Received: 31 May 2023 | Accepted: 4 January 2024

DOI: 10.1111/inm.13290

International Journal of Mental Health Nursing

REVIEW ARTICLE

Ethical challenges for nurses delivering coercive interventions in community mental health settings: A scoping review

Stephen Haines[1,2] | **Robert Stanton**[1] | **Carina Anderson**[2,3] | **Anthony Welch**[2]

[1]Cluster for Resilience and Wellbeing, School of Health, Medical and Applied Sciences, CQUniversity Australia, Rockhampton, Queensland, Australia

[2]School of Nursing, Midwifery and Social Sciences, CQUniversity Australia, Rockhampton, Queensland, Australia

[3]School of Nursing and Midwifery, University of Southern Queensland, Ipswich, Queensland, Australia

Correspondence
Stephen Haines, Cluster for Resilience and Wellbeing, School of Health, Medical and Applied Sciences, CQUniversity Australia, Rockhampton, Qld, Australia.
Email: s.haines@cqu.edu.au

Funding information
Commonwealth Government's Research Training Program/Research Training Scheme

Abstract

The number of Australians subject to coercive interventions in community mental health services continues to increase. This is in the context of a growing awareness of the harms from coercion, increasing concerns about potential breaches of human rights and an ongoing uncertainty regarding the clinical benefits of community treatment orders, the primary instrument of legislated coercion in community mental health services. Nurses in community mental health services are on the frontline with regard to coercion. They police the requirements of the community treatment order, administer medication to people in community settings without their consent and facilitate re-hospitalisation if indicated. Coercive practice contradicts the person-centred, recovery-oriented and trauma-informed care principles that inform contemporary mental health nursing. This contradiction may generate ethical challenges for nurses and result in ethical distress. The aim of this scoping review was to map the research literature on how nurses in community mental health settings recognise and manage the harm associated with the administration of coercive interventions and consider the ethical challenges that may arise within this practice. The search strategy yielded 562 studies with author consensus determining a total of three articles as meeting the inclusion criteria. The resulting literature identified three themes: (1) maintaining the therapeutic relationship, (2) promoting autonomy and (3) using subtle forms of control. This review demonstrated that there is minimal research that has considered the ethical challenges related to the use of coercion by nurses in community mental health settings.

KEYWORDS
bioethics, coercion, community mental health centres, mental health, psychiatric nursing

INTRODUCTION

The ICN Code of Ethics for Nurses defines and guides an ethical approach to nursing care that respects autonomy, promotes human rights and supports a person's right to choose or refuse treatment and care (International Council of Nurses, 2021). However, these principles can be challenged when nurses are required to respond coercively to the needs of people experiencing mental illness. Coercion can be defined as any action or practice which is inconsistent with the wishes of the person in question to make them behave or stop behaving in a certain way (World Health Organization, 2019). Coercive interventions in mental health settings are exercised along a continuum of treatment pressures from persuasion to compulsion and force (Szmukler & Appelbaum, 2008). Persuasion is the least coercive of these treatment pressures involving an appeal to reason that is respectful of the person's rationale and value system (Szmukler & Appelbaum, 2008). The application of force in mental health settings includes coercive interventions such as

involuntary hospitalisation, administration of medication against the person's will, physical and pharmacological restraint, and seclusion (Gooding et al., 2020). As such, coercion remains common practice in mental health nursing despite the evidence that it can have serious, negative impacts for consumers (Paradis-Gagné et al., 2021).

Regardless of the intent behind the coercion, the experience of being forced to receive psychiatric treatment can be traumatic and cause further distress and harm (Watson et al., 2014). The perception of coercion at the time of psychiatric admission confers a higher risk of suicide post discharge (Jordan & McNiel, 2020). Coercive interventions may result in a loss of trust in clinical staff with increased suspicion and wariness (Rose et al., 2017), leading to avoidance of mental health services for some people potentially preventing them from accessing further treatment and support (Allison & Flemming, 2019). These interventions can be considered as antithetical to contemporary, person-centred, recovery-oriented mental health care since they reduce consumer self-efficacy, personal empowerment and the trust required for collaborative relationships (Harris & Panozzo, 2019).

Coercive interventions are also regarded as incompatible with a human rights-based approach to mental health care (Sashidharan et al., 2019). Mental health legislation extinguishes the common law right to refuse medical treatment, thus contradicting the terms of the United Nations Convention on the Rights of Persons with Disabilities which asserts there is no place for non-consented treatment based on the presence of mental illness (Callaghan & Ryan, 2014). These ethical tensions between coercion and the respect for fundamental human rights remain understudied in mental health (Hem et al., 2018).

Whilst much of the research into coercion in mental health treatment has investigated hospital practices such as seclusion and restraint, coercion is also being increasingly experienced by consumers in community mental health services outside of hospitals through the use of community treatment orders (Gooding et al., 2020). Community treatment orders, also known as involuntary outpatient treatment (IOT) in the United States (Geller et al., 2006), require people to accept treatment as prescribed from community mental health services or face the sanction of hospitalisation (O'Brien, 2014). Legislative grounds for the use of community treatment orders are available in over 70 jurisdictions around the world including Canada, USA, United Kingdom and some European and Asian countries (Mikellides et al., 2019). These legal mechanisms currently apply to 15% of all community mental health service contacts in Australia (Australian Institute of Health and Welfare (AIHW), 2022). The number of mental health hospital beds in Australia is declining whilst the number of overnight admissions is increasing (AIHW, 2022). This allocation of mental health resources has resulted in hospital services experiencing managerial pressure for early consumer discharge and ultra-short admissions (Gooding et al., 2020). Hospital teams frequently discharge consumers still experiencing acute mental health issues on community treatment orders to ensure there is adequate community service engagement and follow-up (Coffey & Jenkins, 2002). Additionally, some consumers in Australian community mental health settings remain on involuntary orders for extended periods 'just in case' they experience mental health crises at some later date (Patel, 2008). This is despite a lack of empirical evidence that community treatment orders result in beneficial outcomes for consumers (Brophy et al., 2018). A Cochrane review on compulsory community treatment was unable to find any clear difference in service use, quality of life or social functioning when compared to voluntary care (Kisely et al., 2017). Similarly, a large randomised control trial involving 336 patients with psychosis compared mental health care under community treatment orders to voluntary treatment found that community treatment orders failed to deliver clinical or social benefits for consumers. Subsequently, the authors suggested the use of community treatment orders be restricted or stopped (Burns et al., 2016).

