. Phillip reports that he has been depressed in the past but that this is his first time experiencing thoughts of killing himself. He denies having any suicidal plan, and he states he has not thought of a method. Phillip also denies thoughts of harming others or experiencing hallucinations. He explains that he has been especially stressed because he has been struggling in his schoolwork and he has been worried about what his parents will think of him if he does not get good grades, as they pay for his education at the local

university. He adds that he has been talking about his struggles with some of his friends, though he has found it difficult to discuss his current situation with his parents.

Phillip reports that he recently took some Adderall that a friend gave him because he thought it would help him perform better in his studies, denying any other substance use. He describes the following symptoms as present when not under the influence of Adderall and amplified when using the substance: excessive and uncontrollable worry his parents will stop paying for his college education, difficulty concentrating, frequent tension in his shoulders, nausea, as well as trouble getting and staying asleep. The crisis clinician discusses anxiety with Phillip and tells him that his current symptoms align with an anxiety disorder and that he may want to consider therapy to address the way he responds to anxiety, as it is troubling that his recent responses have included using Adderall as well as thoughts of suicide. Phillip says he does not want to stay at the mental health center's voluntary inpatient unit because he just wanted to talk with someone about his recent experience, he has multiple exams coming up at school, and he feels like he can remain safe at home with his parents. He initially does not want the crisis specialist to tell his parents about what has been going on, and the crisis clinician tells him that he cannot return home without someone responsible knowing the circumstances and agreeing to help. Phillip then consents for the crisis specialist to contact his parents to discuss Phillip's current mental status and establish a collaborative safety plan, and he agrees to return to the mental health center if his symptoms worsen.

Conversing. With Phillip's consent, the crisis specialist calls Phillip's parents, Shirley and Mark, on speaker phone with Phillip in the room. Shirley answers the phone and the crisis specialist tells her Phillip has come to the community mental health center for an evaluation due to his recently increasing anxiety and thoughts of suicide. Shirley expresses concern as this is the first she or Mark have heard of this, and she puts Mark on speaker as well. Phillip speaks up and tells his parents that he wanted to talk with a mental health professional first because he was afraid to tell them about his recent emotional state. He says he felt afraid to discuss it with them because he thought they would be disappointed in him.

Shirley tells Phillip that she and Mark want only for him to be happy and healthy and that they will help him however they can, and Mark echoes this sentiment. Mark tells Phillip that both sides of the family have struggled with anxiety issues in the past but they never talked about it because they did not want to worry Phillip. The crisis clinician then mentions that after talking about his recent mental state Phillip has decided that he feels safe to return home with his parents, with whom a crisis management plan would need to be established. Shirley and Mark agree that Phillip can be safe in their home and that they will assist however they can, and they agree to encourage Phillip to return to the community mental health center or call the regional crisis hotline if his anxiety and thoughts of suicide worsen. Shirley and Mark then say they will meet Phillip at the center to follow him home. The crisis clinician has decided that sending Phillip home with a crisis management plan is appropriate because while he is experiencing anxiety and thoughts of suicide, his decision-making and insight—which form the crucial components of autonomy—do not appear impaired, his parents agree that his decision-making is sound, and the parents agree to offer further social support to Phillip. The crisis specialist employed mild coercion in convincing Phillip to consent to informing his parents of the clinical situation.

Cases like Phillip's, in which service recipients maintain their autonomy, require trust between the clinician and service recipient, as well as an ability to coordinate with family members and friends to create a sound crisis management plan. The crisis clinician employed mild coercion—through conversing—in persuading Phillip to allow his parents to know about his recent mental status, and this was done to ensure that no harm would occur if Phillip went home (non-maleficence), Phillip and his family could begin openly talking about anxiety and ways to cope (beneficence), and that the crisis management process was equitable to all parties involved, in this case Phillip and his parents (justice).

