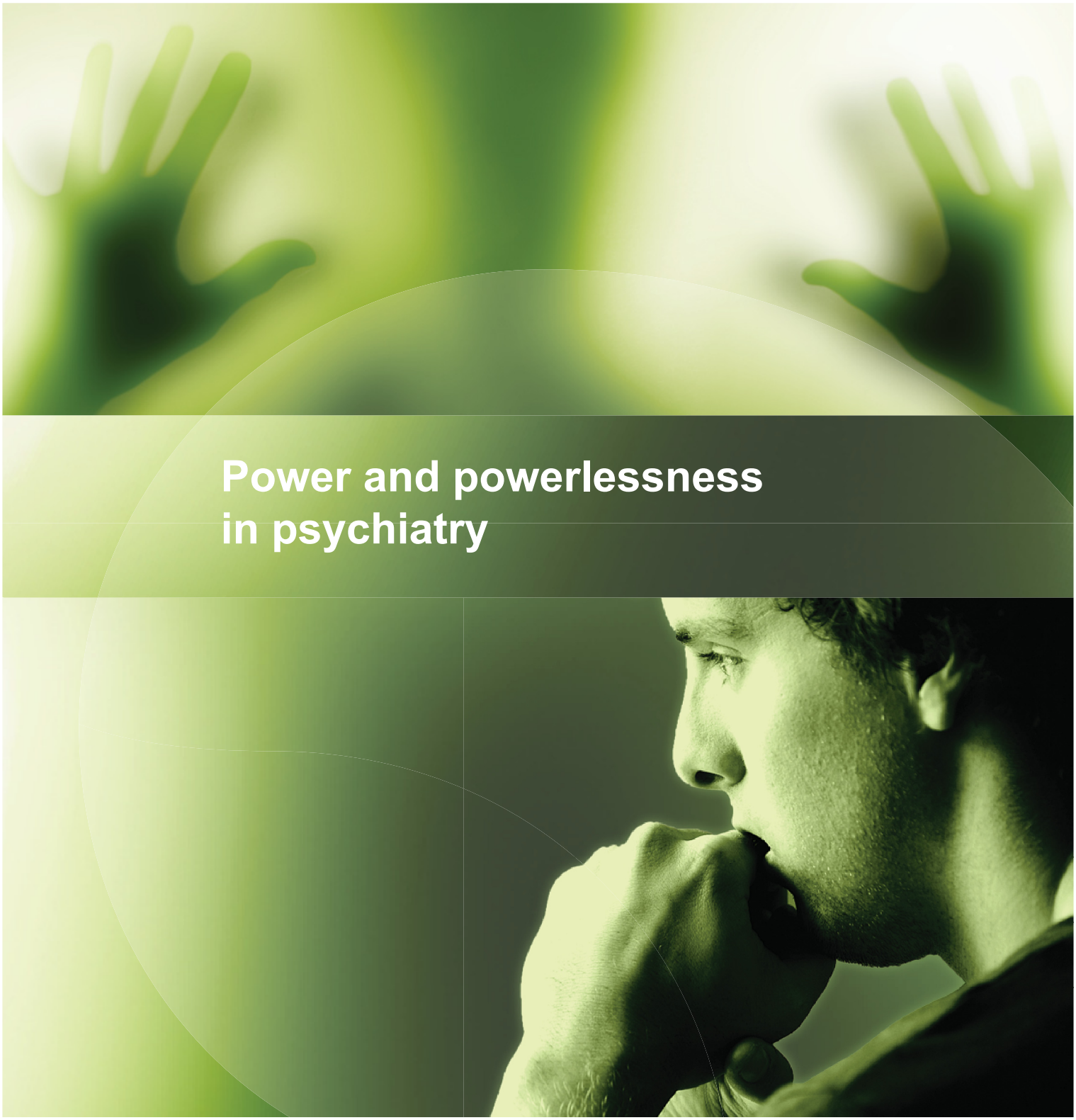
THE DANISH COUNCIL OF ETHICS

# *The Danish Council of Ethics' statement on coercion in psychiatry*



## Power and powerlessness in psychiatry

**Members of the Danish Council of Ethics as at 1 June 2012**

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# *The Danish Council of Ethics' statement on coercion in psychiatry*