Nurses have a central and pivotal role in the delivery of coercive interventions in mental health treatment settings (Martello et al., 2018), and are the health professionals most likely to use coercive measures in their mental health clinical practice (Paradis-Gagné et al., 2021). Nurses may be required to monitor and review compliance with medically prescribed community treatment orders (Coffey & Jenkins, 2002) and facilitate involuntary hospitalisation should a person breach the conditions of their community treatment order (Gooding et al., 2020; Heslop et al., 2016). Additionally, in community mental health settings, it is nurses who have the responsibility for the coercive administration of antipsychotic medications by injection, prescribed to involuntary consumers as a condition of their community treatment order (Heslop et al., 2016). In these contexts, nurses use their 'caring' skills such as empathy and respect and their 'therapeutic alliance' to 'deploy the power of the medicolegal system' (Jager & Perron, 2018, p. 150).

The requirement to exercise legally sanctioned powers to deliver enforced treatment alongside a professional focus on care and compassion can generate tensions for nurses in community mental health settings (Felton et al., 2018). An additional tension is that coercion is practiced by nurses within service frameworks that promote recovery-oriented and person-centred care (Dawson et al., 2016). These tensions can lead to ethical challenges for nurses and ethical distress can occur when the nurse is obliged to administer coercive interventions despite their personal disagreement

or discomfort with the treatment or management plan as prescribed by the community treatment order (Horsfall et al., 1999).

RESEARCH QUESTION

Increasing numbers of people in community mental health settings are subject to coercive practice with evidence of potential harm to consumers and to nurses from these interventions. In this context the research question underpinning this review asks how nurses in community mental health settings recognise and manage the ethical challenges associated with coercive interventions.

Aim and objectives

The aim of this scoping review was to systematically map the research literature that investigates how nurses in community mental health settings recognise and manage the harm associated with the administration of coercive interventions to mental health consumers, and how these nurses consider the ethical challenges that may arise for them within this practice.

Specifically, the objectives of this scoping review were as follows:

1. To assess the breadth and depth of research literature related to this aim.
2. To describe any fundamental concepts identified by the research literature related to this aim.
3. To identify any gaps or inconsistencies in the research literature related to this aim to inform future research.

METHODS

An initial search revealed a dearth of research related to the ethical challenges for nurses when delivering coercive interventions in community mental health settings. In this context, a scoping review was considered the most appropriate methodology to explore the breadth of the research literature and to map and summarise any available evidence (Peters et al., 2020).

Protocol and registration

The Cochrane, Joanna Briggs Institute (JBI) and PROSPERO databases were searched to identify whether similar reviews regarding ethical challenges for nurses in community mental health services related to coercive practice were planned or in progress, without result. Guidelines from the Preferred Reporting Items for Systematic Reviews and Meta-analysis extension for Scoping Reviews (PRISMA-ScR) checklist (Tricco et al., 2018) were applied to develop and review the final protocol which was registered prospectively with the Open Science Framework on 3 February 2023 (https://osf.io/8j7vt).

Eligibility criteria

To be included in this review, papers needed to be published in peer-reviewed journals demonstrating original research examining the perspectives and experiences of nurses when experiencing ethical challenges associated with coercive interventions in community mental health settings. Studies and systematic reviews involving a mixed population of mental health professionals, or combined settings such as hospital and community locations without distinct data from nurses in community mental health settings were excluded. The protocol allowed for both experimental and quasi-experimental study designs, including randomised controlled trials and non-randomised controlled trials. In addition, the search strategy included analytical and descriptive observational studies, case series, individual case reports and descriptive cross-sectional studies. Qualitative studies that focused on, but not limited to, methodologies such as phenomenology, grounded theory, ethnography, qualitative description, action research and feminist research were also included in the search strategy.

The search was date-limited from to 1992 to 2022. The year 1992 was chosen as a date limiter being the year of publication of the Australian National Mental Health Policy which shifted the focus of funding of mental health services from institutions to community mental health services (Rosen, 2006). Public mental health services in Australia are still using this structure nearly 30 years later. Due to resource limitations, only references available in English were included. The 'PCC' mnemonic (population, concept and context) was used to identify the focus and context of the review (Peters et al., 2020).

Population

Enrolled and registered nurses, with or without specialist mental health nursing qualifications or experience.

Concept

Ethical challenges associated with coercive interventions.

Context

Public and private community mental health settings, including outpatient services, assertive outreach teams, acute community treatment teams and case management teams.

TABLE 1 Search terms.