Shawnda and Convincing

Case. Shawnda, a 36 year-old woman, was brought to an emergency room by law enforcement officers after one of her neighbors called the local dispatch reporting she heard Shawnda screaming and slamming objects against the wall of her apartment. Emergency department reports written by a nurse and a physician indicate that Shawnda agreed to be transported to the hospital by law enforcement officers so she could "get some help." The reports also note that she states her reason for admission to the emergency room as, "My landlord put demons in the walls at my place and I was hoping to speak with a shaman or exorcist." Shawnda had begun yelling loudly for a shaman or exorcist while in the ER, so the attending physician ordered that she be offered small doses of risperidone—an anti-psychotic drug—and lorazepam—an anxiety medication—in an attempt to calm her down. The physician states that she is familiar with Shawnda because of previous presentations to the ER under similar circumstances in the last four years, adding that the patient has a historical diagnosis of paranoid schizophrenia with religious preoccupation. Standard urine drug screening indicates no drug use prior to admission. ER admission paperwork lists no emergency contact.

During the crisis specialist's assessment, Shawnda appears to have calmed down significantly and says with disappointment in her voice, "It happened again, huh?" She is able to relay that she believed there were demons in the walls of her apartment placed there by her landlord and this disturbed her greatly, as her faith plays an important role in her life. Shawnda adds that she began hitting the walls with her hands and shouting for the demons to leave her alone. She denies wanting to harm herself or others, stating that she could never harm anyone because of her spiritual beliefs. She further denies that she has seen the demons, but reports she has heard them say, "We will always be with you, no matter where you go. We will get you." Shawnda tells the crisis specialist she has had similar experiences at multiple residences with different landlords and she fears that the demons will "get her," adding that she simply wants to get rid of them. She tells the crisis specialist she has been sent to a state psychiatric hospital in the past and this was not helpful for her because she was afraid in that environment. She requests that she not have to stay at a psychiatric facility because she needs to find a new place to live, though she reports having no one to stay with in the interim.

Convincing. Following the conversation with Shawnda, the crisis specialist goes to discuss treatment options with the ER physician. The physician states that she thinks Shawnda is a good candidate for the local crisis stabilization unit, a voluntary inpatient treatment. The crisis specialist informs the physician that Shawnda does not want to stay at a psychiatric facility and thus more restrictive treatment through civil commitment may be needed. The physician asks that the crisis specialist first see if the crisis stabilization unit would accept Shawnda for admission and then try to convince her to stay there for a few days. The crisis specialist calls the crisis stabilization unit and relays the clinical situation to the unit's charge nurse, who says Shawnda meets criteria but that she must also be willing to come to the unit.

With this information, the crisis specialist returns to talk with Shawnda again, informing her that the physician thinks she needs to stay at the crisis stabilization unit due to her psychotic symptoms. Shawnda reiterates that she does not want to stay at a psychiatric facility and adds, "I don't need to stay anywhere either. I don't want to hurt myself or anyone else; I just want to get rid of these demons!" The crisis clinician informs Shawnda that if she does not agree to voluntary inpatient treatment that then the clinically appropriate alternative, given the circumstances, is commitment and involuntary hospitalization because there is no one reliable with whom to establish a crisis management plan. The crisis specialist then gives Shawnda information about what the unit is like: there are therapy groups, medication consultation, and discharge planning services. Shawnda appears irritated and says, "I'm not happy about this, but I'll go there if it keeps me out of a hospital." The crisis clinician informs the ER physician of the decision and arranges transportation for Shawnda to the crisis stabilization unit. Psychosis clouds Shawnda's insight to her current mental status but she remains able to make the responsible decision to get treatment, and so her autonomy is impaired but still partially intact.

The crisis clinician used moderate coercion in threatening Shawnda with civil commitment if she still could/would not decide to take part in voluntary inpatient treatment. In doing this, the crisis clinician gave Shawnda the opportunity to make a responsible decision (autonomy), ensured that she received treatment for her psychotic symptoms (beneficence), guaranteed that she would not inadvertently cause harm to self or others if she returned to her apartment (non-maleficence), and saw that the process maintained the liberties and well-being of Shawnda's neighbors and landlord (justice).