Below, the Danish Council of Ethics presents its views on the issues and dilemmas associated with the use of force and coercion on patients with mental illnesses. The use of coercion cannot be viewed as an isolated phenomenon, but is closely intertwined with other aspects of psychiatry such as the culture on the wards, involvement of relatives, and the link between therapeutic psychiatry and social psychiatry. For that reason this statement deals with matters other than the use of coercion. In the course of the working process the Council also considered it relevant to take a separate position on the questions of duty of confidentiality and involvement of relatives.

The Council's views have been divided into five blocks. Some general statements of views have been declared under each block. Two of the blocks further contain more concrete and directive recommendations. The Council feels the strong need to point out that the views should largely be seen as a stimulus for debate. In the Council's opinion, given the complexity and richness of perspectives characteristic of the field, any statements on such matters should be subject to a degree of cautiousness.

The Council's key points of view can be summarized as follows:

- The use of coercion always represents a violation. The focus must therefore be on preventing coercion. In the Council's view, there is still great potential for preventing coercion.
- Fostering a culture in which the patient is encountered and treated as a person of equal value is a collaborative and managerial task.
- Relatives must be regarded as a resource along the therapeutic pathway. Staff must make a special effort to involve relatives.
- Regard for relatives is an independent ethical consideration. The Council does not think there should be any difference between the rules governing confidentiality in the psychiatric and somatic fields. According to the legislation, deciding when confidentiality can be overridden for the sake of the patient or for other reasons is always a matter of judgement. The Council acknowledges that in many cases a patient's relatives can have a great need to be informed about admission or institutionalization. Following on from this, the Council finds that consideration should be given to preparing the way for flexible administration of the rules regarding confidentiality in connection with acute hospitalization.
- In order to ensure satisfactory transitions between the various parts of the psychiatric system, special efforts must be made to coordinate based on a collaborative and interdisciplinary approach.
- Capacity in the psychiatric system as a whole should be so great as to rule out any question of discharging a patient unless this is considered safe from a holistic eva-

luation of the patient's situation. This assessment must also take into account the patient's social circumstances.

- For a great many years now the psychiatric field has been downgraded by comparison with the somatic field and therefore calls for special attention.
- Targeted work is necessary in order to continue developing a respectful dialogue in the psychiatric system and between employees, relatives and individuals with mental disorders. The aim must be to develop common goals for and a collective understanding of the treatment.
- It is important to research the possibilities for preventing the use of coercion in psychiatry.

# 1. Use of coercion in psychiatry

The Danish Council of Ethics recognizes that the use of coercion in psychiatry can be justified, but at the same time the Council would stress that coercion is invariably a violation as well. That applies irrespective of the reason for using force. Wherever possible, therefore, the use of coercion must be avoided. It must be constantly maintained that the use of coercion is an exception which must not be allowed to become a routine solution to the problems. It must therefore be attempted to avoid creating a culture in which such coercion becomes more or less self-justifying due to its association with responsibility. That applies in connection with covert coercion too, where a patient is pressured verbally to do something against his or her will, e.g. by means of manipulation or threats. This form of coercion also constitutes a violation, because the patient's ability to make decisions is invalidated due to the lack of transparency inherent in the exertion of covert coercion.

The need to employ coercion in some cases is due to patients being unable to protect their own interests owing to their illness. In that case, others must take over—e.g. by ensuring that patients receive the necessary treatment or refrain from harming themselves physically. In other instances coercion can be a necessary means of preventing patients from harming others as a result of their illness—be it other patients or the staff.[1]

According to the Danish National Board of Health's statement *Anvendelse af tvang i psykiatrien 2010* [Use of coercion in psychiatry, 2010], the overall use of coercion on psychiatric wards in Denmark has remained unchanged for a considerable number of years. Each year since 2000 every fifth patient or so has been affected by one or more coercive measures. During this period there have been minor shifts in terms of the types of coercive measures primarily resorted to. For example, the number of people submitted to compulsory admission and detained by force is higher in 2010 than in any of the previous years from 2002 inclusive, whereas conversely, the number of belt fixations is lower in 2010 than in previous years. But it is difficult to say with any degree of certainty whether such coercive measures have become more or less radical during the period, since the different forms of coercion used have different consequences and can be experienced differently by those concerned.