Population	Concept		Context
Enrolled and registered nurses, with or without specialist mental health nursing qualifications or experience	Ethical challenges	Coercive interventions	Public and private community mental health settings, including outpatient services, assertive outreach teams, acute community treatment teams and case management teams
Nurs* OR Psychosocial nursing OR Psychiatric nurse OR Mental health nurse	Ethical difficulties OR Ethical dimensions OR Ethical questions OR Ethical tensions OR Ethical complications OR Ethical components OR Ethical discussions OR Ethical disquiet OR Ethical elements Or Ethical factors Or Ethical obstacles OR Ethical struggles OR Ethical uncertainties OR Moral challenges OR Moral dilemmas OR Moral conflict OR Moral courage OR Moral considerations OR Moral issues OR Moral problems OR Moral question Or Morally relevant topics OR Moral situations OR Bioethics OR Ethics OR Ethical Theory OR Morality OR Morals OR Clinical Ethics OR Professional Ethics OR Nursing ethics OR Medical ethics OR Situational Ethics	Coercion OR Involuntary treatment OR Involuntary admission OR Involuntary Hospitalisation or Involuntary commitment OR Behavioural control OR Persuasive Communication OR Threat OR Restraint OR Restrictive interventions OR Restrictive practice OR Perceived coercion OR Mandated treatment OR Mandatory programs OR Forced treatment OR Commitment of Mentally ill OR Force OR Control	Mental Health Services OR Mental Hygiene Services OR Community mental health services OR Community mental health centers OR Outpatient mental health services OR Assertive Community Treatment

Information sources

The final search strategy was developed in consultation with a research librarian and refined through team discussion. The following bibliographic databases were searched between August 2022 and September 2022; Medline, CINAHL Ultimate, Embase and PsychInfo. A search of the PubMed database was conducted in December 2022.

The reference lists of the selected articles were also reviewed to identify any additional potentially relevant manuscripts.

Search terms

The list of search terms for the concept of 'ethical challenges' was informed by the rapid review undertaken by Schofield et al. (2021) into the definition of this concept. Their definition included terms such as 'ethical issues', 'moral challenges' and 'moral dilemmas'. The final search strategy for all bibliographic databases as listed above was conducted by the primary author in consultation with the research librarian using the terms listed in Table 1.

RESULTS

The search resulted in 660 studies which were uploaded into Covidence software (https://www.covidence.org). Ninety-eight duplicates were removed by the primary author leaving 562 studies for screening. The 562 studies were screened by SH, CA and RS identifying 491 studies as irrelevant with two papers unable to be found. The remaining 69 studies proceeded to full-text review by SH, CA, RS and AW. Sixty-six studies were excluded following discussion and consensus by the authors due to wrong population (not exclusively nurses, $n=2$), wrong concept (not investigating ethical challenges related to coercive practice, $n=23$) and wrong context (not exclusively community mental health settings, $n=21$). Fourteen articles were not a primary study and were therefore excluded. Two systematic literature reviews were subject to full-text review; however, one (Hem et al., 2018) was eventually excluded as all of the 22 studies explored in this review were located in hospital settings, and a comprehensive conceptual analysis examining coercion and mental health nursing (Paradis-Gagné et al., 2021) was excluded as this study combined results from inpatient and community mental health settings. This left three studies meeting the criteria for data extraction (see Figure 1). Consistent with the scoping review guidelines from the JBI Scoping Review Methodology Group, a methodological appraisal of these studies was not conducted as the objective of the study was to develop a comprehensive overview of the research findings, rather than a qualitative synthesis of data (Peters et al., 2021; Pollock et al., 2023).

The data from the remaining eligible studies were charted using an abstraction tool that was designed for this study by SH to capture the key study characteristics of author name and date, title of study, country of study and key findings (see Table 2). Only data items