Frank and Compelling

Case. A crisis specialist is dispatched to the home of 48 year-old Frank after receiving a call from his father, who houses his son in a trailer on his rural property, reporting that Frank has threatened to rape his young niece and has also threatened to kill his father if he calls the police. Frank's father adds that "He's talking out of his head again and I don't know what to do. The cops don't do anything when I call them out here because he knows what to say." The father reports that he is unsure what Frank's diagnosis is but that he has been to the state hospital multiple times for violent behavior after being awake several days in a row. He describes Frank's home as "destroyed," with shattered glass scattered around the trailer and the domicile being in a general state of disarray. Frank's father says he is afraid of his son and what he might do, and he understands law enforcement may need to be present during the crisis specialist's assessment. After contacting local law enforcement, the crisis specialist goes to Frank's home accompanied by two police officers.

Upon arrival to Frank's home, the crisis clinician sees two men in the driveway engaged in an apparent argument, a car between them. The younger man can be heard yelling from a substantial distance, though what he says in unclear. The officers tell the crisis clinician that Frank has been incarcerated several times in the last few years for threats and violence toward his family after ceasing to take his psychiatric medications, and he has a history of harming himself under similar circumstances. As the crisis clinician and law enforcement officers approach the men, Frank gestures and yells at his father that "You old (expletive), you got the (expletive) law out here!" Visibly upset, Frank begins walking toward the crisis clinician and officers shouting that he will cooperate and answer whatever questions need to be asked. When asked why crisis services might have been called out to speak with him, Frank responds with a rambling rant involving his father, racial slurs, and claims that he is Malcolm X. He continues loudly rambling without prompt and frequently gesticulating, saying that "the law" does not want him to run the Underground Railroad. Frank states he has not threatened to harm himself or anyone else and says he does not see or hear things out of the ordinary. He says, "You have no reason to be here and I'm not going anywhere." Frank's father looks to the crisis clinician and officers with fear in his eyes, pleading, "Help me."

Compelling. The crisis clinician pulls one of the law enforcement officers to the side and says that Frank will likely need to be committed due to instilling a reasonable fear of violence to self and others in his father and demonstrating a clear unwillingness to seek treatment. The officer states that Frank is not making threats at this time but concedes that his history of violence toward his family and himself is concerning when paired with his current psychotic rage. The crisis clinician tells the officer, "I think we need to involuntarily hospitalize Frank. I can sign commitment papers which will place a legal hold on him and force him to get emergency psychiatric care. Once I have completed the commitment papers, I will need you to transport Frank to the local emergency room so he can get medical clearance and await psychiatric placement in a secure environment." The officer takes the paperwork and tells the crisis clinician, "That's fine, but we'll need you to explain the situation to him. He's never gone with us easily in the past. We usually end up having to use physical force with him."

The crisis clinician returns to talk with Frank and explains that he is being committed to involuntary hospitalization, during which he will receive psychiatric medication and talk therapy, due to his psychotic symptoms and voiced threats to harm others. Noticing that Frank is showing signs of agitation, the crisis specialist goes on to explain that Frank has no say in this process and that if he is

uncooperative and violent with law enforcement, he will likely be arrested and sent to a state psychiatric hospital. Clenching his jaw and clearly agitated, Frank goes with the law enforcement officers for transport to the emergency department (ED). As he gets into the officers' vehicle, Frank looks at the crisis clinician and yells, "I'm gonna kill you, (expletive)!" The officers drive off to take Frank to the ED for clearance and psychiatric placement. Frank demonstrates impaired insight and judgment due to psychosis, his father and other family members are fearful of physical violence from him, and therefore he has lost any semblance of autonomy to his mental health disorder. The crisis clinician utilized heavy coercion through civil commitment procedures.