However, although the overall use of coercion has been relatively constant on psychiatric wards for a great many years, there is no certainty that the use of coercion is at an appropriate level. The Council of Ethics has reason to assume that the use of coercion can be reduced without compromising the quality of treatment and care.[2] In the Council of

[1] For a discussion of the justifications for using coercion, see the text *Psykiatri og tvang i en etisk kontekst* [Psychiatry and coercion in an ethical context] (in Danish only) on the Council's website www.etiskraad.dk under the heading *Magt og afmagt i psykiatrien* [Power and powerlessness in psychiatry].

[2] For a review article, see Jesper Bak et al. 2011. Mechanical Restraint - Which Interventions Prevent Episodes of Mechanical Restraint? - *A Systematic Review; Perspectives in Psychiatric Care.* See also: Anna Bjorkdah. 2010. *Violence prevention and management in acute psychiatric care: aspects of nursing practice.* Karolinska Institutet: Doctoral thesis,

Ethics' view, the scope for preventing coercion in psychiatry has not been exhausted by any means. However, an effective preventive effort does call for a broad-based campaign of action, involving a number of problem issues at widely divergent levels, like:

- the tangible encounter between staff and patient,
- involvement of and collaboration with relatives,
- prioritization of the psychiatric field, and
- cooperation between the different sectors in psychiatry.

If these efforts are to be coordinated, in the Council's opinion it will require an overall, long-term plan to be drawn up for psychiatry in Denmark.

# 2. Meeting the patient and the culture on the wards

One of the most obvious places to initiate preventive efforts is with the culture in psychiatry. By this the Council above all means to focus on the way the patient is met and the social conventions that characterize the environment on the ward. Many of the players in psychiatry that the Council of Ethics has had as collaboration partners have voiced the view that the use of coercion is sometimes connected with the culture that has developed on individual wards. According to the players mentioned, changing the culture on these wards for the better will have a positive spill-over effect on the use of coercion and the quality of care in general.

The assumption that a change in culture can lead to reduced use of coercion is confirmed by *the National Breakthrough Project on Coercion in Psychiatry*, conducted from 24 August 2004 to 30 June 2005 on a total of 27 psychiatric bed wards.[3] The aim of the project was to try to reduce the use of coercion. At the end of the project period one of the conclusions was that the "improvements made indicate that, as a result of the Breakthrough Project, the units taking part have seen the beginnings of a change in culture, including a greater focus on dialogue and involvement of patients".[4] Against this background it is important to note that the Breakthrough Project's declared aim of reducing the use of coercion was actually achieved. In regard to the total number of coercive episodes, 33% of the bed wards thus achieved a drop of at least 20%, while 8% achieved a drop of at least 50%.[5] In the Council of Ethics' view, following on from this, it is particularly imperative to take a stance on ways of improving the culture on the individual wards.

In the Council of Ethics' opinion, the therapeutic culture that develops on the individual psychiatric wards is largely determined by the staff's attitude towards the patients and their illnesses. This attitude reflects, more or less directly, the view of humanity that characterizes the staff's dealings with patients. Certainly, there are a number of different views of humanity at play in the psychiatric setting. A feature of some of these is that they differ from more common ways of perceiving one another. It may be, for instance, that the patient is regarded as a physiological mechanism, whose functions must in as far as possible be restored with the aid of medication. This view is best known as the "broken machine model". The patient can also be regarded as someone who, to put it popularly, "is" their illness, in the sense that nearly all the patient's reactions are perceived as an expression of the mental illness from which they are suffering. Or the patient can be per-

[3] For a more detailed description of the project, see the text *Kulturen i psykiatrien* [The culture in psychiatry] on the Council's homepage www.etiskraad.dk under the heading of *Magt og afmagt i psykiatrien* [Power and powerlessness in psychiatry].