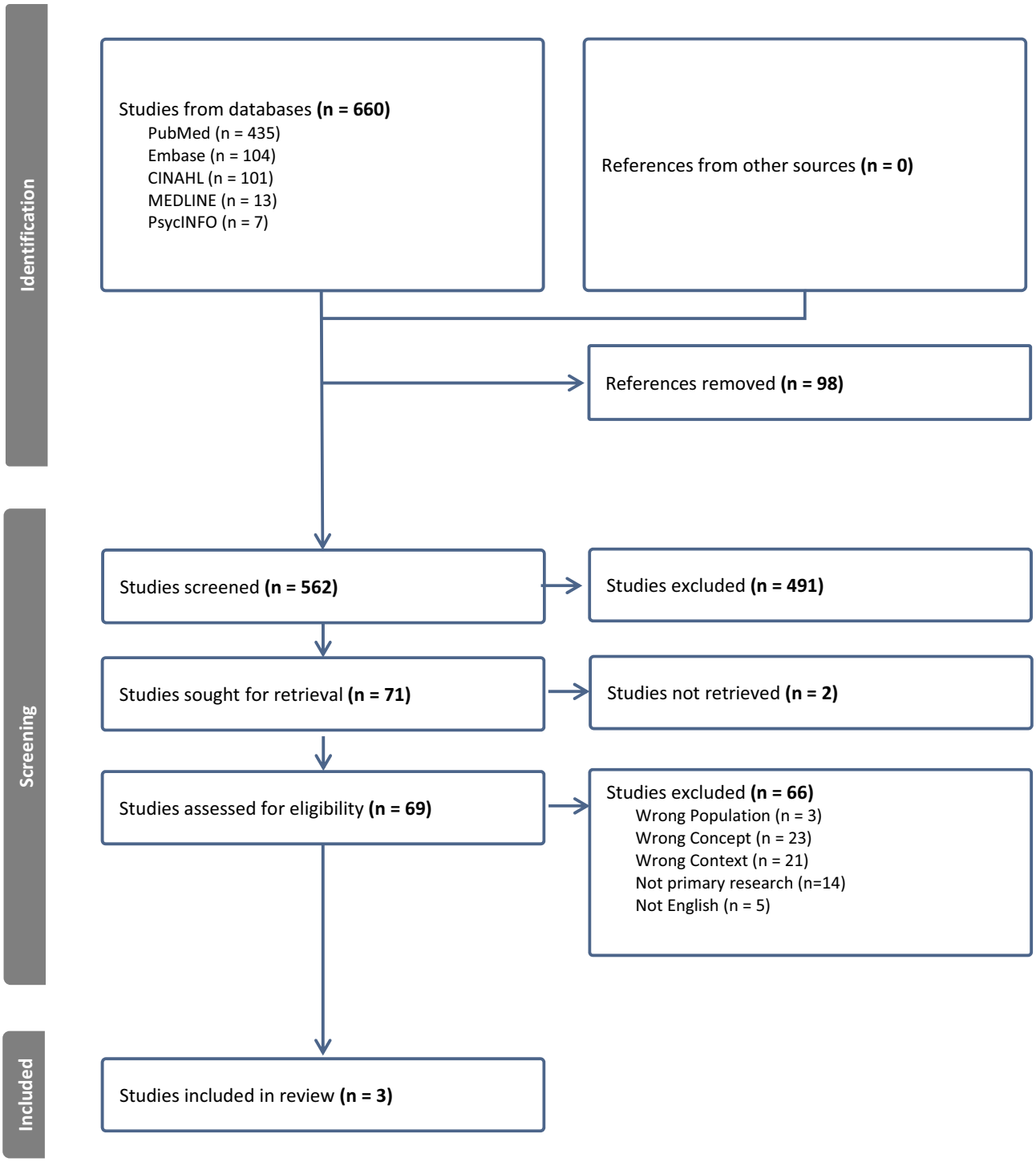

FIGURE 1 PRISMA flow chart of selected articles.

that were relevant to the scoping review questions were extracted consistent with the population, concept and context framework (Pollock et al., 2023). Each author used this tool to extract and summarise their key findings, using open coding to allocate these findings into overall categories. The authors then came together to develop the coding framework through consensus which enabled the organisation of the extracted data into themes (Pollock et al., 2023).

Summary of results

A total of three articles met the inclusion criteria (Coffey & Jenkins, 2002; Karanikola et al., 2018; Magnusson et al., 2004). All three studies discussed ethical issues associated with the provision of mental health care by nurses in community mental health settings and included the concept of coercion. Consistent with scoping review intention of providing a map and summary

TABLE 2 Data extraction table.

Author (year)	Coffey and Jenkins (2002)	Karanikola et al. (2018)	Magnusson et al. (2004)
Country	England and Wales	Cyprus	Sweden
Aim	To examine the perceptions of nurses with regard to team-working, legal powers and their effects upon compliance	To investigate the living experience of Greek-Cypriot CMHNs of their professional role	To describe psychiatric nurses' experience of how the changing focus of mental health care, from in-patient treatment to community-based care, has influenced their professional autonomy
Study type/ source	Mixed methods. Survey plus qualitative analysis of written responses	Phenomenological approach with purposive sampling	Interviews with qualitative content analysis
Population	Forensic Community Mental Health Nurses (FCMHNs) attached to NHS Medium Secure Units	Community mental health nurses	Mental health nurses caring for people in the consumer's own homes
Sample size	Total sample = 122	5	11
Context	Community mental health settings with a specific forensic focus	Community mental health settings	Community mental health settings
Concept	(Research Question One) How do FCMHNs address issues of power and control with their patients?	The lived experience of community mental health nurses of their professional role, with special focus on related emotions and perceptions	The moral responsibilities of nurses when providing care in the person's home
Key findings relating to this review	Tensions exist between striving to be therapeutic and concurrently monitoring or policing. Recognition of limitations to the imposition of compulsion in community mental healthcare and that organisations and systems are better served than individuals in receipt of care. Coercion is detrimental to the therapeutic relationship	Challenges of providing professional help without giving the impression of invading the person's home. Interplay of power relationships and having to balance 'visitor' over authoritative role. Subtle management of the recovery process superficially the patient seemed to be in control. A clinician-centred approach still exists despite the development of a therapeutic relationship. The nurse manages a person's 'needs' as identified by the nurse rather than the person's 'wants'	The nurse must take control ('share the person's responsibility for themselves') if the person's mental state is deteriorating and they are less able to discern their best interests, mindful of the impact of this control on the therapeutic relationship. Nursing in community mental health settings forces nurses to find a balance between their professional responsibilities and the person's wish to manage on their own. The role of the nurse to motivate people to take responsibility for themselves. When the person refuses to co-operate, the nurse must take a moral stand in either respecting their wishes or using subtle coercion Supporting and supervising patients to help them cope with living in their own homes and to integrate into society also implied a kind of control or checking up on how they managed their everyday lives

of available evidence rather than a synthesis of collected data (Pollock et al., 2021), the findings from these studies were summarised into three themes: (1) maintaining the therapeutic relationship, (2) promoting the autonomy of the person and (3) using subtle forms of control.