Cases like Frank's in which the individual seems likely to intentionally or unintentionally endanger the safety and well-being of self and others while also refusing treatment show disordered autonomy and require restrictive crisis interventions. Thus, the crisis clinician committed Frank and compelled him to involuntary psychiatric hospitalization. By taking this course of action, the crisis clinician made a difficult decision for Frank that he could not or would not make himself in order to help him regain his ability to make reasonable decisions for himself (autonomy), protected Frank from the inevitable, long-lasting, and dire consequences of his threats (beneficence), concluded that non-intervention or inaction would lead to possible death or injury and therefore protected Frank and his family (non-maleficence), and kept Frank's family free from infringements on their liberty and well-being (justice). The crisis clinician further practiced ethical clinical skills in collaborating with law enforcement. Since they had fairly extensive experience with Frank, it was important to involve them in discussions to ensure that they agreed that commitment was the most appropriate and fairest decision to make (justice).

Discussion

A Critical Analysis of Coercion in Crisis Management

The above case studies illustrate how crisis intervention clinicians respond to a continuum of threat posed by individuals to themselves and others. We attempt to be clear that coercion is used in all three cases of conversing, convincing, and compelling. We are mindful of important critiques of psychiatric and psychological practices, especially critiques of the exertion of forceful interventions such as we describe above, and we think that these critiques are important to understand and respond to in the context of crisis intervention practices. Following Bracken and Thomas (2010), we find that comparing and contrasting the approaches of Thomas Szasz (1960; 1974) and Michel Foucault (1965; 1977) usefully informs a critical exploration of coercion in crisis intervention.

Bracken and Thomas (2010) state that while Szasz and Foucault both critique psychiatric and psychological knowledge and practice, they do so in in ways that are relatively less helpful (Szasz) and more helpful (Foucault) for those who wish to critically examine their own professional practices. In Bracken and Thomas' view, Szaz's thinking is heavily predicated on the use of binary structures (i.e., Biology/Social science, Individual/State, Body illness/Mental illness, and Freedom/Coercion) in which the first item in the binary construct generally inhabits a position of privilege and is therefore considered "normal" or "better." For Szaz, biology prevails over social sciences like psychology, the will of the individual carries more weight than the will of the state, physical illness is more important than mental illness, and most importantly the prospect of freedom takes precedence over coercion. It is also worth noting that Szaz believes clearer distinctions should be made regarding the roles of medical and psychological practitioners, as medical staff have the role of healing distress in the physical realm while psychology clinicians are meant to alleviate mental suffering.

By way of contrast, Bracken and Thomas (2010) describe Foucault as an archaeologist digging through layers of conceptual sediment and uncovering the historical development of methods for dealing with and talking about psychological distress. Whereas Szaz uses the history of psychiatry to lend ideological superiority to medical practice and freedom, Foucault looks at history to describe the development of our cultural assumptions and how they inform our present and future practice. By

demonstrating the development of the psychiatric complex through the history of asylums in Europe and in his examination of the history of the prison, Foucault (1965; 1977) reveals the rise of disciplinary power, which reconceptualizes power from something wielded by the state to quell individual freedom through brute force to something exercised by trusted professionals to discipline the body and behaviors of individuals via clinical practice. Foucault (1977) suggested that power and knowledge are inextricably related, that "power and knowledge directly imply one another" and that "there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations" (p. 27). From Foucault's perspective, the construction of any knowledge, including knowledge about the mental life of human beings, is simultaneously a construction of power relations that tend to limit and control those who do not actively participate in the power/knowledge constructions—in this case, the non-experts of mental health.

The essential difference between the two approaches is that one tends to fall into rather simplistic and naïve dichotomies (Szasz) while the other can be used to usefully frame questions that challenge the state of affairs in a disciplinary or professional practice (Foucault). As Bracken and Thomas (2010) suggest, one way of looking at Foucault is that he "does not position psychiatry as something bad, or wrong, but instead shows that its history is not a necessary one, that is, something that simply had to develop the way it did, according to a logic that is independent of particular human interests" (p. 223) and that in his critical analyses, Foucault outlines a historical progression in which "problems with our behaviors, relationships, beliefs, and sexualities show up not as religious, spiritual, or moral issues, but as technical problems that are open to examination, classification, analysis, and intervention by suitably trained experts. Although this has brought benefits, there are also losses and losers in this process" (p. 226).