[4] See *Det nationale gennembrudsprojekt om tvang i psykiatrien – Evaluering af projektet* [The National Breakthrough Project on Coercion in *Psychiatry – Project evaluation*], January 2006, p. 8.

[5] Cf. p. 62 of *The National Breakthrough Project on Coercion in Psychiatry – Project evaluation*, January 2006.

ceived as someone whose behaviour is socially deviant as a result of the influences they themselves have been subject to earlier in their lives.

In the Council of Ethics' view it is particularly important to place great emphasis not only on recognizing the person through the illness, but on regarding the patient as an equal in order to establish an empathetic and respectful relationship with him or her on that basis. It is also necessary for the staff in both therapeutic and social psychiatry to be present and accessible to patients.

According to a number of scientific studies, a therapeutic culture based on a view of the patient as an equal lends itself particularly well to reducing the use of coercion. As one of many examples of studies on the relation between attitudes towards the patient and the use of coercion, one of the conclusions from a Swedish study will be quoted:

"For the patient the worst seems to be the inner violation that is the violation directed towards the patient as a human being. This violation can be hard to handle and can trigger a (new) violent encounter. The feelings that the violation gives rise to can sometimes occupy most of the patient's world."[6]

The Council of Ethics realizes that it is not feasible to give a brief and uncontroversial description of what it means to perceive another person as an equal. In this context, therefore, the Council will confine itself to highlighting a few aspects which, in its opinion, are necessary constituents of such a view.[7]

Firstly, a prerequisite for treating another person as an equal is that the other person's understanding of themselves and their existence is basically taken seriously. Every effort must therefore be made to look at reality from the other person's perspective and to try to acknowledge and take seriously the fact that the other person has that perception of themselves as well as the values, aspirations and experiences the person may happen to have. In addition—and especially in a psychiatric context—it is important to relate to the despair and possible change in perspective on future existence which may be brought about by the emergence of the illness. Although it is essential to take the other person's understanding of their own existence as a starting point, it is legitimate to question the person's experiences or self-understanding. Nonetheless, such questions must be posed in a respectful and empathetic manner, acknowledging that the other person's position is different from one's own, and that the other person can seldom be coerced or pressured into changing their perception of themselves and their situation.

Secondly, it is essential to involve the other person in the decisions that concern them and to transfer as many of the decisions as possible to that person. In this connection it is positive that, under Danish legislation, follow-up interviews must be conducted after a coercive intervention such as immobilization has taken place. With regard to patients on whom it has repeatedly been necessary to use coercion, there should always be discussion as to whether they have any wishes or suggestions about how to tackle similar

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[6] G. Carlsen et al. (2006): "Patients longing for authentic personal care: A phenomenological study of violent encounters in psychiatric settings"; *Issues in Mental Health Nursing*, 27: pp. 287-305, p. 295.

[7] For an in-depth description of the view of humanity involved, see the text *Kulturen i psykiatrien* [The culture in psychiatry] on the Council's website www.etiskraad.dk under the heading *Magt og afmagt i psykiatrien* [Power and powerlessness in psychiatry].

situations in future, should they arise—and how they think the use of coercion could be avoided in a similar situation.

Thirdly, and finally, it is essential to respect other people's so-called "inviolable zones" or privacy. Such zones are areas which it is particularly essential to protect, because they underpin the other person's identity and integrity. The key inviolability zone is perhaps the body. Healthcare professionals must be cautious about taking access to mind and body as a fundamental given in the context of professional healthcare or treatment. Consent must normally first be given for access to be gained. Another important inviolability zone is a person's home or place of habitual residence, usurping or invading which without permission can also constitute an essential violation.[8] Time can also be mentioned as a kind of inviolability zone. It is essential for psychiatric patients to be able to manage their time themselves to some extent, not least in particular contexts such as during "leisure time".

## RECOMMENDATIONS

The Council of Ethics views the development of an appropriate culture that expresses a view of humanity based on respect as a collaborative task and a managerial responsibility. Part of developing this culture should include making room for staff to express their views on the prevailing conditions and, where necessary, take a position on one another's way of addressing patients. On a number of occasions the Council of Ethics has been made aware that the atmosphere on some wards is evidently unconducive to staff adopting a position or commenting on established practice.