Maintaining the therapeutic relationship

Nurses recognise that establishing a therapeutic relationship with consumers and their families is of paramount importance for nurses in community mental health settings with this 'rapport' being the means to achieve optimal clinical outcomes (Karanikola et al., 2018). Nurses reported thinking carefully about the tensions between care and control, and the power imbalances between the person and the nurse within this relationship (Coffey & Jenkins, 2002). Retaining a person's trust within the therapeutic relationship whilst providing coercive measures was considered a challenge (Magnusson et al., 2004). Coercion was found to restrict this alliance and tensions existed between the nurse's intent to be therapeutic and the concurrent requirement to monitor and police people subject to legislated compulsory treatment orders (Coffey & Jenkins, 2002). It is also acknowledged that coercion may better serve the needs of the organisation and the system than the individuals in their care, particularly with in the case of forensic mental health orders (Coffey & Jenkins, 2002). In these circumstances, community mental health nurses may regard themselves as 'critical

participants' seeking to ensure that the care needs of the people subject to coercion in mental health services are considered and scrutinised (Coffey & Jenkins, 2002). It was recognised however that this advocacy may be regarded antipathetically by policy makers and senior management, and could result in increased occupational stress for 'dissenting' nurses (Coffey & Jenkins, 2002).

Promoting autonomy

The theme of promoting autonomy was reflected in nurses recognising that encouraging and supporting people with mental illness to live an independent life is a primary area of responsibility (Magnusson et al., 2004). It was understood by nurses that limiting a person's autonomy can lead to reduced self-esteem (Karanikola et al., 2018) and nurses identify an ethical conflict between their professional respect for a person's autonomy and their role as caregivers trying to help (Magnusson et al., 2004). This may be particularly problematic when the consumer is resentful or opposing the control to which they are subject. Nurses felt a sense of conflict with their usual therapeutic stance in situations in which they needed to take decisions contrary to the wishes of the person (Magnusson et al., 2004). In these circumstances, the nurse sought to strike 'a balance between care and control' (Coffey & Jenkins, 2002). Striking this balance appeared to be less ethically challenging when the person's mental health was considered to be seriously deteriorating. In this situation, the decision to take control was regarded as a primary clinical responsibility, with nurses believing that people with mental illness may lack the ability to manage themselves (Magnusson et al., 2004). However, negotiation is still regarded as an important aspect of the role of the nurse in community mental health settings, irrespective of the person's legal and mental health status, with the knowledge that an approach that is too controlling leaves people frustrated and angry, with subsequent treatment options being 'doomed to fail' (Coffey & Jenkins, 2002, p. 525).

Using subtle forms of control

The third theme from these studies is using subtle forms of control. When nurses first start to practice in community mental health settings, they may find it difficult to relinquish the levels of control they exercised in institutional settings (Magnusson et al., 2004). The loss of an authority that is automatically ascribed in hospital-based settings was regarded as the greatest challenge to the professional role of a community mental health nurse (Karanikola et al., 2018). This 'reversed power dynamic' may require nurses to 'subtly control' the situation to develop the therapeutic alliance (Karanikola et al., 2018). For example, home visiting to 'check-up' on a person was a strategy nurses use to exercise their control and supervision in community mental health settings (Magnusson et al., 2004). Control was also exercised subtly through the use of education and the nurse's explanation of the consequences for a person should they not adhere to prescribed treatment (Magnusson et al., 2004).

DISCUSSION

This scoping review aimed to systematically map the research literature investigating how nurses in community mental health settings recognise and manage the harm associated with the administration of coercive interventions to mental health consumers, and consider the ethical challenges that may arise within this practice. A key finding from this review is that a paucity of literature exists on the topic, both justifying the scoping review approach and opening avenues for future research. More specifically, the included research recognises the ethical challenges for nurses associated with a perceived requirement to deliver coercive interventions and the need to maintain a therapeutic relationship that promotes personal recovery in community mental health settings.

Nurses in community mental health settings primarily deliver their care through models of case management which combine counselling (supportive and family), care coordination (brokerage) and medication management (Happell et al., 2012). Nurses working with people subject to legislated coercion have additional responsibilities to manage the requirements of this coercion including informing the person and their family of the legal processes, participating in review and tribunal hearings, and facilitating involuntary hospital admission when required (Dawson et al., 2016). Effective case management is based upon a meaningful therapeutic alliance. The development of this alliance based on trust is fundamental to the practice of mental health nursing (Peplau, 1991; Zugai, 2023). For people with experiences of mental illness, a therapeutic alliance based on trust between the clinician and the person has the greatest impact on treatment outcomes, irrespective of the actual treatment modality (Hartley et al., 2020). The relational continuity of care which underpins case management aligns with the establishment of a therapeutic alliance and is also associated with improved clinical outcomes (Weaver et al., 2017).

There is a consistent finding of a poorer therapeutic alliance in relationships that are perceived by consumers to be coercive (Kidd et al., 2017). Some consumers have reported that the development of a therapeutic alliance was impossible with the nurse who was required to enforce the community treatment order (Lessard-Deschênes & Goulet, 2022). In the studies identified through this scoping review, nurses recognised that coercion impacts on the rapport and trust necessary to

establish and maintain the therapeutic relationship. The use of coercion risks the ability of the nurse in community settings to respond therapeutically to the mental health needs of people in their care. In this context, the role of the nurse, having continued involvement in the person's life without a therapeutic alliance and without consent, reverts to that of custodian, albeit in a restricted community setting rather than the total institution as described by Goffman (2017).

