When Structural Inequity Is Ubiquitous, Can Force Ever Be Compassionate?

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Abstract

This article contextualizes and challenges race, class, and gender inequity in psychiatric use of force. In particular, this article examines (1) how uses of force—seclusion, restraint, compulsion—have been codified in policy and law, (2) inequity in force utilization, and (3) connections between systemic oppression and individuals' responses—including fear and retraumatization—to feeling threatened by force in clinical settings. This article proposes multilevel strategies to abolish inequity in uses of force in clinical settings and questions whether it is ever possible to use force compassionately where inequity persists.

Introduction

Force utilization in US mental health care settings reifies structural inequity and must be abolished. Evidence for this stance includes myriad harms of force[1,2,3,4,5] and the experience of individuals living with mental illnesses who, for over a decade, have decried uses of force in carceral, emergency department, and psychiatric settings.[6,7,8,9] Force utilization in health care is not only widely documented as a source of harm but also inequitably applied based on race, gender, age, and diagnostic history.[9,10,11,12] This article contextualizes uses of force through intergroup threat theory, argues that the possibility for compassionate intention in the use of force is extremely remote amidst pervasive inequity, and suggests how to render force obsolete.

Contextualizing Force

The COVID-19 pandemic has disproportionately affected people with mental illnesses[13] and Black people[14] and exacerbated extant conditions of police brutality, anti-Black racism, and carceral violence.[15,16] Approximately one-third to one-half of all people killed by police have a disability.[17] As movements for racial justice build, clinicians in hospital, nursing home, community health, and private psychiatric settings must interrogate how force reifies structural violence and oppression. Force can be applied mechanically, pharmacologically, or legally and implemented by *seclusion* (ie, isolating a person from staff and patients),[18] *restraint* (ie, physically limiting a person's mobility through manual holds, mechanical tools, or pharmacologic agents),[19] and *compulsion* (ie, involuntarily hospitalizing and treating a person).[20]

Force is typically utilized to prevent people from harming themselves or others, especially when a person's decision-making capacity is compromised. It is most frequently used in emergency departments and inpatient psychiatric units to promote safety and should be regarded as a "last resort," according to the American Psychiatric Association,[21] Recovery Innovations' "no force first" policy,[22] and the Joint Commission.[23] Yet, in one study of 317 US hospitals, monthly administrative data indicated no change in frequency of force use between 2007-2011 and 2012-2013, although there was a nonsignificant decrease in the average length of episode.[24] Reforms in force implementation practices have shown some success.[1,25] It remains ethically important, however, to imagine health care *without* force practices at all.

Reformers argue that force might be needed in extraordinary circumstances, such as when patients decompensate to a point at which they threaten their own or others' safety. Similarly, those calling for compassionate use of force argue that force practices can be ethically implemented when collaboratively considered, prior to need for their implementation. Indeed, individuals with recurrent conditions can request that force be used (ie, if and when their condition worsens to the point at which they lack insight or capacity) by psychiatric advance care planning, sometimes documented as "Ulysses contracts."[26,27,28]

Force Equity?

Whether force can be compassionate is controversial. Mental Health America (ie, position statements 22 and 24)[29,30] and the American Psychiatric Nurses Association[31] decry its use outright. Abolition of force is perhaps most easily justifiable in terms of its inequitable implementation. Across critical incident studies, quality surveys, and meta-analyses, seclusion and restraint are widely documented as inequitably administered to men[3] or to people who are Black, unemployed, or homeless or who have been previously hospitalized and had longer hospital stays.[24,32] Among women, Black women and those with prior interactions with police are more likely to experience involuntary interventions.[33] These patterns persist in children's inpatient psychiatry settings, where younger age and Black race are associated with seclusion,[34] and in emergency departments, where Black patients are more likely than White patients to be restrained.[10] We acknowledge that staff and patients must be kept safe, but we must also acknowledge that the pervasiveness of anti-Black racism means our Black patients are more likely to be subject to force and its iatrogenic harms. Indeed, the American Psychiatric Association in January 2021 issued an "Apology to Black, Indigenous and People of Color" for supporting structural racism in psychiatry.[35] Although it did not mention force per se, the statement decries "abusive treatment" as well as racial inequities in clinical treatment.