The Council of Ethics considers it desirable—at some appropriate time, e.g. in conjunction with a revision of the legislation—to have the Danish Psychiatry Act expressly state that treatment and care must be given with respect for the equal value of all individuals and the dignity of the individual. In its present formulation the Psychiatry Act places the emphasis on preventing coercion and, where the exercise of coercion cannot be avoided, exercising it in such a way as not to cause undue violation or inconvenience. The Council deems it important, however, that the legislation should also declare explicitly that it is crucial to the quality of both treatment and care as well as the possibility of preventing coercion that staff generally encounter the patient as an equal person and display empathy and respect.

The Council of Ethics recommends that the aspiration should be to raise both the level of education and the level of social refinement in psychiatry by creating better possibilities for training and supplementary training as well as reflection. Among other things, training courses should be instrumental in honing the staff's eye for the ethical and value-based problems they will be confronted with. In many cases the ethical problems and dilemmas cannot be satisfactorily managed with the help of set procedures or standards. The staff is often required to have an eye for the particular circumstances and opportunities linked with the individual situation and the dialogue with the specific patient or patients involved in the situation. Therefore it is necessary to support cultured staff etiquette, by which is meant a cultivated aptitude for outward attentiveness, empathy and ethical judgement, rooted in a view of people based on respect and humanity. It must be recognized that working in psychiatry can make immense demands on the individual's aptitude for empathy and intuitive appreciation of a situation. It seems reasonable, therefore, to create

[8] See e.g. Martinsen, K. (2005): At bo på sygehus og at erfare arkitektur, in: Larsen, K. (ed.) *Arkitektur, krop og læring*. Publ. Hans Reitzels Forlag, Copenhagen.

space and, above all, time to allow the individual to have a chance to develop the skills vital to the exercise of this demanding assignment.

The Council of Ethics recommends that management create space for critical reflection and for evaluation processes that hone management's and staff's eye for the appropriate and less appropriate practices and routines employed. This can provide scope for considerateness and help support some of the routines while trying to change others. The scheme can take the form of critical reflection and self-evaluation, talking through situations, amongst others, which have been hard to handle. But since one's own ingrained routines can be hard to spot, it is only appropriate that both the users and people outside the ward or department regularly be included in that critical reflection and evaluation. The latter can be e.g. staff from other wards or institutions. One possibility might also be to take on board former patients in evaluation and supplementary training, as they would be able to pass on their experiences of how the culture and individual routines work, as seen from the patient's perspective. Some of these former patients might possibly be people who have gone on to acquire health-professional training and have themselves worked in psychiatry.

# 3. Involving and cooperating with relatives

In the Council of Ethics' view, involving relatives in psychiatry can pose a dilemma. On the one hand relatives are entitled to be considered—and their involvement often benefits the patient too. On the other hand it should be the patient's decision whether or not to involve relatives—and it cannot be taken for granted that involving relatives is to the patient's advantage. There is no unambivalently correct and uniform way of handling this dilemma. It is up to the staff to decide how to tackle the challenges in the individual situation, and this calls for empathy, discretion and judgment.

In the Council of Ethics' view, large parts of psychiatry have periodically had a problematic relationship in terms of handling the involvement of the patient's relatives in the treatment process. There are a number of reasons for this presumably. One of them may be lack of resources, as it can be very time-consuming to get involved with relatives, who are often in a crisis themselves owing to the patient's illness progression.

Another reason is that relatives used to be regarded as part of the problem rather than part of the solution, as some psychiatric disorders—e.g. schizophrenia—were perceived as a consequence of dysfunctional family relations by some psychiatrists. At any rate, there is a very strained relationship between the patient and the relatives in some cases when the patient comes into contact with the psychiatric system for the first time. This may be due to the relatives having been involved in a wearing process prior to their contact with the psychiatric system. It can be difficult for the staff to navigate the conflicted waters between patient and relatives, since the patient may not even want relatives to be involved. It is important to be aware that relatives—like patients—are different, have different resources and have also been involved in the preceding events in different ways.