More than 80% of consumers of community mental health services in Australia have treatment periods longer than 3 months (AIHW, 2022). In the UK, the mean duration of a community treatment order is 3.2 years (Barkhuizen et al., 2020). This means that the therapeutic relationship in community mental health nursing is required to extend beyond the acute phase of mental illness into a recovery phase. Nurses in mental health services are required to establish collaborative partnerships respectful of an individual's choices to promote recovery (Australian College of Mental Health Nurses Inc, 2010). Autonomy in personal decision making is recognised as a cardinal principle of personal recovery (World Health Organization, 2022). Nurses understand the importance of supporting a person's autonomy but may be required to restrict this through the use of coercion due to concerns of risk, family pressure or medical or legal prescription. Nursing interventions such as medication management and psychoeducation may be considered coercive if the desired outcomes align with the aims of the nurse to ensure compliance with medication. This may be at odds with the desire and wishes of the person themselves. The included studies recognise that the use of coercion is ethically problematic with regard to the concept of autonomy as nurses seek to strike 'a balance between care and control' (Coffey & Jenkins, 2002). The lack of research to guide nurses to achieve this balance was recognised by Coffey and Jenkins back in 2002 (Coffey & Jenkins, 2002). The present scoping review failed to identify any research subsequent to the original work of Coffey and Jenkins (2002) that has considered this ethical challenge from the perspective of the community mental health nurse.

CONCLUSION

There is minimal literature that considers the ethical challenges related to the use of coercion by nurses in community mental health settings. Our review did not find any studies from North America nor from Australia and New Zealand, countries which now have decades of experience with related legislated coercion. The spread of community treatment orders into over 70 jurisdictions means that international perspectives are critical. Consistent with the concerns of Hem et al. (2018), our review confirms a lack of research that explicitly considers the ethical challenges associated with coercion in mental health care more broadly. The authors of this review found only one study (Coffey & Jenkins, 2002) that explicitly considered the issues of coercion and forcible treatment for nurses in community settings. The growing number of people subject to involuntary treatment in community mental health settings coupled with the lack of evidence for its efficacy means it is critical for nurses to understand how they are able to develop and maintain a therapeutic alliance in this context and manage the many potentials for harm.

LIMITATIONS

The present scoping review is not without limitation. A number of studies were excluded as they considered the ethical challenges faced by the broader membership of the multidisciplinary team which combined the data from nurses with other disciplines such as psychology and psychiatry. Similarly, studies were excluded that combined the different clinical contexts of coercion in both inpatient and community mental health services. The authors have argued that the specific roles of nurses in community mental health settings warrant a separate consideration of the ethical challenges they experience. However, the review has a number of strengths including the breadth and depth of the literature searches and reference to previous work in this field.

RELEVANCE TO CLINICAL PRACTICE

Given the prevalence of coercion in community mental health nursing and the growing number of people subjected to these interventions, it is imperative that nurses be highly sensitive to the potentials for harm. In this context, it is right that nurses experience ethical challenges in this aspect of their practice. Failure to acknowledge and reflect upon these challenges raises the potential for harm from our interventions.

Clinical supervision may assist individual nurses to meaningfully reflect upon these concerns in their practice, however further research into how nurses in community mental health settings can balance their 'care and control', and enhanced guidelines to assist their practice are urgently required to ensure their role remains therapeutic for people requiring community mental health care.

AUTHOR CONTRIBUTIONS

All authors listed meet the authorship criteria according to the latest guidelines of the International Committee of Medical Journal Editors. All authors are in agreement with the manuscript.

ACKNOWLEDGEMENTS

The authors wish to acknowledge the support from the CQUniversity Australia Library for their assistance in developing and reviewing the search strategy. Open access publishing facilitated by Central Queensland University, as part of the Wiley - Central Queensland University agreement via the Council of Australian University Librarians.

FUNDING INFORMATION

The PhD candidature of the principal researcher was supported under the Commonwealth Government's Research Training Program/Research Training Scheme.

CONFLICT OF INTEREST STATEMENT

The authors declare that they hold no known conflicts of interest.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

ORCID

Stephen Haines https://orcid.org/0000-0002-2236-0619
Robert Stanton https://orcid.org/0000-0002-6684-5087
Carina Anderson https://orcid.org/0000-0001-7805-6205
Anthony Welch https://orcid.org/0000-0001-7768-4234

REFERENCES

Allison, R. & Flemming, K. (2019) Mental health patients' experiences of softer coercion and its effects on their interactions with practitioners: a qualitative evidence synthesis. *Journal of Advanced Nursing*, 75(11), 2274–2284. Available from: https://doi.org/10.1111/jan.14035

Australian College of Mental Health Nurses Inc. (2010) *Standards of practice for Australian mental health nurses 2010*. Canberra: ACMHN.

Australian Institute of Health and Welfare. (2022) *Mental health services in Australia*. Available from: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia. [Accessed 21st May 2023].

Barkhuizen, W., Cullen, A.E., Shetty, H., Pritchard, M., Stewart, R., McGuire, P. et al. (2020) Community treatment orders and associations with readmission rates and duration of psychiatric hospital admission: a controlled electronic case register study. *BMJ Open*, 10(3), e035121. Available from: https://doi.org/10.1136/bmjopen-2019-035121

Brophy, L., Edan, V., Gooding, P., McSherry, B., Burkett, T., Carey, S. et al. (2018) Community treatment orders: towards a new research agenda. *Australasian Psychiatry: Bulletin of Royal Australian and New Zealand College of Psychiatrists*, 26(3), 299–302. Available from: https://doi.org/10.1177/1039856218758543

Burns, T., Rugkåsa, J., Yeeles, K. & Catty, J. (2016) Coercion in mental health: a trial of the effectiveness of community treatment orders and an investigation of informal coercion in community mental health care. *Programme Grants for Applied Research*, 4(21), 1–354. Available from: https://doi.org/10.3310/pgfar04210

Callaghan, S.M. & Ryan, C. (2014) Is there a future for involuntary treatment in rights-based mental health law? *Psychiatry, Psychology and Law*, 21(5), 747–766. Available from: https://doi.org/10.1080/13218719.2014.949606