Intergroup threat theory can help us understand how inequitable application of force transpires in health care settings. Intergroup threat theory suggests that members of certain groups perceive members of other groups as threats simply due to their group membership and the ways we are socialized to fear the "other." The perception of threat contributes to disparate force utilization, especially among people who have experienced racism. In hostile or violent interactions, people can respond to feeling threatened by expressing negative attitudes, biases, verbal and nonverbal behaviors, and aggression[36] and with "fight, flight, or freeze" responses.[37] Clinicians, even clinicians of color, who have internalized White supremacy can express pro-White biases in their responses to Black patients, whom they view as threatening, and can engage "fight" responses that include implementing force. Of course, patients also respond to

feeling threatened. People who have experienced negative bias or even covertly racist incidents can experience trauma.[38] Accordingly, when people feel harmed within a hostile, restrictive environment dictated by punishment and control, they can respond behaviorally and in ways that can be perceived by others as threatening. Violence begets violence,[39] exacerbating historically entrenched oppression in clinical settings that recurs at micro, meso, and macro levels.[40] At the micro (personal) level, inequity can manifest in clinician bias[41,42] and be expressed in elevated rates of psychiatric diagnoses among people of color[43,45,45] and clinicians' negative feelings toward people of color who are or are perceived as aggressive.[46] At the meso (community) level, inequity can manifest in health care organizations' force protocols' neglect of how aggression and anger might be reasonable responses to experiences of systemic oppression or a specific threat of harm.[47,48] And, at the macro (social, cultural) level, inequity manifests in greater police brutality against people with disabilities and people of color.[49]

Where Inequity Persists, Abolition
Calls for abolition of force in mental health care are not new. In the mid-1800s, proponents of "moral treatment" for psychiatric patients advocated for the end of force, particularly restraint.[31] In the 21st century, clinicians began to argue that restraint use was not evidence based and was counter-therapeutic.[1] Multidisciplinary, global efforts to prevent force utilization with aggressive patients continue, and one study assessing responses to patient violence in psychiatric settings across the European Union prioritized reducing force.[50] The World Health Organization also argues that seclusion and restraint are neither evidence based nor therapeutic and calls for regulatory changes and abolition of these practices.[47]

As psychologists and health services researchers who have studied, been complicit in, and resisted using force to treat patients, we recognize the complexity in rendering seclusion, restraint, and compulsion obsolete. We acknowledge important work being done to reform these force practices, which call for equitable, compassionate force implementation. The New York State Office of Mental Health (NYSOMH), for example, requires that force (a) can only be utilized as a last resort to prevent injury, (b) can only be valid for 2 hours by a physician's order, (c) cannot be used as punishment, (d) must include regular vital monitoring procedures, (e) must not be used excessively, and (f) must be followed by a debrief on how to prevent future uses of force.[51] Notably absent from the NYSOMH website, however, are guidelines for mitigating inequity or creating a path toward rendering force obsolete.[52] Two facts are undeniable: (1) force is utilized disproportionately on men, Black people, unemployed people, and homeless people and disproportionately harms Black men[3,10,24,32,33,34]; and (2) multiple advocacy groups decry the use of force.[6,7,8,29,30,31,53,54] Thus, we argue for the immediate end to seclusion, restraint, and compulsion.

Because some people with mental illnesses might harm themselves or others, we acknowledge that there are cases in which *not* using force might be considered neglect or abuse. Although we recognize the merits of this perspective, we call for consideration of feminist accounts of oppression that attribute the poorer psychiatric outcomes of some patients to their lack of power and agency.[55] Feminist psychiatric ethical and clinical approaches suggest that restoring power and agency to patients is a key mechanism of therapeutic action that mitigates the need for seclusion, restraints, or compulsion and that can help end what have been called "aggression-coercion cycles."[56]

There are several ways clinicians, staff, and organizations can mitigate and seek to eliminate inequity in force implementation, with the primary goal of abolishing seclusion, restraint, and compulsion in health care settings.

1. *Commit to anti-racist practice.* Interrogate internalized racism,[57] deconstruct White privilege,[58] and practice decolonization[59] to uproot conditions that necessitate the use of force.
2. *Draw on intergroup threat theory to discern, mitigate, and de-escalate racialized responses to feeling threatened*.
3. *Be accountable in relationships and create space for reflection and analysis to shift the sociocultural dynamics in health care settings*. Provide trauma-informed care to patients.[60] Provide time and space for clinicians to reflect on and be accountable for racist beliefs and to center the resilience of people of color.[56]
4. *Promote health care organizational change*. Implement alternatives to the use of force, do not invite police or security personnel to patient care settings, de-escalate conflict,[61] and focus on restorative justice after conflict.[62] Collect data about force utilization inequity. Hire clinicians who represent patient populations.
5. *Partner with mental health community and advocacy groups.* For example, through MAD PRIDE,[51] Fireweed Collective,[52] and the Hearing Voices Network[63] learn about the call to demedicalize diversity in mental illness experiences. Support interventions that reduce the need for involuntary admission.[52,64] Join extant movements for institutional accountability.
6. *Promote abolition of force where inequity persists.* In line with a statement from Mental Health America,[30] work to identify and uproot conditions contributing to inequity.

Conclusion
As health care professionals, it is critical that we identify the root causes of inequity in force use in clinical settings. Some professionals in health care and in law enforcement use the language of compassion to justify using force in their practices, so we must be wary of when compassionate intention actually manifests as racism, violence, and dehumanization. It is our duty to strive to share power, promote liberation, question impulses to control, and render force use on anyone obsolete.

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