Finally, many healthcare professionals express the view that their professional secrecy has made involvement of relatives difficult, because expressing their views about the patient is not allowed without first having obtained consent from the patient him/herself.

There is much to indicate that attitudes to involving relatives are changing within the psychiatric system and the healthcare workers have increasingly begun to see relatives as a resource that can beneficially be used in connection with the treatment pathway. This shift in attitudes towards the relatives presumably has to do with many scientific studies indicating that in most cases involving the relatives benefits the patient.[9] It would appear that this can reduce the probability of relapse and readmission as well as contribute to a greater degree of patient compliance with a fixed treatment plan than otherwise.[10] However, it must be mentioned that the effect of involving relatives has by no means been sufficiently studied in connection with all disease groups.

The Council of Ethics has considered whether the rules on confidentiality pose a disincentive to involving relatives. The rules on healthcare professionals' confidentiality in

[9] This has been particularly well documented in connection with schizophrenic patients, see e.g. Pharoah F. et al. (2010): *Family intervention for schizophrenia* (Review),The Cochrane Collaboration.

[10] Ibid.

relation to relatives are set out in the Danish Health Act and the Guideline on health professionals' confidentiality, under dialogue and cooperation with patients' relatives. Under this legislation, patients over the age of 18 basically have to grant their consent for information to be disclosed to relatives, whereas parents are normally entitled to receive information about a patient under this age. Even if a patient is of age, however, disclosing information to the relatives without the patient's consent is permitted if there are weighty grounds for doing so. That also applies in connection with admission and discharge. The following quotation from the Guideline on healthcare professionals' confidentiality shows that the point at which information about the patient can be passed on to the relatives without consent is always discretionary: "The rules on confidentiality are not simple. Interpreting the rules often calls for a concrete judgement to be made, which can entail a difficult balancing of confidentiality versus the relatives' desire to be able, through information and dialogue, to help the patient through the process".[11]

The Guideline on healthcare professionals' confidentiality further states that as a natural part of the routines adopted for admission, treatment, discharge etc., attempts must be made to obtain the patient's consent to disclose information . Further, consent should be obtained in dialogue with the patient on the basis of providing the patient with adequate information in terms of his or her particular situation. Among other things, that dialogue should include reflections on the potential significance, in practical as well as psychological terms, of whether the relatives are informed or not informed,.

The Council has noted that, according to the above Guideline on healthcare professionals' confidentiality, healthcare professionals can without infringing their confidentiality inform relatives,  about general aspects of an illness and the treatment options available—and about the relatives' possibilities for providing and obtaining support in general. They can also enter into a dialogue with relatives about their perception of the situation and the problems the relatives are experiencing.

In the Council of Ethics' view, regard for relatives must be considered an independent ethical regard, to which the healthcare staff and other healthcare players should assign importance and weight in its own right. Regard for the relatives, then, derives not solely from regard for the patient with a mental disorder and relatives should not only be involved to the extent that it benefits the patient. On the other hand it needs to be acknowledged that there is a genuine conflict of interests in some cases between the patient with a mental disorder and the relatives. As a rule, therefore, a patient with a mental disorder—in the same way as all other patients—must determine who is to be given information about him or her.

## RECOMMENDATIONS

Owing to the rules of professional secrecy it can be difficult for a person to gain information of whether his or her relative has been admitted to a psychiatric ward. Understandably, that is very frustrating and painful. The Council, however, thinks that setting down rules which applies only to the psychiatric field should generally be done with some caution, as it can lead to additional stigmatization of patients with mental illnesses. Under the legislation the point at which confidentiality can be overridden for the sake of the patient or for other reasons is always a discretionary matter. The Council recognizes that in many cases a patient's relatives may have a great need to be informed about the admission. That

[11] Quotation from point 2 of the Guideline, Background.

applies in both the psychiatric and the somatic field. Following on from this, the Council finds that consideration should be given to paving the way for flexible administration of the rules regarding confidentiality in connection with acute admission. Note that such practice is already well known within the somatic field.