Coffey, M. & Jenkins, E. (2002) Power and control: forensic community mental health nurses' perceptions of team-working, legal sanction and compliance. *Journal of Psychiatric and Mental Health Nursing*, 9(5), 521–529. Available from: https://doi.org/10.1046/j.1365-2850.2002.00490.x

Dawson, S., Lawn, S., Simpson, A. & Muir-Cochrane, E. (2016) Care planning for consumers on community treatment orders: an integrative literature review. *BMC Psychiatry*, 16(1), 394. Available from: https://doi.org/10.1186/s12888-016-1107-z

Felton, A., Repper, J. & Avis, M. (2018) Therapeutic relationships, risk, and mental health practice. *International Journal of Mental Health Nursing*, 27(3), 1137–1148. Available from: https://doi.org/10.1111/inm.12430

Geller, J.L., Fisher, W.H., Jr., Grudzinskas, A.J., Clayfield, J.C. & Lawlor, T. (2006) Involuntary outpatient treatment as "desintitutionalized coercion": the net-widening concerns. *International Journal of Law and Psychiatry*, 29, 551–562.

Goffman, E. (2017) *Asylums: essays on the social situation of mental patients and other inmates*, 1st edition, London: Routledge. Available from: https://doi.org/10.4324/9781351327763

Gooding, P., McSherry, B. & Roper, C. (2020) Preventing and reducing 'coercion' in mental health services: an international scoping review of English-language studies. *Acta Psychiatrica Scandinavica*, 142(1), 27–39. Available from: https://doi.org/10.1111/acps.13152

Happell, B., Hoey, W. & Gaskin, C.J. (2012) Community mental health nurses, caseloads, and practices: a literature review. *International Journal of Mental Health Nursing*, 21(2), 131–137. Available from: https://doi.org/10.1111/j.1447-0349.2011.00777.x

Harris, B. & Panozzo, G. (2019) Barriers to recovery-focused care within therapeutic relationships in nursing: attitudes and perceptions. *International Journal of Mental Health Nursing*, 28(5), 1220–1227. Available from: https://doi.org/10.1111/inm.12611

Hartley, S., Raphael, J., Lovell, K. & Berry, K. (2020) Effective nurse–patient relationships in mental health care: a systematic review of interventions to improve the therapeutic alliance. *International Journal of Nursing Studies*, 102, 103490. Available from: https://doi.org/10.1016/j.ijnurstu.2019.103490

Hem, M.H., Gjerberg, E., Husum, T.L. & Pedersen, R. (2018) Ethical challenges when using coercion in mental healthcare. A systematic literature review. *Nursing Ethics*, 25(1), 92–110. Available from: https://doi.org/10.1177/0969733016629770

Heslop, B., Wynaden, D., Tohotoa, J. & Heslop, K. (2016) Mental health nurses' contributions to community mental health care: an Australian study. *International Journal of Mental Health Nursing*, 25(5), 426–433. Available from: https://doi.org/10.1111/inm.12225

Horsfall, J., Cleary, M. & Jordan, R. (1999) *Towards ethical mental health nursing practice*. Greenacres: Australian & New Zealand College of Mental Health Nurses Inc.

International Council of Nurses. (2021) *The ICN code of ethics for nurses: revision 2021*. Geneva: ICN – International Council of Nurses.

Jager, F. & Perron, A. (2018) Caring as coercion: exploring the nurse's role in mandated treatment. *Journal of Forensic Nursing*, 14, 148–153. Available from: https://doi.org/10.1097/JFN.0000000000000207

Jordan, J.T. & McNiel, D.E. (2020) Perceived coercion during admission into psychiatric hospitalization increases risk of suicide attempts after discharge. *Suicide and Life-Threatening Behavior*, 50(1), 180–188. Available from: https://doi.org/10.1111/sltb.12560

Karanikola, M., Kaikoushi, K., Doulougeri, K., Koutrouba, A. & Papathanassoglou, E. (2018) Perceptions of professional role in community mental health nurses: the interplay of power relations between nurses and mentally ill individuals. *Archives of*

Psychiatric Nursing, 32(5), 677–687. Available from: https://doi.org/10.1016/j.apnu.2018.03.007

Kidd, S.A., Davidson, L. & McKenzie, K. (2017) Common factors in community mental health intervention: a scoping review. *Community Mental Health Journal*, 53(6), 627–637. Available from: https://doi.org/10.1007/s10597-017-0117-8

Kisely, S.R., Campbell, L.A. & O'Reilly, R. (2017) Compulsory community and involuntary outpatient treatment for people with severe mental disorders. *Cochrane Database of Systematic Reviews*, 2017(6), CD004408. Available from: https://doi.org/10.1002/14651858.CD004408.pub5

Lessard-Deschênes, C. & Goulet, M. (2022) The therapeutic relationship in the context of involuntary treatment orders: the perspective of nurses and patients. *Journal of Psychiatric and Mental Health Nursing*, 29(2), 287–296. Available from: https://doi.org/10.1111/jpm.12800

Magnusson, A., Högberg, T., Lützén, K. & Severinsson, E. (2004) Swedish mental health nurses' responsibility in supervised community care of persons with long-term mental illness. *Nursing & Health Sciences*, 6(1), 19–27. Available from: https://doi.org/10.1111/j.1442-2018.2003.00171.x

Martello, M., Doronina, O., Perillo, A., La Riccia, P. & Lavoie-Tremblay, M. (2018) Nurses' perceptions of engaging with patients to reduce restrictive practices in an inpatient psychiatric unit. *The Health Care Manager*, 37(4), 342–353. Available from: https://doi.org/10.1097/HCM.0000000000000235