In a similar way, we are not positing that the use of coercive practices in crisis intervention simply had to develop the way that it did. We recognize that modern crisis intervention practices have arisen, along with other psychiatric and psychological practices (e.g., the medicalization of psychiatry), in an overall movement toward a view of human experience as a problem solvable by suitably trained experts—and that *though this has brought benefits, it has also produced losses, and losers, particularly for those who have been historically disenfranchised, those who traditionally have not actively participated in the construction of power/knowledge.* The experiences of the writers of this article are limited in that their practice of mental health crisis management has occurred in a primarily Caucasian and Westernized setting, necessitating discussion of crucial cultural issues dealing with coercion across diagnostic, geographic, and demographic borders. One population subset of particular interest in regards to coercion is people with serious mental illness (SMI) like major depression, bipolar disorder, schizophrenia spectrum disorders, and personality disorders. Findings indicate that people with SMI have been misrepresented in legislation as being deviants and thus have historically been unfairly subjected to coercive measures of reproductive control like sterilization (Perry, Frieh, & Wright, 2018).

Interview results from clients subjected to coercive measures in Norway indicate that dominant themes reported by clients include powerlessness and a need for systemic change (Norvoll & Pederson, 2006). Women in particular have been subjected to unethical treatment through coercion and involuntary hospitalization as seen with the abandonment crisis in India wherein the disciplinary power of "family" has left many divorced women committed in perpetuity (Pinto, 2009), showing the need for a continual Foucauldian re-examination of pre-existing and privileged gendered modes of practice. In addition to gender inequality, literature on coercion also indicates issues of misunderstanding cultural values between races which often lead to mis-diagnosis and thus mistreatment, as is the case of culturally appropriate "Black paranoia" of White clinicians (Whaley, 2001).

The debate continues: Some professionals argue that commitment rates are too high (Wynn, 2018), some outright criticize the use of coercion (Lorem, Hem, & Molewijk,2014), and others state that autonomy has been wrongly prioritized over other ethical values (Lepping, Pamlstierna, & Raveesh,

2016). A frequent but erroneous Szazian view is that there must be an absolute respect of the autonomy of the service recipient such that no interference is justified; this is problematic in situations where service recipients are incapable or unwilling to make responsible decisions which results in de-humanization of that individual (van den Hooff, & Goossensen, 2015), and contradicts the ethical principles of beneficence, non-maleficence, and justice toward others. This concerning attitude of non-interference could reflect a political change in health and mental health practice (Richardson, Bishop, & Garcia-Joslin, 2018; Sugarman, 2015) that may prove detrimental to both service recipients and crisis-involved professions entirely (Whyte, 2017). We question whether autonomy should receive privilege over other ethical values such as beneficence, non-maleficence, and justice; we suggest, rather, that the values must all be considered in the context of one another (Lepping, Pamlstierna, & Raveesh, 2016; WHO, 2015; Beauchamp & Childress, 2001).

Moral Distress

At the macro level of academic research, debate about coercive practices continues to flare; at the micro level of the individual crisis intervention clinician, the internal debate can be debilitating. Crisis management clinicians, by the nature of their work, experience high-stress situations frequently and must balance the seemingly contradicting demands of ethical principles which can lead them to embody moral distress. Austin (2012) defines moral distress as "the name increasingly used by health professionals to refer to experiences of frustration and failure arising from struggles to fulfill their moral obligations to patients, families, and the public" (p. 28). Austin's definition accentuates clinician perceptions of failing to fulfill *all* ethical principles of crisis management, creating cognitive dissonance and job frustration. Crisis cases such as Shawnda's demonstrate that managing seemingly competing ethical demands can end in an unpleasant way, as it can leave service recipients frustrated with the clinicians who, weighing options, had to be responsible enough to decide to constrain people's freedom when necessary.