- The Council recommends ensuring that:the psychiatric staff is completely familiar with the Guideline on healthcare professionals' confidentiality,
- the Guideline is possibly expanded to include a series of examples, illustrating cases in which confidentiality can be overridden,
- healthcare professionals are knowledgeable as to whether they can receive information from relatives without overriding their duty of confidentiality.

The Council of Ethics recommends that staff generally make a major effort to involve relatives in the treatment pathway. That is normally in both parties' interest, but there may be exceptions, of course, in which case the patient's interests come first. In most instances the staff should attempt to motivate the patient to grant consent for the relatives to be involved. If, when calm, collected and legally competent, the patient expresses the view that he or she does not wish relatives to be involved or informed, that must be respected by the staff. During quiet periods, they should discuss with the patient whether, in future and in the event of any readmissions, he or she wishes for the relatives to be informed and involved, or would rather be spared this. The patient's wishes, views and reasons must be respected.

If consent is granted, the staff should then contact the relatives as early on in the process as possible with a view to involving them. At this early stage it is important that the staff also have an eye for the relatives' need of counselling and support, paying special attention to those needs. The Council of Ethics would stress that the existing focus on self-determination and autonomy should not lead to staff in psychiatry disassociating themselves from patients and relatives. In many cases the healthcare personnel will be fully justified in expressing their views as to how the situation should be managed, in their opinion, and in making reasonable demands concerning the participation of those involved. However, the Council does realize that this is a difficult balancing act because, conversely, it is important that the staff does not attempt to manipulate or impose their own views. For the Council, the fact that the staff is inevitably faced with this type of deliberation is a good example of the need to give staff the chance to develop their aptitudes for ethical and value-related attentiveness and judgment.

The Council of Ethics recommends making development of training and involvement programmes mandatory as a service for relatives. It is not always sufficient to lay down standards and set procedures for involving relatives, for instance, as each individual situation can present its own very special challenges. These involvement programmes must be constructed in such a way, and be of sufficient duration, to satisfy the minimum requirements that need to be met according to the scientific literature and to be able to contribute to the patient's improvement and prevent relapse and readmission. The Council of Ethics is aware that the minimum requirements will presumably differ from one disease group to another. Furthermore, there is no definite evidence of the benefit of involving relatives in connection with all disease groups. If the lack of evidence is due to a lack of scientific studies, the Council recommends that relatives be involved on a trial basis.

# 4. Capacity and quality in psychiatry

During the Council of Ethics' working process, various parties in psychiatry have repeatedly led our attention toward inappropriate discharges, which typically take place just prior to a weekend or in the run-up to a holiday period. The discharged patients have a mental illness, and, on the basis of a purely medical assessment, dismissing them is not appropriate. They are being sent home because it is necessary to make room for even sicker patients with an immediate need for admission. Their discharge, then, is a consequence of inadequate capacity at the psychiatric hospitals. Some patients anticipate these discharges with great nervousness because they do not wish to be sent home and do not feel ready for it. A number of the players in the psychiatric system with whom the Council of Ethics has been in touch take the view that discharging patients too early is largely to blame for many patients being readmitted after a relatively short period—and sometimes having to be readmitted forcefully.

The Council of Ethics' view is that capacity in the psychiatric system as a whole should be so great as not to entertain the idea of discharging patients unless deemed safe to do so by the responsible doctor in collaboration with the other team of therapists in consideration of the patient's overall situation, including e.g. social aspects. Following on from this, the Council finds that there should be further investigation into the actual scope of the problem of inappropriate discharges due to capacity problems. If possible, one of the things to be evaluated is whether premature discharge leads to increased readmission, with prolongation of the illness pathway as a result.

It is the Council of Ethics' assessment that for a great many years psychiatry has been underprioritized in relation to the rest of the health sector. Health expenditure on treating physical disease rose by 25% in the first decade of this century, while it rose by 8% in psychiatry.[12] One possible interpretation of this is that there is no commensurate prioritization between somatics and psychiatry. In addition, the temporary rate adjustment pool funding granted by Danish parliament makes up an ever increasing proportion of the total expenditure on regional therapeutic psychiatry. In 2003, for example, it was 2.6%, whereas in 2010 it was 9.3%.[13]

[12] See e.g. Anne Lindhardt (2011): *Etik og værdier i psykiatrien*, Psykiatrifondens Forlag, p. 150.