Mikellides, G., Stefani, A. & Tantele, M. (2019) Community treatment orders: international perspective. *BJPsych International*, 16(4), 83–86. Available from: https://doi.org/10.1192/bji.2019.4

O'Brien, A.J. (2014) Community treatment orders in New Zealand: regional variability and international comparisons. *Australasian Psychiatry*, 22(4), 352–356. Available from: https://doi.org/10.1177/1039856214531080

Paradis-Gagné, E., Pariseau-Legault, P., Goulet, M., Jacob, J.D. & Lessard-Deschênes, C. (2021) Coercion in psychiatric and mental health nursing: a conceptual analysis. *International Journal of Mental Health Nursing*, 30(3), 590–609. Available from: https://doi.org/10.1111/inm.12855

Patel, G. (2008) Community treatment orders in Victoria: a clinico-ethical perspective. *Australasian Psychiatry*, 16(5), 340–343. Available from: https://doi.org/10.1080/10398560802233017

Peplau, H.E. (1991) *Interpersonal relations in nursing: a conceptual framework of reference for psychodynamic nursing*. New York, NY: Springer Publishing Company.

Peters, M.D.J., Marnie, C., Colquhoun, H., Garritty, C.M., Hempel, S., Horsley, T. et al. (2021) Scoping reviews: reinforcing and advancing the methodology and application. *Systematic Reviews*, 10(1), 263. Available from: https://doi.org/10.1186/s13643-021-01821-3

Peters, M.D.J., Marnie, C., Tricco, A.C., Pollock, D., Munn, Z., Alexander, L. et al. (2020) Updated methodological guidance for the conduct of scoping reviews. *JBI Evidence Synthesis*, 18(10), 2119–2126. Available from: https://doi.org/10.11124/JBIES-20-00167

Pollock, D., Davies, E.L., Peters, M.D.J., Tricco, A.C., Alexander, L., McInerney, P. et al. (2021) Undertaking a scoping review: a practical guide for nursing and midwifery students, clinicians, researchers, and academics. *Journal of Advanced Nursing*, 77(4), 2102–2113. Available from: https://doi.org/10.1111/jan.14743

Pollock, D., Peters, M.D.J., Khalil, H., McInerney, P., Alexander, L., Tricco, A.C. et al. (2023) Recommendations for the extraction, analysis, and presentation of results in scoping reviews. *JBI Evidence Synthesis*, 21(3), 520–532. Available from: https://doi.org/10.11124/JBIES-22-00123

Rose, D., Perry, E., Rae, S. & Good, N. (2017) Service user perspectives on coercion and restraint in mental health. *BJPsych International*, 14(3), 59–61. Available from: https://doi.org/10.1192/S2056474000001914

Rosen, A. (2006) Australia's national mental health strategy in historical perspective. *Bulletin of the Board of International Affairs of the Royal College of Psychiatrists*, 3(4), 19–21.

Sashidharan, S.P., Mezzina, R. & Puras, D. (2019) Reducing coercion in mental healthcare. *Epidemiology and Psychiatric Sciences*, 28(6), 605–612. Available from: https://doi.org/10.1017/S2045796019000350

Schofield, G., Dittborn, M., Selman, L.E. & Huxtable, R. (2021) Defining ethical challenge(s) in healthcare research: a rapid review. *BMC Medical Ethics*, 22(1), 135. Available from: https://doi.org/10.1186/s12910-021-00700-9

Szmukler, G. & Appelbaum, P.S. (2008) Treatment pressures, leverage, coercion, and compulsion in mental health care. *Journal of Mental Health*, 17(3), 233–244. Available from: https://doi.org/10.1080/09638230802052203

Tricco, A.C., Lillie, E., Zarin, W., O'Brien, K.K., Colquhoun, H., Levac, D. et al. (2018) PRISMA extension for scoping reviews (PRISMA-ScR): checklist and explanation. *Annals of Internal Medicine*, 169(7), 467–473. Available from: https://doi.org/10.7326/M18-0850

Watson, S., Thorburn, K., Everett, M. & Fisher, K.R. (2014) Care without coercion—mental health rights, personal recovery and trauma-informed care. *Australian Journal of Social Issues*, 49(4), 529–549. Available from: https://doi.org/10.1002/j.1839-4655.2014.tb00327.x

Weaver, N., Coffey, M. & Hewitt, J. (2017) Concepts, models and measurement of continuity of care in mental health services: a systematic appraisal of the literature. *Journal of Psychiatric and Mental Health Nursing*, 24(6), 431–450. Available from: https://doi.org/10.1111/jpm.12387

World Health Organization. (2019) *Freedom from coercion, violence and abuse: WHO QualityRights core training: mental health and social services: course guide*. World Health Organization. Available from: https://apps.who.int/iris/handle/10665/329582. [Accessed 23rd January 2023].

World Health Organization. (2022) *Autonomy in health decision-making—A key to recovery in mental health care*. Available from: https://www.who.int/news-room/feature-stories/detail/autonomy-was-the-key-to-my-recovery. [Accessed 29th March 2023].

Zugai, J.S. (2023) The ethical integrity of the power differential in mental health nursing. *Issues in Mental Health Nursing*, 44(4), 343–346. Available from: https://doi.org/10.1080/01612840.2022.2148028

How to cite this article: Haines, S., Stanton, R., Anderson, C. & Welch, A. (2024) Ethical challenges for nurses delivering coercive interventions in community mental health settings: A scoping review. *International Journal of Mental Health Nursing*, 00, 1–10. Available from: https://doi.org/10.1111/inm.13290