Crisis clinicians, as empathic mental health professionals, can understand the traumatic circumstances surrounding mental health crises from a client's point of view. A client may experience the "choice" of accepting voluntary treatment or enduring commitment as no choice at all, and crisis clinicians can deeply and empathically feel the client's feelings of being powerless. It is no wonder, then, that a worker's sense of autonomy or personal agency can weaken in the face of high-stress work and competing moral and ethical principles (Theorell, & Karasek, 1996). This weakening of a crisis clinician's sense of professional autonomy paired with high moral sensitivity, or "an understanding of patients' vulnerable situation as well as an awareness of the moral implications of decisions that are made on their behalf," has been shown to lead to higher levels of occupational frustration and more frequent thoughts of quitting one's profession (Lützen, Blom, Ewalds-Kvist, & Winch, 2010, p. 216). In short, crisis intervention specialists are particularly susceptible to professional burnout and while burnout has been generally studied in mental health counselors (Lee et al., 2007) and social workers (Newell & MacNeil, 2010), there does not appear to be much research specific to burnout in crisis management clinicians.

Implications for Research and Practice

Crises will continue to occur, and mental health responders stand as the vanguard at the intersection of individual and community rights. It seems, then, that until society makes the next great advancement as a people, coercion will remain a "necessary evil" in crisis work, and clinicians must be trained to use it in the most respectful and empathetic ways possible, maintaining a therapeutic stance with clients. In addition to the client perspectives mentioned earlier, it can be helpful to examine clinician-perceived deficits within crisis management. In a survey of psychiatric staff across 17 European countries, clinicians from multiple disciplines identified the following major challenges to effective and empathetic crisis management: staff management and teamwork, competence, education and training, support from management, and risk assessment (Cowman et al., 2017). Moreover, crisis-specific training

must be offered at all levels of client interaction with crisis services, including medical, mental health, and law enforcement domains (Lloyd-Evans et al., 2018; Cowman et al., 2017; Balfour et al., 2016). Further, research on occupational stress and moral distress demonstrates that lowering a clinician's "moral burden" through professional support, i.e. support from superiors and clinical supervision, can reduce detrimental effects that contribute to the problem of burnout (Lützen et al., 2010; Theorell & Karasek, 1996), indicating a need for further study in the field of crisis work. Issues of support and self-advocacy must not be addressed only in workplaces, but must also receive adequate attention in counseling and social work education programs by teaching soon-to-be mental health professionals the necessity of self-advocacy through self-care practices such as engaging creativity and spirituality, requesting social support from family and friends, and seeking counseling as needed (Newell & MacNeil, 2010). Again, while the professional fields of counseling and social work have produced a robust literature on self-care, little scholarship exists specifically pertaining to mental health crisis clinicians (Edward, 2005).

Since the deinstitutionalization of international mental health systems began and nations gave individuals with acute and persistent mental health issues the opportunity to lead average lives, the use of community-based mental health crisis management has become the principal method of clinical intervention, placing ethical and moral responsibility on the shoulders of professionals involved in crisis management, including medical, mental health, and law enforcement staff. In particular, the counselors and social workers that make up mental health crisis intervention staff are often confronted with ethical challenges when assessing individuals for potential risk of harm to self and others and making clinically appropriate treatment recommendations, which often include—to varying degrees based on individual cases—the use of coercive measures when at-risk individuals refuse or are incapable of making responsible treatment decisions. This use of coercion brings to light conflicting ethical values of autonomy, beneficence, non-maleficence, and justice which stirs significant scholarly debate and gives rise to the occurrence of moral distress and burnout in crisis clinicians. While some writers and scholars are drawn to the binary distinctions made by Szaz, the writers of this article urge a Foucauldian approach of continual self-examination and professional deconstruction which promote evaluating and changing practices as needed, as binary thinking generally proves unhelpful for helping professionals.

Research on the issues of managing ethical challenges, coercion, moral distress, and burnout in crisis intervention has been done internationally in the fields of medicine and psychiatric nursing (Cowman et al., 2017; Hem et al., 2018; Lorem et al., 2014); however, little scholarly attention is devoted to the fields of social work and mental health counseling in the context of crisis work. Thus future research in crisis management should include measuring crisis clinician perceptions of ethical guidelines, studying the occurrence of moral distress and burnout in crisis counselors and social workers, and evaluating how well social work and counseling programs train clinicians to deal with ethical challenges and to self-advocate through self-care practices.

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