[13] See *Fra satspulje til psykiatri: Bevillinger, udgifter og aktivitet* (http://krevi.dk/publikationer/rapporter/fra-satspulje-til-psykiatri-bevillinger-udgifter-og-aktivitet)

# 5. The collaboration between the different sectors in psychiatry

The problem of discharging patients prematurely highlights the need, in the view of the Council of Ethics, for therapeutic psychiatry—consisting of district and hospital psychiatry—and social psychiatry to be seen as directly interconnected. Whether discharging a patient from a psychiatric hospital is warranted thus depends on what the patient is being discharged to. If social and district psychiatry have ample capacity and function properly, other things being equal, discharging a patient is less problematic than if these parts of psychiatry have inferior capacity and function poorly, e.g. in in regard to their outreaching work. In other words, the capacity and quality of the overall psychiatric system are the relevant factors. How to prioritize between the various sectors of psychiatry is no simple matter.

In a number of contexts, including meetings and workshops, the Council of Ethics has been made aware that the problem of patients being discharged from psychiatric hospitals prematurely is exacerbated by the fact that collaboration between the hospitals and the other part of psychiatry does not function satisfactorily in a good many cases. That may be due, for example, to the transition from the hospital to district psychiatry having been inadequately planned and coordinated, or to the patient's social circumstances not having been clarified prior to the patient being discharged. In some cases this results in the patient not receiving the support he or she needs outside of the hospital, which can be a contributory cause in the patient subsequently being readmitted.

It is possible that some of these coordination problems are due to the provision of therapeutic psychiatry (district and hospital psychiatry) being in the hands of the regions, whereas social psychiatry is provided by the municipal authorities. If that is the case, however, it merely serves to accentuate the need for all-embracing solutions to the problems of psychiatry, with the various parts of psychiatry working together as a whole. In the Council of Ethics' view it should be a matter of course that the transitions between the different parts of psychiatry are sufficiently well planned and coordinated. The various parts of psychiatry should be considered interconnected, as mentioned. The Council therefore feels a special effort must be made to ensure that the transitions between the different parts of psychiatry are functioning satisfactorily.

The field of psychiatry is generally characterized by the parties involved often having very different perspectives on a particular situation. What, from the patient's viewpoint for example, may seem like an unjustified assault may, from the staff's angle, take the form of medically and professionally well-founded treatment, whereas on the relatives' part it can be perceived as reflecting a lack of empathy, possibly even combined with lack of resources in the psychiatric system.

To a certain extent this difference in perspectives exists even between the professionals in psychiatry; between individual specialist groups as well as between individual sectors. Presumably, it will often be the case that none of the parties in the specific instance can

be said to “be right”. Nonetheless, it can be valuable if those involved present their perspectives to one another, so that this can contribute to greater mutual understanding and hence better cooperation. At a more general level the difference in perspectives paves the way for expanding interdisciplinary collaboration with a view to making possible the greatest possible appreciation of the other players’ perspectives.

# *In conclusion*

In June 2012 the Danish Council of Ethics published a lengthy text entitled Magt og afmagt i psykiatrien [Power and powerlessness in psychiatry]. Among other things the publication contains further references to scientific studies documenting the assumptions about actual conditions on which the Council bases its views and recommendations set out above. In addition, the arguments and views incorporated in the present text are elaborated on.

During its work on psychiatry the Council of Ethics has consulted widely with the various players operating in the field. The Council's collaboration with the consultancy firm Dacapo A/S has been altogether central to the Council's endeavour to gain a subtly nuanced picture of the psychiatric field. During 2011 and 2012 the Council conducted a series of meetings, two workshops and a debate day with the participation of a wide range of players from psychiatry. Using methods from the world of theatre, Dacapo has developed a debating platform that has proved well suited to identifying the many challenges of psychiatry by taking on board the multiple "voices" in the field. In the process described, based on input from the many players, a series of scenarios has been devised, focusing on a number of the issues the Council has chosen to raise in its recommendations.

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